

Amy R. Sheon, PhD,
MPH
Executive Director
Urban Health Initiative
10900 Euclid Avenue
Cleveland, OH 44106-4956
Phone 216.368.0915

Before the

**Federal Communications Commission
Washington, D.C. 20554**

In the Matter of

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Promoting Telehealth for Low-Income Consumers

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WC Docket. No. 18-213

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COMMENTS OF AMY R. SHEON, PhD, MPH, CASE WESTERN RESERVE UNIVERSITY

As a private citizen and Director of the Urban Health Initiative at Case Western Reserve University, I submit these comments in response to the FCC's Notice of Inquiry regarding Promoting Telehealth for Low-Income Consumers.

I write as a private citizen whose comments reflect my experience directing a program that seeks to improve the health of Northeast Ohio residence by leveraging the assets of the University and our clinical affiliates (Cleveland Clinic Foundation, University Hospitals and the MetroHealth System) to improve health of the local urban population.

The federal government has invested billions of dollars in health information technology, creating incentives to move health care online and to engage consumers in their meaningful use. As I recently published in the Journal of Medical Internet-Diabetes,¹ I believe that patient portals to electronic health records represent a profound ability to leverage the "blockbuster drug of the century" – patient engagement. Patient portals are free to patients, are infinitely customizable to address every health condition, every health care setting, with the potential for adaptation to patients' language, health literacy and even physical disabilities. Through portals, patients can check their laboratory test results, learn about their health conditions, communicate with health care providers, manage the health of loved ones, schedule appointments, pay bills, receive alerts about needed preventive care, be invited to participate in clinical trials, and streamline appointments by completing questionnaires in advance of visits. The patient portal can also be regarded as a "gateway drug" to all digital health tools such as remote monitoring of glucose levels or blood pressure, telehealth visits, joining virtual support groups, and more.

To date, adoption of portals has been very low, and usage among low income patients is especially lagging. Colleagues studied portal use among 243,248 ambulatory care patients at our local public hospital and found that portal adoption for Black and Hispanic patients (23.4% and 23.8%, respectively) lagged behind that of white patients (34.1%) and especially lagged for recipients of Medicaid (26.5%) and uninsured (17.4%) compared with commercially insured patients (39.3%). The especially noteworthy finding of the paper, however, was that in an analysis that controlled for these sociodemographic factors, initiation of portal use and use of the portal to send messages to providers were strongly associated with the level of broadband internet access in their neighborhoods.² Findings of this study reflect Cleveland's ranking as the 6th worst connected city in the country with 81,424 households, 48.6% of all households in the city lacking internet connectivity.³

What we learned from this study and other qualitative research underway is that ***if patients do not have home broadband and/or a smartphone with an ample data plan, there is little chance they will use patient portals, much less any other digital health technology***, including telehealth which is being seen as the savior of the U.S. health care system.

To address this gap—in hopes of ensuring that digital health technology reduces rather than exacerbates health disparities—we have developed and pilot tested a model that we think should be of great interest to the FCC, one that we would hope to pilot test at scale in the proposed "Connected Care Pilot Program."

That is, we are advocating for all health systems to:

- Screen all patients for digital skills and connectivity,
- Refer patients with gaps to local digital inclusion experts for general digital skill training and free or low cost equipment and connectivity; and
- Train them to use patient portals and other digital health tools.

We have trained Community Health Workers at the local community college to perform the screening, referral and eHealth training functions. Such efforts are well aligned with the Community Health Worker Scope of Practice, and this an efficient and cost effective way of helping patients to make meaningful use of digital health tools. Even for patients with good connectivity and digital skills, we find that just a few minutes of training can engage perhaps 1/3 of non-portal users. Surely this "low hanging fruit" should be a high priority of every health system; yet we have not found any systems that have adopted universal screening and training. And then beyond that, we believe that, by having Community Health Workers help low income patients become digital technology users, patients can address their social determinants of health; with specific digital health tool training, patients can be empowered to manage chronic conditions and attain better health.

We therefore strongly commend the FCC's effort to improve health outcomes through expanding broadband access. We urge the FCC to focus on increasing access for low income Americans in all areas in which they are underserved, including urban areas that have been digitally redlined. In addition, we urge that the FCC will also provide funding for low income consumers to obtain equipment and training needed to take advantage of digital connectivity. We hope that the "Connected Care Pilot Program" will give us the chance to demonstrate the significant return on investment that could ensue from addressing all of these dimension through the "Cleveland Model."

Sincerely,

A handwritten signature in cursive script, reading "Amy R. Sheon".

Amy R. Sheon