care, and accelerate lifesaving research for those impacted by childhood cancer.

Childhood cancer patients and survivors have unique needs, and this bill will ensure that those needs are addressed through continued child-focused research. We must continue the fight until no child is lost to cancer. I urge my colleagues to support childhood cancer patients, survivors, and families by supporting the Childhood Cancer STAR Act.

Ms. MATSUI. Mr. Speaker, I urge my colleagues to support the Childhood Cancer STAR Act.

I yield back the balance of my time.

Mr. BURGESS. Mr. Speaker, I urge all Members to vote in favor of H.R. 3381.

I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Texas (Mr. BURGESS) that the House suspend the rules and pass the bill, H.R. 3381, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

EXPANDING CAPACITY FOR HEALTH OUTCOMES ACT

Mr. BURGESS. Mr. Speaker, I move to suspend the rules and pass the 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 Clerk read the title of the bill.

The text of the bill is as follows:

S. 2873

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. 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.

(2) CONSULTATION.—In the examination required under paragraph (1), the Secretary shall consult 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, Education, 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 examination under subsection (a) and each of the following:

(A) An analysis of—

(i) the use and integration of technology-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.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Texas (Mr. BURGESS) and the gentlewoman from California (Ms. MATSUI) each will control 20 minutes.

The Chair recognizes the gentleman from Texas.

GENERAL LEAVE

Mr. BURGESS. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days in which to revise and extend their remarks and insert extraneous materials into the RECORD on the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. BURGESS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in support of S. 2873, the Expanding Capacity for Health Outcomes Act, also known as the ECHO Act. This bipartisan legislation by Senators HATCH and SCHATZ passed the Senate 97–0 on November 29. House companion legislation has been introduced and championed by Representative MATSUI and me.

This legislation requires the Secretary of Health and Human Services to examine technology-enabled collaborative learning and capacity building models and their impact on the healthcare workforce, the implementation of public health programs, and the delivery of health services in rural and underserved areas to underserved populations. The bill would require the Secretary to consult with public and private stakeholders with expertise in these delivery models to evaluate their potential and larger adoption in States and within the Federal Government.

Within 2 years, the Secretary then would submit to Congress and publicly post a report that includes an analysis of these programs which utilize technology in a novel manner. One such method these programs may employ is using a hub-and-spoke approach to connecting specialty and primary care workers for health surveillance and

proper intervention. This holds particular promise for rural and underserved areas where it can be difficult to recruit and retain health professionals but could offer opportunities for continuing provider education and engagement.

This legislation enjoys broad bipartisan support. It has been endorsed by a number of health professional organizations, including America's Essential Hospitals, the American Academy of Pediatrics, the American Medical Association, the American Nurses Association, and the National Association of Community Health Centers, to name but a few.

This legislation does not impact direct spending or revenues. It offers a means by which to evaluate successful models in the private sector and opportunities to build upon them and adopt them if successful.

Mr. Speaker, I urge my colleagues to vote ''yes'' on S. 2873.

I reserve the balance of my time.

Ms. MATSUI. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in support of S. 2873, the ECHO Act, that I co-led with my colleague Representative BURGESS in the House and Senators HATCH and SCHATZ in the Senate.

The ECHO Act elevates the successful Project ECHO model, which uses technology to remotely connect healthcare providers to one another so they can communicate best practices and new techniques.

UC Davis Medical Center, in my district of Sacramento, has some of the best and brightest doctors, and they are working hard to share their expertise across our region and the country. We are also fortunate in Sacramento to have a strong safety net of top-notch community health centers that work to provide the primary care needs of underserved populations. However, primary care is a big job, and often these providers have not received the education or training they need in specialty areas such as pain management.

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UC Davis is successfully partnering with over 125 community health centers in California, to provide that collaborative education on responsible and safe pain management, resulting in increased use of evidence-based tools and reduced prescriptions for high-dose opioids. Better understanding of pain and effective pain management will contribute toward combating our Nation's devastating opioid abuse and heroin epidemic.

This Project ECHO bill is a first step in scaling approaches like this nationwide to ensure that every provider has access to the best information on a variety of topics, from pain to addiction, dermatology, infectious diseases, neurology, and much more.

We need to build on this progress to ensure that we are harnessing the power of technology to improve patient care and save lives. I urge my colleagues to support S. 2873.

Mr. Speaker, I want to thank Congressman BURGESS for his work on this, and I urge my colleagues to send S. 2873 to the President's desk for signature.

Mr. Speaker, I yield back the balance of my time.

Mr. BURGESS. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, only 10 percent of physicians practice in rural areas in this country, but those areas contain 25 percent of the population. Obviously, there is a mismatch.

Access to care in underserved areas is especially challenging for patients with chronic or complex conditions. Overburdened primary care providers often will have to refer complex patients to hospitals or specialists for care that actually could just as well be delivered at home. These unnecessary referrals delay care and increase costs for patients in the system. The Project Extension for Community Health Outcomes, or Project ECHO, is one example of an innovative model that is being used to address this challenge.

Project ECHO uses interactive videoconferencing to link specialist teams with primary care providers in medical education clinics that include didactic teaching and case-based learning.

Project ECHO has equipped local providers across the country with the extraordinary skills necessary to take on healthcare challenges threatening our communities. Project ECHO has been used to increase the number of docs able to prescribe for opioid abuse, to rapidly educate providers on public health crises, such as a novel flu outbreak, and to train providers to address complex mental health disorders.

This bipartisan, bicameral bill has broad support from healthcare providers and systems. It passed the Senate 97–0 last week. Again, I want to thank Congresswoman MATSUI of California for her partnership on the bill. I encourage my colleagues to support its passage.

Mr. Speaker, I yield back the balance of my time.

Mr. CARTER of Georgia. Mr. Speaker, I rise today in support of S. 2873, Expanding Capacity for Health Outcomes Act, which would increase access to health care services in rural areas.

This bill authorizes the Department of Health and Human Services to study the Project ECHO model, which launched a revolutionary long distance health care model that uses videoconferencing for collaboration and case-learning.

The Project ECHO model has proven to be successful in bringing much needed health care to some of our nation's most remote regions.

By taking study of this model to the national level, we have the opportunity to fully harness emerging technologies to transform the way health care is practiced.

As a life long health care professional from a district with rural and underserved areas, I know firsthand how challenging it can be to provide access to high quality health care to these areas.

Connecting primary care providers with specialists through video streaming helps bridge the gap in both distance and access, reducing travel and costs for both patient and provider alike.

I urge my colleagues to support this legislation so that we can continue working to provide specialty care to all Americans across the nation.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Texas (Mr. BURGESS) that the House suspend the rules and pass the bill, S. 2873.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

IMPROVING BROADBAND ACCESS FOR VETERANS ACT OF 2016

Mr. LATTA. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 6394) to require the Federal Communications Commission to submit to Congress a report on promoting broadband Internet access service for veterans.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 6394

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 ''Improving Broadband Access for Veterans Act of 2016''.

SEC. 2. REPORT ON PROMOTING BROADBAND INTERNET ACCESS SERVICE FOR VETERANS.

(a) VETERAN DEFINED.—In this section, the term ''veteran'' has the meaning given the term in section 101 of title 38, United States Code.

(b) REPORT REQUIRED.—Not later than 1 year after the date of the enactment of this Act, the Federal Communications Commission shall submit to Congress a report on promoting broadband Internet access service for veterans, in particular low-income veterans and veterans residing in rural areas. In such report, the Commission shall—

(1) examine such access and how to promote such access; and

(2) provide findings and recommendations for Congress with respect to such access and how to promote such access.

(c) PUBLIC NOTICE AND OPPORTUNITY TO COMMENT.—In preparing the report required by subsection (b), the Commission shall provide the public with notice and an opportunity to comment on broadband Internet access service for veterans, in particular low-income veterans and veterans residing in rural areas, and how to promote such access.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Ohio (Mr. LATTA) and the gentleman from Vermont (Mr. WELCH) each will control 20 minutes.

The Chair recognizes the gentleman from Ohio.

GENERAL LEAVE

Mr. LATTA. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and insert extraneous materials in the RECORD on the bill.