AN ACT

To require studies and reports examining the use of, and opportunities to use, technology-enabled collaborative learning and capacity building models to improve programs of the Department of Health and Human Services, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,
SECTION 1. SHORT TITLE.

This Act may be cited as the “Expanding Capacity for Health Outcomes Act” or the “ECHO Act”.

SEC. 2. DEFINITIONS.

In this Act:

(1) HEALTH PROFESSIONAL SHORTAGE AREA.—The term “health professional shortage area” means a health professional shortage area designated under section 332 of the Public Health Service Act (42 U.S.C. 254e).

(2) INDIAN TRIBE.—The term “Indian tribe” has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304).

(3) MEDICALLY UNDERSERVED AREA.—The term “medically underserved area” has the meaning given the term “medically underserved community” in section 799B of the Public Health Service Act (42 U.S.C. 295p).

(4) MEDICALLY UNDERSERVED POPULATION.—The term “medically underserved population” has the meaning given the term in section 330(b) of the Public Health Service Act (42 U.S.C. 254b(b)).

(5) NATIVE AMERICANS.—The term “Native Americans” has the meaning given the term in section 736 of the Public Health Service Act (42 U.S.C. 254m).
(6) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

(7) TECHNOLOGY-ENABLED COLLABORATIVE LEARNING AND CAPACITY BUILDING MODEL.—The term “technology-enabled collaborative learning and capacity building model” means a distance health education model that connects specialists with multiple other health care professionals through simultaneous interactive videoconferencing for the purpose of facilitating case-based learning, disseminating best practices, and evaluating outcomes.

(8) TRIBAL ORGANIZATION.—The term “tribal organization” has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304).

SEC. 3. EXAMINATION AND REPORT ON TECHNOLOGY-ENABLED COLLABORATIVE LEARNING AND CAPACITY BUILDING MODELS.

(a) EXAMINATION.—

(1) IN GENERAL.—The Secretary shall examine technology-enabled collaborative learning and capacity building models and their impact on—

U.S.C. 293) and includes Indian tribes and tribal organizations.
(A) addressing mental and substance use disorders, chronic diseases and conditions, pre-
natal and maternal health, pediatric care, pain management, and palliative care;

(B) addressing health care workforce issues, such as specialty care shortages and pri-
mary care workforce recruitment, retention, and support for lifelong learning;

(C) the implementation of public health programs, including those related to disease prevention, infectious disease outbreaks, and public health surveillance;

(D) the delivery of health care services in rural areas, frontier areas, health professional shortage areas, and medically underserved areas, and to medically underserved populations and Native Americans; and

(E) addressing other issues the Secretary determines appropriate.

(2) Consultation.—In the examination re-
quired under paragraph (1), the Secretary shall con-
sult public and private stakeholders with expertise in using technology-enabled collaborative learning and capacity building models in health care settings.

(b) Report.—
(1) IN GENERAL.—Not later than 2 years after
the date of enactment of this Act, the Secretary
shall submit to the Committee on Health, Edu-
cation, Labor, and Pensions of the Senate and the
Committee on Energy and Commerce of the House
of Representatives, and post on the appropriate
website of the Department of Health and Human
Services, a report based on the examination under
subsection (a).

(2) CONTENTS.—The report required under
paragraph (1) shall include findings from the exam-
ination under subsection (a) and each of the fol-
lowing:

(A) An analysis of—

(i) the use and integration of tech-
nology-enabled collaborative learning and
capacity building models by health care
providers;

(ii) the impact of such models on
health care provider retention, including in
health professional shortage areas in the
States and communities in which such
models have been adopted;

(iii) the impact of such models on the
quality of, and access to, care for patients
in the States and communities in which such models have been adopted;

(iv) the barriers faced by health care providers, States, and communities in adopting such models;

(v) the impact of such models on the ability of local health care providers and specialists to practice to the full extent of their education, training, and licensure, including the effects on patient wait times for specialty care; and

(vi) efficient and effective practices used by States and communities that have adopted such models, including potential cost-effectiveness of such models.

(B) A list of such models that have been funded by the Secretary in the 5 years immediately preceding such report, including the Federal programs that have provided funding for such models.

(C) Recommendations to reduce barriers for using and integrating such models, and opportunities to improve adoption of, and support for, such models as appropriate.
(D) Opportunities for increased adoption of such models into programs of the Department of Health and Human Services that are in existence as of the report.

(E) Recommendations regarding the role of such models in continuing medical education and lifelong learning, including the role of academic medical centers, provider organizations, and community providers in such education and lifelong learning.

Passed the Senate November 29, 2016.

Attest: JULIE E. ADAMS,

Secretary.