STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. MERKLEY (for himself and Mr. ALEXANDER):

S. 1402. A bill to amend the Internal Revenue Code of 1986 to increase the amount allowed as a deduction for start-up expenditures; to the Committee on Finance.

Mr. MERKLEY. Mr. President, I rise today to discuss legislation that will make it significantly easier for small businesses to open their doors. Providing a helping hand to small businesses is important at any time, but never more so than now, when so many Americans are out of work.

Small businesses are the engines of our economy. By some estimates, they employ approximately half the private workforce, and, in rural America, comprise nine out of ten businesses. In my home State of Oregon, many of the rural counties have unemployment rates approaching—or even surpassing—20 percent. Clearly, small businesses are going to be instrumental in turning things around.

Furthermore, small businesses are innovators—they produce 13 times more patents per employee than large firms. Right now, the U.S. needs this kind of innovation more than ever.

Our economy cannot thrive if small businesses are not doing well.

Unfortunately, it can be very difficult for small businesses to succeed. Start-up expenses are often prohibitive and it can take a few years before business owners begin to see a profit. There are administrative systems to create, employees to hire, a client base to build and supplies to purchase. This adds up to a lot of expenses. A Gallup poll showed that the average small business incurs $10,000 in expenses during that first year. However, if a business can last 4 years, it is much more likely to survive in the long term. We need to do more to help these businesses get through this difficult period.

Today, I am joining with my colleague from Tennessee, Senator ALEXANDER, to introduce legislation that will help small businesses through their first year. The Small Business Jump Start Act of 2009 lessens the tax burden on new small businesses by doubling the deduction they can take for start-up expenses to $10,000. The Act also widens the pool of businesses eligible to take the full amount of the deduction in their first year of business. The Small Business Jump Start Act gives these new businesses a boost that first year, and for some, will eliminate the tax complications of amortizing start-up expenses. The Small Business Jump Start Act of 2009 is supported by the U.S. Chamber of Commerce, the National Federation of Independent Businesses, the National Association of the Self-Employed, and the National Association of Small Businesses.

I will highlight one Oregon small business that the Jump Start Act could have helped. Jack and Giovanina Giaccarini moved to Grants Pass, Oregon after Hurricane Katrina came through their town in Mississippi. It was their dream to start a business installing systems to help quadriplegics and disabled veterans maneuver around their homes. The first year of their business was tough—finding start-up capital was difficult and purchasing just one system to use for demonstrations cost $10,000. They struggled. Now they are in their third year of business and finally making a profit. Having a Jump Start in that first year would have made a significant difference early on.

This bill will go a long way for new small businesses looking to open their doors and employ people in their communities. Colleagues, in order to help America's small businesses and the economies of rural America, I urge you to support the Small Business Jump Start Act of 2009. It is time to reach out a helping hand to entrepreneurs and assist them in starting that new business now, to jump start our economy and create new jobs across America.

Mr. President, I ask unanimous consent that the text of the bill and letters of support be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 1402

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Small Business Jump Start Act of 2009''.

SEC. 2. INCREASE IN AMOUNT ALLOWED AS DEDUCTION FOR START-UP EXPENDITURES.

(a) IN GENERAL.—Subsection (b) of section 195 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(3) SPECIAL RULE FOR TAXABLE YEARS BEGINNING IN 2009, 2010, OR 2011.—In the case of a taxable year beginning in 2009, 2010, or 2011, paragraph (1)(A)(ii) shall be applied—

''(A) by substituting '$10,000' for '$5,000', and

''(B) by substituting '$60,000' for '$50,000'.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid or incurred in taxable years beginning after the date of the enactment of this Act.

CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA,
Washington, DC, June 26, 2009.

Hon. JEFF MERKLEY,
U.S. Senate,
Washington, DC.

DEAR SENATOR MERKLEY: As a long-standing advocate of tax relief for small businesses, the U.S. Chamber of Commerce applauds your leadership on introducing the ''Small Business Jump Start Act of 2009.'' This bill would increase the small business start-up expense deduction from $5,000 to $10,000 and increase the threshold for the deductions phase-out from $50,000 to $60,000.

A robust small business community is a vital component to America's economic recovery. Allowing small business owners the opportunity to expense additional start-up costs up front would foster more entrepreneurial activity and further encourage the important role of small business as the job producers in our economy.

The U.S. Chamber of Commerce is the world's largest business federation, representing more than three million businesses and organizations of every size, sector, and region. More than 96 percent of the Chamber's members are small businesses and organizations with 100 or fewer employees. On behalf of these small employers, the Chamber strongly supports your efforts to encourage investment and growth in America's 27 million small enterprises and looks forward to working with you to pass this important legislation.

Sincerely,

R. BRUCE JOSTEN,
Executive Vice President, Government Affairs.

NATIONAL ASSOCIATION FOR THE SELF-EMPLOYED,
Washington, DC, July 7, 2009.

Hon. JEFF MERKLEY,
U.S. Senate,
Washington, DC.

DEAR SENATOR MERKLEY: On behalf of the National Association for the Self-Employed (NASE) and our 250,000 member businesses, I am pleased to announce our support for the Small Business Jump Start Act of 2009. We strongly believe that in this uncertain economic time it is more important than ever to assist our nation's budding entrepreneurs.

By increasing the start up business expenses deduction, the Small Business Jump Start Act will greatly assist start up ventures at the most critical time—their first year of business—and give them the financial boost they need to succeed.

The NASE believes that entrepreneurs have been pillars of innovation and job creation, fueling much of what is great about America. Legislation that supports and invests in these enterprises is in the best interests of our economy and our nation. We feel that the Small Business Jump Start Act of 2009 will encourage many individuals who have been considering entrepreneurship, to take the next steps to open their small business and in turn, help create jobs in this tough economy.

If you have any questions or comments, please contact Kristie Arslan, NASE's executive director. We are looking forward to working with you and your staff to gain passage of this legislation.

Thank you for your leadership on this important small business issue.

Sincerely,

ROBERT HUGHES,
President.

NATIONAL FEDERATION OF INDEPENDENT BUSINESS,
Nashville, TN, July 7, 2009.

Hon. JEFF MERKLEY,
Russell Senate Office Building,
Washington, DC.

DEAR SENATOR MERKLEY: On behalf of the National Federation of Independent Business (NFIB), the nation's leading small business advocacy organization, I want to thank you for introducing the Small Business Jump Start Act, a bill to increase the start-up deduction for new small businesses from $5,000 to $10,000.

While a typical business can deduct its ordinary business expenses in the year the expenses are paid, a start-up business is limited as to how much and when it can deduct start-up expenses. Start-up business expenses are the costs associated with formation of a business made prior to the actual opening of the business. Most new small businesses face significant start-up costs, including advertising, obtaining licenses, permits and fees, paying rent, hiring business and financial consultants and providing employee training. Under this bill, expenses

connected with setting up or investing in the creation of a new business are deductible up to $10,000 in the first year of the business.

During a time of economic uncertainty, this legislation provides a significant incentive for entrepreneurs—as well as many people who have recently lost their jobs—to start their own business. By increasing the start-up cost deduction, small business owners will be able to put money back into their business sooner, creating greater opportunities for job creation and investment in local economies.

Thank you again for introducing this bill to help America's small businesses. I look forward to working with you on this issue as the 111th Congress continues.

Sincerely,

SUSAN ECKERLY,
Senior Vice President,
Federal Public Policy.

NATIONAL SMALL
BUSINESS ASSOCIATION,
JULY 7, 2009.

Hon. JEFF MERKLEY,
U.S. Senate, Russell Senate Office Building, Washington, DC.

DEAR SENATOR MERKLEY: On behalf of the National Small Business Association, I would like to thank you for your leadership in crafting the Small Business Jump Start Act of 2009. As the nation's oldest nonpartisan small business advocacy group, NSBA reaches more than 150,000 small businesses nation-wide, and our members have highlighted tax relief as a top priority for the 111th Congress.

Small business is one of the primary catalysts of both job growth and innovation in our national economy. In fact, according to the Small Business Administration since the mid-1990s, small businesses have created 60 to 80 percent of the net new jobs annually.

However, over the past year, small businesses have experienced marked economic challenges. Between skyrocketing gas prices, a weak real estate market and the credit crunch, today's slow economy is having a noticeable effect on our entrepreneurs. This new reality is coupled with the fact that the first year of a small business is often difficult and expensive. New employer establishments face challenges keeping up with growing first year demands—building a client base, hiring employees, creating new products and services, and often opening a facility.

Yet, small businesses that make it past the first four years have a better chance of surviving long-term and this is why your legislation is so crucial. It will boost the federal tax deduction for small business start-up costs and broaden the pool of businesses eligible for the deduction.

Start-up businesses are currently eligible for a $5,000 tax deduction if they spend $50,000 or less to open their doors. The legislation proposed by you would boost the deduction to $10,000 and also expand eligibility to companies that spend up to $60,000 on start-up costs. The deduction would be phased out dollar-for-dollar for expenditures above $60,000. A business that spends $61,000 in start-up costs, for example, could deduct $9,000 under the proposed legislation and take the remaining $1,000 deduction over 15 years, just as in current law.

Small businesses are the lifeblood of all communities, and this bill supports them by providing the financial assistance they need to achieve success. The Small Business Jump Start Act of 2009 will give small businesses the necessary financial boost in their first year which will encourage investments that create jobs and economic growth. NSBA supports this measure, and commends you for working to bring this legislation to the Senate floor.

Sincerely,

TODD MCCRACKEN,
President.

By Mr. INOUYE:

S. 1404. A bill to implement demonstration projects at federally qualified community health centers to promote universal access to family-centered, evidence-based behavioral health interventions that prevent child maltreatment and promote family well-being by addressing parenting practices and skills for families from diverse socioeconomic, cultural, racial, ethnic, and other backgrounds, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mr. INOUYE. Mr. President, today I introduce the Supporting Child Maltreatment Prevention Efforts in Community Health Centers Act of 2009. I am introducing this bill on behalf of the American Psychological Association and the National Association of Community Health Centers. This much-needed legislation would help address a critical problem in our country, the abuse and neglect of millions of children. Today, I am introducing legislation that will help address this preventable tragedy.

Unfortunately, child maltreatment continues to be a serious public health problem in our country that affects millions of children and their families. Child abuse and neglect can take many forms, including neglect of children's medical needs, physical or psychological maltreatment, sexual abuse, and multiple types of maltreatment.

In 2007 alone, an estimated 5.8 million were allegedly victims of maltreatment, 3.2 million referrals were made to Child Protective Services agencies, and 794,000 children were determined to be victims of abuse and neglect. During that same year, 1,760 children died as a result of abuse or neglect, most of them younger than 4-years old.

Nearly 80 percent of the perpetrators of child maltreatment were parents, and approximately seven percent were other relatives. Therefore, child maltreatment is a tragedy that impacts millions of children in their own families. Considering that not all maltreatment is reported to the authorities, the actual numbers are estimated to be higher.

Focusing on prevention will help save billions of dollars that are currently spent annually—due to victimization and injuries—with hospitalization, visits to ER, out-of-home placements, CPS services, investigations, incarceration of abusers, services to address mental health issues, and other related costs.

At the same time, we know that community health centers represent a unique resource for many families who depend on their services to obtain much-needed health and mental health care. Community Health Centers, CHCs, served 16 million individuals in 2007, most of them poor, uninsured, and at-risk for child maltreatment. In fact, one in five low-income children in the U.S. receives health care at a CHC. Furthermore, the centers provide comprehensive primary care services that set up the stage for an integrated care model.

Given this evidence, the American Psychological Association, APA, convened a group of experts to review the best available science to identify and recommend public health strategies to prevent child maltreatment within the context of behavioral health integration at community health centers. For decades, the APA and its members have been at the forefront of child maltreatment prevention efforts in research, development of interventions, and evaluation. The findings of this report provided the seed to develop this critical legislation on behalf of children and families in our country.

Among its provisions, this important legislation supports the implementation of demonstration projects at federally qualified health centers to promote universal access to a family-centered integrated and voluntary services model, evidence-based behavioral health interventions that prevent child maltreatment and promote family well-being by addressing parenting practices and skills for families from diverse socioeconomic, cultural, racial, ethnic, and other backgrounds. The bill would also support program evaluation outcomes, technical assistance, project coordination, and the design and implementation of a cross-site evaluation plan.

I have been committed to the support of psychology contributions to children and families and the vital role of community health centers for decades. This bill will help address the critical need to help and protect our nation's children by giving their parents and caregivers the tools and skills they need to be become the best parents and caregivers they can be and to, ultimately, help prevent child abuse and neglect.

It is my hope that the science-based recommendations utilized in the development of this legislation will serve as a useful resource to inform current health care reform legislative efforts.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 1404

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Supporting Child Maltreatment Prevention Efforts in Community Health Centers Act of 2009''.

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress finds as follows:

(1) Child abuse and neglect are serious public health problems in this country. During

2007, approximately 3,200,000 referrals, involving the alleged maltreatment of approximately 5,800,000 children, were sent to child protective services agencies.

(2) The most recent data show 794,000 substantiated cases of child abuse and neglect in 2007, and child maltreatment-related deaths rose 15.5 percent in 2007. Approximately 1,760 children in the United States, nearly ¾ of whom were under 4 years of age, died as a result of abuse or neglect.

(3) Early childhood experiences may have lifelong effects. Severe and chronic childhood stress, including from maltreatment and exposure to violence, is associated with persistent effects and can lead to enduring health, behavior, and learning problems.

(4) Child maltreatment has—

(A) psychological and behavioral consequences such as depression, anxiety, suicide, aggressive behavior, delinquency, posttraumatic stress disorder, and criminal behavior;

(B) health consequences, including injuries and death, chronic obstructive pulmonary disease, smoking, heart disease, liver disease, and drug use; and

(C) developmental consequences that can compromise brain development and learning.

(5) Child maltreatment has significant financial consequences, including the short-term costs associated with case handling by child protective services and investigations, hospitalization or emergency room visits for medical treatment of injuries, out-of-home placement alternatives, services to address mental health and substance abuse problems, loss of productivity, and poor physical health requiring multiple treatments.

(6) Child maltreatment can be prevented. Given that parents and caregivers are responsible for the majority of the abuse and neglect, caregiver-focused strategies and interventions that address parenting skills and parental risk factors such as depression, substance abuse, and intimate partner violence, as well as strategies and interventions that promote family well-being are critical. Parenting practices are amenable to change, given reasonable efforts, and the building of safe, stable, nurturing parent-child relationships is a scientifically proven strategy for the prevention of child maltreatment.

(7) Prevention of child maltreatment should have a focus on primary prevention (before any maltreatment), emphasizing community-centered and population-based strategies.

(8) Prevention of child maltreatment should focus on promoting healthy parent-child relationships and an environment that provides safe, stable, nurturing relationships for children.

(9) Primary health care is an existing and widely-accessed system in which a range of prevention strategies can be implemented, and there is growing evidence that primary health care settings are promising venues in which to conduct child maltreatment prevention and behavioral health promotion programs.

(10) Community health centers (referred to in this Act as ''CHCs'') serve more than 18,000,000 individuals in the United States annually, including individuals who are poor, uninsured, hard-to-reach, and at-risk for child maltreatment.

(11) One in 5 low-income children in the United States receives health care at a CHC.

(12) CHCs are an existing network of neighborhood health clinics widely and regularly accessed by families in need that can serve as a fitting venue for child maltreatment prevention initiatives.

(13) In the last decade, behavioral issues have had an expanding presence in the portfolio of services of CHCs. Seventy percent of CHCs have some, if minimal, on-site mental health and substance abuse services. When demand exceeds capacity or on-site services do not exist, CHCs refer individuals to off-site options.

(14) The integration of behavioral health services in primary care settings is a promising framework. Evaluation results of integrated care have shown—

(A) improvement in service utilization, such as shorter waiting time and fewer sessions to complete treatment;

(B) reduction in the stigma related to mental health services; and

(C) improvement in access to services.

(b) PURPOSES.—The purposes of this Act are as follows:

(1) To fund the implementation of a minimum of 10 demonstration projects of evidence-based and promising parenting programs at federally qualified health centers.

(2) To provide universal access to a family-centered integrated and voluntary services model that prevents child maltreatment and promotes family well-being and which may include:

(A) implementation of evidence-based preventive parenting skills training programs at health centers or permanent or temporary residences of caregivers to strengthen the capacity of parents to care for their children's health and well-being and promote their own ability to create safe, stable, nurturing family environments that protect children and youth from abuse and neglect and its consequences and support children's optimal social, emotional, physical, and academic development;

(B) screening to identify parental risk factors such as depression, substance abuse, and intimate partner violence that are associated with the likelihood that parents will abuse or neglect their children, and to further develop screening methods and instruments; and

(C) linkage with, and referral to, on-site individualized quality mental health services provided by trained mental health professionals for parents and caregivers screening positive for child maltreatment risk factors to help them overcome the impediments to effective parenting and change their behaviors toward child rearing and parenting.

(3) To coordinate the design and implementation of an evaluation plan to assess the impact and feasibility of integrated services model implementation at each federally qualified health center participating in the demonstration project for health outcomes, cost effectiveness, patient satisfaction, program local adaptation, reduction of child maltreatment and injuries, and improvement of parenting behaviors and family functioning.

(4) To implement critical system factors for successful implementation of the integrated services model to prevent child maltreatment. Such factors include training of a culturally- and linguistically-competent workforce, use of best available technology, establishment of cooperation among FQHCs participating in the demonstration project, and building internal and external buy-in and support for the project.

(5) To coordinate the design and implementation of the cross-site system-wide evaluation plan to assess the impact and feasibility of an integrated services model on the reduction of child maltreatment and injuries, to increase a family's access to services, to evaluate the effectiveness of the response of FQHCs organizational systems to the model implemented, and to identify lessons learned and outline recommendations for system-wide areas for improvement and changes.

SEC. 3. DEFINITIONS.

In this Act:

(1) FEDERALLY QUALIFIED HEALTH CENTER OR FQHC.—The term ''federally qualified health center'' or ''FQHC'' means an entity receiving a grant under section 330 of the Public Health Service Act (42 U.S.C. 254b).

(2) CAREGIVERS.—The term ''caregiver'' means an adult who is the primary caregiver, including biological, adoptive, or foster parents, grandparents or other relatives, and non-custodial parents who have an ongoing relationship, and provides physical care for, 1 or more children under the age of 10. Caregivers may be individuals who were born in, or outside of, the United States and individuals whose main language is not English, including American Indians and Alaska Natives. Caregivers may be heterosexual or homosexual, and may have learning, physical, and other disabilities.

(3) CENTER-BASED EVIDENCE-BASED PREVENTIVE PARENTING SKILLS PROGRAM.—The term ''center-based evidence-based preventative parenting skills program'' means research-based and proven, promising interventions provided and located at a health center that—

(A) have the potential for broad impact across multiple types of maltreatment, including physical and psychological abuse and neglect;

(B) are associated with effective parent behaviors and parenting practices and with reducing child behavior problems;

(C) may be expected to reduce child maltreatment rates; and

(D) may be implemented at the FQHCs.

(4) HOME VISITATION PROGRAM.—The term ''home visitation program'' means an evidence-based program in which trained professionals visit a caregiver in the permanent or temporary residence of the caregiver, and provide a combination of information, support, or training regarding child development, parenting skills, and health-related issues.

(5) MENTAL HEALTH SERVICES.—The term ''mental health services'' means psychotherapeutic interventions offered at health centers, or off-site locations in partnership with health centers, by mental health professionals to caregivers that screen for or are referred for child maltreatment.

(6) SCREENING.—The term ''screening'' means a form of triage, using valid, culturally-sensitive tools such as scales or questionnaires applied universally by trained professionals to identify caregivers who are at-risk for maltreating or neglecting children. Screening assesses parental risks for child maltreatment such as depression, substance abuse, and intimate partner violence.

SEC. 4. GRANTS FOR DEMONSTRATION PROJECTS ON INTEGRATED FAMILY-CENTERED PREVENTIVE SERVICES.

(a) DEMONSTRATION PROJECT GRANTS.—The Secretary of Health and Human Services, acting through the Director of the National Center for Injury Prevention and Control of the Centers for Disease Control and Prevention, shall award competitive grants to eligible federally qualified health centers to fund a minimum of 10 demonstration projects to promote—

(1) universal access to family-centered, evidence-based interventions in the FQHCs that prevent child maltreatment by addressing parenting practices and skills; and

(2) behavioral health and family well-being for families from diverse socioeconomic, cultural, racial, and ethnic backgrounds, including addressing issues related to sexual orientation and individuals with disabilities.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

(1) be a federally qualified community health center; and

(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) USE OF GRANT FUNDS.—A federally qualified health center receiving a grant under subsection (a) may use such funds to—

(1) conduct a needs assessment for the demonstration project, including the need for proposed integrated services, the number of caregivers involved, an organizational assessment, workforce capacity and needs, and technological needs;

(2) use available technologies to collect, organize, and provide access to health and mental health information of patients, and to provide referrals, train staff, monitor service delivery and outcomes, and create networking opportunities for on-site providers and others in the community;

(3) adapt and implement evidence-based parenting skills training programs for caregivers from all backgrounds who use the health center for health care and child well-visits, through on-site programs or programs operated at permanent or temporary residences and administered, supervised, and monitored by trained professionals employed by the FQHC;

(4) adapt instruments and screen caregivers for child maltreatment risk factors such as depression, substance abuse, and intimate partner violence, provided that such screening is conducted by trained professionals employed by the FQHC;

(5) provide access to mental health services to caregivers screened positive for child maltreatment risk factors, which may include services offered at the health centers or at off-site locations in partnership with the health centers, and which shall be conducted by mental health professionals;

(6) promote models of integrated care that involve behavioral health specialists and primary care providers working collaboratively in integrated teams to deliver services that prevent child maltreatment and promote family well-being;

(7) develop public education campaigns to increase community awareness of the integrated services offered by the health centers; and

(8) evaluate patient satisfaction, project cost effectiveness, results of the integrated services model, and effectiveness of evidence-based parenting programs in improving parenting practices and reducing child abuse and neglect.

(d) DURATION OF GRANT.—A grant under subsection (a) shall be awarded for a period not to exceed 5 years.

(e) TECHNICAL ASSISTANCE AND PROJECT COORDINATION.—

(1) IN GENERAL.—The Secretary shall award a contract to 1 or more eligible entities to provide—

(A) technical assistance and project coordination for the recipients of grants under subsection (a);

(B) training for health care professionals, including mental health care professionals, at FQHCs that receive grants under subsection (a); and

(C) cross-site evaluation of the demonstration projects under subsection (a).

(2) ELIGIBLE ENTITIES.—To be eligible to receive a contract under this section, an entity shall—

(A) be—

(i) an institution of higher education (as defined in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001));

(ii) a nonprofit organization that qualifies for tax exempt status under section 501(c)(3) of the Internal Revenue Code of 1986; or

(iii) such national and professional organizations and community-based organizations as the Secretary determines appropriate;

(B) have expertise in parent-child relationships, parenting programs, prevention of child maltreatment, the integration of behavioral health in primary and community health center settings, and coordinating multi-sites projects;

(C) demonstrate a defined or proposed collaboration with purveyors of evidence-based child maltreatment prevention interventions; and

(D) submit to the Secretary an application that includes—

(i) an outline of a technical assistance and coordination plan and timeline;

(ii) a description of activities, services, and strategies to be used to reach out and work with the FQHCs and others involved in the demonstration projects under subsection (a); and

(iii) a description of the evaluation methods and strategies the entity plans to use, and an outline of the progress and final reports required under subsection (f)(2).

(3) PRIORITY.—In awarding contracts under this subsection, the Secretary shall give priority to eligible entities whose applications under paragraph (2)(D) demonstrate that the evaluation design of such eligible entity uses strong experimental designs that capture a range of health and behavioral outcomes and include feasibility evaluation of the integrated health-behavioral health services model. Such evaluation designs should provide evaluation results that identify lessons learned and generate recommendations for improvements and changes.

(4) AUTHORIZED ACTIVITIES.—Each recipient of a contract under this subsection shall use such award to provide technical assistance to the FQHCs receiving a grant under subsection (a) and to provide coordination and cross-site evaluation of such demonstration projects to the Secretary. Such technical assistance and coordination and cross-site evaluation may include—

(A) establishing and implementing uniform tracking and monitoring systems across FQHCs participating in the demonstration project, using the best available, highest level of technological tools;

(B) developing and implementing a cross-site, multi-level evaluation plan using rigorous research and evaluation designs to evaluate the demonstration projects across FQHCs;

(C) ensuring that, in implementing the evidence-based parenting training programs, each such FQHC follows standardized manuals and protocols, and ensuring effectiveness of the integrated services of each FQHC in promoting positive stable, nurturing parent-child relationships and preventing child maltreatment and injuries;

(D) ensuring an effective and feasible evaluation of the outcomes of the demonstration projects, including an assessment of—

(i) improvement of parent knowledge of child social, emotional, cognitive development;

(ii) improvement of parent-child relationships;

(iii) parental use of positive discipline methods and effective communication skills;

(iv) health outcomes for children;

(v) reduction of incidence of child maltreatment;

(vi) cost-effectiveness of the demonstration projects;

(vii) implementation that follows standardized manuals and protocols;

(viii) the interdisciplinary collaborative model;

(ix) cultural sensitivity and local adaptation of the projects;

(x) any increase in access to services; and

(xi) further improvements and changes needed at the FQHCs;

(E) establishing and coordinating the implementation of a workforce development and training plan to ensure that professionals working at the health centers, including physicians, nurses, nurse practitioners, psychologists, social workers, physician's assistants, clinical pharmacists, and others, are trained to participate in interdisciplinary teams and work collaboratively to provide culturally-competent and linguistically-sensitive integrated services to all caregivers coming to such center, with a focus on the development and strengthening of—

(i) knowledge of the public health model, child development, family functioning, the problem of child maltreatment, and methods of prevention;

(ii) core attitudes, including the belief that child maltreatment is preventable, professionals have a role in prevention, families are partners in preventing maltreatment, and evaluation is a critical element of interventions;

(iii) ability to conduct screenings, implement evidence-based parenting programs, provide mental health services, and collaborate with evaluation efforts;

(iv) ability to manage the site project, participate in interdisciplinary teams, work on integrated efforts, and master technology for best results;

(v) the knowledge, skills, and attitude to work with individuals from diverse cultural, racial, ethnic, and other backgrounds; and

(vi) an understanding of cross-field culture and language to effectively participate in interdisciplinary teams and collaborate in integrated activities;

(F) educating and involving the governing boards of FQHCs participating in the demonstration projects in the integrated service efforts;

(G) promoting partnerships with State and local institutions of higher education, community networks, and professional associations for staff training and recruitment;

(H) promoting collaboration and networking among FQHCs participating in the demonstration projects; and

(I) establishing and coordinating child maltreatment prevention collaboratives across FQHCs participating in the demonstration projects and helping such FQHCs partner with local departments of child welfare and community mental health centers.

(5) ADVISORY GROUPS.—

(A) IN GENERAL.—Each recipient of a contract under this subsection shall establish an advisory group. Each such advisory group shall provide feedback and input to the contract recipient to ensure such recipient's effectiveness in providing quality services.

(B) MEMBERSHIP.—Each such advisory group shall be composed of representatives of—

(i) national organizations representing community health centers;

(ii) national professional organizations representing professionals from various fields, including pediatrics, nursing, psychology, and social work; and

(iii) government agencies with relevant expertise, as determined by the Director of the National Center for Injury Prevention and Control of the Centers for Disease Control and Prevention.

(f) EVALUATION AND REPORTING.—

(1) DEMONSTRATION PROJECT REPORTING.—

(A) ANNUAL PROGRESS EVALUATION AND FINANCIAL REPORTING.—For the duration of the grant under subsection (a), each FQHC shall submit to the Secretary an annual progress evaluation and financial reporting indicating activities conducted and the progress of the health center toward achievement of established outcomes, including cost effectiveness, patient satisfaction, program local adaptation, reduction of child maltreatment and injuries, and improvement of parenting behaviors and family functioning.

(B) FINAL REPORT.—At the end of the grant period, each FQHC shall submit a final report with evaluation data analysis and conclusions related to the outcomes of the demonstration project.

(2) TECHNICAL ASSISTANCE REPORTING.—

(A) ANNUAL PROGRESS AND FINANCIAL REPORT.—For the duration of the contract under subsection (e), each technical assistance provider shall submit to the Secretary an annual progress and financial report indicating activities conducted under such contract.

(B) FINAL REPORT.—At the end of the contract period, each recipient of a technical assistance contract under subsection (e) shall submit to the Secretary a final report that includes—

(i) an analysis of comparative data related to effectiveness and feasibility of projects implemented at the FQHCs, workforce training, and achievement of outcomes at the FQHCs;

(ii) overall recommendations for system improvement and changes that would allow the demonstration projects to be expanded;

(iii) an outline of the project results; and

(iv) a plan that outlines opportunities and vehicles for the dissemination of cross-site evalution results, findings, and recommendations.

(g) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—To carry out the demonstration project grant program described in subsection (a), there are authorized to be appropriated $10,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2014.

(2) TECHNICAL ASSISTANCE.—The Secretary shall reserve not less than 10 percent of the amounts appropriated under paragraph (1) to carry out the technical assistance program described in subsection (e).

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 208—TO CONSTITUTE THE MAJORITY PARTY'S MEMBERSHIP ON CERTAIN COMMITTEES FOR THE ONE HUNDRED ELEVENTH CONGRESS, OR UNTIL THEIR SUCCESSORS ARE CHOSEN

Mr. REID submitted the following resolution; which was considered and agreed to:

S. RES. 208

Resolved, That the following shall constitute the majority party's membership on the following committee for the One Hundred Eleventh Congress, or until their successors are chosen:

COMMITTEE ON THE JUDICIARY: Mr. Leahy (Chairman), Mr. Kohl, Mrs. Feinstein, Mr. Feingold, Mr. Schumer, Mr. Durbin, Mr. Cardin, Mr. Whitehouse, Ms. Klobuchar, Mr. Kaufman, Mr. Specter, and Mr. Franken.

SENATE RESOLUTION 209—RECOGNIZING THE 40TH ANNIVERSARY OF THE NATIONAL EYE INSTITUTE AND EXPRESSING SUPPORT FOR DESIGNATION OF THE YEARS 2011 THROUGH 2020 AS THE ''DECADE OF VISION''

Mr. ISAKSON (for himself and Mr. CARDIN) submitted the following resolution; which was considered and agreed to:

S. RES. 209

Whereas vision impairment and eye disease are major public health problems, especially due to the aging of the population;

Whereas there is a disproportionate incidence of eye disease in minority populations;

Whereas vision loss as a result of diabetes and other chronic diseases costs the people of the United States $68,000,000,000 each year in health care expenses, lost productivity, reduced independence, diminished quality of life, increased depression, and accelerated mortality;

Whereas approximately 38,000,000 people in the United States over 40 years of age currently experience blindness, low-vision, or an age-related eye disease, and this number is expected to grow to 50,000,000 by 2020, as the tidal wave of approximately 78,000,000 baby boomers who will begin to reach 65 years of age in 2010, many of whom will continue working well beyond age 65, crashes;

Whereas, in public opinion polls conducted during the past 40 years, people in the United States have consistently identified fear of vision loss as second only to fear of cancer, and, as recently as 2008, a study by the National Eye Institute showed that 71 percent of respondents indicated that a loss of eyesight would have the greatest impact on their life;

Whereas, with wisdom and foresight, Congress passed an Act entitled ''An Act to amend the Public Health Service Act to provide for the establishment of a National Eye Institute in the National Institutes of Health'' (Public Law 90–489; 82 Stat. 771), which was signed into law by President Johnson on August 16, 1968;

Whereas the National Eye Institute (in this resolution referred to as the ''NEI'') held the first meeting of the National Advisory Eye Council on April 3, 1969;

Whereas the NEI leads the Federal commitment to basic and clinical research, research training, and other programs with respect to blinding eye diseases, visual disorders, mechanisms of visual function, preservation of sight, and the special health problems and needs of individuals who are visually-impaired or blind;

Whereas the NEI disseminates information aimed at the prevention of blindness, specifically through public and professional education facilitated by the National Eye Health Education Program;

Whereas the NEI maximizes Federal funding by devoting 85 percent of its budget to extramural research that addresses a wide variety of eye and vision disorders, including ''back of the eye'' retinal and optic nerve disease, such as age-related macular degeneration, glaucoma, and diabetic retinopathy, and concomitant low vision, and ''front of the eye'' disease, including corneal, lens, cataract, and refractive errors;

Whereas research by the NEI benefits children, including premature infants born with retinopathy and school children with amblyopia (commonly known as ''lazy eye'');

Whereas the NEI benefits older people in the United States by predicting, preventing, and preempting aging eye disease, thereby enabling more productive lives and reducing Medicare costs;

Whereas the NEI has been a leader in basic research, working with the Human Genome Project of the National Institutes of Health to translate discoveries of genes related to eye disease and vision impairment, which make up ¼ of genes discovered to date, into diagnostic and treatment modalities;

Whereas the NEI has been a leader in clinical research, funding more than 60 clinical trials (including a series of Diabetic Retinopathy Clinical Trials Networks, in association with the National Institute for Diabetes and Digestive and Kidney Disorders) which have developed treatment strategies that have been determined by the NEI to be 90 percent effective and to save an estimated $1,600,000,000 each year in blindness and vision impairment disability costs;

Whereas the NEI has been a leader in prevention research, having reported from the first phase of its Age-Related Eye Disease Study that high levels of dietary zinc and anti-oxidant vitamins reduced vision loss in individuals at high risk for developing advanced age-related macular degeneration by 25 percent, and, in the second phase of Age-Related Eye Disease Study, studying the impact of other nutritional supplements;

Whereas the NEI has been a leader in epidemiologic research, identifying the basis and progression of eye disease and the disproportionate incidence of eye disease in minority populations, so that informed public health policy decisions can be made regarding prevention, early diagnosis, and treatment;

Whereas the NEI has been a leader in collaborative research across the National Institutes of Health, working with the National Cancer Institute and the National Heart, Lung, and Blood Institute to identify factors that promote or inhibit new blood vessel growth, which has resulted in the first generation of ophthalmic drugs approved by the Food and Drug Administration to inhibit abnormal blood vessel growth in the form of age-related macular degeneration commonly known as the ''wet'' form of age-related macular degeneration, thereby stabilizing, and often restoring, vision;

Whereas the NEI has been a leader in collaborative research with other Federal entities, and its bioengineering research partnership with the National Science Foundation and the Department of Energy has resulted in a retinal chip implant, referred to as the ''Bionic Eye'', that has enabled individuals who have been blind for decades to perceive visual images;

Whereas the NEI has been a leader in collaborative research with private funding entities, and its human gene therapy trial with the Foundation Fighting Blindness for individuals with Leber Congenital Amaurosis, a rapid retinal degeneration that blinds infants in their first year of life, has demonstrated measurable vision improvement even within the initial safety trials;

Whereas, from 2011 through 2020, the people of the United States will face unprecedented public health challenges associated with aging, health disparities, and chronic disease; and

Whereas Federal support by the NEI and related agencies within the Department of Health and Human Services is essential for prevention, early detection, access to treatment and rehabilitation, and research associated with vision impairment and eye disease: Now, therefore, be it

Resolved, That the Senate—

(1) recognizes the 40th anniversary of the NEI, commends the NEI for its leadership, and supports the mission of the NEI to prevent blindness and to save and restore vision;

(2) supports the designation of the years 2011 through 2020 as the ''Decade of Vision'', to—

(A) maintain a sustained awareness of the unprecedented public health challenges associated with vision impairment and eye disease; and

(B) emphasize the need for Federal support for prevention, early detection, access to treatment and rehabilitation, and research; and

(3) commends the National Alliance for Eye and Vision Research, also known as the ''Friends of the National Eye Institute'', for