identified in approved applications under this section with respect to planning, developing, and operating programs under the grant.

(j) Authorization of appropriations

There are authorized to be appropriated, such sums as may be necessary to carry out this section for each of fiscal years 2010 through 2014.

(k) Definitions

In this section:

(1) Community health worker

The term ''community health worker'' means an individual who promotes health or nutrition within the community in which the individual resides—

(A) by serving as a liaison between communities and healthcare agencies;

(B) by providing guidance and social assistance to community residents;

(C) by enhancing community residents' ability to effectively communicate with healthcare providers;

(D) by providing culturally and linguistically appropriate health or nutrition education;

(E) by advocating for individual and community health;

(F) by providing referral and follow-up services or otherwise coordinating care; and

(G) by proactively identifying and enrolling eligible individuals in Federal, State, local, private or nonprofit health and human services programs.

(2) Community setting

The term ''community setting'' means a home or a community organization located in the neighborhood in which a participant in the program under this section resides.

(3) Eligible entity

The term ''eligible entity'' means a public or nonprofit private entity (including a State or public subdivision of a State, a public health department, a free health clinic, a hospital, or a Federally-qualified health center (as defined in section 1861(aa) of the Social Security Act [42 U.S.C. 1395x(aa)])), or a consortium of any such entities.

(4) Medically underserved community

The term ''medically underserved community'' means a community identified by a State—

(A) that has a substantial number of individuals who are members of a medically underserved population, as defined by section 254b(b)(3) of this title; and

(B) a significant portion of which is a health professional shortage area as designated under section 254e of this title.

(July 1, 1944, ch. 373, title III, § 399V, as added and amended Pub. L. 111–148, title V, § 5313(a), title X, § 10501(c), Mar. 23, 2010, 124 Stat. 633, 994; Pub. L. 113–128, title V, § 512(z)(1), July 22, 2014, 128 Stat. 1716.)

Editorial Notes

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (b)(3), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XVIII, XIX, and XXI of the Act are classified generally to subchapters XVIII (§ 1395 et seq.), XIX (§ 1396 et seq.), and XXI (§ 1397aa et seq.), respectively, of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

AMENDMENTS

2014—Subsec. (e). Pub. L. 113–128 substituted ''one-stop delivery systems under section 3151(e) of title 29'' for ''one-stop delivery systems under section 2864(c) of title 29''.

2010—Subsec. (b)(4). Pub. L. 111–148, § 10501(c)(1), substituted ''identify and refer'' for ''identify, educate, refer, and enroll''.

Subsec. (k)(1). Pub. L. 111–148, § 10501(c)(2), struck out '', as defined by the Department of Labor as Standard Occupational Classification [21–1094]'' before ''means'' in introductory provisions.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2014 AMENDMENT

Amendment by Pub. L. 113–128 effective on the first day of the first full program year after July 22, 2014 (July 1, 2015), see section 506 of Pub. L. 113–128, set out as an Effective Date note under section 3101 of Title 29, Labor.

§ 280g–12. Primary Care Extension Program

(a) Establishment, purpose and definition

(1) In general

The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall establish a Primary Care Extension Program.

(2) Purpose

The Primary Care Extension Program shall provide support and assistance to primary care providers to educate providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services (including substance abuse prevention and treatment services), and evidence-based and evidence-informed therapies and techniques, in order to enable providers to incorporate such matters into their practice and to improve community health by working with community-based health connectors (referred to in this section as ''Health Extension Agents'').

(3) Definitions

In this section:

(A) Health Extension Agent

The term ''Health Extension Agent'' means any local, community-based health worker who facilitates and provides assistance to primary care practices by implementing quality improvement or system redesign, incorporating the principles of the patient-centered medical home to provide high-quality, effective, efficient, and safe primary care and to provide guidance to patients in culturally and linguistically appropriate ways, and linking practices to diverse health system resources.

(B) Primary care provider

The term ''primary care provider'' means a clinician who provides integrated, accessible health care services and who is accountable for addressing a large majority of personal

health care needs, including providing preventive and health promotion services for men, women, and children of all ages, developing a sustained partnership with patients, and practicing in the context of family and community, as recognized by a State licensing or regulatory authority, unless otherwise specified in this section.

(b) Grants to establish State Hubs and local Primary Care Extension Agencies

(1) Grants

The Secretary shall award competitive grants to States for the establishment of State- or multistate-level primary care Primary Care Extension Program State Hubs (referred to in this section as ''Hubs'').

(2) Composition of Hubs

A Hub established by a State pursuant to paragraph (1)—

(A) shall consist of, at a minimum, the State health department, the entity responsible for administering the State Medicaid program (if other than the State health department), the State-level entity administering the Medicare program, and the departments that train providers in primary care in 1 or more health professions schools in the State; and

(B) may include entities such as hospital associations, primary care practice-based research networks, health professional societies, State primary care associations, State licensing boards, organizations with a contract with the Secretary under section 1320c–2 of this title, consumer groups, and other appropriate entities.

(c) State and local activities

(1) Hub activities

Hubs established under a grant under subsection (b) shall—

(A) submit to the Secretary a plan to coordinate functions with quality improvement organizations and area health education centers if such entities are members of the Hub not described in subsection (b)(2)(A);

(B) contract with a county- or local-level entity that shall serve as the Primary Care Extension Agency to administer the services described in paragraph (2);

(C) organize and administer grant funds to county- or local-level Primary Care Extension Agencies that serve a catchment area, as determined by the State; and

(D) organize State-wide or multistate networks of local-level Primary Care Extension Agencies to share and disseminate information and practices.

(2) Local Primary Care Extension Agency activities

(A) Required activities

Primary Care Extension Agencies established by a Hub under paragraph (1) shall—

(i) assist primary care providers to implement a patient-centered medical home to improve the accessibility, quality, and efficiency of primary care services, including health homes;

(ii) develop and support primary care learning communities to enhance the dissemination of research findings for evidence-based practice, assess implementation of practice improvement, share best practices, and involve community clinicians in the generation of new knowledge and identification of important questions for research;

(iii) participate in a national network of Primary Care Extension Hubs and propose how the Primary Care Extension Agency will share and disseminate lessons learned and best practices; and

(iv) develop a plan for financial sustainability involving State, local, and private contributions, to provide for the reduction in Federal funds that is expected after an initial 6-year period of program establishment, infrastructure development, and planning.

(B) Discretionary activities

Primary Care Extension Agencies established by a Hub under paragraph (1) may—

(i) provide technical assistance, training, and organizational support for community health teams established under section 256a–1[1] of this title;

(ii) collect data and provision of primary care provider feedback from standardized measurements of processes and outcomes to aid in continuous performance improvement;

(iii) collaborate with local health departments, community health centers, tribes and tribal entities, and other community agencies to identify community health priorities and local health workforce needs, and participate in community-based efforts to address the social and primary determinants of health, strengthen the local primary care workforce, and eliminate health disparities;

(iv) develop measures to monitor the impact of the proposed program on the health of practice enrollees and of the wider community served; and

(v) participate in other activities, as determined appropriate by the Secretary.

(d) Federal program administration

(1) Grants; types

Grants awarded under subsection (b) shall be—

(A) program grants, that are awarded to State or multistate entities that submit fully-developed plans for the implementation of a Hub, for a period of 6 years; or

(B) planning grants, that are awarded to State or multistate entities with the goal of developing a plan for a Hub, for a period of 2 years.

(2) Applications

To be eligible for a grant under subsection (b), a State or multistate entity shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

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[1] See References in Text note below.

(3) Evaluation

A State that receives a grant under subsection (b) shall be evaluated at the end of the grant period by an evaluation panel appointed by the Secretary.

(4) Continuing support

After the sixth year in which assistance is provided to a State under a grant awarded under subsection (b), the State may receive additional support under this section if the State program has received satisfactory evaluations with respect to program performance and the merits of the State sustainability plan, as determined by the Secretary.

(5) Limitation

A State shall not use in excess of 10 percent of the amount received under a grant to carry out administrative activities under this section. Funds awarded pursuant to this section shall not be used for funding direct patient care.

(e) Requirements on the Secretary

In carrying out this section, the Secretary shall consult with the heads of other Federal agencies with demonstrated experience and expertise in health care and preventive medicine, such as the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Administration, the Health Resources and Services Administration, the National Institutes of Health, the Office of the National Coordinator for Health Information Technology, the Indian Health Service, the Agricultural Cooperative Extension Service of the Department of Agriculture, and other entities, as the Secretary determines appropriate.

(f) Authorization of appropriations

To awards grants as provided in subsection (d), there are authorized to be appropriated $120,000,000 for each of fiscal years 2011 and 2012, and such sums as may be necessary to carry out this section for each of fiscal years 2013 through 2014.

(July 1, 1944, ch. 373, title III, § 399V–1, formerly § 399W, as added, amended, and renumbered § 399V–1, Pub. L. 111–148, title V, § 5405, title X, § 10501(f)(1), (2), Mar. 23, 2010, 124 Stat. 649, 996.)

Editorial Notes

REFERENCES IN TEXT

Section 256a–1 of this title, referred to in subsec. (c)(2)(B)(i), was in the original ''section 3602 of the Patient Protection and Affordable Care Act'', and was translated as meaning section 3502 of the Patient Protection and Affordable Care Act, Pub. L. 111–148, to reflect the probable intent of Congress.

AMENDMENTS

2010—Subsec. (b)(2)(A). Pub. L. 111–148, § 10501(f)(2), substituted ''and the departments that train providers in primary care in 1 or more health professions schools in the State'' for ''and the departments of 1 or more health professions schools in the State that train providers in primary care''.

§ 280g–13. National congenital heart disease research, surveillance, and awareness

(a) In general

The Secretary shall, as appropriate—

(1) enhance and expand research and data collection efforts related to congenital heart disease, including to study and track the epidemiology of congenital heart disease to understand health outcomes for individuals with congenital heart disease across all ages;

(2) conduct activities to improve public awareness of, and education related to, congenital heart disease, including care of individuals with such disease; and

(3) award grants to entities to undertake the activities described in this section.

(b) Activities

(1) In general

The Secretary shall carry out activities, including, as appropriate, through a national cohort study and a nationally-representative, population-based surveillance system, to improve the understanding of the epidemiology of congenital heart disease in all age groups, with particular attention to—

(A) the incidence and prevalence of congenital heart disease in the United States;

(B) causation and risk factors associated with, and natural history of, congenital heart disease;

(C) health care utilization by individuals with congenital heart disease;

(D) demographic factors associated with congenital heart disease, such as age, race, ethnicity, sex, and family history of individuals who are diagnosed with the disease; and

(E) evidence-based practices related to care and treatment for individuals with congenital heart disease.

(2) Permissible considerations

In carrying out the activities under this section, the Secretary may, as appropriate—

(A) collect data on the health outcomes, including behavioral and mental health outcomes, of a diverse population of individuals of all ages with congenital heart disease, such that analysis of the outcomes will inform evidence-based practices for individuals with congenital heart disease; and

(B) consider health disparities among individuals with congenital heart disease, which may include the consideration of prenatal exposures.

(c) Awareness campaign

The Secretary may carry out awareness and educational activities related to congenital heart disease in individuals of all ages, which may include information for patients, family members, and health care providers, on topics such as the prevalence of such disease, the effect of such disease on individuals of all ages, and the importance of long-term, specialized care for individuals with such disease.

(d) Public access

The Secretary shall ensure that, subject to subsection (e), information collected under this section is made available, as appropriate, to the public, including researchers.

(e) Patient privacy

The Secretary shall ensure that the data and information collected under this section are