**Request for Comments**: Promoting Telehealth for Low-Income Consumers. **Due August 29, 2019**

**REPLY TO Lifeguard Health Networks, Inc. COMMENTS (in green text below) and CONFIRMATION of original comments FROM DR. DAVID FINLEY, Dartmouth-Hitchcock’s Louise R. and Borden E. Avery Clinical Chair of Surgery Chief, Thoracic Surgery; Director, Comprehensive Thoracic Oncology Program at Norris Cotton Cancer Center; Director, Tobacco Cessation Program; Co-Director, Surgical Robotics Program; and,** **Associate Professor of Surgery, Geisel School of Medicine, Dartmouth.**

Request for comments on Pilot program within the Universal Service Fund (USF or Fund) to support connected care for low-income Americans and veterans.

Comments to:

Commission’s Secretary, Office of the Secretary, Federal Communications Commission

445 12th St. SW

Room TW–A325

Washington, DC 20554

You may submit comments, identified by WC Docket No. 18–213:

- Electronic Filers: Comments may be filed electronically using the internet by accessing the ECFS: http:// fjallfoss.fcc.gov/ecfs2/

FOR FURTHER INFORMATION CONTACT: Jodie Griffin, Wireline Competition Bureau, (202) 418–7550

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**David Finley, MD**

**David Finley is a Surgeon-Scientist in the field of Thoracic Oncology focusing on improving outcomes through the development and implementation of technology in the treatment of patients with thoracic malignancies.** The primary goal of the proposed work is to better understand provider barriers and facilitators of shared decision making for lung cancer screening to improve patient participation through the use of TeleHealth and Mobile Lung Cancer Screening Units. The National Lung Cancer Screening Trial randomized 53,454 patients to either low-dose computed tomography (CT) or chest X-ray for high risk patients. They reported a 20% lung-specific mortality reduction, as well as an overall mortality reduction of 6.7% in a high-risk cohort that underwent low-dose CT. As a result of these findings, many professional have recommended annual low-dose CT for “high-risk” patients defined as those (1) 55-77 years of age, (2) with at least a 30 pack-year smoking history, (3) who are current or former smokers who have quit in the last 15 years. However, despite these important findings, screening is still underutilized with only 4% of eligible high-risk patients participating. *This leads to excess and avoidable deaths from lung cancer each year*. While the reasons for this are likely multifactorial, there is a critical need to better understand provider factors, especially those concerning shared decision making, that contribute to low patient referral and participation. With his expertise in thoracic surgery, his research and experience with the evaluation and utilization of technology, as well as being the Director of both the Comprehensive Thoracic Oncology Program and the C. Everett Koop Tobacco Cessation Program, Dr. Finley has the skillset to support the research and logistic aspects of related studies. In addition, his team recently completed a pilot project to evaluate the use **of an electronically monitored, unsupervised, pre-operative exercise program (uPEP) for patients scheduled to undergo surgery for lung cancer.**  This experience will be invaluable as we assessed the adoption of technology in our rural population through the use of TeleHealth. With Dartmouth-Hitchcock Medical Center (DHMC) as one of only a few LCS centers located in a rural area, our 6 years of screening efforts have resulted in a database of 220 providers, which have referred approximately1,400 patients, and uniquely positions Dr. Finley to complete this work.

Dr. David Finley received his medical degree from the University of Vermont’s Robert Larner, M.D. College of Medicine and completed a prestigious thoracic surgery fellowship at Memorial Sloan-Kettering Cancer Center. He uses cutting-edge technologies in his approach to thoracic medicine, offering robotic surgery options whenever they provide benefits. As Director of the Comprehensive Thoracic Oncology Program at Dartmouth-Hitchcock Medical Center, Dr. Finley encourages an individualized and team-based approach to the treatment of thoracic malignancies. He also believes thoracic medicine should emphasize both prevention and early detection of lung, chest and esophageal cancers.

He feels that harnessing technology for the benefit of patients is the wave of the future. Utilizing personal fitness devices to improve exercise tolerance before and after surgery, employing telemedicine to better connect patients in his rural communities and advancing care in the operating room with robotics and navigational bronchoscopy are all areas in which he has developed and implemented programs, as well as assessed their utility in the care of his patients. Making sure that technology is both useful and beneficial is paramount.

**Lifeguard Health Networks, Inc**

Lifeguard Health Networks, Inc. is a digital health technology company that supports healthcare organizations – hospitals, health systems, clinics (including physicians, nurses, administrators, therapists, navigators and other patient support staff) and, payer and managed care organizations; as well as patients and their family and trusted friends who serve as patient caregivers – especially for those patients that require support at home due to chronic and complex conditions or because of compromising circumstances including comorbidity or age - the very young and the very old.

**Lifeguard technology in brief**

Lifeguard Health Networks has built and deployed a sophisticated cloud-based mobile platform that enables the utilization of the most ubiquitous technology in use today – the smartphone – to support and manage patient “Connected Care”. Core to Lifeguard Health Networks technology is “LifeguardRx®” which exploits access and communication capabilities already in place and used by a continuing and growing number of citizens that cross virtually all demographic populations. In fact, survey data indicates that some of the fastest growing segments of smartphone users include older and lower socioeconomic populations. Introduction of Lifeguard as a “telehealth platform” brings the clinician and patient closer together in a “virtual care center” which can be critically important in between patient appointments.

**Providers use of Lifeguard**

Healthcare providers (physical *and* behavioral) use the Lifeguard platform to provision individual patient care plans to the patient’s Lifeguard app on their smartphone. And multiple, even unaffiliated providers can each use Lifeguard to provision their own unique care plan for a common patient. Lifeguard presents a multi-specialty care plan that delivers a simple and seamless patient experience. Each care plan is based on the patient’s specific therapy regimen and each authoring provider is appropriately informed of their patient status (per their authored care plan) and can view all elements of the patients combined digital therapeutic care plan from all providers. In this way, clinicians have a broader view of the patient’s care plan across healthcare providers, which has intrinsic and obvious coordinated care benefits, including medication reconciliation.

Lifeguard captures and records every touch point as a discrete data element in the form of patient reported outcomes (PROs). Data is then delivered either as information via predefined automated mechanisms (clinically relevant events or trends alerts), or on demand reports, or as raw data via export functionality, which supports the healthcare organization to evaluate and analyze patient data from virtually any perspective.

**Patients use of Lifeguard**

Patients use Lifeguard to record their “scheduled/prescribed” actions (symptoms, side-effects, vitals, medications and elements of wellness) which are measured against provider defined protocols. Lifeguard uses built-in analytics to virtually monitor patient measures remotely. And if a patient is unable or unwilling to participate, Lifeguard supports a HIPAA-compliant patient proxy functionality that enables the primary caregiver to participate in remote patient monitoring on behalf of the patient, directly supporting the clinical team between patient visits.

Because it’s a “rich mobile client” Lifeguard requires very low bandwidth to operate and, in fact, can function in a no bandwidth area with predefined (time and date) reminders that support Patient Reported Outcome (“PRO”) measures as well as medication reminders according to specific time and dosage information.

**Dr. Finley and Lifeguard Summary** of support for Promoting Telehealth for Low-Income Consumers and implementation of a Connected Care Program pilot funded by the Universal Service Fund.

Lifeguard is a growth company that has implemented its technology in the US and Canada and, is in the pre-implementation phase for a population health program in Australia. Lifeguard is currently in discussions with a handful of hospitals and health systems in the US and has also been engaged in meaningful discussions with the FCC and the NCI most notably in the context of the L.A.U.N.C.H. Initiative. We have provided transparent information to our colleagues at L.A.U.N.C.H. with regard to these discussions, including the interest of these institutions to use Lifeguard and engage in a collaboration with the L.A.U.N.C.H. Initiative partners.

Lifeguard is in an advantageous position to support the Connected Care Program pilot through our current and unfolding relationships with hospitals and cancer centers and have committed our support to these institutions. Specifically, we are in collaborative discussions with healthcare providers that separately deliver care to patients who live in catchment areas that include: eastern and northern Michigan, the state of Oklahoma including Tribal populations, the Central Valley of California, (and potentially the rural areas of western and northern New England). We are confident that we will be able to support submissions from one or more institutions when request for submission to make application for the Connected Care Program pilot is announced. One such healthcare provider is Dr David Finley, Chief Thoracic Surgery at the Norris Cotton Cancer Center (NCCC) at Dartmouth Hitchcock, which has earned recognition from the National Cancer Institute as an NCI-designated comprehensive cancer.

Dr. Finley is focused data science and has “always followed my data,” and he videotapes most surgeries he performs with consent from his patients. “It is very important to me to know what I am doing well and finding when I can make things better for patients,” he says. Dartmouth has a database that documents more than 1,000 data points for each patient who goes through any thoracic surgery at Dartmouth-Hitchcock Medical Center (DHMC). The data includes details like patients’ smoking history, medical comorbidities, any complications they may experience and tracks how long they are in the hospital.

Dr. Finley is excited about the potential that is represented by the FCC’s Connect2HealthFCC Task Force, their engagement with the NCI in the L.A.U.N.C.H. Initiative plus his unfolding collaboration with Lifeguard. The data collected by NCCC can be significantly extended through outpatient engagement and monitoring in the home using telehealth technologies, such as Lifeguard.

Lifeguard is also excited to continue its support of the L.A.U.N.C.H. Initiative and our cooperative support to deliver connected care that optimizes outpatient care, increases access, improves health outcomes, health quality and patient satisfaction, while reducing overall medical costs for patients, providers and the healthcare system.

**Dr Finley welcomes the opportunity to join Lifeguard Health Networks with confirming REPLY and COMMENTS to Lifeguard’s prior responses of 29 August to the Commission’s request for comments**:

1. This Pilot program would help the Commission better understand how the Fund can play a role in helping patients stay directly connected to health care providers through telehealth services and improve health outcomes among medically underserved populations that are missing out on these vital technologies.

Lifeguard and Dr Finley support a pilot program utilizing broadband to support connected care services for patients that are most vulnerable, including underserved populations, those in rural areas where healthcare can be limited and distant, and patients who are dealing with chronic, complex and comorbid conditions.

2. The Pilot aim is to allow the Commission to obtain valuable data concerning connected care services and also help to better understand the relationship of affordable patient broadband internet access service to the availability of quality health care, the health care cost savings that result from connected care services, and the role of connected care on patient health outcomes. The Commission’s proposal seeks to bring these innovative telemedicine technologies to medically underserved populations, including low-income communities and veterans, by empowering health care providers to connect directly with their patients.

Lifeguard and Dr Finley agree with the Commission in its desire to use connected care services to better understand the value of broadband in the delivery of virtual care especially between patient visits. We know there is a cost savings to be enjoyed through the use of connected care program, but more importantly, we know there is an opportunity for increased health quality and outcomes for patients and providers that remain virtually connected between patient visits.

3. The Commission proposes that the Connected Care Pilot program will operate as a new program within the USF, which would provide funding to eligible health care providers to defray the qualifying costs of providing connected care services to low-income Americans and veterans.

Lifeguard and Dr Finley welcome the opportunity to collaborate in delivering lost cost solutions that support low-income Americans and veterans. It should be noted that Lifeguard business model provides for a sponsorship structure whereby the provider acquires a license to use the existing Lifeguard platform at fee based on the number of patients, but there are no fees ever charged to the patient – and any caregiver that the patient authorizes to support them is also free to use Lifeguard’s technology to support that patient. Lifeguard is also enabled for an unlimited number of the sponsoring provider’s clinicians and staff, which support outpatient care and their family caregivers.

4. The Commission expects this Pilot could benefit Americans that are responding to a wide breadth of health challenges, including **diabetes management, opioid dependency, high- risk pregnancies, pediatric heart disease, mental health conditions, and cancer**.

Lifeguard is disease agnostic. It is designed to support virtually any condition and also supports comorbidities including physical *and* behavior health conditions. Being a provider at a cancer center, Dr Finley is focused on thoracic and cancer populations, but does engage with patients with comorbid conditions and welcomes the opportunity to use technology to effectively and collaboratively manage patient care with other providers.

5. By encouraging more health care providers to make use of connected care technologies, the Commission may help create a model for the nationwide adoption of such technologies, which could lead to improved health outcomes for patients and savings to the country’s health care system overall.

Lifeguard and Dr Finley agree and welcome the opportunity to cooperatively support the delivery of a connected care program that will demonstrate optimized outpatient care, increased access, improved health outcomes, health quality and patient satisfaction, while reducing overall medical costs for patients, providers and the healthcare system.

6. The Commission proposes a three-year Connected Care Pilot program (Pilot) with a $100 million budget that would provide support for eligible health care providers to obtain universal service support to offer connected care technologies to low-income patients and veterans. Through this Pilot program, the Commission seeks to develop a record that will help to understand the benefits that subsidization of broadband service for connected care brings.

Dr Finley supports Lifeguard’s capabilities to engage the targeted patient populations (disease type and demographics) in a connected care program and capture data that can bring benefit in near real-time as well as on demand longitudinal data to evaluate individual patient status and progress – and capture, export and analyze “big data” it captures over time. Data can be used, in particular, to measure pre-connected care program health outcomes of the target populations to post-connected care program health outcomes and the associated costs for each (by multiple measures). Then measure those results against the outcomes and cost of care for the general population. We submit this perspective will provide an argument that supports the premise that the cost to expand broadband will have a greater impact on better health outcomes and lower costs, illustrating an overall health and ROI win.

7. The Commission seeks to design a cost-effective and efficient Pilot program that incentivizes participation from a wide range of eligible health care providers and broadband service providers, provides meaningful data about the use of connected care services provided over broadband for low- income Americans and veterans, and provides insight into how universal service funds could better promote the adoption of connected care services among low-income Americans and veterans and their health care providers.

Lifeguard exploits the continuing and growing number of citizens that cross virtually all demographic populations, including low income Americans and veterans. In fact, survey data indicates that some of the fastest growing segments of smartphone users include older and lower socioeconomic populations. Dr Finley supports introduction of Lifeguard as a “telehealth platform” that can bring the clinician and patient closer together in a “virtual care center” which can be critically important in between patient appointments. Extending into, or increasing current band width in, rural areas in particular present certain business challenges. We suggest that with increased use of technology that drives better health outcomes, there is opportunity for broadband providers to maximize their market penetration (patients and family caregivers) in rural areas that support a connected care program.

8. The Commission proposes implementing a flexible Pilot program that will give health care providers some latitude to determine specific health conditions and geographic areas that will be the focus of the proposed projects. Under this proposal, the Pilot program would provide funding to selected Pilot project health care providers to defray the costs of purchasing broadband internet access service necessary for providing connected care services directly to qualifying patients. The Commission seeks comment on this proposal.

Lifeguard and Dr Finley submit that the formal purchasing of broadband services may not be a strict requirement. For example, hospitals that serve underserved populations almost always have connectivity capabilities in place to enable basic internet access. This is a simple minimum requirement for use of Lifeguard. In this scenario, Lifeguard’s technology can fully support remote patient monitoring of patients who participate using a smartphone, tablet or computer. With this as an example of how a connected care program can be supported, we suggest that the “non-broadband costs” to implement a connected care program can be used to better support the engagement of *more* providers, nurses and other clinicians that can support *more* patients. Lifeguard’s rich mobile client combined with its cloud-based mobile platform uses minimum bandwidth for data transport and fully communicates changes which are made available in near real-time to all authorized participants supporting each “Lifeguard patient”.

8. The Commission proposes limiting the Pilot program to projects that primarily focus on health conditions that typically require at least several months or more to treat—such as **behavioral health, opioid dependency, chronic health conditions (e.g., diabetes, kidney disease, heart disease, stroke recovery, [cancer]), mental health conditions, and high-risk pregnancies** – collecting data across at least several months would provide more meaningful, statistically significant data to track health outcomes and cost savings.

Lifeguard and Dr Finley welcome the opportunity and can immediately support cancer population health that is managed and coordinated between providers of a common patient – across high cost health conditions and can capture and report data in near real time for immediate intervention as appropriate as well as longitudinal data, available on demand for further research and analysis, which can include evaluation of health quality as well as health costs.

9. The Commission also seeks information from commenters regarding the marketplace for connected care services, specifically whether health care providers typically purchase complete packages or suites of services that include patient broadband internet access service and other functionality necessary to provide connected care services, or whether health care providers typically purchase broadband internet access service connections for connected care as a stand-alone product.

As stated previously, ownership of smartphone is growing across all demographics, the fastest of which includes older and low-income populations. Assuming the consumer/patient owns technology (smartphone, tablet, computer), there are two distinct cost considerations: 1) technology (e.g. Lifeguard) and 2) “carrier” cost for data plans allowing access to general consumer broadband services i.e., the cellular network. Lifeguard and Dr Finley submit that with more and more people owning technology, especially smartphones, the primary cost subsidy consideration should be weighted toward the cost of “information services”. Some of the largest single purchases made by providers is information technology or more specifically Electronic Medical Record systems. Unfortunately, EMRs do not extend well beyond the brick and mortar walls of hospitals. Lifeguard can integrate with EMR and enhance the investments already made by provider organizations. Candidly, though, remote patient monitoring and other outpatient services are comparatively newer technologies and more data is necessary to scientifically demonstrate data-based value. The Commission’s proposed Connected Care Program pilot is a mechanism that can drive and illustrate objective value of remote patient monitoring, the capture of PRO data and other connected care benefits.

10. Comments invited on the costs of: (1) The broadband connectivity that eligible low-income patients of participating hospitals and clinics would use to receive connected care services; and (2) the broadband connectivity that a participating hospital or clinic would need to conduct its proposed connected care pilot project. Many commenters also expressed support for funding both fixed and mobile broadband for connected care.

Lifeguard and Dr Finley believe that Lifeguard’s technology can fully operate within existing hospital systems through integrated channels and therefore does not require additional “broadband” connectivity to function within the hospital or clinic. Lifeguard technology allows providers to be untethered from workstations and hardwired station-to-station requirements.

On the patient side, Lifeguard supports both mobile (smartphone/tablet) and fixed (computer/laptop) connectivity. Dr Finley acknowledges that flexible support (fixed and mobile) allows patients and their family caregivers to choose their preferred communication platform to participate in a connected care program.

It should also be said that Lifeguard is device and system agnostic. It can capture machine entered data from devices as well as manual inputs from patients or their designated proxies. And data is transmitted via binary differentials requiring very limited bandwidth with extremely limited impact on broadband capacity.

11. Related to the above: “Several health care providers asserted that the Pilot program should not fund internet connections between health care providers. The Commission agrees, as doing so would be duplicative with the existing Rural Health Care (RHC) programs and propose to exclude such connections from the Pilot program.”

Lifeguard and Dr Finley agree with the Commission that “the Pilot program should not fund internet connections between health care providers.” As stated elsewhere, Lifeguard requires only minimum broadband connectivity for Internet access and virtually all hospitals and clinics already have that capability. Funds would be better directed toward the support of technology and information services.

12. The Commission considers ‘‘telehealth’’ for the purposes of this proceeding to include a wide variety of remote health care services beyond the doctor-patient relationship; for example, involving services provided by nurses, pharmacists, or social workers.

Lifeguard and Dr Finley agree with the Commission’s view of telehealth. Overseen by providers, Lifeguard can be most effectively and efficiently managed by nurses, care coordinators, navigators and social workers – to support clinical care, as well as behavioral care and patient navigation. Telehealth must include a broader category of participants that can engage directly with the patient or authorized HIPAA compliant patient proxy, and intermediate and/or refer to providers as appropriate. *This is the model we actually use today* whenever a patient calls by phone for support!

12. The Commission also defines the term ‘‘telemedicine’’ as using broadband internet access service-enabled technologies to support the delivery of medical, diagnostic, and treatment-related services, usually by doctors. The Commission seeks comment on these definitions and their applicability to the Connected Care Pilot program.

Lifeguard and Dr Finley recognize the patient-physician relationship is intrinsically tied to “telemedicine”. We also recognize that “telemedicine” as a one-to-one (synchronous) relationship presents challenges in particular with regard to its ability to “scale”. In this light, Lifeguard and Dr Finley are supportive of expanding acceptance of telehealth as a support mechanism to scale connected care and that telemedicine can demonstrate is value when patients must interact directly with their physician. That value is further enhanced when that patient can be seen more immediately – at home – without need to drive to a local center or to the location of the physician. This capability may save hours and significant dollars when all is taken into account (transportation costs, lost wages for missed work, etc.). In addition to its telehealth capabilities, Lifeguard also have built-in secure video conferencing for “telemedicine”, that can not only connect physician and patient, but can include caregivers (pre-authorized by the patient) to participate and other authorized providers to collaborate in the virtual visit. It is important to note that there is a growing number of scenarios for telemedicine or virtual patient visits that are being reimbursed by CMS and commercial insurance plans. The next step is to increase the number of scenarios where telehealth is also a reimbursable service that supports quality outpatient care.

12. The Commission seeks comment on these definitions and their applicability to the Connected Care Pilot program. In addition, the Commission also proposes to define the term ‘‘**connected care**’’ as a subset of telehealth that is focused on delivering remote medical, diagnostic, and treatment-related services directly to patients outside of traditional brick and mortar facilities. The Commission seeks comment on this proposed definition of connected care.

Lifeguard and Dr Finley applaud the Commission’s definition of connected care as a subset of telehealth and further recommends that the Commission ensures that the Pilot program is focused on remote healthcare outpatient services that are delivered directly to patients (or managed on their behalf by authorized, HIPAA-compliant proxies) outside of traditional medical facilities through broadband-enabled technologies.

13. The record indicates that remote patient monitoring devices are generally single-purpose, meaning that they cannot be used to access the public internet or for uses outside of the health care context.

Lifeguard and Dr Finley suggest that the Pilot allow technology that supports asynchronous connectivity and general access to other internet-based services and information not currently available via single purpose devices. This added capability should not discount the value of the services provided to the patient. As a matter of fact, we suggest that the added functionality could potentially increase the utilization of the technology to remain connected with their provider. Think of the free games that are included with computers and smartphones. The more a person uses the device the more comfortable they become with the technology the more inclined they will be to participate in the connected care program pilot.

14. What types of services would be considered information services, as well as any applicable precedents and should it be funded through the Pilot program? How do service providers currently fund these types of services and what are the typical costs? Are specific types of health care providers or provider locations more likely to be unable to purchase these types of information services?

Lifeguard and Dr Finley recognize the value of “information services” much more than “technology”. Technology is only a means to capture and/or delivery actionable information. Lifeguard is primarily an information service provider that delivers relevant information to the authoring provider of a provisioned care plan for the most appropriate and most timely care of the patient that can be acted upon to optimize the right care at the right time – at the point of care. “Information services” must also include longitudinal information that can be evaluated on a patient level (e.g. health status trends, correlated data sets including medication management) and can be analyzed across populations.

15. Should the Pilot program fund ‘‘network equipment necessary to make a broadband service functional’’ and for consortia applicants ‘‘equipment necessary to manage, control or maintain an eligible service or a dedicated health care broadband network’’ as is done in the Healthcare Connect Fund program.

Lifeguard and Dr Finley may have a myopic view of “network equipment” as Lifeguard’s cloud-based software enabled technology *does not require any investment in hardware whatsoever*. Virtually all hospitals and clinics have sufficient existing broadband connectivity on which Lifeguard’s platform can operate. Our perspective therefore does not support the funding of provider networking equipment or hardware of any kind to enable a connected care program.

15. The Commission proposes *not* to permit duplication of funding for this equipment and equipment funded through the Healthcare Connect Fund program – and seeks comment on this interpretation and approach.

Lifeguard and Dr Finley agree that if funding for equipment is available through other programs, that such funding should not be duplicated through the connected care program pilot.

16. Should the Pilot program support health care provider administrative and outreach costs associated with participating in the Pilot program (such as personnel costs, and program management costs)? Past experience in the RHC support programs and RHC Pilot program demonstrates that ‘‘[health care providers] will participate even without the program funding administrative expenses.’’

Lifeguard and Dr Finley recognize the required commitment of provider organizations that engage in research programs and pilots. If the percentage of subsidized costs for other aspects of the connected care program (e.g. 85%) is covered, then there would be more latitude and ability to participate. If the percentage of subsidized costs is lower, then some coverage for administrative, overhead and associated outreach costs must be considered as part of the funding.

17. Should the Pilot program fund end-user equipment, medical devices, or mobile applications for connected care. Many commenters supported funding such items. That said, traditionally, the Commission has declined to fund these items through the Universal Service Fund because of section 254’s focus on the availability of and access to services. As such, the Commission proposes to make end-user devices, medical devices, or mobile applications (**excepting those applications that may be part of a service that could be considered an *information service***) ineligible for support in the Pilot program. Would health care providers still be interested in and be able to participate in the Pilot program if the Pilot program does not fund end-user devices, connected care medical devices, or connected care mobile applications?

Although smartphone ownership is significant and on the rise across all demographics, there are some patients that do not have smartphones or other technology compatible with connected care programs. Health care providers remain challenged to fund the costs of connected care programs regardless of the source of costs (communications costs, hardware costs, or software costs) making it difficult for physician champions – who remain eager to engage - to gain internal support to even pilot innovative programs to support underserved populations. The added costs to provide technology such as smartphones make it more difficult. Therefore, some partial funding of end-user devices, connected care medical devices, or connected care mobile applications – and appropriate data plans – should be considered for the most vulnerable portions of our patient populations, especially if the intent of the program is to incorporate the widest representation of a population cohort. Lifeguard as an information service can enable patients, proxies and other patient caregivers the ability to participate in a provider directed connected care program with a just a smartphone, tablet or computer.

18. Commenters in the record identify reimbursement as a major barrier to telehealth adoption. They urge the Commission to coordinate with the Centers for Medicare and Medicaid Services (CMS) to implement reforms to reimbursement policies for telehealth. How can the Commission most easily obtain data through the Pilot that would be informative on issues such as reimbursement and licensure?

Lifeguard and Dr Finley support the concept of analysis of data gathered from Lifeguard correlated against other provider data to measure both clinical outcomes and associated costs, evaluated against related claims data, for targeted populations.

19. The Commission therefore proposes to adopt a $100M budget for the Pilot program. The Commission also proposes a three-year funding period for the Pilot program. How should the total Pilot program budget be distributed over the three-year funding period? Should each selected project’s funding commitment be divided evenly across the Pilot program duration?

In order to properly fund a Pilot that extends over three years, the payment schedule should be flexible especially considering that first costs can be significantly higher than follow on years of operation. For example, a $5M pilot may require $2.5M in the first year followed by equal payments of $1.25M in year two and three.

20. The Commission proposes requiring the Universal Service Administrative Company (USAC) to separately collect on a quarterly basis the funds needed for the duration of the Pilot program. The Commission also proposes to have excess collected contributions for a particular quarter carried forward to the following quarter to reduce collections.

If the Commission agrees to support “unequal payments” across three years of the Pilot program and USAC collects “excess funds”, pragmatism suggests that the funds should be accumulated quarter-to-quarter (and not reduce future collections) to provide for quicker recovery of potential higher payments in the first year than may be made in the following years of the Pilot.

21. The proposed $100M funding is based on up to 20 projects with awards of $5 million each. The Commission proposes to provide a uniform percentage of **eligible services or equipment** (currently proposed at 85% - the amount received of the total cost of the pilot) to be funded, rather than fully funding any Pilot projects, consistent with the strategy implemented by the **Healthcare Connect Fund** program and the **RHC Pilot** [and **E-Rate**] program.

Lifeguard and Dr Finley support the idea of supporting 85% (or more, if appropriate) of the cost of eligible services or equipment. However, in light of the potential of administrative support services and associate outreach being potentially ineligible for funding, Lifeguard is interested in understanding the Commission’s perspective on the value of “in-kind services” (by the service/technology vendor as well as the provider) and how, if allowed, would that be calculated in the cost of any proposed individual pilot? How will the value of in-kind contributions by collaborative participants in a consortium be calculated into the cost of a pilot 9 - e.g. engagement and support from L.A.U.N.C.H. Initiative partners?

22. To further ensure the cost-effective use of Pilot funds, in addition to adopting a flat, uniform discount percentage, should the Commission cap the monthly amount of support that can be paid for broadband internet access service to a health care provider for each participating patient?

From a health care provider perspective, cost for broadband access is typically flat, but the use of services that utilize broadband can vary based on data volume (e.g. data transfer) or time spent (e.g. video conferencing). The variable then is more related to the service providers that use broadband than actual broadband access. That is not to say that broadband carriers don’t increase cost with volume of utilization, but that variable is more stable and more predictable – and can even be negotiated with a projected cap and carry over month-to-month. With Lifeguard’s technology, it is highly unlikely that there would be any impact on broadband costs above what the provider organization has already contracted. Lifeguard suggests that broadband services costs will have a small impact on the cost of the overall connected care program.

23. For the Healthcare Connect Fund program, the health care provider is required to pay the non-discounted share of the eligible costs from eligible sources (e.g., the applicant, eligible health care provider, or state, federal, or Tribal funding or grants), and is prohibited from paying the non- discounted share of eligible costs from ineligible sources (e.g., direct payments from vendors or service providers). The Commission seeks comment on whether it should apply this same limitation to health care providers participating in the Pilot program.

We do not fully understand this subject matter and therefore cannot accurately comment at this time.

23. Should the Commission limit the portion of the non-discounted costs that health care providers can require participating patients to pay for the supported broadband internet access service? If so, what would be an appropriate limit on the patient share of the costs? For purposes of the Pilot program, should the Commission place any limitation at all on the source of funding for the non-discounted share of the costs - that are not tied to the Healthcare Connect Fund program rules?

Lifeguard only charges the provider organization for the Lifeguard services. Providers sponsor access to participating patient’s data and Lifeguard’s platform that manages all aspects of the connected care program. As mentioned elsewhere, patient’s caregivers can also participate in supporting their patient at no cost, and at no additional cost to the provider organization. Lifeguard can therefore support a program that does not charge patients, nor their caregivers, for their participation.

24. (Follow on to #21.) On further consideration of the record, the Commission proposes not to expressly limit the number of funded Pilot projects, and to permit flexible and varied funding for each selected Pilot project. While the Commission proposes allowing varied funding amounts for selected projects, the Commission does not anticipate spending all of the Pilot program funds on one or two large projects. Should the Commission establish a ceiling on the amount of the total budget that can be allocated to a single project.

Lifeguard and Dr Finley agree with the Commission. The amount of funding for submitted pilot projects should be viewed on their own merit and without strictly capping the amount of funding required to support the proposed Pilot.

25. The Commission also seeks comment on whether cost allocation should be required for services or other items supported through the Pilot program that are used for non-health care purposes or include ineligible components. For example, if a Pilot project permits patients to use the supported broadband service for non- health care purposes, should the Commission require cost allocation of the non-health care usage?

Same response as #13. Lifeguard and Dr Finley suggest that the Pilot allow technology that supports connectivity and general access to other internet-based services and information not currently available via single purpose devices. This added capability should not discount the value of the services provided to the patient. As a matter of fact, we suggest that the added functionality could potentially increase the utilization of the technology to remain connected with their provider. Think of the free games that are included with computers and smartphones. The more a person uses the device the more comfortable they become with the technology the more inclined they will be to participate in the connected care program pilot.

26. comment on whether the Pilot program should have a two- or three- year funding duration and six-month ramp-up and wind-down periods.

Lifeguard and Dr Finley endorse the three-year duration and would agree to up to six-month ramp-up and wind-down periods (inclusive or exclusive of the three year duration).

27. The Commission proposes a three-year funding period and separate ramp-up and wind-down periods of up to six months in order to give projects time to complete set up and other administrative matters related to the Pilot program. Should funding disbursements begin during the ramp-up period, and if so, how should funding be split between the ramp-up period and the Pilot project term?

Lifeguard and Dr Finley believe that the ramp-up and wind-down periods require work effort and attention and should be included in the funding plan.

28. The Commission proposes to limit health care provider participation in the Pilot program to non-profit or public health care providers within section 254(h)(7)(B): (i) Post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (ii) community health centers or health centers providing health care to migrants; (iii) local health departments or agencies; (iv) community mental health centers; (v) not-for-profit hospitals; (vi) rural health clinics; (vii) skilled nursing facilities; (viii) and consortia of health care providers consisting of one or more entities described in clauses (i) through (vii).

Lifeguard and Dr Finley believe that the parameters listed provide for a broad enough audience to attract sufficient interest and participation in the connected care program pilot.

29. The Commission seeks comment on whether section 254 requires it to limit health care provider participation to these categories of providers. And if not, the Commission believes that applying this limitation to the Pilot program would provide significant benefits.

Lifeguard and Dr Finley agree with the Commission.

30. Is there an interpretation of section 254(h)(7)(B) that would allow the Commission to provide funding to certain health resources (i.e. EMTs, health kiosks, school clinics)? Would the definition of ‘‘health care provider’’ under section 254(h)(7)(B) preclude sites like the VA’s Virtual Living Room sites, community center or similar sites in convenient locations with broadband connections for patients to virtually connect with providers of medical care? The Commission seeks comment on whether limitations on eligible entities could limit the effectiveness of the Pilot program, the ability to obtain meaningful data on connected care services – and, are the proposed eligible health care providers sufficiently well versed in medical research methods to be able to properly evaluate the health outcomes linked to the provision of connected care?

Lifeguard and Dr Finley support the inclusion of a broader definition of health care provider (and locations eligible for delivery of telehealth services, including the home). It may serve to more definitively illustrate the value of early “traditional” telemedicine settings against more agile, more robust, less costly telehealth systems such as Lifeguard which can deliver support to the patient in the home.

31. under section 254, the Commission proposes requiring interested health care providers to indicate their respective category(ies) for eligibility by submitting FCC Form 460, which USAC uses to determine the eligibility of health care providers in the Healthcare Connect Fund Program. The Commission proposes requiring eligible health care providers to have prior experience with telehealth and long- term patient care.

In light of evolving innovative technologies, services and novel collaboratives, Lifeguard and Dr Finley believe that the notion of a prior experience requirements would be highly limiting of incorporation of next generation solutions participating in the connected care program pilot.

32. the Commission proposes to have consortia applicants file FCC Form 460 identifying all sites that would participate in the Pilot program, including off-site data centers and administrative offices, and propose permitting consortia applicants to file FCC Form 460 on behalf of any site in the consortium that would participate in the Pilot program to determine that site’s eligibility. Consistent with the Healthcare Connect Fund program, the Commission proposes requiring consortia applicants to have in place a Letter of Agency.

This is currently out of scope for our comments

33. The Commission also proposes that the Pilot program be open to both urban and rural eligible health care providers. Several commenters assert that the Pilot should not be limited to projects serving only rural areas. To the extent that section 254(h)(2)(A) applies to the Pilot program, it does not limit universal service support to rural health care providers, and the Commission believes the Pilot program should not be limited to rural health care providers.

Lifeguard and Dr Finley agree that underserved communities exist in both rural and urban settings – and Dr Finley serves patients in both settings. Therefore, the pilot should not be limited to rural health care providers. Lifeguard recognizes that the Commission may weight urban and rural settings uniquely.

34. To promote geographic diversity, the Commission seeks comment on limiting participation in the Pilot program to health care providers that are located in or serve an area that has received the Health Resources and Services Administration’s Health Professional Shortage Areas designation or Medically Underserved Areas designation, which correlate with professional shortages and lower- income areas, respectively, within a defined geographic area. What are the benefits and drawbacks of limiting participation by using these designations? Should the Commission also, or alternatively, consider limiting participation in the Pilot program only to eligible health care providers that currently provide care to at least a certain percentage of uninsured and underinsured patients, or to a certain percentage of Medicaid patients?

Same response as #33. Lifeguard agrees that underserved communities exist in both rural and urban settings - and Dr Finley serves patients in both settings. Therefore, the pilot should not be limited to rural health care providers. Lifeguard recognizes that the Commission may weight urban and rural settings uniquely.

35. As connected care services continue to grow, health care providers that only offer connected care have entered the marketplace. These new market entrants may bring innovative new services and inject competition that benefits patients, but it is not clear whether they would qualify as eligible health care providers under section 254(h)(7)(B). The Commission seeks comment on this question. Additionally, the record indicates that these types of providers may not be involved in long- term patient treatment.

Lifeguard and Dr Finley believe that participants must meet minimum requirements under the definition of health care provider. If such minimum is met and they meet other required criteria, they should be eligible to submit application for funding for the Pilot.

36. Specifically, should the Commission limit eligibility in the Pilot program to health care providers that are federally designated as Telehealth Resource Centers or as Telehealth Centers of Excellence, or to otherwise demonstrate their experience providing telehealth services? Should the Commission exclude health care providers that have no prior connected care experience?

Lifeguard and Dr Finley believe that the Commission should not limit eligibility as stated in 36. And should not exclude, out-of-hand, health care providers that have no prior connected care experience.

37. section 254(h)(2)(A) directs the Commission ‘‘to enhance to the extent technically feasible and economically reasonable, access to advanced telecommunications services and information services’’ for health care providers and, thus, allows support for non-ETCs (eligible telecommunications carriers). The Commission has previously explained that the ETC limitation in section 254(e) applies to the section 254(c) supported services, but not to additional supported services under section 254(h)(2)(A).

This is currently out of scope for our comments.

38. The Commission proposes not to limit Pilot program funding to only ETCs. The Commission anticipates that it would provide funding to eligible health care providers to purchase broadband internet access service that would be provided to the patient through a connected care offering, or that the health care provider would use USF funding to purchase telehealth services that qualify as information services.

Lifeguard and Dr Finley fully support USF funding to purchase telehealth services that qualify as “information services”. As stated before, Lifeguard does not require additional broadband to fully enable a connected care program.

39. If the Commission were to conclude that only ETCs would be able to receive support for providing broadband internet access service to patients participating in the Pilot, what impact would this approach have on service provider and health care provider participation in the Pilot program?

This is currently out of scope for our comments.

40. comment on the application process for the Pilot program and proposed several categories of information that should be contained in the application. 1) first submit an application describing the proposed pilot project and providing information that will facilitate the selection of high- quality projects 2) should the Commission require participating health care providers to have already identified specific broadband providers

Lifeguard and Dr Finley support 1) in #40 above and, are neutral on 2) as the latter is not a critical factor for enabling Lifeguard services in a provider location that already has basic broadband service for internet access.

41. Based on the Commission’s review of the record and prior experience with Pilot programs, it proposes that applications contain, at a minimum, the following information:

• Names and addresses of all health care providers that would participate in the proposed project and the lead health care provider for proposals involving multiple health care providers.

• Contact information for the individual(s) that would run the proposed pilot project (telephone and email).

• Health care provider number(s) and type(s) (e.g., non-profit hospital, community mental health center, community health center, rural health clinic, community mental health center), for each health care provider included in proposal.

• Description of each participating health care provider’s experience with providing connected care services and conducting clinical trials or the experience of a partnering health care provider.

• Description of the connected care services the proposed project will provide, the conditions to be treated, the health care provider’s experience with treating those conditions, the goals and objectives of the proposed project (including the health care provider’s anticipated goals with respect to reaching new or additional patients, improved patient health outcomes, or cost savings), and how the project will achieve the goals of the Pilot program.

• Description of the clinical trial design intended to measure the effect of the connected care pilot on health outcomes.

• Description of the estimated number of eligible low-income patients to be served.

• Description of the plan for implementing and operating the project, including how the project intends to recruit eligible patients, plans to obtain the end-user and medical devices for the connected care services that the project would provide, and transition plans for participating patients after Pilot program funding ends.

• List all Department of Health and Human Services, Health Resources and Services Administration (HRSA) designated Health Care Professional Shortage Areas (for primary care or mental health care only) or HRSA designated Medically Underserved Areas that will be served by the proposed project.

• Description of whether the health care provider will primarily serve veterans or patients located in a rural area, or the provider is located in a rural area, on Tribal lands, or is associated with a Tribe, or part of the Indian Health Service.

• Description of the anticipated level of broadband service required for the proposed project, including the necessary speeds/technologies and relevant service characteristics (e.g., 10/ 1 Mbps, or 4G).

• Detailed estimated break-down of the total estimated costs for the broadband internet access services and any other eligible costs.

• Estimated total ineligible costs and description of the anticipated sources of financial support for the project’s ineligible costs.

• Description of how the participating health care provider will ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy and reimbursement laws and regulations, and applicable medical licensing laws and regulations, and how it will safeguard the collected patient information against data security breaches.

• Description of the health outcome metrics that the proposed project will measure and report on, and how those metrics will demonstrate whether the supported connected care services have improved health outcomes.

• Description of how the health care provider intends to collect and track the required Pilot program data.

Lifeguard’s and Dr Finley’s view of these requirements are not untypical of what would be expected for submitting and application for funding.

42. Is the proposed application information sufficient to determine whether projects have processes in place to ensure compliance with the applicable medical licensing laws and regulations, HIPAA and any other applicable privacy laws, etc.…?

This is currently out of scope for our comments.

43. Should the Commission require health care providers to submit a self- certification regarding their patient care and telehealth qualifications with their applications…etc…?

This is currently out of scope for our comments.

44. If the Commission ultimately issues an order establishing the proposed Pilot program, would requiring that applications be submitted within 120 days from the release of such an order give health care providers sufficient time to develop and submit a meaningful application for the Pilot program?

Lifeguard and Dr Finley agree that this is an acceptable time frame

45. To facilitate the review and selection of proposals, should the Commission also seek advice from other expert health care entities with telehealth expertise? For example, should the Commission consult with the federally designated Telehealth Resource Centers or Telehealth Centers of Excellence?

Lifeguard and Dr Finley would support inclusion of entities with telehealth experience for advice. There should be multiple entities to ensure *more diverse perspective* in the proposal selection process to ensure that review includes evolving and novel approaches to delivering simple and effective telehealth services.

46. should a project’s ability to further the goals of the Pilot program be more important than the estimated cost of the project compared to the total Pilot program budget? Should the Commission decline to consider proposals that do not have a plan for how participating patients will obtain the necessary connected care medical devices, end user devices (e.g., smartphones or tablets), or connected care applications?

Lifeguard and Dr Finley believe any application should state how the proposal will further the goals of the Pilot. And the greater the aspiration (with some assurance of achieving goals) the less weight should be applied to the cost as a limiting factor. All proposals should include full consideration of how every participant will engage, including processes to enable “activation” that is how to enable access and participation.

47. The Commission proposes awarding additional points to proposed projects that would serve geographic areas or populations where there are well- documented health care disparities (Tribal lands, rural areas, or veteran populations) or that treat certain health crises or chronic conditions that significantly impact many Americans and are documented to benefit from connected care, such as opioid dependency, diabetes, heart disease, mental health conditions, and high-risk pregnancy [and cancer]. For all of the additional point factors the Commission proposes in the following, to seek comment on the relative importance of these factors compared to each other and compared to the other standard objective evaluation factors. Are there any other factors for which additional points should be awarded to a particular project?

Lifeguard and Dr Finley support the concept of weighted points according to desired participants, conditions and locations. We also suggest that there could be weighted points for proposing more goals with limited technology requirements, enabling prospective achievement of goals at a relatively lower cost.

48. the Commission proposes awarding extra points during the evaluation process to proposals that satisfy the following factors: (a) The health care provider is located in a rural area; (b) the project would primarily serve patients who reside in rural areas; (c) the project would serve patients located in five or more Health Professional Shortage areas (for primary care or mental health care only) or Medically Underserved Areas as designated by HRSA by geography; (d) the health care provider is located on Tribal lands, is affiliated with a Tribe, or is part of the Indian Health Service; or (e) the health care provider would primarily serve patients who are veterans.

Lifeguard and Dr Finley support the Commission’s proposal with one exception, suggesting that (d) should read as revised as follows: “the health care provider is located on Tribal lands, ***or serves*** *(include a percentage here)* ***native American population***, is affiliated with a Tribe, or is part of the Indian Health Service

49. The Commission also seeks comment on the criteria that should be used to determine whether a project would primarily serve patients who reside in rural areas

Since fewer patients live in rural areas, Lifeguard and Dr Finley suggest including geography that a provider’s catchment area includes, for example the number of rural counties in which the health care provider supports/delivers healthcare services.

50. The Commission proposes relying on the health care provider’s certification that it is located on Tribal lands, affiliated with a Tribe or is part of the Indian Health Service.

Lifeguard and Dr Finley can support this proposal

51. the Commission seeks comment on the criteria that should be used to determine whether a project would primarily serve veterans. What threshold would be appropriate?

Lifeguard and Dr Finley believe that supporting veterans should be included in all proposals. The Commission may want to give weighted points to proposals that incorporate targeting of a certain percentage of veterans in their proposed connected care program.

52. The Commission seeks comment on awarding additional points for projects that are primarily focused on treating certain chronic health conditions or conditions that are considered health crises, such as opioid dependency, high-risk pregnancies, heart disease, diabetes, [cancer] or mental health conditions. The Commission seeks comment on these proposals. Are there any other health conditions that would warrant awarding additional points to specific project proposals during the selection process?

Lifeguard is a condition agnostic solution and can virtually support all of the identified health conditions. Lifeguard suggests formally including cancer in the targeted list of health conditions. In particular, Lifeguard and Dr Finley would like to be able to incorporate collaboration with the L.A.U.N.C.H. Initiative which has a focus on remote patient monitoring for cancer patients in rural areas of the country.

53. the Commission seeks comment on whether to permit a project to serve a patient population that is primarily, but not entirely low-income?

Parallel to other similar proposals, Lifeguard and Dr Finley believe that supporting low-income populations should be included in all proposals. The Commission may want to give weighted points to proposals that incorporate targeting of a certain percentage of low-income (urban or rural) populations in their proposed connected care program.

54. seeks comment on potential requirements for Pilot program participants, including requirements for the vendor selection for Pilot-eligible costs, requesting funding, and requesting disbursements.

Lifeguard would be identified as a “sub” in any provider submitted proposals (including those supported by Dr Finley) and would provide details of costs and schedule of funding requirements to launch and support a pilot program over the course of 3 years.

55. The Commission proposes that participating health care providers, and not the participating patients, procure the services and equipment that could be funded through the Pilot program.

Lifeguard and Dr Finley fully support all funding being distributed to the participating health care provider for all eligible costs associated with the connected care program

56. the Commission requests additional information on how health care providers typically purchase broadband internet access service connections for connected care efforts.

As previously stated, Lifeguard does not require additional broadband services beyond the providers existing basic broadband services for internet access. No further comment is therefore offered.

57. the Commission proposes requiring the participating health care providers to conduct a competitive bidding process and, select the most cost-effective service. For example, the Commission has traditionally required schools and libraries and health care providers to competitively bid for the supported services and equipment,

Lifeguard would be identified as a “sub” in any provider submitted proposals (including those supported by Dr Finley) and we would provide details of costs and schedule of funding requirements to launch and support a pilot program over the course of 3 years. In addition, as stated elsewhere, no additional equipment or hardware is required (other than existing patient-owned and provider-owned smartphone, tablet or computer) to enable a connected care program using Lifeguard.

58. If the Commission requires health care providers to competitively bid any services and equipment that could be funded through the Pilot program, should the Commission use the existing Request for Services Form (Form 461) for the Healthcare Connect Fund program

This is currently out of scope for our comments.

59. are there public resources or entities that could help health care providers identify potential vendors or service providers? Should the Commission require ETCs to indicate their interest in participating in the Pilot program and their service areas, and make this information publicly available before the application deadline for the Pilot program?

This is currently out of scope for our comments.

60. The Commission also proposes prohibiting gifts from participating service providers to participating health care providers.

Lifeguard and Dr Finley support this proposal.

61. Requiring health care providers to submit funding requests for the Pilot program would allow USAC to ensure that the Pilot projects only request funding for eligible services and that the health care providers requesting funding are in fact eligible.

Lifeguard and Dr Finley support this proposal.

62. the Commission proposes requiring Pilot program applicants who are selected to submit funding requests within six months of the date of their respective selection notices for the Pilot program.

Lifeguard and Dr Finley support the notion of a six-month limit to submit specific funding request – but suggests a much shorter timeframe (e.g. 30 days) would be more appropriate to drive momentum in enabling a (paid) ramp-up period prior to formal launch of the Pilot.

63. The Commission also proposes requiring selected projects to certify that the provided funding will only be used for the eligible Pilot program purposes for which the support is intended.

Lifeguard and Dr Finley support this proposal.

64. how often disbursements should be issued and which entity should receive disbursements through the Pilot program. One commenter supported monthly disbursements. Another commenter asserted that disbursements should be issued to service providers to minimize health care providers’ administrative burdens, while two other commenters asserted that the disbursements should be issued directly to health care providers.

Disbursements should be made in alignment with timing of incurred costs as much as is reasonably possible. From Lifeguard’s and Dr Finley’s perspective, all payments should be made to the participating health care provider organization that is running the connected care program. As stated elsewhere, Lifeguard’s costs are higher in the first year (project planning, program design, workflows, integration where possible, initial training, etc.) and less in subsequent years. Payments can be made aligned with achievement of milestones to ensure appropriate achievement of the goals of the connected care program.

65. The Commission proposes issuing disbursements to the service provider, as is the current practice for the RHC programs, for the purchase of connectivity or other eligible items pursuant to its legal authority. In practice, this would equate to monthly discounts paid towards the cost of service or eligible equipment purchased by the health care provider. The Commission seeks comment on this proposal and any alternatives that commenters may provide.

As stated elsewhere, Lifeguard does not require additional or increased bandwidth beyond what virtually every health care provider has for basic internet connectivity. Costs associated with a Lifeguard enabled connected care program are for Lifeguard’s information services (and some integration costs if required as part of a proposed Pilot program) and the costs incurred by the provider to support the program (implementation, operation, overall management, research and evaluation, etc.) Therefore, Lifeguard and Dr Finley strongly recommend that the Commission allow for flexibility in making payments to service providers (internet/broadband only as appropriate) AND especially health care providers, as determined by the requirements of the specific connected care program.

66. The Commission seeks comment on the best methods to ensure participants are regularly reporting useful and required program data including whether and how to tie the data submission requirement to the reimbursement of Pilot program support.

Lifeguard and Dr Finley support regular reporting of meaningful information regarding progress of the program. It should be clear however, that patient outcomes or other measures should not have any impact on payment of allocated funds. Only “program” based factors should be considered in light of planned payments from the fund. Clinical outcomes may only be truly validated after conclusion of the Pilot program.

67. participating health care providers and service providers to retain documentation sufficient to establish compliance with the rules and requirements for the Pilot program for at least five years and produce such documents to the Commission, any auditor appointed by the Administrator or the Commission, or any other state or federal agency with jurisdiction.

Lifeguard retains all data for not less than 7 years and is therefore already compliant with this proposal.

68. The Commission believes that a five-year document retention period after the final disbursement is made would provide sufficient time to conduct audits and any other investigations related to the Pilot program

Lifeguard and Dr Finley are in agreement with this proposal

69. The Commission proposes to focus on four primary program goals and seeks comment on this approach: (1) Improving health outcomes through connected care; (2) reducing health care costs for patients, facilities, and the health care system; (3) supporting the trend towards connected care everywhere; and (4) determining how USF funding can positively impact existing telehealth initiatives.

Lifeguard and Dr Finley are in agreement with this proposal

70. …Section 254(h)(2)(A) directs the Commission to establish rules to enhance access to advanced telecommunications and information services for health care providers. Additionally, section 254(b)(3) provides that ‘‘[c]onsumers in all regions of the Nation, including low-income consumers and those in rural, insular, and high cost areas, should have access to advanced telecommunications and information services . . . that are reasonably comparable to those services provided in urban areas and that are available at rates that are reasonably comparable to rates charged for similar services in urban areas.’’ The Commission believes the proposed goals will help advance these principles and, seeks comment on that conclusion.

Lifeguard and Dr Finley agree with the Commission’s conclusion.

71. First, the Commission intends that the Pilot will help improve health outcomes through connected care. According to the American Heart Association, a ‘‘strong and growing body of evidence identifies telehealth and remote patient monitoring as cornerstones of advanced healthcare systems.’’

Lifeguard and Dr Finley agree with the Commission’s conclusion.

72. Commenters also identified several specific ways in which broadband access can improve health outcomes. For example, the Medical University of South Carolina (MUSC) and Gila River Telecommunications, Inc. (GRTI) both note that greater access to telehealth can enable health care providers to more easily engage their patients in the daily management of chronic conditions. Other commenters stated telehealth purposes increases the likelihood that patients will seek out medical care, and also increases the likelihood that patients will follow a prescribed course of treatment. And others commented that telehealth can reduce emergency room visits and hospital admissions and readmissions and, can lead to increased contact with specialists. The Commission agrees with these assessments and therefore proposes to include improvement of health outcomes through connected care as a goal of the Pilot program.

Lifeguard and Dr Finley agree with the Commission’s conclusion.

73. The Commission also believes the Pilot program can ultimately help reduce health care costs for patients, facilities, and the health care system, and proposes to adopt that program goal. Improving health care affordability for patients, including by reducing the burden of out-of-pocket expenses like transportation costs for rural and remote patients. Similarly, the Commission stated that the Pilot program could help identify the circumstances in which support for telehealth services could create savings for health care providers and the Medicaid program.

Lifeguard and Dr Finley agree with the Commission’s conclusion.

74. Many commenters noted the potential for the Pilot program to greatly reduce travel time for rural and remote patients, significantly reducing out-of- pocket costs for patients, in addition to reducing the need to miss work or school to see a health care provider. Commission believes the program could help reduce health care costs for patients, facilities, and the health care system overall and seeks comment on this program goal

Lifeguard and Dr Finley agree with the Commission’s conclusion.

75. the Commission proposes to establish a goal of supporting the trend toward bringing health care directly to the consumer. there is a trend towards a ‘‘connected care everywhere’’ model—a trend that has shown promising results for patients, communities, and the health care system.

Lifeguard and Dr Finley fully and enthusiastically agrees with this as a goal. This is Lifeguard!

76. The American Heart Association (“AHA”), commenting on the benefits and costs of the move towards ubiquitous connected care, noted the ability of telehealth to provide ‘‘instant healthcare at a fraction of the cost regardless of the patient’s health care status or geographic location,’’ but also noted potential ethical issues, including questions of trust, confidentiality, privacy, and informed consent. The Commission encourages commenters to specifically address how making USF dollars available to support the connectivity that enables telehealth applications can promote access to health care services for patients outside of the confines of brick-and-mortar medical facilities.

Lifeguard and Dr Finley support ubiquitous connected care (enabled via Lifeguard) that can provide “instant healthcare at a fraction of the cost regardless of the patient’s health care status or geographic location” as stated by the AHA. Lifeguard has built its platform with the utmost concern to protect confidentiality and privacy. Lifeguard provides one of the most secure environments that supports all stakeholders trust and includes fully auditable informed digital consent for each and every participant that uses Lifeguard for any connected care program.

77. ensure that the pilot program enhances existing telehealth initiatives by the Commission and other federal agencies.’’ The Commission observed that it currently has several initiatives to assist with the expansion of health care connectivity in rural and underserved areas including through the Rural Health Care programs and the Connect2Health Task Force.

Lifeguard has been engaged in discussions with the L.A.U.N.C.H. Initiative nearly since its inception and has had additional, separate but transparent discussions with the Connect2 HealthFCC Task Force and the NCI. Lifeguard has introduced Dr. Finley and Dr. Finley has since independently and directly supported L.A.U.N.C.H. and together we fully support the Commission’s engagement in other telehealth initiatives.

78. Numerous commenters assert that the Commission should consider working with HHS, in particular CMS, the National Coordinator for Health Information Technology (ONC), the Health Resources and Services Administration (HRSA), and the Indian Health Service.

Lifeguard and Dr Finley fully support the Commission’s engagement with other agencies that support connected care programs that can bring benefit to all Americans.

79. How can the funding of connectivity for telehealth through the Connected Care Pilot complement other Commission initiatives, such as the Rural Health Care Program and the Connect2Health Task Force?

This is currently out of scope for our comments.

80. the Commission proposed several metrics: Reductions in emergency room or urgent care visits in a particular geographic area or among a certain class of patients; decreases in hospital admissions or re-admissions for a certain patient group; condition- specific outcomes such as reductions in premature births or acute incidents among suffers of a chronic illness; and patient satisfaction as to health status. Are there other metrics for measuring this goal? For example, measuring adherence to medication and care plans as a possible metric, because of the correlation with reducing morbidity and mortality.

Lifeguard and Dr Finley are fully supportive of the proposed metrics (and are open to offering others) as they are key to validating not only care quality and associated benefits as outlined above, they also may also directly validate Lifeguard in its envisioned implementation in a Pilot, as a unique, efficacious, easy to use and cost effective mechanism that supports optimum outpatient care, especially for patients at high risk (who are also typically patients that drive high total cost of care). Lifeguard and Dr Finley support adding medication adherence and care plan compliance support as well, as these are core values that Lifeguard already supports today.

81. how can universal service support for connectivity improve health outcomes through telehealth. Do low-income consumers face budget constraints that are not adequately addressed by existing programs that prevent them from adopting connected care services via broadband internet access service? Do health care providers face budgetary shortfalls with respect to funding broadband internet access connections for connected care services, or other information services, etc.…?

In light of evolving innovative technologies, services and novel collaboratives, Lifeguard and Dr Finley believe that the gap is closing between consumer technologies, such as smartphone ownership, and virtual healthcare services. And since Lifeguard uses basic broadband to enable very low data demand services to fully support a connected care program, Lifeguard has the opportunity to piggyback on existing patient-owned and provider-owned technologies (literally only seconds-at-a-time usage) to support a growing number of patients in underserved populations such as those served by Dr Finley. Budgets for such patient-owned and provider-owned technology is typically a non-factor regarding Lifeguard since the technology has already been acquired.

82. The Commission further asks commenters to provide information on the specific way in which universal service support for connectivity to enable telehealth will produce cost savings. How can the Commission best measure the savings from, for example, reduction in travel miles and travel time for patients and physicians? How can the Commission measure the effect of healthier patients on costs faced by health care providers and insurers? What metrics exist to determine the cost savings from a reduction in hospital admissions or re- admissions, or a reduction in emergency room visits?

Lifeguard is not a healthcare provider but understands from Dr Finley that there are existing data that can be used to measure multiple aspects of health status before and after implementation of a program, such as the contemplated connected care program pilot, as well as claims-based data that can compare overall comparative population cohorts pre- and post- a connected care program. Regarding patient side benefits, including subjective perspectives, it would be reasonable to incorporate patient focus groups to gather information on the benefits (health quality, costs including travel related) of the connected care program.

83. Will that funding enable access for patients and providers that would not otherwise have access to telehealth, perhaps by bringing telehealth into new geographic areas or attracting new funding for existing telehealth services? Will funding connected care pilots draw attention to, and increase the effectiveness of, future connected care applications, thereby promoting the development of connected care? The Commission also seeks comment on any potential costs of ubiquitous connected care, including the ethical issues raised (*Lifeguard note… assuming from previously stated: trust, confidentiality, privacy, and informed consent*) by the American Heart Association. How should these issues impact whether the Commission sets increased use of connected care as a goal of the Pilot program?

Similar to #76. Lifeguard and Dr Finley support expanded support for telehealth in all its forms. As it becomes more ubiquitous, such as enabled via Lifeguard, telehealth will spread deeper into underserved geographies. Additional funding can be an accelerant to that growth. As stated elsewhere, Lifeguard has built its platform with the utmost concern to protect confidentiality and privacy. Lifeguard provides one of the most secure environments that supports all stakeholders’ trust and includes fully auditable informed digital consent for each and every participant that uses Lifeguard for any connected care program. Promoting and support for increased smartphone ownership in particular may be the fastest path toward truly ubiquitous patient engagement capabilities for participation in connected care programs.

84. comment on how (the Commission) can determine whether the Pilot program supports existing Commission and federal efforts to promote telehealth.

This is currently out of scope for our comments.

85. For the Commission to evaluate the success of the Pilot program, it is critical to establish tools and procedures to gather data from the Pilot program participants on progress toward achieving the stated Pilot program goals.

Lifeguard, if awarded funding for a connected care program, and with contributed guidance from Dr Finley, would cooperatively support development and reporting requirements of processes to mark progress on achievement of the program’s goals.

86. The Commission seeks comment on the required reporting intervals (e.g., quarterly, annually) and the information that should be included in the reports. What types of information are reported on an interim basis and would such results provide reliable information? Or should the Commission delay reporting of health outcomes until the study is completed?

Lifeguard and Dr Finley suggest interim reports on no more than on a quarterly basis, with a more detailed report annually. We believe progress on achievement of program goals can be adequately measured and managed in these timeframes. The final formal report should be presented only at the conclusion of the connected care program pilot.

87. The Commission seeks comment on the appropriate methods for measuring the health effects of the connected care Pilot projects. Should all projects be required to conduct randomized controlled trials to determine the effect of the treatments on patients’ health? Are there alternative, less costly methods that are statistically sound and can accurately measure the effect of the treatment? Are there other valid perspectives, such as the impact on the costs of providing health care or the broader impacts of subsidized access to broadband internet access services for connected care, is there any need to require the reporting of health outcomes?

Since Lifeguard is not a healthcare provider and since Lifeguard would participate as a “sub” with a provider organization, as well as with other collaborators, such as the L.A.U.N.C.H. Initiative team, it is not possible for Lifeguard to suggest any one specific outline, method, or design to measure success of a connected care program. Lifeguard and Dr Finley, however, suggests that the Commission allow for mechanisms to measure success with more flexibility that might be less strictly rigorous than “randomized controlled trails that might be implemented aligned with formal clinical studies”.

88. Should the Commission require participants to file a detailed annual report, and shorter reports on a quarterly basis? The Commission is mindful of the burden that reporting can create for participants, particularly those that do not regularly report information to the Commission and seek to minimize this burden while still providing a mechanism for participants to provide valuable information.

Same as 86. Lifeguard and Dr Finley suggest interim reports on no more than on a quarterly basis, with a more detailed report annually. We believe progress on achievement of program goals can be adequately measured and managed. The final formal report should be presented only at the conclusion of the connected care program pilot.

89. The Commission proposes several data fields that should be part of regular reporting from Pilot participants. These fields include: The number of patients participating in the pilot project each month; the number of patients participating in the pilot project being treated for specific health conditions; the types of connected care services provided for each condition; average frequency of patient use of each type of connected care service; health outcomes for patients; and average cost- savings per patient. Are there other types of information the Commission should require Pilot program participants to report on a regular basis?

Lifeguard and Dr Finley are in agreement with this proposal acknowledging that some data might be more difficult to obtain from a “recent” perspective (e.g. avg cost savings per patient), especially on a more frequent or recurring basis and may be better suited for an annual review.

90. the Commission proposes requiring health care providers to conduct regular surveys of participating patients. The purpose of these surveys is to collect information regarding data such as patient cost savings, saved travel miles, patient satisfaction and comfort with the provided connected care services. Given the additional time and expense in administering patient surveys, reviewing data, and reporting it to the Commission, should health care providers conduct these surveys on a quarterly basis, or on a longer timeframe,

Lifeguard and Dr Finley support the concept of a patient focus group to gather suggested information and data – on no more than a quarterly basis.

91. The Commission also proposes collecting additional information from Pilot program patient participants at the time of enrollment to better understand the impact of the Pilot program on the goals identified in this document, including whether the patient already has a mobile and/or home broadband connection, the speed, technology and broadband data usage for any broadband connection the patient already has, and what devices the patient uses to connect to the internet. What other information might be important to know at the time of enrollment to help establish a baseline for measuring the impact of the Pilot program?

Lifeguard’s current enrollment/registration process may be able to capture many of the data points, as well as others, suggested here. Lifeguard and Dr Finley support this proposed concept.

92. As noted in this document, the Commission proposes that all data provided by Pilot program participants should be anonymized and aggregated. Should the Commission allow project participants to request delay of publication until the project is completed if publication might impact the experiment? Further, are there other privacy or security measures that the Commission and USAC should take to ensure proper receipt, storage, and use of the data?

Lifeguard and Dr Finley support the most appropriate approach for promotion of the connected care program pilot and further supports promotion that could help accelerate program success. Lifeguard has the highest regard for data integrity and security while in active use, at rest, in temporary storage and in archive.

93. The Commission is interested in measuring the costs that Pilot program participants experience in designing their programs, submitting applications to the Commission, and ensuring ongoing compliance with the Pilot’s rules and procedures. The Commission proposes to ask on a regular basis for these types of cost and time estimates to evaluate whether the Pilot program is an administratively feasible method of distributing funding for connected care services.

This requires more specific input from the provider side but Lifeguard and Dr Finley – are collectively and generally supportive of engaging in a discussion related to costs, measures, rules and procedures. especially in the context of the early work associated with the ramp up period.

94. Should the Commission establish new forms for the purposes of the Pilot program?

This is currently out of scope for our specific comments.

95. the services that are eligible for universal service funding are bound by section 254 of the Act, as amended by the 1996 Act. Are there any additional potential sources of legal authority that the Commission should consider?

This is currently out of scope for our specific comments.

96. Section 254(h)(2)(A) directs the Commission to ‘‘establish competitively neutral rules, (A) to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for all public and non-profit . . . health care providers. . . .’’

This is currently out of scope for our specific comments.

97. The Commission believes the most feasible way to structure the Pilot program would be to have the health care provider purchase the broadband internet access service needed by the patient to access connected care services from a broadband carrier or a connected care company (e.g., a remote patient monitoring company) and then provide the telehealth service, including the underlying internet broadband access service, to the patient directly.

As mentioned elsewhere, Lifeguard does not require additional broadband services beyond what patients and providers have already acquired from their service provider.

98. The Commission requests information on how providing health care providers support for patient- centered connected care enhances health care provider ‘‘access to advanced telecommunications and information services’’

Lifeguard offers an innovative leading-edge technology for health care providers and their patients (and caregivers.) With respect to connected care programs Lifeguard is already incorporated in the category of “advanced telecommunications and information services”. Funding a healthcare provider that uses Lifeguard as its connected care partner immediately elevates that provider to the level of leading innovation for patient-centered connected care.

99. the Commission to provide funding under the Pilot program for health care provider purchases of services—other than patient connectivity—that are used to provide connected care services but that are not already eligible for support through the Healthcare Connect Fund program. For example, companies may offer cloud-based solutions, finished service packages, or complete suites of services that allow health care providers to provide telehealth, including connected care. Are these services ‘‘information services’’ under section 254(h)(2)(A), for which the Commission is required to develop competitively neutral rules to enhance access for health care providers?

Lifeguard directly supports bi-directional provider-patient connectivity and should be considered “information services” which could be eligible for support by the Commission funding of the connected care program pilot.

100. USF support to enable health care providers to provide connected care technologies to eligible low-income consumers. Sections 254(b)(1) and (b)(3), provide, respectively, that the Commission’s universal service policies must be based on the principles that ‘‘[q]uality services should be available at just, reasonable, and affordable rates’’ and ‘‘[c]onsumers in all regions of the Nation, including low-income consumers . . . should have access to telecommunications and information services . . . that are reasonably comparable to those services provided in urban areas and that are available at rates that are reasonably comparable to those services provided in urban areas.’’

Dr Finley contributes expertise to Lifeguard that enables us to meaningfully collaborate with providers to reduce disparities in access and support low-income populations.

101. would relying on the low-income legal authority require the Commission to limit Pilot projects to those serving exclusively low-income individuals?

The Commission has noted elsewhere that it has previously relied on sections 254(b)(1) and (b)(3) and 154(i) to establish the limited Lifeline Broadband Pilot program, which provided participating low-income consumers support for bundled broadband service or stand-alone broadband service to test the impact of Lifeline support on broadband adoption. Lifeguard and Dr Finley would support specific funding for low-income populations that have no smartphone and/or broadband capabilities – and suggest that potential healthcare cost savings may offset the cost of providing such capabilities.

102. should the Commission rely on its low-income legal authority to provide support for broadband internet access connections for connected care services through the Pilot program, and rely on its rural health care legal authority to provide support for information services not already funded through the Healthcare Connect Fund program that health care providers use to provide connected care services

Lifeguard and Dr Finley support the Commission regarding its low-income and rural health care authority to provide information support services, such as Lifeguard.

103. if a health care provider contracts with a remote patient monitoring solution provider for a package that includes broadband connectivity for patients, patient remote monitoring equipment, and software for the health care provider to process data received by the patient’s remote monitoring equipment, could the Commission fund some parts of that overall package via its Rural Health Care legal authority and other parts through its low-income legal authority?

This is currently out of scope for our specific comments. (Note however, that Lifeguard requires no additional broadband and no additional equipment – other than existing patient-owned and provider-owned technology – to enable a connected health program.)

104. In the Commission’s Rural Health Care Pilot Program, participants were permitted to purchase equipment integral to running their broadband networks, such as servers, routers, firewalls, and switches, or to upgrade their existing equipment and increase bandwidth. The Commission seeks comment on its legal authority to fund such services here.

We cannot comment on the Commission’s legal authority but can restate that Lifeguard’s technology operates in low bandwidth environments and can in fact support patients in no bandwidth areas through its rich mobile client. Reminders and recordings are fully enabled while in no bandwidth areas and immediately updates the Lifeguard platform – which displays the updates to any authorized user on demand – as soon as bandwidth connectivity is regained.

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Lifeguard and Dr Finley support the Commission, in particular the following Procedural Matters, as copied below:

109. The Commission proposes four goals for the proposed Pilot program and also propose a three-year duration and budget of $100 million for the Pilot program. The Commission also proposes and seeks comment on the application process and the objective criteria for selecting projects among the applications the Commission receives for the Pilot program, and proposes and seeks comment on awarding additional points during the evaluation process for proposed projects that would primarily serve veterans or rural or Tribal areas or populations or primarily treat diabetes, heart disease, opioid addiction, mental health conditions, or high-risk pregnancy. The Commission should be able to fund a range of diverse projects throughout the country. The Commission proposes the specific requirements for health care providers, including vendor selection requirements, requirements for requesting funding and reimbursements, and audit and document retention requirements, and data reporting requirements. Finally, the Commission proposes specific requirements for participating service providers including indicating interest in participating in the Pilot program, requesting disbursements, and document retention and audit requirements. Participating consumers may also be required to complete consumer surveys.

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117. To participate in the Pilot program, the Commission proposes that health care providers satisfy the definition of an eligible health care provider under section 254(h)(7)(B) of the Act and submit an application by the application deadline that the Commission ultimately adopts for the Pilot program. The NPRM proposes specific information that health care providers would be required to submit in an application for each pilot project proposal, including, but not limited to, information on the participating health care provider(s), description of the project and how it would further the goals of the Pilot program, estimated project budget, patient populations and the geographic areas to be served and health conditions to be treated. The NPRM also proposes that the applications be made publicly available.

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122. The Commission proposes awarding additional points during the application process for projects that are located in a rural area, would primarily serve rural patients or veterans, would serve five or more Medically Underserved Areas and Healthcare Provider Shortage Areas, as designated by the Health Resources and Services Administration by geography, or are located on Tribal lands, associated with a Tribe, or part of the Indian Health Service. This recognizes the disparities in health care in rural areas and Tribal areas, and areas that are designated as Medically Underserved Areas and Healthcare Provider Shortage Areas and is aimed at increasing the likelihood projects serving these areas will be selected.

On behalf of Lifeguard Health Networks, Inc, and Dr Finley, this reply to the Commission’s request for comment is respectfully submitted, 27 September 2019

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