



August 27, 2019

Re: FCC 19-64; WC Docket No.18-213

Jodie Griffin
Wireline Competition Bureau
Federal Communications Commission
445 12th Street, SW,
Washington, DC 20554

Re: Promoting Telehealth for Low-Income Consumers

Dear Ms. Griffin:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the proposed Connected Care Pilot program. ACEP applauds the Federal Communications Commission (FCC) for initiating this pilot and believes that promoting access to telehealth services in both urban and rural areas can significantly improve patient care.

As the FCC finalizes the structure of the pilot, we ask the FCC to consider broadening its scope slightly to support high quality, cost-effective telehealth programs in the emergency department (ED) setting that allow greater access to an emergency physician in inner city or rural EDs that would not normally be able to economically support that level of provider on a 24/7 basis, if at all. There are established and successful examples of such programs and expanding the pilot's scope would encourage their growth. Additionally, telehealth access from the ED setting to other medical specialists such as neurologists or psychiatrists can help provide faster access to specialty care and reduce delays in critically needed treatment and the time these patients remain in the ED waiting for a psychiatric bed to become available (i.e. ED "boarding").

As more and more small and rural hospitals close, their EDs close too, leaving large gaps in emergency care in a region.¹ To fill these gaps, emergency physicians housed in what may be a state's only large or teaching hospital provide telehealth services to patients and providers in smaller rural or community hospitals that are staffed by registered nurses (RNs) and Advance Practice Nurses (APNs). These valuable services provide clinical expertise in real time to stabilize patients who may need to be transferred long distances or may be observed at timely intervals over several hours by the emergency physician team at the teaching hospital before a decision is made to transfer, admit locally, or release the patients.

Across the country, innovative telehealth initiatives have helped improve care and lower costs in both urban and rural areas. Different types of emergency care telehealth models

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¹ Tribble, Sarah Jane. "After A Rural Hospital Closes, Delays In Emergency Care Cost Patients Dearly." Kaiser Health News. August 19, 2019. <https://khn.org/news/emergency-room-care-rural-hospital-closes-uncertain-future/>.

have been tested, from “direct-to-consumer” models to models that involve a hub that connects emergency physicians to EDs in remote locations or allows emergency physicians to provide consultations for specific clinical conditions.

In general, studies have shown that physicians and patients are extremely satisfied with the care being provided through these models, and costs have decreased due to avoided ED visits and inpatient admissions.

Some successful programs of note include:

- In Pennsylvania, Jefferson Health has implemented the JeffConnect Program, which connects Jefferson emergency physicians to patients 24 hours a day seven days a week through On-Demand Video Visits. This initiative has been extremely successful in treating patients with stomach aches, flu symptoms, and for other similar conditions. Results from the program have been promising:
 - 83 percent of patients reported that they would have sought treatment elsewhere—of these, 45 percent would have higher cost ED or urgent care visits.
 - Cost savings to the patient or payer is \$19 to \$121 per episode of care, taking into account alternate care sites and post-visit care.

Also in Pennsylvania, the Lehigh Valley Health Network’s Advanced ICU (AICU) has showed a significantly lower mortality rate (31 percent relative mortality risk reduction) and a lower rate of the use of mechanical ventilation. The AICU is an off-site monitoring center staffed by a team of physicians that monitors all intensive care patients and can immediately flag changes in vital signs and quickly alert the patient’s ICU team.²

- The city of Houston initiated ETHAN (Emergency Telehealth and Navigation) in 2014, a program that helps redirect 9-1-1 callers who have non-emergent conditions to alternative locations besides the ED. Under the model, paramedics responding to patients on the scene can connect remotely to an ETHAN emergency physician located at a command center. The emergency physician can help provide a clinical assessment of the patient and determine the best course of action, which could include a non-ambulance transport to a primary care or urgent care clinic.
- Emory University Hospital has just completed a successful pilot study focusing on care delivered in their emergency department observation units (EDOU). Most U.S. hospitals do not have protocol-driven EDOUTs despite their documented benefits. The observational study took place in Emory's academic hospital 8-bed EDOUT. During a six-day period, the ED attending supervising the EDOUT participated in morning patient rounds entirely via a telehealth device which an advanced practice provider (APP) carted into patient rooms. Immediately after, the same ED attending physician re-examined all patients in person to determine if tele-rounding missed any clinical details. The study found that there were no patient history or examination findings that were missed due to telehealth. The goal of this project, once fully established, would be to use telehealth to oversee remote observation units across numerous hospitals.
- The University of Mississippi Medical Center (UMMC) in Jackson, Mississippi provides emergency medicine specialist expertise to advance practitioners in approximately 20 to 30 rural EDs throughout the state of Mississippi. Many of these EDs may have closed without the UMMC program providing emergency physician back-up and support to the mid-level providers on-site. Since the program’s inception, over 500,000 patients have had access to board certified emergency medicine specialists

² More information on the AICU can be found at:

https://www.lvhn.org/our_services/key_support_services/virtual_health_apcci/advanced_intensive_care_unit_aicu.

without ever leaving their small community. UMMC was recognized by the Health Resources and Services Administration in 2017 as a Center of Excellence in Telehealth for its work and accomplishments in telehealth.

- Avera Health based in Sioux Falls, SD provides telehealth services through a program called eCARE to approximately 440 unique health care facilities in 25 states; 200 of which are rural hospitals. The model centers around a telehealth hub which is staffed 24 hours a day by an interdisciplinary team of physicians, nurses, pharmacists, and social workers. During an eCARE shift, clinicians only see patients via telehealth and are attuned to the specific needs of the rural facilities. Started in 2009, eCARE has provided instant access to board-certified emergency physicians and critical care nurses who operate as a part of the rural emergency team. The eCARE emergency team can expedite care, bring in specialists, assist with patient codes, call in support staff, and arrange transfers or whatever else is needed during a critical emergency case. Results to date include:
 - \$49,841 in average annual savings to hospitals, because of better staffing options³
 - Potential to result in net savings of \$3,823 per avoided Emergency transfer⁴
 - \$117,406 decrease in total ED costs⁵
 - \$30 million saved in avoided transfers
- In the remote international port in the Aleutian Islands in Alaska, Iliuliuk Family and Health Services has partnered with emergency physicians and critical care doctors at Anchorage Hospital, more than 800 miles away, to respond to emergencies. While the volume of cases is low, there are occasionally high-acuity emergent cases. Using satellite technology, primary care physicians can consult with emergency physicians in Anchorage to stabilize patients and prevent the need to have them transported to a hospital that is hundreds of miles away.

Emergency physicians serve as the safety net in our communities, treating people with both acute and chronic illnesses and conditions. We are on the front lines serving populations who are specifically targeted by this pilot, including individuals suffering from opioid dependency, diabetes, heart disease, mental health conditions, and high-risk pregnancy. Given the proven effectiveness of emergency telehealth services and the vital role emergency physicians play in the health care system, we respectfully ask that the FCC specifically allow emergency physicians to be eligible participating providers in the pilot.

While we understand that the definition of eligible providers is currently restricted to those who practice in health care settings that are designated in 47 U.S. Code § 254(h)(7)(B), we encourage the FCC to expand eligibility to include all emergency physicians regardless of where they practice.

³ MacKinney AC, Ward MM, Ullrich F, Ayyagari P, Bell AL, Mueller KJ. The Business Case for Tele-emergency. *Telemed J E Health*. 2015 Dec;21(12):1005-11. <http://www.ncbi.nlm.nih.gov/pubmed/26226603>.

⁴ Natafqi N, Shane D, Ullrich F, MacKinney C, Bell A, Ward M. (2017). Using Tele-Emergency to Avoid Patient Transfers in Rural Emergency Departments: An Assessment of Costs and Benefits. *Journal of Telemedicine and Telecare*. March 7, 2017. doi: <https://doi.org/10.1177/1357633X176965854>.

⁵ Ward M, Merchant AS, Carter KD, Zhu X, Ullrich F, Wittrock A, Bell A. (2018) "Use of Telemedicine For ED Physician Coverage In Critical Access Hospitals Increased After CMS Policy Clarification." *Health Affairs (Millwood)*. 2018, 12, 37. doi: 10.1377/hlthaff.2018.051032.

Thank you for the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory Affairs at jdavis@acep.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Vidor E. Friedman". The signature is fluid and cursive, with a large loop at the end of the last name.

Vidor E. Friedman, MD, FACEP
ACEP President