Healthcare policy can be a particularly vexing area for those of us who like to get things done because over the last 8 years we have mostly just been at each other's throats, arguing about the Affordable Care Act. But we are here to talk about a bright spot—something we are not arguing about—which can reduce costs and improve outcomes. Telehealth is the future of health care. It harnesses technology to provide patients with high-quality care, whenever and wherever they need it. That is why we need to update Medicare to take advantage of these new technologies in telemedicine and remote patient monitoring. That is why I and 18 other Senators from both parties have introduced and cosponsored the CONNECT for Health Act.

I thank Senator HATCH for his support in including provisions from our bill in the Senate Finance Committee's chronic care package.

Telehealth will improve the delivery of care to patients, but it will also support providers by giving doctors and nurses the tools to work with and learn from each other. Simply put, a lot of medical education is financially or geographically out of reach for providers on the frontlines, but we can fix that using technology. It is called Project ECHO, and that is what we are about to vote on. Based at the University of New Mexico and with the strong support of Senators HEINRICH and UDALL, Project ECHO has already had a positive impact across the Nation on patients, providers, and communities.

How does it work? Imagine a VTC—video teleconference—with 15 people on the screen. Participants assemble online 2 hours every week for 6 weeks to learn about a selected disease condition—for example, depression. The leader of the VTC is a specialist physician from an academic medical center with a team which would include, for example, a psychologist, a pharmacist, and a social worker. Throughout the 6 weeks, the session time is divided between lessons, case presentations, and discussions. Providers from across the country can learn the latest best practices and develop a network of colleagues to share information and help with the hard questions. This is a game changer. This is the kind of ongoing training for folks in rural areas that has not been available until now.

Project ECHO has already been used for infectious disease outbreaks and public health emergencies, such as H1N1 and Zika; chronic diseases, such as hepatitis C and diabetes; and mental health conditions, such as anxiety and schizophrenia.

The results are impressive. Patients in rural or underserved areas now have more access to better trained doctors in their own communities, which decreases costs and improves outcomes. Providers feel less isolated and more connected to a network of high-quality providers across their State. As a result, they are more likely to stay in underserved areas where they are needed the most. The health system runs more efficiently and effectively. Providers have the training to see and treat more patients.

We still have many questions about this model, which is new, but among them: What are the best successors? What are the barriers to adoption? For which conditions is it best suited? The ECHO Act, as amended, will direct HHS to study this model and give us the answers we need to make decisions at the Federal level about how to best support expanding it nationally.

One final note of thanks. It is not a coincidence that several of the successful health care-related efforts this year have been a result of collaboration with and leadership of Senator HATCH. His bipartisan spirit, his pragmatism, and his understanding of the legislative process make working with him and his staff a true pleasure.

I encourage my colleagues to continue to join us in supporting this revolutionary health care model.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER (Mr. FLAKE). Morning business is closed.

EXPANDING CAPACITY FOR HEALTH OUTCOMES ACT

The PRESIDING OFFICER. Under the previous order, the Committee on Health, Education, Labor, and Pensions is discharged from and the Senate will proceed to the consideration of S. 2873, which the clerk will report.

The legislative clerk read as follows:

A bill (S. 2873) 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.

The PRESIDING OFFICER. Under the previous order, there will be 30 minutes of debate, equally divided in the usual form.

The Senator from Hawaii.

Mr. SCHATZ. Mr. President, I ask unanimous consent that the time be equally divided between both sides during the quorum call.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SCHATZ. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. DAINES. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 5110

Mr. DAINES. Mr. President, I call up amendment No. 5110 and ask unanimous consent that it be reported by number.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report the amendment by number.

The legislative clerk read as follows:

The Senator from Montana [Mr. DAINES], for Mr. ALEXANDER, proposes an amendment numbered 5110.

The amendment is as follows:

(Purpose: In the nature of a substitute)

Strike all after the enacting clause and insert the following:

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. 293) and includes Indian tribes and tribal organizations.

(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—

(A) addressing mental and substance use disorders, chronic diseases and conditions, prenatal and maternal health, pediatric care, pain management, and palliative care;

(B) addressing health care workforce issues, such as specialty care shortages and primary 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.