September 17, 2019

Marlene H. Dortch
Secretary
Federal Communications Commission
Room TW-A325
Attn: WC Docket No. 18-213
445 12th Street SW, Washington, DC 20554

Dear Ms. Dortch:

UVA Health welcomes this opportunity to comment on the Federal Communications Commission (FCC) proposal to develop and implement a Connected Care Pilot Program, as detailed in its July 11, 2019, Notice of Proposed Rulemaking ("NPRM").

UVA Health is an academic medical center located in Charlottesville, Virginia and includes: University of Virginia Medical Center (UVAMC) with a level I trauma center, neonatology intensive care unit, organ transplant program, nationally recognized cancer and heart centers; primary and specialty clinics throughout Central Virginia; and UVA Transitional Care Hospital, a 40 bed long-term acute care hospital. Relative to most of the state's other hospitals, UVAMC provides a disproportionate share of services to Virginia's indigent and Medicaid beneficiaries, thus serving as a key component of Virginia's safety net providers. More than 65 percent of UVA Medical Center's patients are Medicare, Medicaid and uninsured patients.

In addition, UVA Health includes the Karen S. Rheuban Center for Telehealth, a Center that has improved access to healthcare services for the citizens of the Commonwealth through collaborations that connects UVA Health with over 150 sites across the Commonwealth using a variety of technologies that include high definition video-teleconferencing, store and forward technologies, eConsults, remote patient monitoring, mobile health tools, video-based case conferences, and Project ECHO, along an extensive portfolio of research and educational collaborations. Our clinicians, representing more than 60 subspecialties have supported more than 100,000 clinical encounters ranging from emergency care to chronic disease management across the continuum from pre-natal care to end of life. For example, the Center supports a broad range of connected care initiatives to battle chronic diseases, including remote monitoring for patients with diabetes, screenings for patients with diabetic eye disease, telemedicine and remote monitoring for high risk pregnant women and medically complex infants, cardiac rehabilitation programs for heart failure patients and streamlined access to specialists. The Center also serves as the Health Resources and Services Administration (HRSA)'s designated Mid-Atlantic Telehealth Resource Center offering technical assistance to entities in 8 states and the District of Columbia.

UVA Health unequivocally supports the goals of the pilot and its focus to support health care providers to obtain universal service support to offer connected care technologies to low-income patients and veterans. UVA believes the integration of telehealth and remote patient services in health systems and community-based, outpatient settings enhance patient care quality and value. At UVA, telemedicine has been demonstrated to effectively mitigate the significant challenges of workforce shortages and geographic disparities in access to care, while improving patient triage and timely access to care by the right provider at the right time. Virtual care delivery models have proven to enhance access, care coordination, clinical outcomes and patient engagement.

As the FCC considers eligible entities for the pilot funds, we support the FCC's definition of health care providers and related list. We agree that providers located in both urban and rural areas should be eligible to apply for the pilot. To ensure the funds from the pilot are effectively and appropriately used, we urge the FCC to focus on projects proposed by health care providers who have prior experience caring for a significant number of vulnerable patients, including Medicare, Medicaid, uninsured patients and/or patients who are veterans. We also recommend the Commission take into account providers' ability to establish partnerships focused on improving the health disparities associated with a community's low income populations.

In regard to whether health care providers with little to no experience in telehealth or connected care could be eligible for pilot funding, the FCC could require such applicants to partner with HRSA's telehealth resource centers (TRCs). TRCs, who are funded by HRSA's Office for the Advancement of Telehealth serve to expedite and customize the provision of telehealth technical assistance across the country. The twelve regional centers' reach extends to all 50 states, the District of Columbia, and the affiliated Pacific Islands, and two national TRCs that focus on technology assessment and telehealth policy offering their services to the entire United States. TRCs provide training and support, disseminate information and research findings, promote effective collaboration, and foster the use of telehealth technologies to provide health care information and education for provider who serve rural and medically underserved areas and populations.

While we appreciate that the FCC pilot would assist with the costs of purchasing broadband necessary for providing connected care services directly to quality patients, we urge the FCC to consider making end-user devices, medical devices, or mobile devices also eligible for funding. We have seen that many of our vulnerable patients do have not have the ability to pay for such devices. Relying on providers to fund this equipment through other avenues may act as a deterrent for some otherwise eligible providers to participate.

We also urge the Commission to consider funds for the program be allowed to be spent on any updates, especially if software is involved, end user training and support, and any technical assistance that TRCs would provide to providers with little experience in connected

care. Provider, patients and/or caregivers must be given sufficient support and training on how to use the equipment properly, but more importantly, to establish a comfort level for them to encourage the use of the equipment.

In regard to the Commission interest in metrics and measures used to determine success of the Pilot and health outcomes, our Center for Telehealth tracks a broad range of process and quality metrics to include such metrics as time from consult request to completion of encounter, data transport metrics (as they relate to the transfer of medical images and quality of service of the connection), clinical outcomes measures, miles of travel avoided, patient satisfaction, provider satisfaction and other organizational metrics.

Examples of clinical outcomes include the following:

- Our diabetes remote patient monitoring program has improved outcomes in the setting of a federally qualified health center in Appalachia by combining virtual training in diabetes self-management with remote monitoring tools at home. We track a host of metrics to include hemoglobin A1 C levels, a marker for blood sugar levels and complications of diabetes. A level of 6.5 percent or higher indicates diabetes. In our study population of patients with poorly controlled diabetes, through remote monitoring, telemedicine supported nutritional counseling and remote visits with an endocrinologist. Over a six month period, the mean Hemoglobin A1C level of our cohort dropped from 9.9 percent to 7.7 percent. Via telemedicine, those same patients also received screening for diabetic retinopathy – the number one cause of blindness in working adults.

- Our heart failure remote monitoring and care coordination programs for high risk patients have reduced 30 day readmission rates by 82 percent and ER visits by 77 percent. The cost savings are estimated to be seven times the program's cost - for an illness that costs our nation more than $31 billion dollars annually.

- We use remote monitoring technologies to care for fragile organ transplant patients and dialysis patients at home so as to provide timely interventions and better care coordination for high risk patients.

- We manage medically complex infants and children after hospital discharge with video enabled tablets and an array of FDA approved peripheral devices that transfer vital signs and other important data to the patient's electronic medical record for review by our clinicians. We have documented a full 10 day reduction in length of stay for preterm infants sent home with remote monitoring technologies.

Last, a disparate reimbursement system continues to pose significant barriers to expansion of telehealth. Continued work toward harmonizing inconsistencies in Medicare and state

Medicaid telehealth policies is essential. Medicare has just begun to reimburse providers for a range of virtual care models, including patient remote monitoring, and Medicaid programs reimburse for some forms of remote patient monitoring (RPM). As more than 16 different federal agencies report engagement in telehealth, be it through research and other grant funded opportunities, through the establishment of broadband communications networks, clinical service delivery, and even device development and regulation, improved coordination among the federal agencies is critical. We would urge the FCC to collaborate with the Department of Health and Human Services and specifically with HRSA and the Centers for Medicare and Medicaid Services to ensure its connected health pilot builds on the progress of these agencies. As the UVA Center for Telehealth has been a longstanding participant in the FCC's Rural Healthcare Program, we know firsthand the power of telehealth and connected care. We look forward to working with the FCC on the new Connected Care Pilot Program to bring broadband facilitated connected care models to patients at home, at work, or at other locations to support patient engagement in their own care, to reduce unnecessary emergency visits and hospitalizations and to support improved clinical outcomes.

Sincerely,

Pamela Sutton-Wallace
Acting Executive Vice President for Health Affairs, UVA Health System
Chief Executive Officer, UVA Medical Center