(B) research to determine effective health care interventions to respond to and prevent domestic violence, dating violence, sexual assault, and stalking;

(C) research on the impact of domestic, dating and sexual violence, childhood exposure to such violence, and stalking on the health care system, health care utilization, health care costs, and health status; and

(D) research on the impact of adverse childhood experiences on adult experience with domestic violence, dating violence, sexual assault, stalking, and adult health outcomes, including how to reduce or prevent the impact of adverse childhood experiences through the health care setting.

**(g) Authorization of appropriations**

There is authorized to be appropriated to carry out this section, $10,000,000 for each of fiscal years 2014 through 2018.

**(h) Definitions**

Except as otherwise provided herein, the definitions provided for in section 13925 of this title shall apply to this section.

(July 1, 1944, ch. 373, title III, § 399P, formerly § 399O, as added Pub. L. 109–162, title V, § 504, Jan. 5, 2006, 119 Stat. 3026; renumbered § 399P, Pub. L. 109–450, § 4(1), Dec. 22, 2006, 120 Stat. 3342; amended Pub. L. 113–4, title V, § 501(a), Mar. 7, 2013, 127 Stat. 96.)

REFERENCES IN TEXT

The Family Violence Prevention and Services Act, referred to in subsec. (c)(1)(A), is title III of Pub. L. 98–457, Oct. 9, 1984, 98 Stat. 1757, which is classified generally to chapter 110 (§ 10401 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 10401 of this title and Tables.

AMENDMENTS

2013—Pub. L. 113–4 amended section generally. Prior to amendment, section related to grants to foster public health responses to domestic violence, dating violence, sexual assault, and stalking.

FINDINGS

Pub. L. 109–162, title V, § 501, Jan. 5, 2006, 119 Stat. 3023, provided that: ''Congress makes the following findings:

''(1) The health-related costs of intimate partner violence in the United States exceed $5,800,000,000 annually.

''(2) Thirty-seven percent of all women who sought care in hospital emergency rooms for violence-related injuries were injured by a current or former spouse, boyfriend, or girlfriend.

''(3) In addition to injuries sustained during violent episodes, physical and psychological abuse is linked to a number of adverse physical and mental health effects. Women who have been abused are much more likely to suffer from chronic pain, diabetes, depression, unintended pregnancies, substance abuse and sexually transmitted infections, including HIV/AIDS.

''(4) Health plans spend an average of $1,775 more a year on abused women than on general enrollees.

''(5) Each year about 324,000 pregnant women in the United States are battered by the men in their lives. This battering leads to complications of pregnancy, including low weight gain, anemia, infections, and first and second trimester bleeding.

''(6) Pregnant and recently pregnant women are more likely to be victims of homicide than to die of any other pregnancy-related cause, and evidence exists that a significant proportion of all female homicide victims are killed by their intimate partners.

''(7) Children who witness domestic violence are more likely to exhibit behavioral and physical health problems including depression, anxiety, and violence towards peers. They are also more likely to attempt suicide, abuse drugs and alcohol, run away from home, engage in teenage prostitution, and commit sexual assault crimes.

''(8) Recent research suggests that women experiencing domestic violence significantly increase their safety-promoting behaviors over the short- and long-term when health care providers screen for, identify, and provide followup care and information to address the violence.

''(9) Currently, only about 10 percent of primary care physicians routinely screen for intimate partner abuse during new patient visits and 9 percent routinely screen for intimate partner abuse during periodic checkups.

''(10) Recent clinical studies have proven the effectiveness of a 2-minute screening for early detection of abuse of pregnant women. Additional longitudinal studies have tested a 10-minute intervention that was proven highly effective in increasing the safety of pregnant abused women. Comparable research does not yet exist to support the effectiveness of screening men.

''(11) Seventy to 81 percent of the patients studied reported that they would like their healthcare providers to ask them privately about intimate partner violence.''

PURPOSE

Pub. L. 109–162, title V, § 502, Jan. 5, 2006, 119 Stat. 3024, provided that: ''It is the purpose of this title [enacting this section, sections 294h and 13973 of this title, and provisions set out as a note above] to improve the health care system's response to domestic violence, dating violence, sexual assault, and stalking through the training and education of health care providers, developing comprehensive public health responses to violence against women and children, increasing the number of women properly screened, identified, and treated for lifetime exposure to violence, and expanding research on effective interventions in the health care setting.''

## § 280g–5. Public and health care provider education and support services

**(a) In general**

The Secretary, directly or through the awarding of grants to public or private nonprofit entities, may conduct demonstration projects for the purpose of improving the provision of information on prematurity to health professionals and other health care providers and the public and improving the treatment and outcomes for babies born preterm.

**(b) Activities**

Activities to be carried out under the demonstration project under subsection (a) may include the establishment of—

(1) programs to test and evaluate various strategies to provide information and education to health professionals, other health care providers, and the public concerning—

(A) the core risk factors for preterm labor and delivery;

(B) medically indicated deliveries before full term;

(C) the importance of preconception and prenatal care, including—

(i) smoking cessation;

(ii) weight maintenance and good nutrition, including folic acid;

(iii) the screening for and the treatment of infections; and

(iv) stress management;

(D) treatments and outcomes for premature infants, including late preterm infants;

(E) the informational needs of families during the stay of an infant in a neonatal intensive care unit; and

(F) utilization of evidence-based strategies to prevent birth injuries;

(2) programs to increase the availability, awareness, and use of pregnancy and post-term information services that provide evidence-based, clinical information through counselors, community outreach efforts, electronic or telephonic communication, or other appropriate means regarding causes associated with prematurity, birth defects, or health risks to a post-term infant;

(3) programs to respond to the informational needs of families during the stay of an infant in a neonatal intensive care unit, during the transition of the infant to the home, and in the event of a newborn death; and

(4) such other programs as the Secretary determines appropriate to achieve the purpose specified in subsection (a).

**(c) Authorization of appropriations**

There is authorized to be appropriated to carry out this section $1,900,000 for each of fiscal years 2014 through 2018.

(July 1, 1944, ch. 373, title III, § 399Q, as added Pub. L. 109–450, § 4(2), Dec. 22, 2006, 120 Stat. 3342; amended Pub. L. 113–55, title I, § 103(b), Nov. 27, 2013, 127 Stat. 642.)

AMENDMENTS

2013—Subsec. (b)(1). Pub. L. 113–55, § 103(b)(1)(A), added subpars. (A) to (F) and struck out former subpars. (A) to (F) which read as follows:

''(A) the signs of preterm labor, updated as new research results become available;

''(B) the screening for and the treating of infections;

''(c) counseling on optimal weight and good nutrition, including folic acid;

''(D) smoking cessation education and counseling;

''(E) stress management; and

''(F) appropriate prenatal care;''.

Subsec. (b)(2). Pub. L. 113–55, § 103(b)(1)(B), added par. (2) and struck out former par. (2) which read as follows: ''programs to improve the treatment and outcomes for babies born premature, including the use of evidence-based standards of care by health care professionals for pregnant women at risk of preterm labor or other serious complications and for infants born preterm and at a low birthweight;''.

Subsec. (c). Pub. L. 113–55, § 103(b)(2), substituted ''$1,900,000 for each of fiscal years 2014 through 2018.'' for ''$5,000,000 for each of fiscal years 2007 through 2011.''

### § 280g–6. Chronic kidney disease initiatives

**(a) In general**

The Secretary shall establish pilot projects to—

(1) increase public and medical community awareness (particularly of those who treat patients with diabetes and hypertension) regarding chronic kidney disease, focusing on prevention;

(2) increase screening for chronic kidney disease, focusing on Medicare beneficiaries at risk of chronic kidney disease; and

(3) enhance surveillance systems to better assess the prevalence and incidence of chronic kidney disease.

**(b) Scope and duration**

**(1) Scope**

The Secretary shall select at least 3 States in which to conduct pilot projects under this section.

**(2) Duration**

The pilot projects under this section shall be conducted for a period that is not longer than 5 years and shall begin on January 1, 2009.

**(c) Evaluation and report**

The Comptroller General of the United States shall conduct an evaluation of the pilot projects conducted under this section. Not later than 12 months after the date on which the pilot projects are completed, the Comptroller General shall submit to Congress a report on the evaluation.

**(d) Authorization of appropriations**

There are authorized to be appropriated such sums as may be necessary for the purpose of carrying out this section.

(July 1, 1944, ch. 373, title III, § 399R, as added Pub. L. 110–275, title I, § 152(a), July 15, 2008, 122 Stat. 2551.)

CODIFICATION

Another section 399R of act July 1, 1944, ch. 373, as added by Pub. L. 110–373, § 2, Oct. 8, 2008, 122 Stat. 4047, was renumbered section 399S and is classified to section 280g–7 of this title.

Another section 399R of act July 1, 1944, ch. 373, as added by Pub. L. 110–374, § 3, Oct. 8, 2008, 122 Stat. 4051, was renumbered section 399T and is classified to section 280g–8 of this title.

### § 280g–7. Amyotrophic lateral sclerosis registry

**(a) Establishment**

**(1) In general**

Not later than 1 year after the receipt of the report described in subsection (b)(2)(A), the Secretary, acting through the Director of the Centers for Disease Control and Prevention, may, if scientifically advisable—

(A) develop a system to collect data on amyotrophic lateral sclerosis (referred to in this section as ''ALS'') and other motor neuron disorders that can be confused with ALS, misdiagnosed as ALS, and in some cases progress to ALS, including information with respect to the incidence and prevalence of the disease in the United States; and

(B) establish a national registry for the collection and storage of such data to develop a population-based registry of cases in the United States of ALS and other motor neuron disorders that can be confused with ALS, misdiagnosed as ALS, and in some cases progress to ALS.

**(2) Purpose**

It is the purpose of the registry established under paragraph (1)(B) to—