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September 10, 2018

Federal Communications Commission
Washington, D.C. 20554
In the Matter of Promoting Telehealth for Low-Income Consumers
WC Docket. No. 18-213

Comment Date: September 10, 2018   *Comments submitted electronically only*
Reply Comment Date: October 10, 2018

**Re: Centerstone's Comments in Response to FCC's Notice of Inquiry Issued August 3, 2018
(WC Docket No. 18-213)**

Dear Chairman Pai, Commissioners O'Rielly, Carr, and Rosenworcel:

        We at Centerstone are enthusiastic about the launch of your inquiry into how the Commission can help improve access to lifesaving broadband-enabled telehealth services. We are grateful for the opportunity to comment on your proposition of creating an experimental "Connected Care Pilot Program" to support the delivery of telehealth services to low-income Americans, with a focus on the delivery of such services to patients beyond the doors of brick-and-mortar health care facilities.[1] We applaud the FCC's initiatives to promote better quality broadband, as well as greater access to broadband, particularly to rural American communities. As an organization providing evidence-based mental health and substance use disorder services in, among other areas, rural areas with health professional shortages, some of which have been inordinately impacted by the opioid crisis, we understand the value of telehealth. In our submission, we first provide some information about our organization, and then provide our specific comments on setting up a $100 million Universal Service Fund (USF) telehealth Connected Care Pilot Program.

About Centerstone
        Centerstone[2] is one of the nation's leading not-for-profit providers of mental health and substance abuse disorder services, dedicated to delivering care that changes people's lives. Centerstone is a multi-state organization bringing evidence-based treatments and care to nearly 180,000 individuals with an array of behavioral health disorder and challenges residing throughout Florida, Illinois, Indiana, Kentucky, and Tennessee. In operation for over 63 years as a front-lines provider of both inpatient and outpatient services, we can easily identify the most significant barriers to systematically providing unencumbered behavioral health care to children and adults, alike, in both urban and rural areas. Further, Centerstone is the only not-for-profit, behavioral health care provider with a research institute embedded within the organization, directly connecting the latest knowledge into clinical care.

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[1] https://docs.fcc.gov/public/attachments/FCC-18-112A1.pdf
[2] https://centerstone.org/

Specifically, Centerstone Research Institute[3] (CRI) develops clinical innovations based upon the very best science that promises to produce better outcomes, increase value, and help close the 17-year science-to-service gap. Finally, through another arm of our enterprise – Centerstone Military Services[4] (CMS) - we offer specialized services to veterans (regardless of service era or discharge status), service members, and their families across the entire swath of the United States.

As you indicate in your Notice of Inquiry, with the rise of interconnected monitoring devices, broadband-enabled video-conferencing, and cloud computing, more and more options for care are arising. Through our Research Institute, Centerstone is continuously developing new models of patient care that embrace the benefits of technological advances. From our experience and growing expertise in caring for individuals with SUDs and mental disorders, we provide the following comments to your specific questions on spearheading a Connected Care Pilot Program.

B. STRUCTURE OF THE PROGRAM
2. Application Process and Types of Pilot Projects to Be Supported
(32) Should we select pilot projects based on whether they address a specific health issue or demographic? For example, should proposed projects focus on opioid addiction, diabetes, stroke, postpartum depression, or post-traumatic stress disorder?

We suggest that pilot projects address needs among individuals experiencing substance use disorder (SUD), including opioid addiction, and mental illness, such as postpartum depression or post-traumatic stress disorder, as individuals experiencing such conditions are at increased risk for negative physical and mental health outcomes that, in turn, lead to increased public costs. In 2014, nearly 20.2 million adults were diagnosed with SUD, and nearly 40% of adults with SUD experience co-occurring mental illness (COD).[5] Substance use is linked to increased risk for physical (e.g., cancer, heart disease, liver disease, diabetes, hepatitis, stroke) and mental (e.g., depression, anxiety) health conditions.[6] Nationally, more died from drug overdose in 2014 than any previous year on record, with 60% involving opioid use. In 2015, 11.7 million adults misused opioids; injection opioid use places individuals at an increased risk of contracting diseases such as HIV/AIDS and hepatitis.[7, 8] In 2014, nearly 90% of individuals experiencing alcohol dependence, and 80% with illicit drug dependence did not receive or perceive the need for treatment, often leading to increased emergency department (ED) use and higher cost of care.[9] Nationally, health care costs associated with alcohol abuse total approximately $27 billion; tobacco use, $168 billion; prescription opioid abuse, $55 billion; and ED and

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[3] https://centerstone.org/locations/research-institute
[4] https://centerstone.org/locations/military-services
[5] Substance Abuse and Mental Health Services Administration (SAMHSA). (2016a). Serious Mental Illness Among Adults Below the Poverty Line. Available: https://www.samhsa.gov/data/sites/default/files/report_2720/Spotlight-2720.html
[6] American Addiction Center (AAC) (2017). Physical Health Consequences of Alcoholism. Available: http://americanaddictioncenters.org/alcoholism-treatment/physical-health/
[7] Substance Abuse and Mental Health Services Administration (SAMHSA). (2017b). 1.5 Million Adults Have Serious Mental Illness and Misused Opioids in the Past Year. Available: https://www.samhsa.gov/data/sites/default/files/report_2734/Spotlight-2734.pdf
[8] Centers for Disease Control (CDC). (2017). HIV and Injection Drug Use. Available: https://www.cdc.gov/hiv/risk/idu.html
[9] Substance Abuse and Mental Health Administration. (2015a). Behavioral Health Barometer United States, 2015. Available: https://www.samhsa.gov/data/sites/default/files/2015_National_Barometer.pdf

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inpatient treatment for opioid poisoning, $20 billion.[10, 11] EDs are often not equipped with resources/wraparound care to effectively treat SUD (e.g., mental health care, detoxification, case management).[12]

In any given year in the U.S., 1 in 5 adults (44 million) experience mental illness and 1 in 25 adults (9.8 million) experience serious mental illness (SMI).[13] Mental health and physical health are interrelated, and untreated mental illness can result in severe emotional, behavioral, and physical health problems.[14] Adults with mental illness die on average 10 years, and adults with SMI, 15-25 years earlier than the general population, largely due to treatable/ preventable health conditions (e.g., cardiovascular, pulmonary, infectious diseases).[15, 16, 17] Up to 68% of adults with a mental illness have one or more treatable/preventable chronic physical conditions.[18] For individuals with schizophrenia or bipolar disorder, the relative risk of experiencing chronic diseases/co-morbid conditions can be up to 5 times that of the general population. Individuals with schizophrenia often are not adequately screened and treated for dyslipidemia (up to 88% untreated) and hypertension (up to 62% untreated) in care settings.[19] People with mental illness are 70% more likely to smoke than the general population, leading to 200,000 tobacco-related deaths each year.[20, 21] Nationally, the per-capita cost of care for adults with a mental illness is $5,400 per hospital stay, and hospital readmission rates are 17.2%, thereby greatly increasing the cost of care, often unnecessarily.[22, 23]

An estimated 7-11.5% of children in the U.S. have serious emotional disturbance (SED) (e.g., developmental, conduct, affective disorders), often associated with negative medical (e.g., eating disorders, SUD) and functional outcomes (e.g., poor coping abilities, school performance, family

[10] National Institute of Health (NIH), National Institute on Drug Abuse (NIDA). (2017). Trends and Statistics. Available: https://www.drugabuse.gov/related-topics/trends-statistics

[11] U.S. Department of Health and Human Services (HHS). (2016). The Opioid Epidemic: By the Numbers. Available: https://www.hhs.gov/sites/default/files/Factsheet-opioids-061516.pdf
Zickuhr, K. (2011, February 3). Generations and their gadgets. Pew Research Center's Internet & American Life Project. Pew Research Center: Washington, DC. Retrieved on June 1, 2011 from http://pewinternet.org/Reports/2011/Generations-and-gadgets.aspx

[12] Healthcare Cost and Utilization Project (HCUP). (2010). Emergency Department Use for Mental and Substance Use Disorders. Available: https://www.hcup-us.ahrq.gov/reports/ED_Multivar_Rpt_Revision_Final072010.pdf

[13] National Alliance on Mental Illness (NAMI). (n.d.a). Mental Health By The Numbers. Available: https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers

[14] Mayo Clinic. (2015). Diseases and Conditions: Mental Illness, Complication. Available: http://www.mayoclinic.org/diseases-conditions/mental-illness/basics/complications/con-20033813

[15] Insel, Thomas. (2015). Post by Former NIMH Director Thomas Insel: Mental Health Awareness Month: By the Numbers. National Institute of Mental Health. Available: https://www.nimh.nih.gov/about/directors/thomas-insel/blog/2015/mental-health-awareness-month-by-the-numbers.shtml

[16] De Hert, M., Correll, C. U., Bobes, J., Cetkovich-Bakmas, M., Cohen, D., Asai, I., … Leucht, S. (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry*, *10*(1), 52–77.

[17] Parks, J., Svendsen, D., Singer, P., and Foti, M.E. (2006). *Morbidity and Mortality in people with serious mental illness*. National Association of State Mental Health Program Directors. Available: http://www.nasmhpd.org/docs/publications/MDCdocs/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf

[18] Substance Abuse and Mental Health Services Administration. (2014). *Can we live longer?: Integrated healthcare's promise.* National Council for Behavioral Health. Available: http://www.thenationalcouncil.org/wp-content/uploads/2013/10/CIHS-infographic.jpg

[19] De Hert, M., Correll, C. U., Bobes, J., Cetkovich-Bakmas, M., Cohen, D., Asai, I., … Leucht, S. (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry*, *10*(1), 52–77.

[20] Centers for Disease Control and Prevention. (2013). Vital Signs: Current Cigarette Smoking Among Adults Aged ≥18 Years with Mental Illness — United States, 2009–2011. *Morbidity and Mortality Weekly Report*. Available: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6205a2.htm?s_cid=mm6205a2_w.

[21] National Alliance on Mental Illness (NAMI). (2015). Smoking cessation. Available: http://www2.nami.org/Content/NavigationMenu/Hearts_and_Minds/Smoking_Cessation/Smoking_and_Mental_Illness.htm.

[22] Agency for Healthcare Research and Quality. (2013). Costs for Hospital Stays in the United States, 2011. Available: http://www.hcup-us.ahrq.gov/reports/statbriefs/sb168-Hospital-Costs-United-States-2011.jsp

[23] Agency for Healthcare Research and Quality. (2013). Readmissions to U.S. hospitals by diagnosis, 2010. Available: http://www.hcup-us.ahrq.gov/reports/statbriefs/sb153.pdf

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functioning).[24, 25, 26] Approximately 43% of parents of children with SED indicate the presence of chronic health conditions in their children, compared to 30% of parents of children without mental health conditions.[27] Co-occurring physical health conditions exacerbate emotional problems and functional impairment associated with SED, as indicated in studies involving children with anxiety disorders and co-occurring health conditions.[28] When mental illness goes untreated in children, negative health outcomes and associated social impacts (e.g., poverty, unemployment) will likely continue into adulthood with these individuals using more health care services and accruing higher health care costs than the general population.[29]

Service efforts among this demographic are hampered by obstacles to clear and rapid communication among providers and clients. Frequent changes in this demographics' residence/phone number, limited cellular minutes/texts, etc. often lead to blocked or delayed communication with providers, causing missed appointments/follow-up and lower rates of medication adherence. Information-sharing among providers is limited, causing disconnected treatment episodes, frequent misdiagnosis, and unnecessary costs. ***Leveraging broadband-enabled telehealth services could enhance communication between these individuals and their behavioral health care providers to ensure access to and continuity of care. Thus, given the cited disparities in access to important treatment and health outcomes for individuals with substance use disorder and/or mental illness, we recommend that this telehealth pilot project focus on individuals exhibiting substance use disorder(s) and mental illness(es).***

3. Eligible Health Care Providers
(35) Should we consider location as a factor in selecting participating clinics and hospitals? If so, should the pilot program prioritize participating clinics and hospitals in rural areas?

We recommend that the pilot program prioritize participating clinics and hospitals serving individuals located in rural areas, where disparities in treatment access and use result in negative health outcomes. Centerstone's geographic footprint includes large clusters of rural counties located up to 100 miles from urban amenities. In Florida, Centerstone has facilities in Manatee and Sarasota counties. In Illinois, Centerstone has facilities in 4 counties, with one considered a rural county by the Health Resources & Services Administration (HRSA)[30, 31], and 2 experiencing population declines. Illinoisans come to our facilities from at least 54 other counties across the state, most of which are rural.

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[24] Substance Abuse and Mental Health Services Administration (SAMHSA). (2016). Mental and Substance Use Disorders. Available: https://www.samhsa.gov/disorders

[25] Substance Abuse and Mental Health Services Administration (SAMHSA). (2016). DSM-5 Changes: Implications for Child Serious Emotional Disturbance. Available: https://www.samhsa.gov/data/sites/default/files/NSDUH-DSM5ImpactChildSED-2016.pdf

[26] ODMHSAS. (n.d.). Definition of Serious Emotional Disturbance (SED). Available: http://www.odmhsas.org/eda/advancedquery/sed.htm

[27] Combs-Orme, T., Heflinger, C.A., & Simpkins, C.G. (2002). Comorbidity of Mental Health Problems and Chronic Health Conditions in Children. *Journal of Emotional and Behavioral Disorders,* 10(2), 116-125.

[28] Chavira, D.A., Garland, A.F., Daley, S., & Hough, R. (2008). The Impact of Medical Comorbidity on Mental Health and Functional Health Outcomes among Children with Anxiety Disorders. Journal of Developmental and Behavioral Pediatrics, 29(5), 394-402.

[29] National Alliance on Mental Illness (NAMI). (n.d.b). Facts on Children's Mental Health in America. Available: http://www.namihelps.org/assets/PDFs/fact-sheets/Children-and-Adolescents/Facts-on-Childrens-Mental-Health--in-America.pdf

[30] https://www.hrsa.gov/sites/default/files/ruralhealth/resources/forhpeligibleareas.pdf

[31] Centerstone has facilities in the following Illinois counties: Franklin*, Jackson, Madison, and Williamson. Those designated by an asterisk (*) are considered rural counties by the HRSA.

In Indiana, 10 of the 18 counties with Centerstone facilities are considered rural by the HRSA, with 9 counties experiencing population declines.[32] In Kentucky, we serve 7 counties.[33] In Tennessee, 17 of the 30 counties we serve are defined as rural by the HRSA, with 3 experiencing population declines.[34] These areas could benefit from increased access to telehealth services.

Comprehensive treatment options in primarily rural areas are limited, particularly for those who lack Medicaid coverage. Rural counties are often designated Health Provider Shortage Areas (HPSA) and medically underserved areas. Many of these counties are remote and isolated, with limited community services, an inadequate number of health providers, and few public transportation options, hindering access to treatment services. This can have profound consequences for rurally-located populations experiencing behavioral health conditions, such as SUD. For example, individuals in some of Tennessee's rural service counties are twice as likely to overdose on prescription drugs as their urban counterparts.[35, 36] Despite greater need for behavioral healthcare that is focused on chronic care management, rural residents have fewer visits to care providers and are less likely to receive recommended preventative services.[37] Rural residents may also avoid treatment due to the stigma surrounding SUD/COD and the lack of privacy due to close, "small town" relationships, increasing the potential benefits of services beyond brick-and-mortar facilities for those living in such areas.[38]

(36) We seek comment on any additional criteria that participating clinics or hospitals should be required to meet and how we should define that criteria. For example, should we limit the pilot program to clinics and hospitals with established telehealth programs, and if so, how should we define that criterion?

Organizations participating in the pilot program should have the infrastructure in place at the time of application to ensure timely and successful implementation of program services. With a proposed initial pilot timeframe of no more than 3 years, it is reasonable to limit participation to eligible providers who have already established the necessary infrastructure, procedures, and operational details required for the deployment of telehealth services, as those preparations are very time-consuming. ***For that reason, eligibility for participation should include criteria that limits the pilot program to clinics, hospitals, etc., with established telehealth programs.***

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[32] Centerstone has facilities in the following Indiana counties: Bartholomew, Brown, Decatur*, Delaware, Fayette*, Henry*, Jackson*, Jefferson*, Jennings*, Johnson, Lawrence*, Monroe, Morgan, Owen, Randolph*, Rush*, Scott, Wayne*. Those designated by an asterisk (*) are considered rural counties by the HRSA.

[33] Centerstone has facilities in the following Kentucky counties: Bullitt, Henry, Jefferson, Oldham, Shelby, Spencer, Trimble.

[34] Centerstone serves the following counties in Tennessee via outpatient clinics, school-based therapy, or mobile crisis services: Bedford*, Bradley, Cheatham, Coffee*, Davidson, Dickson, Franklin*, Giles*, Hamilton, Hickman, Houston*, Humphreys*, Lawrence*, Lewis*, Lincoln*, Marshall*, Maury, McMinn*, Montgomery, Moore*, Perry*, Polk, Putnam*, Robertson, Rutherford, Stewart*, Sumner, Wayne*, White*, Wilson. Those designated by an asterisk (*) are considered rural counties by the HRSA.

[35] Tennessee Department of Mental Health and Substance Abuse Services. (2014b). *Prescription for success: Statewide strategies to prevent and treat the prescription drug abuse epidemic in Tennessee*. Available: https://www.tn.gov/assets/entities/behavioral-health/sa/attachments/Prescription_For_Success_Full_Report.pdf

[36] Keyes, K.M., Carda, M., Brady, J.E., Havens, J.R., and Galea, S. (2014). Understanding the rural-urban differences in non-medical prescription opioid use and abuse in the United States. *American Journal of Public Health, 104*(2).

[37] Agency for Healthcare Research and Quality. (2008). *Chapter 4: Priority populations, residents of rural areas*. Available: http://archive.ahrq.gov/research/findings/nhqrdr/nhdr08/Chap4d.html

[38] Rural Health Information Hub. (2015). *Substance abuse in rural areas.* Available: https://www.ruralhealthinfo.org/topics/substance-abuse

4. Partnering with Facilities-Based Eligible Telecommunications Carriers

(38) We also seek comment on requiring eligible health care providers to partner with at least one facilities-based ETC on their proposed telehealth pilot projects before submitting their applications for funding. Additionally, we seek comment on any implementation issues with respect to this requirement. For example, would eligible health care providers need to contract with a partnering broadband service provider before submitting their applications for funding?

Eligible health care providers should, as a requirement of the application for funding, provide evidence of relationships (i.e., via Letter of Commitment or Memorandum of Understanding) with ETCs currently serving the providers' proposed pilot program service area, and provide evidence of relationships with ETCs willing to partner to establish services in proposed areas where broadband is not available.

6. Supported Services

(48) Applications. Should the pilot program fund mobile health applications selected by the participating health care providers for use by their participating patients?

Because there is growing evidence that mobile health applications improve quality of and access to behavioral health care, Centerstone is developing new models of patient care that embrace the benefits of technological advances. For instance, we are currently piloting a technology-enabled care application and clinicians' portal that interface to advance treatment gains and monitor continued progress between clinical sessions. The client mobile app directly delivers the following to clients' phones: treatment plans, medications reminders, homework, tasks, and assignments, daily mood assessments, links to resources, robust alert system to notify clinicians when clients go to the local emergency room, 24/7 help and crisis services, and employment assistance. With more frequent patient-provider check-ins, providers are able to identify signs of malaise earlier, rather than later. As development continues, the technology will fully integrate into Centerstone's electronic health record, and additional functionality of the mobile application will enhance comprehensive care. The app will feature capabilities including text chat in full compliance with HIPPA regulations, text appointment reminders, and a GPS system used to identify and alert clients and the care team when clients are near a 'trigger spot' (e.g., liquor store, illegal drug supplier, etc.). Trusting in the benefits of such developing applications, *we recommend that the pilot program fund mobile health applications*. Lawmakers should also establish criteria for the use of grant funding to support third-party applications. Specifically, mobile health applications should be required to comply with HL7 standards.

7. Number of Pilot Projects Selected, Support Amount, and Disbursement

(49) We seek comment on allowing each participating partnership to apply for a set amount of funding through the pilot program. To this end, how many projects should we select for participation in the pilot program and what should be the total funding cap on each selected project, assuming a total program budget of $100 million? We seek comment in particular on selecting a limited number of projects, such as a maximum of 20 projects. Would this number allow us to adequately explore the

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use of USF funding to promote connected care services among low-income households and low-income veterans?

Assuming a total program budget of $100 million, the proposed maximum number of 20 projects is reasonable. ***We recommend that the pilot project stipulate that costs be shared between the applicant organizations and the broadband provider for any construction necessary***, in order to ensure the resulting estimated $5 million maximum funding per project is sufficient for meeting the program aims.

8. Duration
(51) We seek comment on the duration of the pilot program and whether we should adopt a two- or three-year funding period. Would such a timeframe be sufficient to obtain meaningful data and promote long term adoption of broadband-enabled telehealth services? Is two or three years of funding long enough to observe metrics to evaluate the pilot program's performance?

Since 2004, Centerstone and its affiliates have administered $170+ million in federally funded projects of similar scope/size (e.g., SAMHSA, ACF, VA, HRSA) serving similar populations (e.g., SMI, SED, SUD, COD). ***Based on our experience, we recommend a 3-year funding period to provide a sufficient time frame among organizations who have telehealth components in place.*** This recommendation takes into consideration a six-month ramp-up period and six-month wind down period, leaving two years of project deployment, during which time metrics can be collected and observed and program performance evaluated.

9. Compliance with Federal, State, and Local Laws
(52) We seek comment on any federal, state, or local regulatory barriers to telemedicine that we should consider in designing the pilot program.

Lawmakers should fully optimize the value of our behavioral health workforce by affording them a wider latitude to treat SUD patients in hard-to-reach areas via telemedicine. It is estimated that by the year 2025, there will be a workforce shortage in the fields of substance abuse and mental health treatment of approximately 250,000 providers across all disciplines[39]. According to the National Rural Health Association, today there are already "30 million people living in rural counties where treatment is unavailable[40]." With immense gaps in treatment access and fatal opioid-related overdoses at an all-time high, it is imperative that regulators allow for the maximum utilization of our workforce.

The Ryan Haight Act makes it illegal for a practitioner to issue a prescription for a controlled substance via telemedicine without having first conducted at least one in-person medical evaluation of the patient. There are currently three FDA-approved medications for the treatment of opioid use

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[39] https://www.sciencedirect.com/science/article/pii/S0749379718300679
[40]https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/Treating-the-Rural-Opioid-Epidemic_Feb-2017_NRHA-Policy-Paper.pdf

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disorder: naltrexone, methadone, and buprenorphine.[41] These medications are recognized by the National Institute of Drug Abuse[42], American Society of Addiction Medicine[43], and the Substance Abuse and Mental Health Services Administration[44] as essential tools in responding to the opioid epidemic. Under current law, non-SAMHSA practitioners who wish to prescribe Suboxone (brand name for buprenorphine) to a patient they are treating via telemedicine would need to first perform an in-person evaluation, had they not already done so. Following this regulatory mandate for buprenorphine prescribing, however, may be overly burdensome in many circumstances, and may prevent many patients from receiving life-saving treatment. Thus, we believe that *licensed community mental health and addiction providers, who follow nationally recognized models of treatment, should gain access to a special registration process so that they may register with the DEA to prescribe substances now commonly embraced in MAT practice, without a prior in-person patient/provider encounter*.

11. Protecting Patient Information
(55) Patient health information is among the most sensitive type of data. We therefore seek comment on how the Commission would obtain data on health outcomes while safeguarding patient information and complying with medical information privacy laws. Should patients participating in the program be required to authorize disclosure of their protected health information?

Beyond confidentiality laws imposed by HIPAA, the Confidentiality of Substance Use Disorder Patient Records rule – 42 CFR Part 2 – is a stringent rule that prevents providers from systematically treating OUD/SUD patients in reliance on complete and accurate patient histories. In moving towards more robust integrated care models where every member of a patient's treatment team needs to understand a patient's full medical/SUD history, Part 2 stands as a hindrance to whole-person, safe care. We at Centerstone aim to do everything we can to evaluate what is most appropriate for each individual on a case-by-case basis in order to provide the highest quality, individually-tailored care. Without a full understanding of the challenges an individual is facing, however, the care of even the best-intentioned providers will fall short of the care they could offer if they understood the whole person. Therefore, *we suggest that patients participating in the pilot program be required to authorize disclosure of their protected health information to facilitate safer, more coordinated, integrated, and faster care.*

C. MEASURING EFFECTIVENESS OF THE PROGRAM
(61) Measuring Patient Health Outcomes and Behavior. We seek comment on which metrics should be used to measure improvements in the health of qualifying patients.

We recommend that the effectiveness of the pilot program be measured by examining potential overlap between lack of broadband deployment in communities, low income, and poor

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[41] Dr. McCance-Katz, Oral Testimony, November 13, 2017. http://www.aei.org/events/the-opioid-crisis-what-can-congress-do-a-conversation-with-house-committee-on-energy-and-commerce-chairman-greg-walden-r-or/

[42] https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/overview

[43] https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24#search="medication assisted treatmetn"

[44] https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat

health outcomes. Through strategies such as Arc-GIS Mapping, evaluators can analyze demographics data, as well as median household income by census tract, availability of health care, transportation, schools, grocery stores, parks, etc. The next step is to create a complete picture of identified community's broadband coverage using ArcGIS technology to combine the service provider data with detailed street-level maps and local demographics. Once we have maps of those program participants marginalized from broadband internet, we then use internet access (*or lack thereof*) as a key social determinant of health. EHR and analytics tools can demonstrate participant health status (e.g., diagnosis, chronic disease, access to primary care, access to preventative care, etc.), and evaluators can use the Health-Related Quality of Life Questionnaire to measures the impact of a person's perception of his or her health and the effect that produces on satisfaction with life and well-being. HRQOL is influenced by functional and socioeconomic status; by health risks; and by the beliefs, cultural milieu, policies, and practices of society. From there, evaluators can look at other social determinants of health from the perspective of the participant population. There are five well established key areas (determinants) that
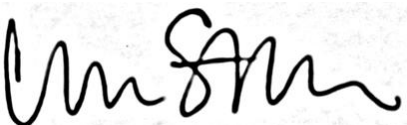
can be studied in terms of access to broadband and key social determinants to answer, ***Does the state of determinants improve as access improves?*** These five determinants are:

- Economic Stability
- Education
- Social and Community Context
- Health and Health Care
- Neighborhood and Built Environment

We hope that our comments and recommendations will be useful to you in determining the direction of the Connected Care Pilot Program. Please do not hesitate to contact us in the event that you have any questions, or if you wish to discuss any issue in more depth. Thank you, in advance, for your consideration of our input.

Sincerely,

Chelsea Stripe
Director of Grants & Service Development
Centerstone America