



The Honorable Mark R. Warner  
United States Senate  
475 Russell Senate Office Building  
Washington, D.C. 20510

The Honorable Johnny Isakson  
United States Senate  
131 Russell Senate Office Building  
Washington, DC 20510

June 22, 2015

Re: University of Virginia Health System Response to Request for Ideas from the Senate Finance Committee's Working Group on Chronic Care

Dear Senators Warner and Isakson,

The University of Virginia Health System is pleased to submit comments to the Senate Finance Committee's working group on chronic care in response to its request for ideas on reforming chronic care for Medicare patients.

The University of Virginia Health System is an academic medical center located in Charlottesville, Virginia composed of the Medical Center and its satellite facilities and programs, the School of Medicine, and the School of Nursing. We provide primary, tertiary and quaternary care for citizens throughout Virginia. In state fiscal year 2014, 42% of our inpatient discharges were Medicare patients, and many of these patients have chronic conditions. Because of our work with Medicare patients with chronic conditions, we have insight concerning this topic which we are happy to share with you for your consideration. For the purposes of this letter, we would like to focus our comments on one particular area in which we have significant expertise—that of telehealth.

**Ideas to effectively use or improve the use of telehealth and remote monitoring technology; Strategies to increase chronic care coordination in rural and frontier areas**

The efficacy of telehealth in improving access to health care has been long established. Through a combination of modalities including store and forward, point to point video-conferencing and remote monitoring, telehealth can provide a comprehensive array of specialty care in rural communities. These capabilities can be provided in rural communities through hospitals, networks of Federally Qualified Community Health Centers, health departments, correctional institutions, rural health facilities, nursing homes, dialysis centers and free clinics.

As a consequence of these capabilities, the management of chronic disease can be addressed for many rural Medicare patients. Chronic diseases – such as heart disease, stroke, cancer, diabetes, end stage renal disease, and arthritis – are among the most common, costly, and preventable of

all health problems in the U.S. and telehealth can be used to prevent and help improve the management of these chronic conditions. The primary role of telehealth in this context has been to: provide education to consumers to improve self-management, enable faster, cheaper and instantaneous transfer of health-related information via tele-monitoring and facilitate communications between patients in rural areas with healthcare professionals.

The outcomes from the use of telehealth are significant. They range from improved access to specialty care, reduced no shows rates, earlier intervention, reduced costs, the reduction of patient expenses such as travel and significant improvements in self-care for chronic disease from remote monitoring resulting in a reduction of the 30 day readmission rate.

While there are demonstrated outcomes in the improvement of chronic disease, success in translating these outcomes into long term savings and positive patient outcomes requires public policy decisions that will accelerate the adoption of telemedicine and remote patient monitoring. In particular, the realignment of reimbursement policies in Medicare is essential.

The Committee should consider a process to advance telehealth that includes a thorough examination around the definitions of rurality to ensure that Medicare patients in rural communities deemed as urban are treated fairly. Other policies decisions must include the investment on telehealth technologies for rural communities, and importantly, the designation of the home, under defined conditions such as patient monitoring, as an originating site for care.

The issue of defining the home as a site for care could yield perhaps the most significant changes to the management of chronic conditions in rural communities. Local providers and health systems would be incentivized to reach patients at home with the potential impact of decreased hospitalization costs, reduced ED visits, improved medication compliance and improved self-care. Consider, for example, patients with end stage renal disease (ESRD). These patients often have treatment plans that require frequent visits with their health care providers. If changes were made to the Medicare program that would allow for increased coverage of ESRD services offered by telehealth, this could allow both home and in-center dialysis patients greater flexibility in scheduling with, and increased access to, their physician or practitioner. The result will be better, patient-centered care.

We look forward to engaging with the Committee further on the topic of reforming chronic care, and we commend you for undertaking this important work.

Sincerely,

Carol H. Craig  
Government Relations Specialist  
University of Virginia Health System