Report to the Congress Presenting HHS's Response to the Recommendations of the Commission to Eliminate Child Abuse and Neglect Fatalities

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Introduction

On March 17, 2016, after two years of effort, the Commission to Eliminate Child Abuse and Neglect Fatalities (referred to hereafter as CECANF or "the Commission") issued its final report, *Within Our Reach*. Reflecting the complex and multi-faceted problem the Commission was tasked with addressing, the group's report included over 100 recommendations on a broad range of topics and aimed at an array of entities at the federal, state and local levels. Many of those recommendations were directed, in whole or in part, toward the U.S. Department of Health and Human Services (HHS).

When Congress created the Commission in the Protect Our Kids Act of 2012 (P.L. 112-275) it also required that "not later than 6 months after the submission of the [Commission's] report…, any Federal agency that is affected by a recommendation described in the report shall submit to Congress a report containing the response of the Federal agency to the recommendation and the plans of the Federal agency to address the recommendation." This Report to the Congress is HHS's response to the Commission's report and recommendations that we interpret as relating to this Department's activities. However, because many of the recommendations were addressed simply to "the Executive Branch," on some recommendations it is not always completely clear which federal agency or agencies the Commission viewed as being responsible for the recommended activity. In addition, for many activities there are multiple parties that would need to take action to realize the Commission's vision.

Overall, HHS heartily embraces the Commission's vision for a robust response to families in crisis: one that intervenes early to prevent maltreatment and strengthen families whenever possible, but also protects children aggressively as needed. This is a vision that, as the Commission suggests, combines leadership and accountability with multidisciplinary support for families and decision making that is grounded in data and research. For the most part we agree with the Commission's intent with respect to the recommendations, though on a number of them HHS believes that somewhat different means can better accomplish the Commission's intent. There are a few recommendations with which we disagree. In addition, available resources and current statutory authorities limit the extent to which we can respond completely to the Commission's recommendations.

In preparing this report, staff carefully reviewed the Commission's final report and determined that HHS has a role with respect to more than 60 of the recommendations. Within HHS, recommendations relate to programs and initiatives operated by a number of agencies. Many of the Commission's recommendations involve programs or activities within the Administration for Children and Families (ACF). In addition, several relate to the Centers for Medicare & Medicaid Services (CMS), the Health Resources and Services

Administration (HRSA), the Centers for Disease Control and Prevention (CDC), and the Indian Health Service (IHS). Finally, one or two recommendations relate to each of the following agencies: the Substance Abuse and Mental Health Services Administration (SAMHSA), the Office of Adolescent Health (OAH), and the Agency for Healthcare Research and Quality (AHRQ). In many cases the recommendations relate to multiple parties rather than being within the purview of a single agency. In addition, while the Commission's recommendations build on existing programmatic infrastructure, a number of their suggested actions would require either additional financial resources or legislative authority that do not currently exist and which only the Congress can provide. We also note that this report does not address any recommendations made in the dissenting opinions submitted by two members of the Commission.

This report will describe HHS's overall vision for improvements to the federal infrastructure of policies and programs most directly related to protecting children from maltreatment and, ultimately, serious injury or death. We identify the areas in which our vision specifically overlaps with the Commission's recommendations. In addition, a chart in the appendix responds briefly to each of the Commission's individual recommendations affecting this Department.

The timing of the Commission's report and the requirement for a response at this time presents both opportunities and challenges. The Fiscal Year (FY) 2017 President's Budget was released on February 9, 2016, roughly five weeks before the Commission released its report, and thus budget proposals could not be informed directly by the Commission's recommendations. That Budget does, however, include a number of proposals that are quite relevant to the Commission's goals. In addition, while we are confident that the prevention of child fatalities and serious injuries will be a continuing priority, new budget and legislative proposals for FY 2018 will be the responsibility of the next Administration. Within this report we respond within the confines of existing programs, resources and legislative proposals established before the Commission's report was released.

A Vision for Improving Child Safety

This Department's vision for improving the safety of children and preventing maltreatment related fatalities and serious injury begins with leadership. Central to our vision are expanded and strengthened preventive services addressing key factors associated with maltreatment to support families in reducing risk and improving children's well-being. Our vision includes tangible steps to improve the quality of data and increase the ability of child welfare agencies to use data in making both program level and child level decisions, and relies on research evidence to improve services delivered to children and families throughout the nation. We also focus on addressing the needs and advancing the capacities

of underserved populations and communities in order to ensure all children are safe from harm.

The following are broad categories in which HHS is currently taking action within child welfare that we believe address various recommendations of the Commission.

Providing Leadership and Promoting Accountability

Ensuring the safety of children features prominently in HHS's strategic plan and we take very seriously our role in preventing child maltreatment generally as well as particularly preventing fatalities and serious injuries resulting from child abuse and neglect. The issue is presented in the Department's strategic plan, in which Strategic Goal 3 is to "advance the health, safety and well-being of the American people." Within that goal, Objective A commits us to "promote the safety, well-being, resilience, and healthy development of children and youth." Addressing risk of maltreatment is integral to our activities in this regard.

Key HHS initiatives in several of HHS's operating divisions advance elements of the Commission's agenda. We have long championed home visiting programs as a key strategy for advancing the safety and well-being of vulnerable infants. Health care reform has increased health insurance coverage and enabled many parents to access treatment for mental and substance use disorders that underlie the maltreatment risk for many children. HHS has long advocated for improved preventive services in the child welfare system and the FY 2017. The President's Budget request2017 budget includes such policies.

HHS's Office on Child Abuse and Neglect (a component office within the Administration for Children and Families) has long chaired the Federal Interagency Working Group on Child Abuse and Neglect that since 1988 has brought together staff of approximately two dozen federal agencies within seven federal cabinet departments that implement programs that touch on issues of child maltreatment. That group often serves as a forum for collaboration between agencies and represents another component of our leadership in this arena.

We do disagree with two of the Commission's recommendations with respect to leadership and accountability. Recommendation 5.1a suggests that HHS move the Children's Bureau out of the Administration for Children and Families to report directly to the Secretary of HHS. While the Commission intends such a change to bring increased visibility and high level attention to child maltreatment issues, there would be significant structural problems with moving a grant making agency such as the Children's Bureau, which currently administers approximately $8.6 billion in funding to state and local agencies, into the Office of the Secretary, which does not have the administrative infrastructure or regional office structure to support program operations. The Children's Bureau shares its program operations infrastructure with other parts of ACF and recreating such a structure as a

stand-alone entity would be inefficient. In addition, recommendation 5.1b suggests that HHS move the Maternal and Child Health Bureau (MCHB) to become part of the Children's Bureau. However, while MCHB was part of the Children's Bureau many decades ago, since then MCHB's work has become integrated into health care systems and the public health infrastructure that serves families. Moving the agency would jeopardize the benefits gained from incorporating child safety into the overall public health approach.

Preventing Fatalities and Serious Injury though Multidisciplinary Support for Families

HHS agrees with the Commission that central to making substantial progress on eliminating child abuse and neglect fatalities is the need to change the dynamic in families in which there is significant risk to the child. The Commission recognizes this reality in its recommendations for improved multidisciplinary support for families. However, we believe that the Commission underestimated the value of primary prevention in its recommendations, which focused almost exclusively on secondary prevention.

The Commission recognized that services for troubled families are significantly underfunded to accomplish the work that needs to be done in order to be successful. However, the Commission faced insurmountable differences of opinion among its commissioners regarding improved funding approaches. Below, we present major HHS activities related to improving the necessary services. The HHS activity noted below will be conducted within the context of current funding levels. The chart in the appendix notes recommendations for where additional resources would be required if they are to be implemented at the level the Commission has suggested.

Promoting Primary Prevention

HHS believes that getting ahead of the issue of child maltreatment fatalities requires not just responding after initial family crises but also creating the infrastructure for primary prevention. Efforts to prevent maltreatment begin with strong programs and activities to address the most common issues underlying risk to children, including deep poverty, substance use disorders, mental illness, and domestic violence. Many HHS programs and activities focus on these issues day in and day out.

The Centers for Disease Control and Prevention (CDC) recently released *Preventing Child Abuse & Neglect: A Technical Package for Policy, Norm, and Programmatic Activities* that identifies the best available evidence for preventing child abuse and neglect in order to help states and communities prioritize prevention activities. These strategies range from a focus on individuals, families, and relationships, to broader community and societal change. This range of strategies is needed to better address the interplay between individual-family behavior and broader neighborhood, community, and cultural contexts. CDC has led a

number of evaluations examining the role of programs and policies in preventing child abuse and neglect. Among other things, these evaluations have found paid parental leave to be associated with lower rates of abusive head trauma, while access to affordable, quality child care and continuity of child health care are associated with decreases in child maltreatment.

This package of strategies is part of CDC's overall framework for preventing child abuse and neglect called Essentials for Childhood. *Essentials for Childhood: Steps to Create Safe, Stable, Nurturing Relationships and Environments* outlines strategies communities can consider to 1) raise awareness and commitment to promote safe, stable, nurturing relationships and environments; 2) use data to inform actions; 3) create the context for healthy children and families through norms change and programs; and 4) create the context for healthy children and families through policies. Five state health departments (California, Colorado, Massachusetts, North Carolina, and Washington) are being funded to implement the *Essentials for Childhood* framework using a collective impact process, with the end goal of determining the effectiveness of the collective impact process and whether a focus on the key goal areas (as opposed to a programs-only focus) leads to better outcomes for children and families. In addition to the five funded states, over 30 additional states use their own resources (i.e., "self-supported states") to participate in this initiative at different levels (e.g., participate in conference calls, webinars, meetings, actively implement the *Essentials for Childhood* framework). The state initiatives have been successful in bringing to the table decision-makers representing several federal initiatives, as well as philanthropic, business and community organizations, to align substantial funds and efforts. In addition to outcomes for children and families, CDC and the states are also documenting the process, lessons learned, and what is necessary to implement strategies in each of the key goal areas.

Primary prevention programs focusing on creating positive parenting situations are also an important part of our vision to protect children and prevent maltreatment fatalities. To this end, CDC has developed a web-based resource titled *Essentials for Parenting Toddlers and Preschoolers* that focuses on positive parenting and creating a positive parent-child relationship early in life. In addition, ACF's Community-Based Child Abuse Prevention program (CBCAP) funds child abuse prevention programs that provide a multitude of services and supports including comprehensive support for parents, the promotion of parenting skills, referrals for early health and development services, supporting the needs of parents with disabilities through respite or other activities, and improving families' access to formal and informal resources. These programs promote meaningful parent leadership and can finance the development of a continuum of preventive services through public-private partnerships, financing the start-up, maintenance, expansion, or redesign or child abuse prevention programs, maximizing funding through leveraging funds, and

financing public education activities that focus on the promotion of child abuse prevention. In recent years the CBCAP program has encouraged grantees to prioritize evidence-based prevention programming and in FY 2014 nearly 90 percent of CBCAP funding supported evidence-based and evidence-informed child abuse prevention programs and practices and 3.1 million children received services through CBCAP and other sources.

Expanding Secondary Prevention Services

HHS has and will continue to advocate for expanding and strengthening services to prevent child abuse and neglect, provide early intervention to families coming to the attention of child protective services agencies, and help family members to keep children safe when parents cannot. Of particular note are HHS proposals included in the FY 2017 President's Budget to allow title IV-E funds, previously used primarily to support children in foster care, to support certain evidence-based interventions for some children who are not in care. The Congress has introduced legislation, the Family First Prevention Services Act, containing a similar provision providing federal funding to support certain evidence-based interventions for some children who are not in care, including treatment services to address mental illness and substance use disorders that are often contributing factors in child fatalities, as well as home visiting services that have the most research evidence showing they help to prevent fatalities and serious injuries.

The Administration for Children and Families has also worked for many years to develop the capacity of state and local child welfare agencies, in partnership with behavioral health agencies and others, to address risks posed to children by parents with substance use disorders. The Regional Partnership Grant Program has strengthened the evidence base around what works to intervene with families with substance use disorders who may endanger their children. The National Center for Substance Abuse and Child Welfare, a technical assistance center that works with the Regional Partnership Program grantees, also will be working with states around the development and implementation of plans of safe care (related to recommendations 7.2a and 7.2b).

This range of efforts to improve intervention strategies for families known to be at high risk is responsive to the Commission's recommendation 7.1 and its subparts as well as recommendation 4.2.

Focusing on Home Visiting Services

Investments in evidence-based home visiting services have been among the Administration's signature initiatives. Since its authorization under the Affordable Care Act, the Maternal and Infant Early Childhood Home Visiting program (MIECHV) has expanded the availability of home visiting services for extremely vulnerable populations in communities throughout the U.S. The Health Resources and Services Administration

(HRSA), in close partnership with the Administration for Children and Families (ACF), funds states, territories and tribal entities to develop and implement voluntary, evidence-based home visiting programs using models that are proven to improve child health and to be cost effective. These programs improve maternal and child health, prevent abuse and neglect, encourage positive parenting, and promote child development and school readiness. The federal home visiting program provided more than 2.33 million home visits from FY 2012 through FY 2015 and served approximately 145,500 parents and children in 825 counties across all 50 states, the District of Columbia and five territories in FY 2015 alone. Initially authorized for five years, MIECHV has been reauthorized and extended twice, including last year through the Medicare Access and CHIP Reauthorization Act of 2015, which funds the program through FY 2017. Through the President's Budget, HHS has proposed to extend the program and expand funding by $15 billion over ten years in order to continue supporting these evidence-based programs and to reach more children and families.

ACF administers the Tribal Home Visiting Program, which funds 25 American Indian and Alaska Native organizations to develop, implement and evaluate home visiting programs that serve Native children and their families. The Tribal Home Visiting program is funded by a three percent set-aside from the larger Federal Home Visiting (MIECHV) program. Tribal Home Visiting grants are awarded to Indian tribes, consortia of tribes, tribal organizations, and urban Indian organizations. Tribal home visiting grantees have significantly and rapidly expanded home visiting services available to American Indian and Alaska Native families, with grantees providing nearly 20,000 home visits to more than 1,500 families between 2012 and 2014. Over this time period, 85 percent of tribal home visiting grantees saw improvements in outcomes related to child injuries, abuse, neglect or emergency room visits.

In addition, to assist those states seeking to include home visiting services in the benefit packages of their state Medicaid programs, the Centers for Medicare & Medicaid Services (CMS) and HRSA in March 2016 issued a Joint Information Bulletin titled "Coverage of Maternal, Infant, and Early Childhood Home Visiting Services."[1]

HHS's activities regarding expanding and strengthening home visiting services are directly responsive to Commission recommendations 7.1a and 7.2.a.

[1] Available at: www.medicaid.gov/federal-policy-guidance/downloads/cib-03-02-16.pdf

Finding New Solutions

One of the factors preventing significant progress in reducing child fatalities is the lack of an evidence base for interventions in this area. As the Commission notes, there is little evidence for particular interventions other than home visiting that reduce child maltreatment fatalities. While we are working to expand the implementation of home visiting program as noted above, particularly for the high risk population of families known to the child welfare system, home visiting programs represent only a partial solution. A broader evidence base is needed on interventions and other strategies that address aspects of serious maltreatment that are not fully addressed by home visiting. Several HHS activities are working to this end.

The Children's Bureau's Regional Partnership Grants program addresses the needs of families with both substance use disorders and child maltreatment issues. The program has been gathering data on grantees' performance for nearly ten years. These grantees have shown that it is possible to keep many families together and children safe while parents address a substance use disorder. Grantees have documented a number of promising service delivery models that are now undergoing more rigorous evaluation. The President's Budget for FY 2017 calls for an expansion of these efforts, as does the pending Family First Prevention Services Act.

A number of states are using title IV-E demonstration waivers to expand the use of evidence-based services for families with children in or at risk of entering foster care. Interventions being tested and evaluated include Intensive Early Intervention Case Management and Services (Michigan), Enhanced Assessment and Family Engagement (Arkansas and Colorado) and intensive services for families with substance use disorders (Illinois). As with earlier rounds of demonstration waivers, we expect the current waivers will add to our knowledge of what works to keep children safe and with their birth families whenever possible.

In an effort to go beyond individual and relationship-level strategies and an intervention-specific focus, CDC's *Essentials for Childhood* encourages a multi-sectoral response to child maltreatment that focuses on creating a context supportive of children and families through norms change, programs, and policies using a collective impact process. CDC is collecting information to determine the effects of the multi-sectoral response and alignment of funds occurring through the collective impact process.

The Administration for Children and Families' Office of Planning, Research, and Evaluation is in the process of awarding a five year contract that seeks to increase the number of evidence supported interventions for the child welfare population. The successful contractor will assist ACF to identify approaches that address ACF's evidence building priorities. It will assess existing research evidence to help ACF determine which

interventions are ready for further evaluation. And it will conduct rigorous evaluation in an effort to move them from "promising" to higher levels of evidence. While the contract will address the full child welfare spectrum, its scope does include preventive interventions that would prevent maltreatment fatalities.

Finally, in May 2016, the U.S. Preventive Services Task Force, an advisory body convened by HHS's Agency for Healthcare Research and Quality (AHRQ), published its *Draft Research Plan for Child Maltreatment: Primary Care Interventions*. The key research question the Task Force will address is "do primary care-feasible or referable interventions to prevent child maltreatment reduce the exposure to abuse or neglect, improve behavioral, emotional, physical or mental well-being; or reduce mortality among children and adolescents without obvious signs or symptoms of abuse or neglect?" Once the research plan is finalized, an evidence review will be prepared and recommendations for primary care physicians will be developed. The Task Force also has a review in process related to postpartum depression, a condition which also is related to child maltreatment fatalities.

Using Data and Research Evidence to Improve Practice

This Administration has long championed an evidence agenda that has sought to bring the most effective strategies to bear on the social and health problems facing America. In addition, this Department has sought to improve the utility of administrative and survey data to better understand and improve the outcomes for our programs. Like the Commission, we believe that a focus on accountability and using data and research evidence in a cycle of continuous improvement, is a key to improving our performance on important outcomes, including child safety. A number of important activities are currently underway or planned that directly relate to the Commission's goals and to its specific recommendations.

Improving Child Death Statistics

Imperative to addressing any problem is to understand its scope. The Commission's report recognizes that there is considerable room for improvement in producing accurate and comprehensive data on child abuse fatalities and serious injuries. HHS is taking a number of steps to strengthen the available data. The CDC's National Violent Death Reporting System includes data on child deaths due to maltreatment and currently operates in 32 states linking information from death certificates, coroner/medical examiner reports, and law enforcement reports. An optional module in the system captures information collected as part of the child death review. We are working to increase participation in the system with the goal of expanding to all states in the coming years. In addition, the Maternal and Child Health Bureau within the Health Resources and Services Administration sponsors the National Center for Fatality Review and Prevention Child Death Review Case Reporting

System. In 2017, the Center will convene subject matter experts and federal agencies to develop standard guidelines for performing fatality reviews on child deaths in which abuse or neglect was either a causative or contributing factor. Further, the National Center for Health Statistics is working with coroners and medical examiners to improve the detail and consistency of vital statistics data gleaned from death certificates so that these data consistently and reliably identify of deaths related to maltreatment.

These activities are responsive to several sub-recommendations under Commission items 6.1, 6.2 and 6.3.

Modernizing the Regulatory Infrastructure for Child Welfare Data and Information Systems

In June 2016, HHS published new final regulations regarding states' development of Comprehensive Child Welfare Information Systems (CCWIS). This rule will assist title IV-E agencies in developing information management systems that leverage new innovations and technology in order to better serve children and families. More specifically, this final rule supports the use of cost-effective, innovative technologies to automate the collection of high-quality case management data and to promote its analysis, distribution, and use by workers, supervisors, administrators, researchers, and policy makers. In order to support states' efforts to modernize their information systems, the FY 2017 President's Budget requested legislative authority to provide an enhanced federal match for administrative costs related to information technology systems development in child welfare. While the Congress has not provided the requested authority, the enhanced match would have allowed child welfare agencies to adopt development projects promoting modernization and use of advancement in technology to meet their unique program requirements. We estimated the costs of the legislative proposal to be $13 million in FY 2017 and $132 million over ten years. Our efforts to enhance state child welfare information systems through CCWIS support Commission recommendation 6.1 and several of its sub-recommendations.

Exploring the Potential of Predictive Analytics

The Commission holds out hope that as the new field of predictive analytics is adapted to child welfare, better use of data can improve decision making by child protective services staff and ensure children are kept safe from harm. We also are intrigued by the potential of this new field, but want to be cautious both about the potential for such technology to amplify bias, as the Commission cautions, but also that we do not let results of computer models prematurely foreclose opportunities to intervene with families facing serious challenges.

HHS is exploring these issues on several fronts. The Office of the Assistant Secretary for Planning and Evaluation has recently awarded a contract that will explore where and how the techniques of predictive analytics are being applied to the child welfare arena. It will then develop materials for child welfare leaders discussing what questions in the child welfare field predictive analytics may be helpful in answering, the limitations of the available techniques, and identifying significant issues that need to be worked through in order to advance the utility of predictive analytics to child welfare practitioners. Options in the contract to be funded if FY 2017 or FY 2018 funds permit would further expand work on these topics. We also expect that further opportunities will become clear over time as ongoing local efforts to develop predictive analytics approaches begin to produce results.

Additional opportunities to utilize predictive analytics will become available as states update their child welfare information systems. Improvements to state and local data systems made possible by the CCWIS regulation described above should allow for improved interoperability and more relevant and reliable data that can be used for predictive analytics applications. The CCWIS regulation will support the further exploration of predictive analytic techniques. The new framework and flexibility provided by the regulation will enable states to design data systems with improved interoperability that will better support the kinds of analysis the Commission envisions.

ACF's Office of Planning, Research and Evaluation also is preparing to support improvements in the use of administrative data for research purposes, including in predictive analytics applications. That office has recently created a Division of Data and Improvement that, in cooperation with ACF programs and others, will work with a range of partners to improve the quality, usefulness, interoperability, integration, and availability of data.

Finally, while the Commission's report focused on the use of predictive analytics in practice with families already involved with the child welfare system, we are also interested in the potential to use predictive analytics in primary prevention. Using information available in birth records, such as birth weight, history of prenatal care, maternal characteristics such as age and education, and child health, may provide opportunities to support families, promote positive parenting, and prevent serious maltreatment before families become involved in the child welfare system. The CDC is exploring these issues and considering future activities in this area.

Addressing Disproportionality

While maltreatment related fatalities and serious injuries occur among all demographic groups, the Commission recognizes that American Indian/Alaska Native children and African American children are disproportionately represented among the victims. Although

not noted by the Commission, some families are at higher risk of child abuse or neglect because of conditions (e.g., parents working multiple low wage jobs, housing instability, food insecurity) in which children are being raised. As with so many health and social problems, addressing the phenomenon of child maltreatment fatalities requires attention to many other factors, including culturally competent interventions that are effective with those at particular risk and strong service delivery infrastructures within disproportionately affected communities.

Strengthening Tribal Child Welfare Programs

The Commission's report expresses particular concern about the need to strengthen child fatality prevention efforts in American Indian and Alaska Native (AI/AN) communities. We agree and HHS, in consultation with Indian tribes and often in collaboration with the Department of Interior's Bureau of Indian Affairs and the Department of Justice, is working hard to improve tribes' capacity to deliver effective child welfare services to their people. Over the past several years a number of initiatives have begun making a difference for AI/AN children and are being strengthened over time.

A key effort in addressing maltreatment with tribal communities is the Tribal Maternal, Infant, and Early Childhood Home Visiting program, administered by ACF. This program, funded by a set-aside within the larger federal home visiting program administered by HRSA, provides grants to tribal organizations to develop, implement, and evaluate home visiting programs in AI/AN communities. Approximately 25 grantees operating in 14 states have operated tribal home visiting programs since the initial grants were awarded in 2010. These grantees are adapting home visiting models to be culturally relevant to American Indian and Alaska Native communities and evaluating the results so that we can build an evidence base about what works specifically in these programs.

ACF has also recently issued two grant announcements aimed at enhancing child abuse and neglect prevention services for AI/AN children and families. Grants under these announcements will be awarded by the end of FY 2016.

The National Quality Improvement Center (QIC) for Preventive Services and Interventions in Indian Country (HHS-2016-ACF-ACYF-CA-1175) will gather, generate, and disseminate knowledge regarding effective practice models for strengths-based, culturally relevant, trauma-informed, and preventive services and interventions for all forms of child maltreatment. As part of this work, the QIC will provide technical assistance and implementation assistance for two to five project sites. The purpose of the selected project sites is to implement and assess practice models that show promise in preventing child abuse and neglect and that may be implemented or adapted in other tribal child welfare systems.

In addition, the Community-Based Child Abuse Prevention Program will be funding new grants to tribes, tribal organizations, and migrant programs by the end of the current (FY 2-16) fiscal year (under funding announcement HHS-2016-ACF-ACYF-CA-1119). These grants will support community-based efforts to develop, operate, expand, enhance, and coordinate initiatives, programs and activities in tribal and migrant communities to prevent child abuse and to strengthen and support families to reduce the likelihood of child abuse and neglect, consistent with the goals outlined by Title II of the Child Abuse Prevention and Treatment Act (CAPTA). Some examples of programs that may be funded include, but are not limited to, voluntary home visiting, respite care, parenting education, family resource centers, domestic violence services, and other family support services.

In addition to our child abuse prevention work, HHS has worked diligently to implement tribal title IV-E foster care, adoption assistance, and kin guardianship programs as authorized under the Fostering Connections to Success and Increasing Adoptions Act of 2008. While the program began somewhat more slowly than either we or the tribes had hoped, we have learned from early experiences in order to better anticipate and solve the issues that caused many of the initial challenges of implementing these programs in tribes. The Children's Bureau within ACF has improved the process with tribes of reviewing and negotiating their title IV-E plans. The Children's Bureau has strengthened internal communications among central and regional office staff and is in the process of hiring additional regional office staff to work with tribes. Currently seven tribes have approved title IV-E plans and a number of pending plans likely will be approved in the near future. A number of tribes with title IV-E planning grants are also expected to formally submit title IV-E plans in the coming months and years. Additionally, many tribes have title IV-E agreements with the states in which they are located.

The FY 2017 President's Budget request for ACF proposed several legislative changes and budget proposals that would strengthen child welfare funding for tribes and address some of the challenges we have seen as tribes implement title IV-E programs. These include:

1. Increased start-up funding for tribes approved to operate title IV-E Foster Care and Permanency Programs and an enhanced match for case management and other case work activities performed by tribal casework staff and for training tribal caseworkers. Together the funding for these proposals is estimated at $37 million in FY 2017 and $241 million over ten years.

2. An increase of $20 million in funding for tribes under the title IV-B, subpart 2 Promoting Safe and Stable Families Program, to fund the establishment of a minimum grant amount of $10,000 for all tribes applying for funds and streamlined planning and reporting requirements for tribes receiving funds under title IV-B programs (both Part 1 and Part 2). Current extensive requirements discourage

small tribes from applying for funds from these programs because the value of the grants may be outweighed by the administrative burden of participating.[2]

3. ACF has also proposed an increase in funding for the Family Violence Prevention and Services Program to establish an Alaska Native Tribal Resource Center on Domestic Violence.

We continue to hope that the Congress will consider these proposals to strengthen child welfare and family violence prevention efforts for AI/AN children and families. These efforts support Commission recommendations 3.2b, 3.3c and 3.3f.

Leveraging the Health Care System to Reduce Child Abuse and Neglect Fatalities in Tribal Communities

While hardly mentioned in the Commission's report, the Indian Health Service (IHS) must be considered a key resource in addressing maltreatment with American Indian populations. IHS is the primary healthcare system for approximately 2.2 million American Indians and Alaska Natives (AI/AN) representing 567 federally recognized tribes in 35 states. Direct patient care for child maltreatment is provided by licensed staff including medicine, nursing, social services, and behavioral health in a variety of settings including healthcare facilities, community programs, and home visits. Pediatric morbidity and mortality review committees exist in many IHS programs addressing child maltreatment and fatalities. In addition, the integration of behavioral health into clinical care incorporates routine screening for conditions implicated in the risk for child maltreatment including depression, alcohol/substance use, and intimate partner violence. This integrated approach supports the current understanding of the role of adverse childhood events and providing a trauma-informed approach to care in native communities. Creating a "medical home" through the Improved Patient Care (IPC) concept allows for continuity of care from diagnosis to treatment and referral enhancing interdepartmental communication for care to the child and family.

Home visiting programs such as Public Health Nursing and the Community Health Representative Program provide a variety of services with a culturally respectful approach. The assessment for child maltreatment risk, case identification, education, and follow-up based in the community is ideal for tailored education and intervention for both content and within the appropriate context. The ability to establish and maintain Medicaid

[2] The House Appropriations Committee has included this funding in their version of the appropriations bill that includes HHS funding, per House Report 114-699, accompanying HR 5926.

reimbursement for community-based services is vital to support and expand these valuable programs.

IHS participates in multidisciplinary and community-based child protection teams. Each with its own objectives, team membership represents the multi-jurisdictional intersection of child maltreatment including child welfare, law enforcement/prosecution, social services, and healthcare. Myriad combinations of tribal, state, and federal program involvement exist as each state and tribal government has their own laws for reporting and responding to child abuse which coexist with federal laws specific to Indian country.

Demonstration projects such as the IHS Domestic Violence Prevention and Methamphetamine and Suicide Prevention Initiatives, introduced in 2009, directly impact child maltreatment through project expansion of healthcare to children with suspicion of abuse, addressing children who witness violence, youth-based services to reduce suicide, and interventions for substance use disorders.

Developing, implementing, and monitoring health policy for child maltreatment is an agency priority within the IHS Division of Behavioral Health. The Child Maltreatment Policy, historically associated with Maternal Child Health, is under revision as a stand-alone policy to address the healthcare response to child maltreatment and define provider training specific to the Indian health system's response.

Ensuring Equitable Treatment

Disproportionality remains a significant concern in the child welfare field as both African American and American Indian and Alaska Native children are disproportionately represented in many child welfare systems.

Related to recommendation 4.2a, HHS/ACF is working with the HHS Office of Civil Rights (OCR) and the Department of Justice to issue a Dear Colleague letter to state child welfare agencies and courts on their responsibilities to protect children and families from discrimination based on color, creed or national origin as guaranteed by title VI of the Civil Rights Act and its implementing regulations. Once the letter is issued, OCR will provide technical assistance and tools to assist state agencies and courts in their efforts to protect civil rights and identify possible factors that contribute to disproportionality.

HHS will also explore opportunities to train federal employees on implicit bias and issues that may contribute to disproportionality. This activity is responsive to the Commission's recommendation 4.2f.

Through the Court Improvement Program administered by the Children's Bureau, HHS will continue to encourage courts and legal practitioners to enhance their capacities to assess and remedy legal and judicial practices that may contribute to disproportionality. In

addition, the Capacity Building Center for Courts funded by the Children's Bureau will create learning opportunities to address disproportionality and implicit racial bias. The National Model Judicial ICWA Curriculum, which will soon be available to judges and attorneys nationally as an online learning opportunity, is one example of such an effort.

The Children's Bureau also supports the National Child Welfare Workforce Institute (NCWWI) which is conducting relevant work in this area. The purpose of NCWWI is to increase child welfare practice effectiveness through diverse partnerships that focus on workforce systems development, organizational interventions, and child leadership using data, education, and data development. There are a number of resources on their website (http://ncwwi.org/) that speak to the practices noted by the Commission as needed to address disproportionality, per recommendation 4.2e. In addition, the Child Welfare Information Gateway has developed resources on the topic of disproportionality that are available at:
https://www.childwelfare.gov/topics/systemwide/cultural/disproportionality/

Finally, HHS has long encouraged states to emphasize kinship foster care when appropriate family resources are available to keep children safe when parents are unable to provide safe care. Over the past decade the proportion of children in foster care who are living with foster parents who are relatives has increased from 24 percent in 2005 to 29 percent in 2014. By making good use of relatives as alternative care providers when needed, we can keep children connected to their families and communities, reducing the impact of disproportionality on children.

We do disagree with two of the Commission's recommendations related to disproportionality. Recommendation 4.2c suggests that HHS issue regulations providing guidance on best practices in Structured Decision Making. While we appreciate the Commission's desire to reduce bias in child welfare systems' processes, regulations implement specific statutory requirements and are not the place for best practice guidelines. We will, however, continue to provide technical assistance on these topics. In addition, recommendation 7.1f suggests that HHS mandate the implementation of fatherhood programs and improved drug abuse education programming in Indian Country. Given the sovereign status of Indian tribes, mandates such as the Commission suggests are inappropriate. However, HHS will consult with tribes regarding their most pressing needs in these areas.

Conclusion

We at HHS appreciate the Commission's focus on eliminating child abuse and neglect fatalities and the reminder that collectively we must take responsibility for improving

outcomes for vulnerable children. HHS is taking action related to many of the Commission's recommendations and will pursue additional items as funding becomes available. The Commission's report has provided a number of useful recommendations that will become a guide to priorities as we seek to reduce and ultimately eliminate child fatalities caused by abuse or neglect.

This narrative has described major activities being undertaken within a number of HHS agencies that together begin to address many of the concerns identified by CECANF. We will add additional activities as the resources and legislative authority provided by Congress permit.

Appendix A
Recommendations of the Commission to Eliminate Child Abuse and Neglect Fatalities and Responses of the U.S. Department of Health and Human Services

The following color coding applies to this table:

		Green	Indicates HHS agrees with the intent of this recommendation and is taking steps either to implement it directly or to implement activities that are in the spirit of the recommendation but accomplish it through other means that we believe would be more effective and/or can make progress on the issue with available resources and legislative authority.
		Blue	Indicates that additional financial resources or legislative authority would be needed to implement the recommendation. In some cases HHS is implementing related activities within the confines of existing budget and statute, but to do what the Commission suggests would need further congressional action.
		Red	Indicates recommendations with which HHS disagrees.
		Gray	Indicates that the recommendation was not directed at HHS.

Item #	Directed to	Recommendation	HHS Response
2.1	The Administration and Congress	The Administration and Congress should support states in improving current CPS practice and intersection with other systems through a two-year multidisciplinary action to protect and learn from children most at risk of maltreatment fatalities.	HHS supports the concept of the Commission's recommendation, but lacks legislative authority to mandate such a process. The pending Family First Prevention Services Act, if enacted in its current form, would require states to develop child fatality prevention plans, but would not require the data analysis process the Commission suggests. However, ACF will work with states that voluntarily choose to undertake such a process. HRSA/MCHB will also provide support through the National Center for Fatality Review and Prevention, which works to ensure state and local fatality review teams have the tools, training and skills they need to perform systematic reviews of infant and child deaths and to identify factors at the individual, environmental, clinical or systems levels that can be mitigated to prevent future deaths, including deaths from abuse and neglect.
2.1a	HHS	HHS should provide national standards, proposed	HHS's Office of the Assistant Secretary for Planning and Evaluation has

		methodology, and technical assistance to help states analyze their data from the previous five years, review past child abuse and neglect fatalities, and identify the child, family, and systemic characteristics associated with child maltreatment deaths.	recently awarded a contract on the topic of predictive analytics in child welfare that includes an option to develop a suggested data analysis methodology to examine fatality data that states could adopt or adapt if they choose to undertake an analysis such as what the Commission suggests. Exercising the option will be dependent on the availability of funds in FY 2017. We caution, however, that because child maltreatment fatalities are a low incidence event, the development of a national standard is problematic. States frequently have significant year to year swings in the number and rate of fatalities. In small states, a single incident rather than a systemic issue can dramatically affect annual statistics. In addition, in small states an analysis of data from the past five years (per recommendation 2.1c) would include too few cases to draw definitive conclusions. There are several states in which the five year cumulative total of child fatalities reported to the National Child Abuse and Neglect Data System (NCANDS) is fewer than ten children. In most states, analyses of the complexity envisioned by the Commission would need to be expanded beyond child death outcomes to include life threatening injury (where it can be identified) or other serious outcomes that put children at elevated risk of a maltreatment death.
2.1b	States and HHS	States will submit a methodology to HHS for approval, describing the steps they would like to take in using data to identify under what circumstances children died from abuse or neglect during the previous five years.	As noted above, current legislative authority does not mandate such a process. To the extent states voluntarily choose to engage in such data analysis, HHS will support their efforts through technical assistance. The Family First Prevention Services Act, if passed in its current form, would require that states develop child fatality prevention plans but does not require a data analysis methodology as described here.
2.1c	States	After HHS approval, states will identify and analyze all of their child abuse and neglect fatalities from the previous five years to identify under what circumstances children died from abuse or neglect, protective factors that may prevent fatalities from occurring, and agency policies and practices across multiple systems that need improvement to prevent fatalities.	
2.1d	States and HHS	Based on these data, states will develop a fatality	Current statute does not provide authority for HHS to mandate such plans

		prevention plan for submission to the HHS Secretary or designee for approval.	or approve content. However, the pending Family First Prevention Services Act, in its current form, would require that states provide assurances that they are developing and implementing such a plan and that they describe the steps they are taking to implement that plan. If the bill passes, HHS will review state plans to ensure states include the required assurances.
2.1e	States	If states find during the review of five years of data that investigation policy is insufficient in protecting children, their plans should ensure that the most vulnerable children are seen and supported.	
2.1f	States	Once their fatality prevention plan is approved, states will implement this plan by identifying children currently in the system who are most at risk of fatalities (which may include both children at home with their families and those in foster care, as indicated by the data), putting immediate and greater attention on these children, and conducting multidisciplinary visits and reviews of cases to determine whether the children are safe and whether families need different or additional supports, services, or interventions.	
2.1g	States and HHS	Once a state begins the review of current open cases, as outlined in its fatality prevention plan, each state should provide a report to HHS every month until conclusion of the review.	Current authority does not provide for such plans or HHS review of them. The authority contained in the Family First Prevention Services Act would, if enacted in its current form, allow HHS to review each state's assurances that it is developing and implementing such a plan. However, the provision would not provide authority for HHS to oversee the implementation of states' plans. If Congress were to provide such authority, it should be noted that while accountability is important, monthly reports could be burdensome for states and would require extensive resources at HHS to review and act upon monthly reports from each state. As a comparison, states report progress on their Program Improvement Plans, conducted as a follow up to Child and Family Services Reviews, quarterly unless ACF and the state agree upon less frequent reports.
2.1h	HHS	HHS will increase system capacity at the national	A current contract underway through HHS's Office of the Assistant

		level to apply the latest statistical and big data techniques to the problem of preventing child abuse and neglect fatalities.	Secretary for Planning and Evaluation on predictive analytics in child welfare is exploring the issues involved here and will suggest options for HHS to move forward on these issues.
2.1i	Congress	We strongly recommend a significant appropriation of funds by the federal government to strengthen the child protection system by implementing Recommendation 2.1.	
3.1		Address the lack of data on AI/AN children who die from child abuse and neglect by working with tribes to improve and support data collection and by integrating the data into national databases for analysis, research, and the development of effective prevention strategies.	HHS supports the concept of the Commission's recommendation and is working to improve data regarding AI/AN children where HHS has authority and funds available to do so. Our authority regarding tribal child welfare programs primarily relates to those tribes that receive direct funding for title IV-E foster care, adoption and guardianship programs or title IV-B child welfare service funding. We do not have primary authority over tribes' more general child abuse and neglect prevention and investigation programs or data reporting issues because tribes are not statutorily eligible to participate in the main CAPTA funding stream. We have recently proposed in regulation that states report additional data regarding AI/AN children in foster care with respect to the requirements of the Indian Child Welfare Act (ICWA), though that data collection is being collected from states about children subject to ICWA rather than from tribes. We will confer with the Department of Interior's Bureau of Indian Affairs, which does collect some aggregate data from tribal child abuse prevention programs, about whether there are opportunities to include information based on that data either in the annual *Child Maltreatment* report, or as a special topical analysis.
3.1a	Executive Branch and Congress	Mandate that the Bureau of Indian Affairs (BIA) immediately implement the practice of distinguishing child and adult homicide victims when reporting fatalities in Indian Country.	
3.1b	Executive Branch and Congress	Mandate that the FBI identify key data that tribes could track and that the BIA could collect.	
3.1c	Executive Branch and Congress	To generate accurate crime reports for Indian Country, amend FBI reporting requirements for state and local law enforcement agencies' crime	

		data as follows: (1) include information about the location at which a crime occurred and victims' and offenders' Indian status; and (2) require reservation-level victimization data in its annual reports to Congress on Indian Country crime.	
3.1d	Executive Branch and Congress (HHS)	Mandate that tribal data on AI/AN child abuse and neglect and AI/AN child abuse and neglect fatalities be reported in NCANDS.	The submission of NCANDS data is voluntary, not mandatory, even for states. We would not support including mandates on tribes that go beyond what is required for states. In the past, we have not included tribes in the NCANDS data collection primarily because the authority for NCANDS is based in Child Abuse Prevention and Treatment Act (CAPTA) programs for which tribes are not eligible. Given that the Department of Interior's Bureau of Indian Affairs (BIA) has begun collecting aggregate data on child abuse and neglect among AI/AN children, HHS believes it may be more efficient to build on that existing data system rather than replace that effort in this Department. We will discuss with BIA whether there is information from their data collection that would be worthwhile to feature either in the annual *Child Maltreatment* report, or as a special topical analysis. In addition, we will discuss with BIA and with tribes the possibility of including tribal data in NCANDS on a voluntary basis. There would be resource issues involved in doing so, however, both for tribes and for HHS. From HHS's perspective, there would be additional costs of processing potentially hundreds of tribal data submissions in addition to the approximately 50 submissions typically processed from states, as well as any technical assistance needed to assist tribes in preparing data. And while states may support their work in submitting NCANDS data through CAPTA state grants, as noted above, tribes are not currently eligible for funding through that program.
3.1e	Executive Branch and Congress	Create a pilot program to support the coordinated collection of child welfare and criminal justice data related to child abuse and neglect fatalities in select tribal communities and states.	HHS would be pleased to collaborate with other agencies on such an effort if Congress were to provide authority and resources for such a pilot.
3.1f	Executive Branch and Congress	Ensure the accuracy of data/information and ensure that tribes have the capacity and tools to provide that data/information.	We understand from CECANF staff that this recommendation relates specifically to the pilots recommended in 3.1e. If such pilots were authorized and funded, we agree that tribes' capacities regarding data collection would need to be supported.

3.1g	States and Counties	The National Association of State Registrars should work with states to coordinate the addition of tribal affiliations on death certificates.	
3.2		Improve collaborative jurisdictional responsibility for Indian children's safety.	HHS supports the Commission's intent and is collaborating with other relevant agencies on a range of activities related to the well-being of AI/AN children. Most relatedly, see our response below to recommendation 3.2b.
3.2a	Executive Branch	Taking into account already existing tribal structures, require that there be a jurisdictional committee composed of both state and tribal leaders to determine jurisdictional issues in criminal matters associated with child abuse and neglect fatalities and life-threatening injuries.	
3.2b	Executive Branch	The federal government should release an RFP (request for proposal) for demonstration projects using a multidisciplinary approach to address the needs of AI/AN children and their families that requires tribal, federal, and state partnerships.	ACYF has recently issued two grant announcements related to this recommendation. Grants under these announcements will be awarded by the end of September 2016. First is the funding opportunity for a National Quality Improvement Center for Preventive Services and Interventions in Indian Country. (HHS-2016-ACF-ACYF-CA-1175). The purpose of this funding opportunity announcement is to award a 5-year cooperative agreement to establish a Quality Improvement Center (QIC) on the prevention and intervention of child abuse and neglect in American Indian/Alaska Native (AI/AN) communities. The QIC will gather, generate, and disseminate knowledge regarding effective practice models for strengths-based, culturally relevant, trauma-informed, and preventive services and interventions for all forms of child maltreatment. As part of this work, the QIC will provide technical assistance and implementation assistance for two to five project sites. The purpose of the selected project sites is to implement and assess practice models that show promise in preventing child abuse and neglect and that may be implemented or adapted in other tribal child welfare systems. Second, under the Community-Based Child Abuse Prevention Program is a funding opportunity entitled Grants to Tribes, Tribal Organizations, and Migrant Programs for Community-Based Child Abuse Prevention

			Programs (HHS-2016-ACF-ACYF-CA-1119). The primary purpose of this funding opportunity announcement is to support community-based efforts to develop, operate, expand, enhance, and coordinate initiatives, programs and activities in tribal and migrant communities to prevent child abuse and to strengthen and support families to reduce the likelihood of child abuse and neglect, consistent with the goals outlined by Title II of the Child Abuse Prevention and Treatment Act (CAPTA). Some examples of programs that may be funded include, but are not limited to, voluntary home visiting, respite care, parenting education, family resource centers, domestic violence services, and other family support services. IHS also has efforts underway related to this recommendation. The 2009 IHS Domestic Violence Prevention Initiative (DVPI) is a congressionally mandated, nationally coordinated grant and federal award program for tribes, tribal organizations, federally operated programs, and urban Indian organizations to provide violence prevention and treatment services. The DVPI promotes the development of evidence-based and practice-based models that represent culturally appropriate prevention and treatment approaches to domestic and sexual violence from a community-driven context. The DVPI expands outreach and increases awareness by funding projects that provide victim advocacy, intervention, case coordination, policy development, community response teams, sexual assault examiner programs, and community and school education programs. Concurrently, IHS funds the Methamphetamine and Suicide Prevention Initiative (MSPI), a nationally-coordinated program focusing on providing much-needed methamphetamine and suicide prevention and intervention resources for Indian Country. This initiative promotes the use and development of evidence-based and practice-based models that represent culturally-appropriate prevention and treatment approaches to methamphetamine abuse and suicide prevention from a community-driven context. Currently there are a total of 129 grants and federal program awards, including 60 projects that focus on preventing substance use and suicide among native youth up to age 24.
3.3		Designate one person or office to represent federal leadership in the prevention of AI/AN child	

		maltreatment fatalities and to coordinate efforts with tribes and ensure parity with states with regard to resources.	
3.3a	Executive Branch and Congress	Mandate the appointment or strengthen an existing role of a staff person within the administration with oversight over every federal department concerning child abuse and neglect fatalities of AI/AN children.	
3.3b	Executive Branch and Congress	Explore alternatives to current grant-based and competitive Indian Country criminal justice and child welfare funding in the Department of Justice to ensure that all tribes have fair opportunity for access to those funds.	
3.3c	Executive Branch and Congress	Bring funding for tribal systems providing services and support in the area of child maltreatment into parity.	HHS provides funding and services to tribes in the area of child maltreatment through titles IV-B and IV-E as authorized by Congress. Increasing resources and tribal participation in programs we administer would require legislative changes. Approximately 180 tribes receive grants under the Stephanie Tubbs Jones Child Welfare Services Program (title IV-B, subpart 1 of the Social Security Act) and approximately 130 tribes receive grants under the Promoting Safe and Stable Families program (title IV-B, subpart 2). Since FY 2009, 32 tribes have received grants to support them in developing an approvable plan to receive funds directly to operate their own foster care, adoption assistance and guardianship assistance program under title IV-E of the Social Security Act. Currently seven tribes have approved title IV-E plans and several pending plans are likely to be approved in the near future. A number of other tribes have title IV-E planning grants and are preparing to submit title IV-E plans in the near future. Additionally, many tribes have title IV-E agreements with the states in which they are located. Changes to how funding flows to tribes would require legislative action. The FY 2017 President's Budget request for ACF proposes several legislative changes and budget proposals to strengthen funding for tribes.

			These include: 1. Increased start-up funding for tribes approved to operate a title IV-E program and an enhanced match for case management and other case work activities performed by tribal casework staff and for training tribal caseworkers. Together the funding for these proposals is estimated at $37 million in FY 2017 and $241 million over ten years. 2. An increase of $20 million in funding provided to tribes under title IV-B, subpart 2, the establishment of a minimum grant amount of $10,000 for all tribes applying for funds and streamlined planning and reporting requirements for Tribes receiving funds under Title IV-B programs (both Part 1 and Part 2). Current extensive requirements discourage small tribes from applying for funds from these programs because the value of the grants may be outweighed by the administrative burden of participating.[3] 3. ACF has also proposed an increase in funding for the Family Violence Prevention and Services Program to establish an Alaska Native Tribal Resource Center on Domestic Violence.
3.3d	Executive Branch and Congress	Work to provide for the delivery of mental health services [to Tribes] through Medicaid and title IV-B.	HHS is also concerned about the delivery of mental health services to families involved with the child welfare system and has worked to improve the delivery of trauma informed services. Tribes have discretion in determining the use of funds under the title IV-B Child Welfare Services Program. However, given the generally small size of most tribal grants and the range of service needs in tribal communities, these funds are unlikely to fund significant quantities of mental health services. (More than 40 tribes receive child welfare services program grants of less than $5,000 per year.) Additional funding for tribes under these programs would require legislative change, including an increased

[3] The House Appropriations Committee has included this funding in their version of the appropriations bill that includes HHS funding, per House Report 114-699, accompanying HR 5926.

			appropriation. With respect to Medicaid, while many AI/AN persons are Medicaid eligible and may receive Medicaid funded services through states, Indian Tribes do not operate Medicaid programs. The Indian Health Service rather than Medicaid funds most health services on tribal lands, although IHS may bill Medicaid for eligible services for patients who are enrolled in Medicaid in the state in which they reside. IHS recently launched a project to increase Medicaid and Medicare enrollment of patients at six health facilities in four states. The project is an opportunity for IHS facilities to improve Medicaid and Medicare enrollment, increasing third-party billing revenue and in turn increasing resources available for IHS to spend on patient care. Regarding services funded through Medicaid, state Medicaid Agencies and the Centers for Medicare & Medicaid Services partner to address Medicaid services for persons who are Medicaid-eligible in the states, the District of Columbia and territories. Medicaid covers the Early and Periodic Screening, Diagnostic and Treatment benefit that requires screenings at regular intervals to identify health and developmental issues as early as possible, for children birth to age 21. Covered screening services are medical, mental health, vision, hearing and dental. If screening determines the need for further evaluation, the child must be referred for diagnosis without delay. Finally, coverage must include all medically necessary services for children birth to age 21 listed in section 1905(a) of the Social Security Act regardless of whether such services are covered in the state Medicaid plan. States could consider various benefit categories to cover mental health services in the state plan such as the "preventive services", "rehabilitative services" and "other licensed practitioners'" benefits. CMS has issued relevant guidance that would aid in the delivery of mental health services to children and adults, including guidance on treatment services for mental illness, substance use disorders, maternal depression and home visiting services. Guidance on these topics released in recent years includes the following: 1. Coverage of Peer Support Services, State Medicaid Director (SMD)

			Letter – #07-011, issued 8/15/2007. Clarifying guidance that extended peer services to parents, issued on 5/1/2013. 2. Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, Center for Medicaid & CHIP Services (CMCS) Informational Bulletin, issued 12/3/2012. 3. Prevention and Early Identification of Mental Health and Substance Use Conditions, CMCS Informational Bulletin, issued 3/27/2013. 4. Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions, Joint CMCS and SAMHSA Informational Bulletin, issued 5/7/2013. 5. Tri-Agency letter on Trauma-Informed Treatment, CMS, SAMHSA, ACF, issued 7/11/2013. 6. Medication Assisted Treatment, Joint CMCS, SAMHSA, CDC and NIH Informational Bulletin, issued 7/11/2014. 7. Innovation Accelerator Program (IAP): Delivery Opportunities for Individuals with a Substance Use Disorder, CMCS Informational Bulletin, issued 10/29/2014. 8. Coverage of Behavioral Health Services for Youth with Substance Use Disorders, Joint CMCS and SAMHSA Informational Bulletin, issued 1/26/2015. 9. First Episode Psychosis, Joint CMCS, NIH and SAMHSA Informational Bulletin, issued 10/16/2015. 10. Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction, CMCS Informational Bulletin, issued 2/2/2016. 11. New Service Delivery Opportunities for Individuals with a Substance Use Disorder, SMD Letter #15-003, issued 7/27/2015. 12. Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children, CMCS Informational Bulletin, issued 5/11/2016.
3.3e	Executive Branch and Congress	Ensure that tribes are provided with adequate funding for child abuse and neglect reporting.	HHS provides tribes funds as authorized by Congress. The funding stream most directly related to child abuse and neglect reporting is the Child Abuse Prevention and Treatment Act Basic State Grant Program. Tribes are currently ineligible for that program; legislative change would be required for tribes to receive a share of these funds. The Department of Interior's Bureau of Indian Affairs does operate

			programs relating to child abuse and neglect prevention and we expect they will respond to the Congress regarding programs within their jurisdiction. As noted in item 3.3c above, HHS has several proposals in the FY 2017 President's Budget that would increase funding for tribal child welfare activities, though not specifically for abuse and neglect reporting.
3.3f	Executive Branch and Congress	Create consistent tribal title IV-E guidance and improve the timeliness of the title IV-E assistance and reviews for tribes. In consultation with tribes, Congress and the administration should consider flexibilities in the title IV-E program that will help the tribes implement direct tribal IV-E in the context of sovereignty.	HHS is committed to providing consistent guidance and timely review of title IV-E plan submissions from tribes. The Children's Bureau has strengthened internal communications among central and regional office staff and is in the process of hiring additional regional office staff to work with tribes. In addition, to better support tribes in this effort, as noted above with respect to recommendation 3.3c, the FY 2017 President's Budget request includes proposals relating to upfront funding and increased match in certain areas for tribes participating in title IV-E. We will continue to continue to engage in ongoing tribal consultation around federal programs and policies affecting tribal child welfare services, including tribal participation in the title IV-E program.
4.1		Conduct pilot studies of place-based Intact Family Courts in communities with disproportionate numbers of African American child fatalities to provide preemptive supports to prevent child abuse and neglect fatalities.	HHS would be pleased to administer or collaborate with other Departments on such grants if Congress were to provide funds for such pilot studies.
4.1a	Congress	Congress should incentivize the establishment of Intact Family Court demonstration projects that feature a multidisciplinary team approach in order to promote healthy families and communities where there is a disproportionate incidence of child abuse and neglect and child abuse and neglect fatalities.	
4.2	Executive Branch	Ensure that quality services are available to all children and families and that all families are treated equitably.	HHS supports the Commission's intent here. See comments below on individual recommendations.
4.2a	Executive Branch	Ensure that the newly elevated Children's Bureau addresses racial equity and disproportionality in	HHS/ACF is working with the HHS Office of Civil Rights (OCR) and the Department of Justice to issue a Dear Colleague letter to state child welfare

		child welfare through guidance and policies on agency self-assessment, worker training, and use of decision-making tools.	agencies and courts on their responsibilities to protect children and families from discrimination based on color, creed or national origin as guaranteed by title VI of the Civil Rights Act and its implementing regulations. Following issuance of the letter, OCR will create technical assistance tools to assist state agencies and courts in their efforts to protect civil rights and identify possible contributors to disproportionality. ACF will assist in this effort through dissemination to the child welfare community.
4.2b		Incorporate into the Child and Family Services Reviews (CFSRs) an indicator of the degree to which racial disproportionality is found within various aspects of a state's child welfare system.	HHS will consider the merits of such an indicator when the Child and Family Services Review process is revised for the next (fourth) round of reviews.
4.2c	Executive Branch	Provide guidance, through the regulatory process, on best practices in the use of Structured Decision-Making (SDM) tools in areas where a disproportionate number of child abuse and neglect fatalities have been documented, to effect reduction of bias in child welfare systems' screening, investigations, and interventions.	While we agree in concept with the Commission's desire to reduce bias in child welfare systems' processes, regulations implement specific statutory requirements and are not the place for best practice guidelines. There are no statutory provisions directly related to Structured Decision Making and so regulatory guidance is inappropriate. Technical assistance on Structured Decision Making is available through the Child Welfare Information Gateway.
4.2d	Executive Branch	Encourage states to promote examples, such as the National Council of Juvenile and Family Court Judges (NCJFCJ) Bench Card, to expose practitioners to decision-making tools that are focused on addressing bias directly.	Through the Court Improvement Program administered by the Children's Bureau, HHS will continue to encourage courts and legal practitioners to enhance their capacities to assess and remedy legal and judicial practices that may contribute to disproportionality. In addition, the Capacity Building Center for Courts funded by the Children's Bureau will create learning opportunities to address disproportionality and implicit racial bias. One example is the National Model Judicial ICWA Curriculum, scheduled for completion in early FY 2017, which will be available to judges and attorneys nationally as an online learning opportunity.
4.2e	Executive Branch	Where disproportionality is pervasive, prioritize training of the child welfare workforce, partners, and mandated reporters on the topics of (1) family engagement, development, and strengthening; (2) understanding distinct racial and ethnic cultures and racial and ethnic cultural norms and differences; (3) understanding the historical context of racism; (4) understanding and	The Children's Bureau supports the National Child Welfare Workforce Institute. The purpose of NCWWI is to increase child welfare practice effectiveness through diverse partnerships that focus on workforce systems development, organizational interventions, and child leadership using data, education, and data development. There are a number of resources on their website (http://ncwwi.org/) that speak to the issues identified in this recommendation. In addition, the Child Welfare Information Gateway has developed resources on the topic of

		recognizing biases; and (5) how biases can impact assessment of risk, access to services, and delivery of services.	disproportionality that are available at: https://www.childwelfare.gov/topics/systemwide/cultural/disproportionality/
4.2f	Executive Branch	Require racial equity training across federal, state, and local child welfare agencies and other child-serving systems to ensure that families disproportionately represented are served and supported by a workforce that is trained, prepared, and mobilized around equitable decision-making and shared accountability.	In conjunction with Dear Colleague letter referenced in 4.2a, HHS is undertaking efforts to enhance training resources and opportunities for state child welfare agencies and courts through the Capacity Building Collaborative funded by the Children's Bureau. HHS will also explore opportunities to train federal employees on implicit bias and issues that may contribute to disproportionality. However, no current legislative authority allows us to require such training as the Commission suggests. With respect to health agencies that work with children, HHS has developed an HHS Action Plan to Reduce Racial and Ethnic Disparities led by the Office of Minority Health. Activity associated with the plan includes the National Partnership for Action which works with Regional Health Equity Councils in each HHS region that could be a vehicle for training in the health care community and related human services providers along the lines the Commission suggests.
4.2g	Executive Branch	Require racial equity impact assessments to address issues of disproportionality and disparities at the federal, state, and local levels, when utilizing predictive analytics to develop prevention and intervention strategies.	HHS agrees that it is important to consider potential unintended racial equity impacts when developing and implementing predictive analytics models and applications. However, the Commission's recommendation is unclear about who it expects would be required to do this and under what legislative authorities. Most predictive analytics work is being done by local agencies using their own funds. No current legislative authority allows HHS to require such assessments, particularly when the activities are not supported with HHS funds.
4.2h	Congress	Promote examples such as the focused efforts in Sacramento County, CA, and Michigan in order to inform states and other communities in the replication of a balanced, data-informed, community-driven response to address the reduction of child abuse and neglect fatalities.	
4.2i	Congress	Incentivize states to implement funding mechanisms that integrate assessments, metrics, and accountability structures to ensure that the quality of services is a fundamental component of	

		any program/service approach that is serving disproportionately represented children and their families, with ongoing continuous quality improvement (CQI) strategies also integrated.	
4.2j	Congress	Promote examples from communities and/or also fund demonstration projects that leverage community partnerships (i.e., neighborhood-based work, faith-based partners, and others) to provide supports and services to families to improve outcomes and reduce child abuse and neglect and child abuse and neglect fatalities for children and families who are disproportionately represented.	CDC's Essentials for Childhood Initiative is funding five state health departments over five years to partner with key stakeholders from different disciplines and sectors to facilitate consensus around a common agenda (i.e., shared vision, goals, and strategies) and shared metrics to track their progress in assuring safe, stable, nurturing relationships and environments through programs, norms change, and policies that help prevent child abuse and neglect and address the social determinants of health.
4.2k	Congress	Promote focused research on how implicit biases impact assessment, access to services, and service delivery.	
5.1		Create an effective federal leadership structure to reduce child abuse and neglect fatalities.	While HHS agrees that an "effective leadership structure" is always desirable, as noted below we disagree with the specific recommendations the Commission has presented. We do not believe that the organizational structure proposed by the Commission would represent an improvement. We believe the Children's Bureau is most effective within ACF where the interrelationships and synergies among a range of human services programs and issues can best be considered. The Children's Bureau endeavors to improve current child protective services practice and intersection with other systems through the Federal Interagency Workgroup on Child Abuse and Neglect (FEDIAWG). FEDIAWG meets in-person on a quarterly basis and tie overall goals of the FEDIAWG are: 1) to provide a forum through which staff from relevant federal agencies can communicate and exchange ideas concerning child maltreatment related programs and activities; and 2) To provide a basis for collective action through which funding and resources can be maximized.
5.1a	Executive Branch	Elevate the Children's Bureau to report directly to the Secretary of HHS. Require the HHS Secretary, in consultation with the Children's Bureau, to report annually to Congress on the progress of the	The Commission does not articulate a strong rationale and evidenced reasoning that this move would help reduce child fatalities. There would be significant structural problems with moving a grant making agency such as the Children's Bureau into the Office of the Secretary which does

		implementation of the recommendations of this Commission.	not have the administrative infrastructure to support the extensive program operations needed to administer the over $8.5 billion in federal programs for which the Children's Bureau is responsible. The Office of the Secretary also does not have the regional office infrastructure upon which the Children's Bureau relies. These administrative and regional structures are shared with other parts of ACF and could not be moved with the Children's Bureau without considerable duplication of effort.
5.1b	Executive Branch	Consider moving the Maternal and Child Health Bureau (MCHB) back into the Children's Bureau.	The Commission does not articulate a strong rationale and evidenced reasoning that this move would help reduce child fatalities. While the Maternal and Child Health Bureau (MCHB) was part of the Children's Bureau many decades ago, since then, MCHB's work has become integrated into health care systems and the public health infrastructure that serves families. MCHB weaves child abuse prevention throughout all of its programs, including the MCH Services Block Grant, Home Visiting, and Healthy Start. Child abuse neglect and prevention is a piece of a much larger MCHB strategy, and that overall strategy is best served as part of the Health Resources and Services Administration. Moving the Maternal and Child Health Bureau would put in jeopardy the benefits gained from incorporating child safety into the overall public health approach.
5.1c	Executive Branch	Create a position on the Domestic Policy Council that is responsible for coordinating family policy across multiple issues of priority for the administration, one of which would be child abuse and neglect fatalities.	
5.2		Consolidate state plans to eliminate child abuse and neglect fatalities.	
5.2a	Congress	Through legislation, Congress should require states to develop and implement a coordinated, integrated, and comprehensive state plan to prevent child maltreatment fatalities.	
5.2b	States and Counties	Prepare state fatality prevention plans on child abuse and neglect fatalities, as required above, under the leadership of the governor's office.	
5.3		Strengthen accountability measures to protect children from abuse and neglect fatalities.	HHS supports the Commission's intent here. See comments below on individual recommendations.

5.3a	Executive Branch	Provide examples of best practices in state level policies, including expanding infant safe haven laws to cover infants up to age 1.	Through our extensive technical assistance efforts with states and communities, we strive to provide information on best practices in the child welfare field. HHS currently offers information and practical resources on a wide array of state level child protective policies and best practices through its online clearinghouse, the Child Welfare Information Gateway (www.childwelfare.gov). As part of the Gateway's State Statute Series, ACYF created a publication on Safe Haven Laws to provide information to the field. It discusses states laws that provide safe places for parents to relinquish newborn infants. Users may use the state statutes search tool to find, review, and compare states' and territories' infant safe haven laws with respect to features that include the responsibilities of and immunity from liability for providers who accept the infants, legal protections from prosecution for the parents, and the effect of relinquishment on parental rights also are discussed. Summaries of laws for all states and U.S. territories are included.
5.3b	Executive Branch	Tribal child protection programs that meet accountability and child safety standards, as outlined in federal guidelines, should be operated and implemented at the discretion of the tribe and should enable the tribe to innovate and develop best practices that are culturally specific, while maintaining those standards.	The Bureau of Indian Affairs has the lead role in the child protective services end of the child welfare service spectrum for tribes. However, HHS currently provides tribal child welfare agencies with information and support to help them select and implement best practices in screening and investigation. Our information clearinghouse, the Child Welfare Information Gateway (www.childwelfare.gov) provides a variety of useful resources in this regard. In addition, the Capacity Building Center for Tribes is available to assist tribes in assessing and strengthening their child welfare programs.
5.3c	Congress	Require training and technical assistance for courts on implementation of the federal law relating to the ASFA Reunification Bypass.	
5.3d	Congress	Amend CAPTA to clarify and require that all information currently specified in CAPTA must be released following a death or life-threatening injury from abuse or neglect and must be posted on the state's website no later than 48 hours after receipt of the report, excepting any information that might otherwise compromise an ongoing criminal investigation	
5.3e	States and	Amend state infant safe haven laws to expand the	

	Counties	age of protected infants to age 1 and to expand the types of safe havens accepted, including more community-based entities such as churches, synagogues, and other places of worship. States also should expand public awareness campaigns for safe haven laws, given the correlation between awareness and effectiveness.	
5.3f	States and Counties	Publish child abuse and neglect fatality information on state public websites at least annually, similar to the approach in Florida.	
5.4		Hold joint congressional hearings on child safety.	
5.4a	Congress	Hold joint congressional hearings on child safety in committees that oversee CAPTA, title IV-E, title IV-B, and Medicaid to better align national policies, resources, and goals pertaining to the prevention of and response to safety issues for abused or neglected children.	
6.1		Enhance the ability of national and local systems to share data to save children's lives and support research and practice.	HHS supports the Commission's intent here. See comments below on individual recommendations.
6.1a	Executive Branch	Spearhead a special initiative to support state and local entities engaged in protecting children, such as law enforcement and CPS, in sharing real-time electronic information on children and families.	The Children's Bureau has recently (June 2, 2016) issued new final regulations on Comprehensive Child Welfare Information Systems (CCWIS) which govern states' use of federal funds to develop and maintain the electronic systems for handling child welfare data. In addition, the FY 2017 President's Budget includes proposals to enhance funding to states to upgrade and modernize their information systems. If there were a state program requirement for real time data sharing, CCWIS could support the implementation of such systems. The expectation for data sharing is built into the CCWIS regulation, though the there are no requirements that such sharing be in real time. Several required exchanges are built into the CCWIS regulation, including a requirement that the system incorporate data exchange between the state and tribal child protective services. Other exchanges including law enforcement can be added if a state finds a programmatic need. However, an important consideration in this regard is that there are potentially

			numerous law enforcement systems/jurisdictions in a state (or tribe) that would need to exchange data with the child welfare agency and their data capacities may be variable.
6.1b	Executive Branch	Increase the interoperability of data related to child protection across federal systems.	HHS agrees that this is an important concept that would aid in child protection data collection and policy development. However, the Commission's intent here was unclear. If it is the intent to be able to match data on individual children across systems at the federal level, there would be significant issues with respect to confidentiality and ability to link data that may not be entirely comparable. In addition, many federal systems (including ACF's child welfare administrative systems) do not include personally identifiable information, so there are significant limits to the matching that can be conducted in federal administrative data. If the Commission's intent instead is to better count fatalities that may be represented in different systems, increasing interoperability at the state level may be a better strategy to improve both services and data from multiple systems. We note that making significant efforts toward interoperability would require resources beyond existing funding levels. ACF's Office of Planning, Research and Evaluation has just reorganized to create a Division of Data and Improvement that will focus on improving the quality, usefulness, interoperability, and availability of data. We expect the efforts of that division moving forward will align well with the Commission's goals in this regard. More information on the new Division may be found in the June 24, 2016 Federal Register Announcement announcing the Division's establishment. (https://www.gpo.gov/fdsys/pkg/FR-2016-06-24/pdf/2016-14981.pdf)
6.1c	Executive Branch	Increase system capacity at the national level to apply the latest statistical and big data techniques to the problem of preventing child abuse and neglect fatalities.	HHS's Office of the Assistant Secretary for Planning and Evaluation has recently awarded a contract to examine the issue of predictive analytics in child welfare and present options for ways in which HHS may facilitate the constructive use of improved data capabilities. Options in the contract will allow for some follow up on aspects of the ideas generated if additional funds are available in FY 2017 or FY 2018. We caution, however, that there are significant limitations to the federal

			data sets that may not allow for the best use of these techniques nationally. It may very well be that the better use of these techniques will be at the state and local levels where richer data is available and personally identifiable data can be matched across systems. Supporting state/local efforts and learning from their successes and challenges may be a better use of resources in this regard.
6.1d	Congress	Consider what legislative or funding changes would be required to empower the Executive Branch to carry out Recommendations 6.1a: Enhanced real-time electronic data sharing among state agencies engaged in protecting children; 6.1b: Increased interoperability of data related to child protection across federal systems; and 6.1c: Application of the latest statistical and big data techniques to the problem of preventing child abuse and neglect fatalities.	
6.1e	Congress	Require federal legislation that defines the permissibility of data sharing for children involved in the child welfare system, those who are dependents of active duty military, and those receiving publicly funded prevention services, to require the sharing of information between civilian CPS agencies and Department of Defense family advocacy offices and related agencies.	
6.1f	Congress	Clarify federal legislation that allows CPS agencies access to National Crime Information Center criminal background information.	
6.1g	States and Counties	Require cross-notification for allegations of child abuse and neglect between law enforcement and CPS agencies, implementing a system similar to the Electronic Suspected Child Abuse Report System (E-SCARS) in Los Angeles County.	
6.2		Improve collection of data about child abuse and neglect fatalities.	HHS supports the Commission's intent here. See comments below on individual recommendations.

6.2a	Executive Branch	Rapidly design and validate a national standardized classification system to include uniform definitions for counting child abuse and neglect fatalities and life-threatening injuries.	CDC currently has uniform definitions for surveillance of child maltreatment[4] and pediatric abusive head trauma[5]. While the definitions, particularly those for child maltreatment, may need to be updated, they provide a foundation from which to begin in addressing this recommendation. However, updates to the definitions require resources, including funding and staff capacity. Resources for this activity were not available from FY 2016 funding.
6.2b	Executive Branch	Improve the system of child death investigation and death certification by developing standards of investigation and expertise in investigation and certification.	Agencies including the CDC and HRSA have worked to promote improved data collection in this area. The CDC's National Center for Health Statistics is working with coroners and medical examiners to improve death scene investigation and standard data collection for infant deaths. Further, CDC's Division of Violence Prevention is partnering with other agencies and organizations to develop on-scene/front-line mobile technology that will assist in collecting and standardizing data collection at crime scenes. An expert panel has already occurred, and plans are underway to develop the mobile application. Finally, HRSA's Maternal and Child Health Bureau supports the National Center for Fatality Review and Prevention (NCFRP) which plans to convene subject matter experts and federal agencies in 2017 to develop standard guidelines for performing fatality reviews of children where abuse and neglect was a causative or contributing factor.
6.2c	Executive Branch	Develop the National Fatal and Life-Threatening Child Maltreatment Surveillance System as a National Data Repository to collect, analyze, and report data on fatalities and life-threatening injuries from maltreatment.	Developing a surveillance system as the Commission suggests would require resources beyond what Congress has currently provided. Should Congress fund such an effort, however, HHS agencies would collaborate to implement it. HHS agencies currently operate three complementary information systems, any of which might become the basis for such a repository.

[4] Leeb RT, Paulozzi L, Melanson C, Simon T, Arias I. Child Maltreatment Surveillance: Uniform Definitions for Public Health and Recommended Data Elements, Version 1.0. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2008.
[5] Parks SE, Annest JL, Hill HA, Karch DL. Pediatric Abusive Head Trauma: Recommended Definitions for Public Health Surveillance and Research. Atlanta (GA): Centers for Disease Control and Prevention; 2012.

			ACF maintains the National Child Abuse and Neglect Data System which collects case level information on all child maltreatment reports in the U.S., including deaths known to the child protective services system in all 50 states, the District of Columbia, and the Commonwealth of Puerto Rico. This data is used by a range of agencies and researchers to examine trends in child maltreatment. CDC's National Violent Death Reporting System (NVDRS) currently operates in 32 states and collects information on violent deaths, including deaths that occur among children. The NVDRS system links information from death certificates, coroner/medical examiner (CME) reports and law enforcement (LE) reports. The CME and LE reports include narrative and circumstance information. The ultimate goal of NVDRS is to expand to all 50 states. While NDVRS captures information on child maltreatment deaths, an optional module (i.e., the child fatality review module) captures additional information collected as part of the child death review. Dedicated additional funding could potentially enable states to complete the module as a standard/core part of NVDRS. This system currently does not operate nationwide and does not collect information on life threatening injuries. In addition, HRSA/MCHB supports the National Center for Fatality Review and Prevention (NCFRP) Child Death Review Case Reporting System, which could provide a model for a national repository, in collaboration with CDC and ACF. The system is modeled after the CDC sudden infant death syndrome national case registry and uses standard definitions of maltreatment. None of these systems currently capture cases of life threatening injuries that did not result in death. In addition, these systems cannot currently detect and eliminate duplication of cases that may be reported in multiple systems.
6.2d	Executive Branch	Expand upon the HHS national report of child abuse and neglect fatalities, currently provided in the annual Child Maltreatment report, by collecting and synthesizing all available information (cross-	HRSA's Child Death Review Case Reporting System collects and synthesizes information on the circumstances surrounding child maltreatment deaths to inform program and policy development and quality improvement efforts at the local, state and national level. ACF staff

		agency) on the circumstances surrounding child maltreatment deaths to inform policy.	will work with HRSA to consider whether information from this system would be useful to summarize either in the annual *Child Maltreatment* report or as a special feature.
6.2e	Executive Branch	Conduct longitudinal research about the leading factors related to child abuse and neglect fatalities of AI/AN children, 18 and under.	HRSA/MCHB is already serving AI/AN communities with a preventive lens through the Home Visiting, Healthy Start and Title V programs. The Fatality Review Center captures environmental and system issues once a death occurs that allows for future prevention strategies. Additional resources would be needed to conduct longitudinal research. We caution here that while AI/AN children are disproportionately represented among child abuse and neglect fatalities, the numbers are relatively small, making it unclear that longitudinal research would detect sufficient numbers of fatalities to draw specific and reliable conclusions. We reviewed data from HRSA's Child Death Review System and determined that cumulatively over the 10 year period from 2004-2015, the system records the deaths of 225 AI/AN children from select states in which child abuse or neglect was noted as either causing or contributing to the fatality. The numbers vary substantially from year to year and do not represent all states. The system included 29 such deaths in 2012, 44 in 2013 and 23 in 2014.
6.2f	Congress	Consider whether statutory changes and/or additional funding may be required for the Executive Branch to carry out Recommendation 6.2b: Improve the system of child death investigation and death certification by developing standards of investigation and expertise in investigation and certification; 6.2c: Develop the National Fatal and Life-Threatening Child Maltreatment Surveillance System; and 6.2d: Expand upon HHS's national report of child abuse and neglect fatalities, currently provided in the annual Child Maltreatment report.	
6.2g	Congress	Amend CAPTA to improve the data on fatalities and life-threatening injuries that states are required to collect and submit to NCANDS until the Data Repository is operational. Consider what	

		additional funding may be necessary to support these changes.	
6.3		Fatality reviews and life-threatening injury reviews should be conducted using the same process within all states.	HRSA/MCHB is working to strengthen the practice of child death review through standardized data collection and training to state and local communities to perform systematic fatality reviews for deaths due to child abuse and neglect. Broadening these systems to include life threatening injuries would no doubt strengthen the system, but these changes would require resources. HHS also does not have authority to require that states use the same processes for conducting these reviews.
6.3a	Executive Branch	Lead the analysis and synthesis of all child maltreatment fatality and life-threatening injury review information at the national level; include expanded information in the Child Maltreatment report, and broadly disseminate findings including to state child welfare programs as well as to title V and CDC programs.	HHS agrees that we should hold as a long-term goal the synthesis of federal data sources on child maltreatment fatalities and life threatening injuries. There are significant barriers to doing so, however, and the costs of doing so would also be significant. HRSA's National Center for Fatality Review and Prevention provides public use datasets for researchers and has published and presented findings from the child maltreatment deaths in the CDR database[4]. Future efforts will focus on publishing summary of the child abuse and neglect data in 2017 as part of an effort to strengthen fatality reviews for these deaths. We will explore whether there is a reasonable way to include summary data from National Violent Death Reporting System and the Child Death Review Database in the annual *Child Maltreatment* report, either regularly or as a special feature.
6.3b	Executive Branch	In order to incentivize states to add the reviews of life-threatening injuries caused by child maltreatment into their current child death review activities, receipt of CAPTA funds should be contingent upon states conducting these reviews.	This recommendation was directed at the executive branch, but HHS could not condition CAPTA funds upon such reviews unless authorized to do so by Congress.
6.3c	Executive Branch	Develop uniform standards and guidelines for conducting case reviews of maltreatment deaths so that they will lead to improved case ascertainment, agency policy, and practice improvements and actions for prevention.	HRSA/MCHB supports the National Center for Fatality Review and Prevention (NCFRP) which currently provides a standardized data form and Case Reporting System to all states to review child deaths due to abuse and neglect. Future efforts of the Center will convene subject matter experts to review best practices for the subset of deaths associate with child abuse and neglect.

			The Center has a webpage that discusses review of abuse and neglect case and includes resources for teams. See: https://www.childdeathreview.org/reporting/child-abuse-and-neglect/
6.3d	Congress	Consider whether statutory changes and/or additional funding may be required for the Executive Branch to carry out the preceding recommendations in support of uniform fatality and life-threatening injury reviews.	
7.1		Ensure access to high-quality prevention and earlier intervention services and supports for children and families at risk.	HHS supports the Commission's intent here, though as noted below with respect to the sub-recommendations, we have different preferences for how the goal would best be accomplished.
7.1a	Executive Branch	Permit Medicaid reimbursement for evidence-based infant home visiting services provided to youth in foster care who are parents (Medicaid-eligible by definition) to promote expansion of home visiting services to this high risk population.	HHS has strongly supported the implementation of home visiting programs through a number of means. By statute, the Federal Home Visiting Program (MIECHV) requires states, territories, and tribal entities to direct their home visiting efforts to at-risk communities. The statute defines at-risk communities as those with concentrations of: premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health; poverty; crime; domestic violence; high rates of high school drop-outs; substance abuse; unemployment; or child maltreatment. With respect to funding specifically through Medicaid, coverage of home visiting is determined by each state's Medicaid program. To assist states in designing a benefit package to provide home visiting services for pregnant women and families with young children, CMS and HRSA released a Joint Informational Bulletin titled Coverage of Maternal, Infant, and Early Childhood Home Visiting Services in March 2016 (https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-02-16.pdf). This bulletin describes the funding arrangements within both agencies that would allow home visiting services to Medicaid-eligible individuals when the services meet the requirements of the Medicaid authorities. However, states that seek to cover these kinds of services under their Medicaid state plan could not furnish the home visiting

			services to only a segment of the population under age 21, or to a segment based on disease, condition or disability, but must make the services available to all who met the medical necessity criteria for receipt of the services. In order to target a particular population based on diagnosis, condition or disability, states could use other authorities for these services such as the section 1915(c) home and community-based services waiver program or a section 1115 demonstration program. Depending on the individual State Health Plans and the extent that Public Health Nurses (PHNs) seek reimbursement, home visits with Indian Health Service PHNs are reimbursable through Medicaid. PHNs are not the primary resource for child abuse and neglect in tribal communities but collaborate with other entities/agencies and serve on local teams addressing child maltreatment. Related activities include home safety assessments, childhood immunization surveillance, monitor compliance with well child care (WCC) appointments, coordinate special medical services, family education, follow-up for identified and at-risk children, and provide feedback at CPT and MDT meetings. PHNs are a valuable resource for "case finding" by initiating referrals to CPT and Social Services for concerns for CAN.
7.1b	Executive Branch	Support state waivers that would provide and evaluate the impact of presumptive Medicaid eligibility and reimbursement for parental mental health and substance abuse treatment services on behalf of EPSDT for a Medicaid-enrolled child if those intergenerational services are deemed necessary for the safety of the child.	With respect to the waivers specifically described in this recommendation, we assume that the recommendation is referencing a section 1115 demonstration program. From the 1115 perspective or even the Medicaid state plan authority perspective, treatment for mental illness or substance use disorders could be coverable for the mother if the mother's condition impacts the Medicaid-eligible child. For instance, the Center for Medicaid and CHIP Services recently (May 2016) issued an Informational Bulletin, *Maternal Depression Screening and Treatment: A Critical Role for Medicaid in Care of Mothers and Children* (https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf). In this bulletin, CMS clarified that since the maternal depression screening is for the direct benefit of the child, state Medicaid agencies may allow such screenings to be claimed as a service for the child as part of the EPSDT benefit. Additionally, CMS clarified that diagnostic and treatment services directed solely at the mother would be coverable under the

			Medicaid program if the mother is Medicaid eligible. Mothers who are not Medicaid eligible may receive some benefit from diagnostic and treatment services directed at treating the health and well-being of the child (such as family therapy services) to reduce or treat the effects of the mother's condition on the child. Consistent with current policy regarding services provided for the "direct benefit of the child," diagnostic and treatment services that a non-Medicaid eligible mother receives must actively involve the child, be directly related to the needs of the child and such treatment must be delivered to the child and mother together, but can be claimed as a direct service for the child. Such services also must be coverable under one or more section 1905(a) benefit categories such as rehabilitative services or other licensed practitioner services. Many parents are currently eligible for Medicaid or have health coverage through other sources. The following are ways that state Medicaid agencies can currently provide adult parents with access to the above services, through existing eligibility authority and pathways: (1) Coverage of parents and other caretaker relatives is mandatory in Medicaid; financial eligibility varies by state (2) Coverage of pregnant women (including the post-partum period, which ends on the last day of the month following 60 days from when the pregnancy ends) is mandatory; financial eligibility varies by state. (3) States can cover adults with income up to 133% of the federal poverty level; states may also cover adults to a higher income. At this time, 32 states and DC cover adults with income up to 133% FPL. (4) Coverage of certain people with disabilities is mandatory; financial eligibility and disability determination methodologies vary by state. (5) Coverage of former foster care youth up to age 26 (including young parents who were themselves in foster care) is also mandatory. (6) Prior to disenrolling an individual, such as at the end of a pregnant woman's post-partum period, the state must evaluate the person's eligibility on all other bases of eligibility in the state. (7) All states must allow hospitals to determine presumptive eligibility (PE) for certain mandatory groups in the Medicaid state plan (including parent groups).
7.1c	Executive	Incorporate maltreatment fatality and serious	The HHS Office of Adolescent Health will incorporate language on this

	Branch	injury prevention as a core value in the Office of Adolescent Health's Pregnant and Parenting Teen grant programs.	topic into their next (FY 2017) funding announcement for the Pregnancy Assistance Fund which provides competitive grants to states and tribes to provide integrated supports for expectant and parenting young families.
7.1d	Executive Branch and Congress	Mandate the development and implementation of educational curricula connecting youth to their cultural traditions, particularly around native language renewal and positively presented Native American history, to be used at all levels of pre-collegiate education.	
7.1e	Executive Branch and Congress	Mandate the development of a culturally accurate assessment of how to provide services optimally within tribes, being informed by tribes, particularly being informed by traditional medicine practitioners within tribes, in the context of federal funding opportunities and practice standards/requirements related to child and family well-being.	The Commission's recommendation is unclear as to what it desires to be assessed and by whom. We are unsure whether the Commission is recommending an assessment of fatality/serious injury risk to be performed by child protective services workers, or something else. We believe the efforts described above with respect to recommendation 3.2b, namely the soon to be funded National Quality Improvement Center for Preventive Services and Interventions in Indian Country (HHS-2016-ACF-ACYF-CA-1175) and the Community-Based Child Abuse Prevention Program funding opportunity entitled Grants to Tribes, Tribal Organizations, and Migrant Programs for Community-Based Child Abuse Prevention Programs (HHS-2016-ACF-ACYF-CA-1119), could each be helpful with respect to the Commission's intent here. Also relevant to this recommendation is Project Making Medicine, also funded by the Children's Bureau. Project Making Medicine has provided training to more than 500 mental health and child abuse and neglect service providers working with AI/AN children and families. The activities of this project include the development of a two week culturally sensitive training program on the treatment of child physical and sexual abuse with intensive consultation and follow-up. Once the participant completes the training, the Project Making Medicine staff schedule an on-site visit toto the participant's local community and assist the participant in conducting a community-wide training in the prevention and awareness of child abuse and neglect. The IHS Community Health Representative Program (CHRP), funded with

			IHS-CHR appropriations, is a unique community-based outreach program, staffed by well-trained, medically-guided, tribal and native community people who provide a variety of health services within AI/AN communities. The CHRP expanded the outreach program to include Family Spirit, an evidence-based home visiting model conducted by paraprofessionals designed for and by American Indian communities to address behavioral health issues by optimizing local cultural assets. For more information see: http://www.jhsph.edu/research/affiliated-programs/family-spirit/proven-results/
7.1f	Executive Branch and Congress	Mandate the implementation of fatherhood initiatives in Indian Country as well as mandating improved drug abuse education programming.	Given the sovereign status of Indian tribes, mandates such as the Commission suggests are inappropriate. However, we will consult with tribes regarding their most pressing needs in these areas. We agree with the Commission that drug abuse education programming, in combination with other efforts, is an important component for reducing drug use in Indian Country. Through programs such as the Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Prevention Framework Partnerships for Success Program, tribes are working to prevent underage drinking and misuse/abuse of prescription and illicit drugs. Federally recognized tribes that meet other eligibility requirements may also apply for funding under the Drug-Free Communities grant program to establish or strengthen collaborations to reduce substance use among youth with the intent to also reduce substance use among adults. Through these and several other SAMHSA programs, tribes are engaged in programs that address factors in communities that increase the risk of substance use disorders and promote factors that minimize the risk of substance use. Among ACF's Health Marriage and Responsible Fatherhood program grants are several that address fatherhood issues in tribal communities. The responsible fatherhood programs are designed to help fathers establish or strengthen relationships with their children, improve long-term economic stability, and overcome obstacles and barriers that prohibit them from being the most effective and nurturing parents. Grant funds for all responsible fatherhood activities must be used to support and integrate all three statutory responsible fatherhood activities (i.e.,

			responsible parenting, economic stability, and healthy marriage and relationship education). Eligible participants include fathers, particularly low-income adult fathers, and fathers between the ages of 16 and 24. The Healthy Marriage grants support couples in their relationship skills as well as parenting abilities. Responsible fatherhood grantees include the Denver Indian Center and the Turtle Mountain Band of Chippewa Indians. In addition, the Nez Perce Tribe is implementing a healthy marriage grant.
7.1g	Executive Branch and Congress	Promote and facilitate peer-to-peer connections around examples of well-formed efforts focused on AI/AN children and families.	The Children's Bureau's Capacity Building Center for Tribes is available to facilitate peer-to-peer connections around promising practices as it relates to child welfare in AI/AN communitites.
7.1h	Congress	Maintain flexible funding in existing entitlement programs to provide critical intervention services in mental health, substance abuse, and early infant home visiting services to support earlier identification and mitigation of risk within families at risk for child maltreatment fatalities.	
7.1i	Congress	Increase resources for the development, piloting, and scale-up of evidence-based prevention and intervention supports and services.	
7.1j	States and Counties	Test and develop the ability of home visiting to reduce child abuse and neglect fatalities.	
7.1k	States and Counties	Capitalize on state and payer investment in primary care medical homes and health homes to increase access to trauma-informed programs (for both parents and children), home visiting services, and other family-based social services within primary care settings.	
7.1l	States and Counties	Ensure that CPS-involved children and families at the greatest risk of fatalities have priority access to effective mission-critical services,	
7.1m	States and Counties	Prioritize prevention and support services and skill-building for adolescent parents to prevent and address abuse and neglect by young parents, with a particular focus on youth in the child welfare and juvenile justice systems.	

7.1n	States and Counties	Provide direct purchase of services funds to local CPS agencies, ensuring prioritized access to critical services.	
7.2		Leverage opportunities across multiple systems to improve the identification of children and families at earliest signs of risk.	HHS supports the Commission's intent here. See comments below on individual recommendations.
7.2a	Executive Branch	Ensure that other children's services providers have higher levels of accountability to reduce child fatalities. In health care, Medicaid should create greater accountability for health care providers to screen families at elevated risk for maltreatment and should use payment mechanisms, including reimbursement strategies, to incentivize greater investment in intergenerational services to these families. Communities with home-visiting programs should have greater accountability to demonstrate the connection of these services to highest risk families. Birth hospitals should be held to a higher level of accountability for Plans of Safe Care.	With an eye toward increasing the role of primary care physicians in preventing child maltreatment, including maltreatment related fatalities, in May 2016 the U.S. Preventive Services Task Force published its *Draft Research Plan for Child Maltreatment: Primary Care Interventions*. The key research question the Task Force will address is "do primary care-feasible or referable interventions to prevent child maltreatment reduce the exposure to abuse or neglect, improve behavioral, emotional, physical or mental well-being; or reduce mortality among children and adolescents without obvious signs or symptoms of abuse or neglect?" Once the research plan is finalized, an evidence review will be prepared and recommendations for primary care physicians will be developed. A review is also in process related to postpartum depression, a condition which also is related to child maltreatment fatalities. With respect to the Federal Home Visiting Program, the authorizing statute requires states, territories, and tribal entities to direct their home visiting efforts to at-risk communities. At risk in this context is defined as communities with concentrations of: premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health; poverty; crime; domestic violence; high rates of high school drop-outs; substance abuse; unemployment; or child maltreatment. Home visiting grantees must report data on program performance for eligible families in six benchmark areas, which include prevention of child injuries, child abuse, neglect, or maltreatment and reductions of emergency room visits. Beginning in 2017, Home Visiting grantees will report on the following measures related to maltreatment fatalities: • Percent of infants enrolled in home visiting that are always placed to sleep on their backs, without bed-sharing or soft bedding; • Rate of injury-related visits to the Emergency Department (ED)

			since enrollment among children enrolled in home visiting; and • Percent of children enrolled in home visiting with at least one investigated case of maltreatment following enrollment within the reporting period
7.2b	Executive Branch	Ensure that HHS agencies, specifically, CMS, the Administration for Children and Families (ACF), and the Substance Abuse and Mental Health Services Administration (SAMHSA), issue clear and joint guidance to states to aid in effective implementation of Plans of Safe Care.	ACF and SAMHSA are working through the National Center on Substance Abuse and Child Welfare, which the two agencies fund jointly, to develop technical assistance materials regarding Plans of Safe Care. The Center is available to provide technical assistance to states on this issue. In addition, the Child Abuse Prevention and Treatment Act (CAPTA) State grants are formula grants which provide funds aimed at improving child protective services systems. The program requires states to provide assurances in their plan that the states is operating a statewide child abuse and neglect program that includes numerous programmatic requirements, including policies and procedures that address the development of a plan of safe care for infants born and identified as being affected by illegal substance abuse or withdrawal symptoms or Fetal Alcohol Spectrum Disorder. In an effort to better understand how states are implementing this CAPTA provision and determine whether further clarification is needed, the Children's Bureau instructed states in Program Instruction ACYF-CB-PI-16-03 to provide an update on services to substance-exposed newborns in the Annual Progress and Services Report (APSR) which was due June 30, 2016. While that information is still being analyzed, we expect to learn through our review of that information how states are implementing this provision and will provide any necessary direction to ensure full compliance. In addition, the Infant Plan of Safe Care law amending CAPTA was included in Title V of the Comprehensive Addiction and Recovery Act of 2016 (Public Law 1144-198) which was enacted on July 22, 2016.The law requires HHS to maintain and disseminate information about the CAPTA state plan and best practices related to safe care plans for infants born as affected by illegal substance abuse or fetal alcohol spectrum disorder; modifies the CAPTA state plan requirement to include all "substance abuse" (not just illegal substance abuse as in the existing requirement); adds a new requirement that the plan should ensure the safety and well-

			being of infants following the release from the care of health care providers, including through addressing family needs and implementing monitoring of such plans to determine whether/how local entities are making referrals or delivering services; adds additional NCANDS data elements on these infants; and requires HHS to monitor states to ensure compliance with the requirements related to infant safe care plans. We look forward to working with states to implement these enhanced requirements.
7.2c	Executive Branch	Ensure that CMS encourages pediatric health information exchanges to share information on prior injury visits across provider systems, so that emergency department and acute care settings can access this information during visits for acute pediatric care and better assess children at risk of abuse and neglect.	CMS and AHRQ have been considering for some time issues about what should be included in children's electronic health records. A suggested Children's EHR format was published in 2013 and in enhanced in 2015 with *The Children's EHR Format 2015 Priority List, and Recommended Uses for the Format* (available at https://healthit.ahrq.gov/health-it-tools-and-resources/childrens-electronic-health-record-ehr-format). While some child welfare information is included in the suggested format, it does not currently include information about injury visits. As the work continues and is updated we will consider the Commission's suggested additions.
7.2d	Executive Branch	Ensure that HRSA and CDC expand the rollout of evidence-based screening tools for Adverse Childhood Experiences (ACEs) and parental risk.	HHS operates within a common framework with respect to screening for health conditions. This framework suggests that screening recommendations should be based on the seriousness of the condition for which screening might be conducted; the quality of the screening test (i.e., sensitivity, specificity and predictive value); and the availability of one or more effective interventions. Ideally, the interventions would have been shown effective with the population being screened and that they produce better outcomes than could be achieved for those who would have come to the system's attention without screening. HHS does not believe that universal screening with an ACES tool is yet appropriate within this framework, but we will continue to monitor this issue and consider this as part of our overall strategy to prevent maltreatment fatalities and serious injuries. In the meantime, efforts to address adverse childhood experiences are being implemented in a number of programs within HRSA's Maternal and Child Health Bureau, including Healthy Start, Home Visiting and Bright Futures (which provides clinical preventive services for children and

			adolescents). Relatedly, CDC supports a comprehensive approach to early adversity prevention with actions at all levels of the social ecology and in all systems/sectors as consistent with its technical package for preventing child abuse and neglect.[6] This ensures population level impact versus the individual level focus that occurs with individual-level screening. CDC notes that any evidence-based screening tools would need to be accompanied by referrals to appropriate services and integrated into a comprehensive approach to the prevention of child abuse and neglect.
7.2e	Congress	Demand greater accountability from mandatory reporters.	
7.2f	Congress	Amend CAPTA and relevant health policy to clarify the roles and responsibilities at the federal and state level to improve the implementation of CAPTA's Plan of Safe Care.	
7.2g	States and Counties	Pass state legislation to establish policies for matching birth data to data on termination of parental rights and conducting preventive visits.	
7.2h	States and Counties	Expand the screening of caregivers for elevated risk factors, including toxic stress and social determinants of health, and provide early connections to services.	
7.2i	States and Counties	Ensure that health information exchanges facilitate access to injury and health service histories of children at the point of care,	
7.3		Strengthen the ability of CPS agencies to protect children most at risk of harm.	HHS supports the Commission's intent here. See comments below on individual recommendations.
7.3a	Executive	Ensure that HHS and the Department of Justice	HHS currently provides child welfare agencies with information and

[6] Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). *Preventing child abuse and neglect: A technical package for policy, norm, and programmatic activities.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

	Branch	(DOJ) provide guidance on best practice on screening and investigation models.	support to help them select and implement best practices in screening and investigation. Our information clearinghouse, the Child Welfare Information Gateway (www.childwelfare.gov) provides a variety of useful resources and publications including practical tools and state examples. In addition, the Capacity Building Collaborative offers customized technical assistance and consultation to state and tribal agencies and courts based on their unique needs in this area. We will continue to consider what additional materials might be helpful to states.
7.3b	Executive Branch and Congress	Mandate the implementation of service approaches that prioritize keeping AI/AN children within their tribes as a primary alternative to out-of-home placement.	It is not clear to us what the Commission has in mind beyond the requirements currently in the Indian Child Welfare Act (ICWA) which prioritizes placement of children with their tribes when possible. With respect to ICWA, HHS has recently proposed to collect new data from states about AI/AN children in foster care and whether the determinations and notifications required by ICWA have occurred. We are working with BIA and DOJ on this matter to better understand how states respond to the ICWA requirements. Any additional mandates would require congressional authorization.
7.3c	Congress	Update federal policy in CAPTA to align with and incentivize best practice in multidisciplinary investigations of child abuse and neglect fatalities.	
7.3d	Congress	Require CPS agencies to identify partners/contracted resources	
7.4		Strengthen cross-system accountability	HHS supports the Commission's intent here. See comments below on individual recommendations.
7.4a	Executive Branch	Require states to articulate in their state plans (as detailed in Chapter 2) how they are approaching coordinated case management for families at high risk of child abuse and neglect fatalities.	State plan requirements are laid out in statute and do not currently include such a requirement. While this recommendation is directed at HHS, the Department cannot impose such a requirement without changes to existing legislative authority.
7.4b	Executive Branch	Prioritize the reduction of early childhood fatalities via state or regional demonstration projects within the Centers for Medicare and Medicaid Innovation (CMMI).	We appreciate the Commission's intent here. The Innovation Center will consider this recommendation in the context of the many topics that have been suggested for future demonstration projects. We are concerned that given the low prevalence of maltreatment fatalities and the scale of most Innovation Center models, few jurisdictions would be able to mount a demonstration of sufficient size to have the statistical power to detect decreased fatality rates as a primary outcome.

7.4c	Executive Branch	Develop new pediatric quality measures for ensuring follow-up visits for failure to thrive and tracking early childhood injuries.	Several HHS agencies are involved in various efforts to develop measures for use in pediatric care, including CMS, AHRQ, and HRSA/MCHB. These agencies will consider the need for such measures in each of their efforts according to their protocols for setting priorities. Within MCHB, new measures would be useful to further assess and build on current Bright Futures recommendations for BMI assessment which can capture failure to thrive, and overall screening for well being of the child which can health track unexpected age appropriate injuries.
7.4d	Congress	Establish a multiyear innovation program to finance the development and evaluation of promising multidisciplinary prevention initiatives to reduce child abuse and neglect fatalities.	CDC is currently funding five state health departments to partner with key stakeholders from different disciplines and sectors to assure safe, stable, nurturing relationships and environments and prevent child abuse and neglect.