

Promises vs. Reality

PROMISE	REALITY
 \$280M investment in 2023 to bring multi-gig speeds statewide* Comcast WA PR, Mar 2023	 Only –450 addresses in Silverdale – <1% of target – documented as new parsings Kitsap Co, permit data, 203-24
 "Every community we serve will get upgrades Comcast WA press releases	 Bremerton, Port Orchard, Seabeck absent from upgrade lists Comcast named expians-sites: Battleground, Chattaroy, Key Peninsula, Sumas
 40-50% of WA multi-gig by end of 2023 2025 logs	
 "Private sector is leading broadband expansion	 Kitsap's biggest builds were public-funded: \$6 6M ARPA (2025), 55M+ BTOP match (2010-12)



Original Investigation | Health Policy

Estimated Indirect Cost Savings of Using Telehealth Among Nonelderly Patients With Cancer

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Abstract

IMPORTANCE Patients with cancer typically have greater financial hardships and time costs than individuals without cancer. The COVID-19 pandemic has exacerbated this, while posing substantial challenges to delivering cancer care and resulting in important changes in care-delivery models, including the rapid adoption of telehealth.

OBJECTIVE To estimate patient travel, time, and cost savings associated with telehealth for cancer care delivery.

DESIGN, SETTING, AND PARTICIPANTS An economic evaluation of cost savings from completed telehealth visits from April 1, 2020, to June 30, 2021, in a single-institution National Cancer Institute–Designated Comprehensive Cancer Center. All patients aged 18 to 65 years who completed telehealth visits within the designated time frame and had a Florida mailing address documented in their electronic medical record were included in the study cohort. Data were analyzed from April 2020 to June 2021.

MAIN OUTCOMES AND MEASURES The main outcome was estimated patient cost savings from telehealth, which included 2 components: costs of travel (defined as roundtrip distance saved from car travel) and potential loss of productivity due to the medical visit (defined as loss of income from roundtrip travel plus loss of income from in-person clinic visits). Two different models with a combination of 2 different mileage rates (\$0.56 and \$0.82 per mile) and census tract–level median hourly wages were used.

RESULTS The study included 25 496 telehealth visits with 11 688 patients. There were 4525 (3795 patients) new or established visits and 20 971 (10 049 patients) follow-up visits. Median (IQR) age was 55.0 (46.0–61.0) years among the telehealth visits, with 15 663 visits (61.4%) by women and 18 360 visits (72.0%) by non-Hispanic White patients. According to cost models, the estimated mean (SD) total cost savings ranged from \$147.4 (\$120.1) at \$0.56/mile to \$186.1 (\$156.9) at \$0.82/mile. For new or established visits, the mean (SD) total cost savings per visit ranged from \$176.6 (\$136.3) at \$0.56/mile to \$222.8 (\$177.4) at \$0.82/mile, and for follow-up visits, the mean (SD) total cost savings per visit was \$141.1 (\$115.3) at \$0.56/mile to \$178.1 (\$150.9) at \$0.82/mile.

CONCLUSIONS AND RELEVANCE In this economic evaluation, telehealth was associated with savings in patients time and travel costs, which may reduce the financial toxicity of cancer care. Expansion of telehealth oncology services may be an effective strategy to reduce the financial burden among patients with cancer.

JAMA Network Open. 2023;6(1):e2250211.

Corrected on February 9, 2023. doi:10.1001/jamanetworkopen.2022.50211

Key Points

Question What are the estimated cost savings of using telehealth among patients with cancer?

Findings This economic evaluation of cost savings from completed telehealth appointments included 11 688 patients younger than 65 years, with 25 496 telehealth visits at a National Cancer Institute–Designated Comprehensive Cancer Center from April 1, 2020, to June 30, 2021. According to cost models, the estimated mean total cost savings ranged from \$147.4 to \$186.1 per visit.

Meaning These findings suggest that telehealth saves time, travel, and money for patients, which could improve care delivery and may reduce the financial toxicity of cancer care.

+ Supplemental content

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Introduction

Financial toxicity includes both objective financial burden (ie, costs) and subjective financial distress.^{1,2} Costs of cancer care include: direct cost of care (cost sharing through higher deductibles, copayments, coinsurance, and even entire cost of care for uninsured patients) and indirect costs of care (lost productivity and cost of driving to and from appointments).^{1,3} Patients with cancer have greater time-based costs than those without cancer (eg, time spent traveling back and forth to appointments and time spent receiving medical care).⁴⁻⁶ Strategies are needed to reduce the direct and indirect costs of cancer care delivery.

The rapid adoption of telehealth during the COVID-19 pandemic has allowed patients to receive care in a location that is convenient for them, which may reduce the costs of cancer care. To date, there has been limited research regarding the cost savings of telehealth among patients with cancer. The COVID-19 pandemic is providing a unique opportunity to estimate the potential cost savings of telehealth in oncology care.⁷ Although it is well established that patients with cancer experience substantial financial toxicity, few studies have explored the indirect costs that they face. Thus, this study focused specifically on an oncologic population from a comprehensive cancer center with a substantially large sample size to estimate the indirect cost savings (driving costs and lost productivity) from telehealth visits.

Methods

This was an economic evaluation estimating cost savings from completed telemedicine visits at Moffitt Cancer Center (MCC), the only National Cancer Institute (NCI) –Designated Comprehensive Cancer Center in Florida. Data from telehealth visits were collected from April 1, 2020, to June 30, 2021. All patients aged between 18 and 65 years who completed telehealth visits within the designated time frame and had a Florida mailing address documented in their electronic medical record were included in the study cohort. All patients were offered telehealth if deemed appropriate by the clinical team. Telehealth visits were not offered to patients who needed physical examinations beyond what can be assessed during a telehealth visit. Patients who presented in person for chemotherapy infusion and/or radiation treatment were excluded from the analysis. This study was exempt from MCC institutional review board approval with a waiver of informed consent from patients because the study was deemed low risk. This study used the Consolidated Health Economic Evaluation Reporting Standards (CHEERS) reporting guideline.⁸

Due to the COVID-19 pandemic, implementation of telehealth at MCC was accelerated in March 2020. Telehealth was defined as care delivered through a videoconferencing platform in real time. Starting in April 2020, MCC instituted videoconferencing for their telehealth visits. Patient visits were defined as new, established, or follow-up. New patient visits were patients not having received any previous medical care from MCC; established patient visits had received care at MCC previously but were referred to a new subspecialty for consultation; and follow-up patient visits were seen at MCC for follow-up care by clinicians in the same subspecialty they had previously received care from.

Statistical Analysis

We assessed patient time, travel, and indirect cost savings from using telehealth for cancer care delivery (Figure 1). Analyses were guided by the framework recommended by Sanders and colleagues⁹ for assessing the time and transportation costs of patients. Time savings were calculated as the difference between the roundtrip time required to travel from each patient's home address to an in-person consultation at MCC, plus in-person consultation time vs the time required to attend a telehealth visit from home (ie, time savings = roundtrip drive time + [time for in-person consultation – time for telehealth visit]). Travel savings were calculated as the roundtrip driving distance in miles from each patient's home address to an in-person consultation at MCC. Indirect cost savings were calculated as the roundtrip costs associated with traveling from each patient's home address to an

in-person consultation at MCC. This included 2 components: the costs of travel and the potential loss of productivity due to the medical visit.

The American Community Survey (ACS)¹⁰ was used to determine census tract-level data for hourly median income per year. The census tract income data were then matched to the patient's address. This analysis focused on patients younger than 65 years, because these patients were more likely to be employed full time than those aged 65 years or older.

Two different models were generated with a combination of 2 different mileage rates and hourly wage rates determined via ACS census tract level data. Driving distance traveled in miles was calculated in October 2021 by Buxton Company,¹¹ an analytics organization that uses Alteryx's¹² analytic platform to provide geospatial data. Briefly, the locations are geocoded, and distance is calculated between the 2 geocoded locations by finding the route that results in the least amount of drive time between the 2 locations.

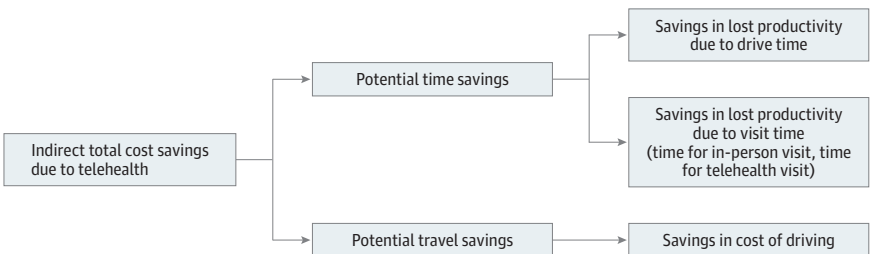
Calculations for different models were conducted using R (R Project for Statistical Computing).¹³ Details are available in the eMethods in Supplement 1. Data were analyzed from April 2020 to June 2021.

Results

A total of 25 496 telehealth visits for 11 688 patients were conducted for patients aged between 18 and 65 years during the study period. There were 4525 (3795 patients) new or established visits and 20 971 (10 049 patients) follow-up visits (Figure 2A). The eTable in Supplement 1 highlights the demographics of the telehealth visits. Median (IQR) age was 55.0 years (46.0-61.0) among the telehealth visits, with 15 663 visits (61.4%) being women, 18 443 visits (72.3%) having private insurance, and 18 360 (72.0%) visits by White non-Hispanic individuals. In travel, an estimated 3 789 963 roundtrip miles (804 969 for new or established visits and 2 984 994 for follow-up visits) were saved, equating to 75 055 hours (15 422 new or established visits and 59 633 for follow-up visits) of savings in total driving time. Per visit, telehealth was associated with mean (SD) savings of 148.6 (143.7) roundtrip travel miles and 2.9 (2.3) hours of roundtrip driving time (Table 1, Figure 2B and 2C). An additional 29 626 hours of in-clinic visits were saved by using telehealth with a mean (SD) savings of 1.2 (0.13) hours per visit (Figure 2D). For new or established visits, telehealth was associated with mean (SD) savings of 177.6 (161.6) roundtrip travel miles, 3.4 (2.6) hours of roundtrip driving time and 1.5 (0.0) hours of in-clinic time per visit (Figure 2B, 2C, and 2D). For follow-up visits, telehealth was associated with mean (SD) savings of 142.4 (138.8) roundtrip travel miles, 2.8 (2.3) hours of roundtrip driving time and 1.1 (0.0) hours of in-clinic time per visit (Figure 2B, 2C, and 2D).

Telehealth was associated with an estimated \$1 170 160 savings in lost productivity (income) due to driving time, \$467 247 savings in lost productivity due to visit time, and \$1 637 407 total savings in lost productivity (Table 2, Figure 2B, 2C, and 2D). For new or established visits, the following savings were noted: \$245 113 savings in lost productivity due to driving time, \$104 522 savings in lost productivity due to visit time, and \$349 655 total savings in lost productivity. For follow-up visits, the following savings were noted: \$925 027 savings in lost productivity due to

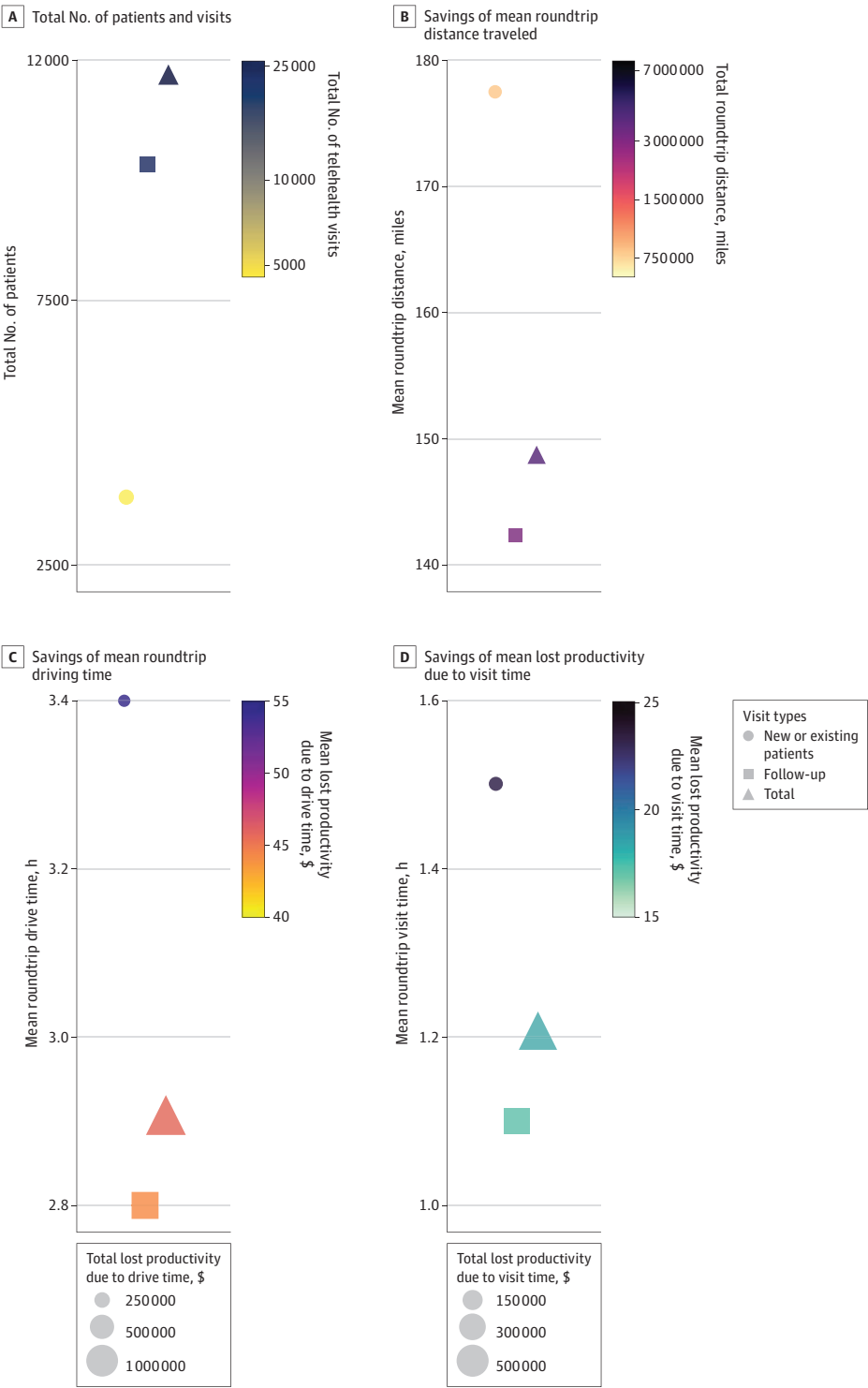
Figure 1. Graphical Representation of Calculation of Estimated Indirect Total Cost Savings Due to Telehealth



Potential time savings was defined as roundtrip time savings arising from the use of telehealth, calculated as the difference between the time required to travel from the patient's home address to in-person consultation at the Moffitt Cancer Center (MCC) plus the in-person consultation time vs the time required to attend a telehealth visit from home (ie, time savings = roundtrip drive time + [time for in-person consultation – time for telehealth visit]). Potential travel savings was defined as roundtrip distance savings arising from the use of telemedicine, calculated as the distance the patient would have traveled for an in-person consultation at the MCC.

driving time, \$362 725 savings in lost productivity due to visit time, and \$1 287 752 total savings in lost productivity. Mean (SD) savings in lost productivity per visit due to driving time were \$45.9 (41.5) per visit overall, and \$54.1 (47.9) for new or established visits and \$44.1 (39.7) for follow-up visits (Table 2, **Figure 3A**). Mean (SD) savings per visit in lost productivity due to visit time was \$18.3 (5.9)

Figure 2. Estimated Total Number of Visits, Roundtrip Drive Time, Roundtrip Distance, Total and Mean Lost Productivity Due to Drive Time, and Total and Mean Lost Productivity Due to Visit Time



A, Total number of patients and visits. B, Savings of mean roundtrip distance traveled. Color represents the total roundtrip distance saved for all patients. C, Savings of mean roundtrip driving time. Color represents the mean lost productivity due to driving time; the size of the marker represents total lost productivity due to drive time. D, Savings of mean lost productivity due to visit time. Color represents the mean lost productivity due to visit time; the size of the marker represents total lost productivity due to visit time.

per visit overall, and \$23.1 (6.9) for new or established visits and \$17.3 (5.1) for follow-up visits. Estimated mean (SD) total savings per visit from lost productivity was \$64.2 (43.6) per visit overall, \$77.2 (50.6) for new or established visits, and \$61.4 (41.4) for follow-up visits. Total driving-cost savings ranged from \$2 122 379 at \$0.56/mile (Figure 3B) to \$3 107 777 at \$0.82/mile (Figure 3C). For new or established visits, total driving-cost savings were \$450 782 at \$0.56/mile to \$660 074 at \$0.82/mile, while for follow-up visits, total driving-cost savings were \$1 671 597 at \$0.56/mile to \$2 447 695 at \$0.82/mile. According to cost models, the mean (SD) driving cost savings per visit ranged from \$83.2 (\$80.5) at \$0.56/mile to \$122.0 (\$118.0) at \$0.82/mile (Table 2, Figure 3B and 3D). For new or established visits, the mean (SD) driving cost savings per visit ranged from \$99.6 (\$90.5) at \$0.56/mile to \$146.0 (\$132.6) at \$0.82/mile, and for follow-up visits, the mean (SD) cost savings per visit was \$79.7 (\$77.7) at \$0.56/mile to \$116.7 (\$113.8) at \$0.82/mile. According to cost models, the mean (SD) total cost savings per visit ranged from \$147.4 (\$120.1) at \$0.56/mile to \$186.1 (\$156.9) at \$0.82/mile (Table 2, Figure 3B and 3D). For new or established visits, the mean (SD) total cost savings per visit ranged from \$176.6 (\$136.3) at \$0.56/mile to \$222.8 (\$177.4) at \$0.82/mile, and for follow-up visits, the mean total cost savings per visit was \$141.1 (\$115.3) at \$0.56/mile to \$178.1 (\$150.9) at \$0.82/mile.

Discussion

This economic evaluation study uses a large data set collected at an NCI-Designated Comprehensive Cancer Center to estimate patients' savings from using telehealth. From April 1, 2020, to June 30, 2021,

Table 1. Total Number of Visits, Roundtrip Drive Time, and Roundtrip Distance of Virtual Visits Seen at Moffitt Cancer Center From April 1, 2020, to June 30, 2021

Characteristic	NP/EP, No. ^a	Follow-up, No. ^a	Total, No.
No. of patients	3795	10 049	11 688
No. of visits	4525	20 971	25 496
Total roundtrip, miles	804 969	2 984 994	3 789 963
Roundtrip, mean (SD), miles	177.6 (161.6)	142.4 (138.8)	148.6 (143.7)
Total roundtrip driving time, h	15 422	59 633	75 055
Roundtrip driving time, mean (SD), h	3.4 (2.6)	2.8 (2.3)	2.9 (2.3)
Visit time saved, h	6561	23 068	29 626
visit time saved, mean (SD), h	1.5 (0.0)	1.1 (0.0)	1.2 (0.13)

Abbreviations: EP, existing patients referred to a different subspecialty; NP, new patients.

^a A portion of patients will have both NP/EP and subsequent follow-up visits.

Table 2. Projected Cost Savings of Virtual Visits Seen at Moffitt Cancer Center From April 1, 2020, to June 30, 2021

Savings type	NP/EP, No. ^a	Follow-up, No. ^a	Total, No.
Savings in lost productivity (income) due to driving time, \$	245 113	925 027	1 170 160
Savings in lost productivity per visit due to driving time, mean (SD), \$	54.1 (47.9)	44.1 (39.7)	45.9 (41.5)
Savings in lost productivity due to visit time, \$	104 522	362 725	467 247
Savings in lost productivity due to visit time, mean (SD), \$	23.1 (6.9)	17.3 (5.1)	18.3 (5.9)
Total savings in lost productivity, \$	349 655	1 287 752	1 637 407
Total savings in lost productivity per visit, mean (SD), \$	77.2 (50.6)	61.4 (41.4)	64.2 (43.6)
\$0.56/mile ^b			
Savings in total driving costs, \$	450 782	1 671 597	2 122 379
Driving cost savings per telehealth visit, mean (SD), \$	99.6 (90.5)	79.7 (77.7)	83.2 (80.5)
Total cost savings per telehealth visit, mean (SD), \$	176.6 (136.3)	141.1 (115.3)	147.4 (120.1)
\$0.82/mile ^b			
Savings in total driving costs, \$	660 074	2 447 695	3 107 777
Driving cost savings per telehealth visit, mean (SD), \$	146.0 (132.6)	116.7 (113.8)	122.0 (118.0)
Total cost savings per telehealth visit, mean (SD), \$	222.8 (177.4)	178.1 (150.9)	186.1 (156.9)

Abbreviations: EP, existing patients referred to a different subspecialty; NP, new patient.

^a A portion of patients will have both NP/EP and subsequent follow-up visits.

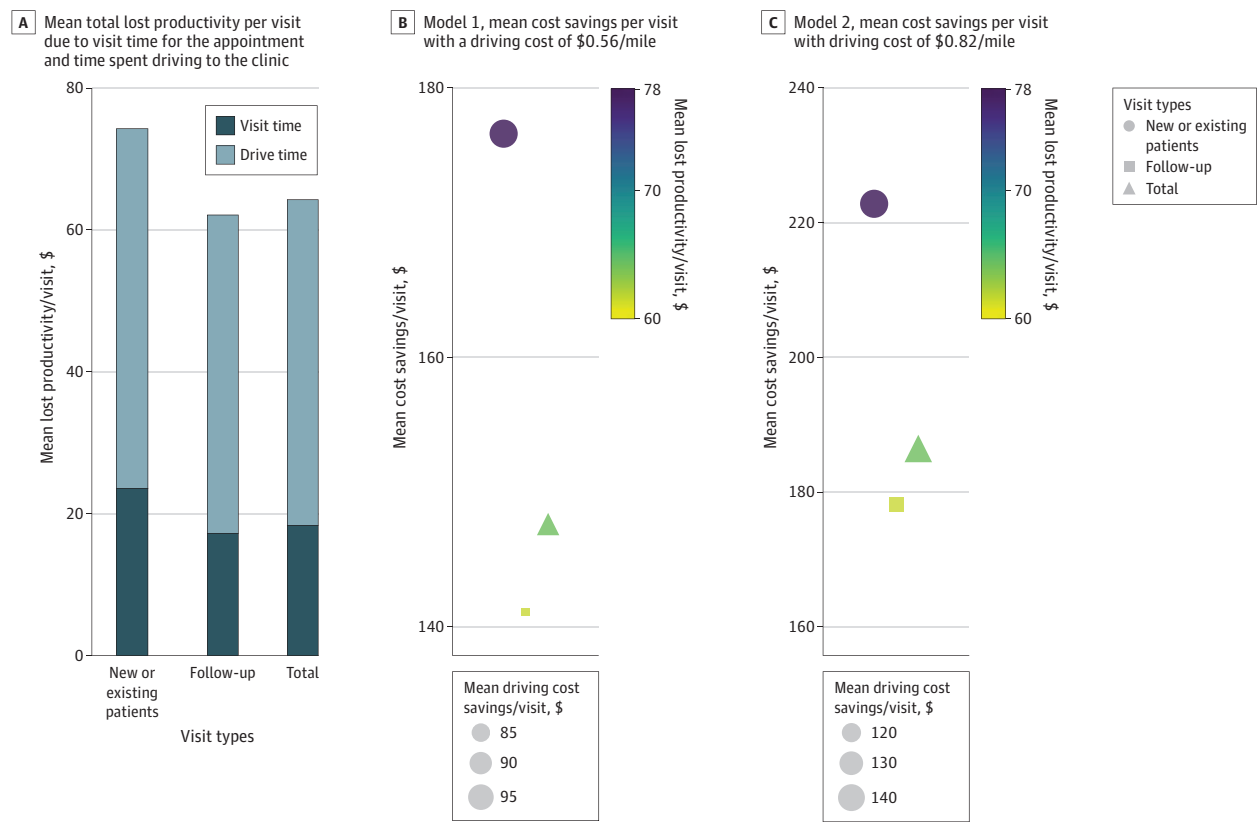
^b Two different models were used with a range of costs per mile (\$0.56/mile and \$0.82/mile).

a total of 25 496 telehealth visits were conducted. Telehealth was associated with a total savings of 3 789 963 roundtrip travel miles, which equates to traveling 152.2 times around the earth, and a total savings of 75 055 roundtrip drive hours, which equates to 8.6 calendar years. An additional 3.4 calendar years (29 626 hours) were saved in clinic visits by using telehealth. Depending on the visit types, mean savings in lost productivity per visit due to driving time ranged from \$44.1 to \$54.1, mean savings in lost productivity due to visit time ranged from \$17.3 to \$23.1, and mean total savings in lost productivity per visit ranged from \$61.4 to \$77.2. Mean driving cost savings per telehealth visits ranged from \$79.71 to \$146.0 depending on visit type and model used. Mean total cost savings per visit ranged from \$141.1 to \$222.8 depending on the visit type and model used.

Some of the main arguments for implementing telehealth are to increase access to care, patient convenience, and cost savings in outpatient clinics.¹⁴ Telehealth may also provide an opportunity to reduce emergency department visits, readmissions, and patient mortality.¹⁴ As patients' financial costs of cancer care increase, telehealth may reduce their burden of travel including costs associated with parking and lodging, and lost income from missing work.

The burden of travel has been identified as an important factor that can change access to diagnosis, treatment of cancer and participation in clinical trials.^{15,16} Transportation is a key determinant of health care access and has been identified as an important source of out-of-pocket nonmedical costs for patients receiving cancer care.¹⁷ Patients without adequate transportation are more likely to miss appointments and rely on emergency department care,¹⁵ and there is substantial variability in the estimated parking costs throughout cancer treatment.¹⁸ In addition, a recent study

Figure 3. Projected Cost Savings of Virtual Visits Seen at Moffitt Cancer Center From April 1, 2020, to June 30, 2021



Two different models were used with a range of costs per mile (\$0.56/mile and \$0.82/mile). A, Mean total lost productivity per visit due to visit time for the appointment and time spent driving to the clinic. B, Model 1, mean cost savings per visit with a driving cost of \$0.56/mile. Color represents mean savings from lost productivity per visit (due to the visit time and driving time), and the size of the marker represents mean driving cost savings/visit. C, Model 2, mean cost savings per visit with driving cost of \$0.82/mile. Color represents mean savings from lost productivity per visit (due to visit time and driving time) and the size of the marker represents the mean driving cost savings per visit.

noted that the number of rural hospitals has decreased over the last decade, resulting in almost double the number of people living outside a 60-minute radius of major hospitals and longer drive times to receive care.¹⁹ Thus, telehealth could be beneficial among rural patients in particular.²⁰

In the models previously mentioned, we did not consider the cost savings of telehealth for cancer caregivers. Caregivers for patients with cancer spend substantial time and effort to coordinate and attend appointments with patients. In 2020, 53 million individuals were caregivers, 6% of whom were caregivers for patients with cancer. The vast majority of caregivers (80%) help with transportation; 18% report high financial strain; and 45% have experienced at least 1 financial impact as a result of caregiving.²¹ Although the current study was focused on indirect cost savings from patients' perspectives, future studies should include caregivers' indirect cost savings as often patients and caregivers function as a unit and share expenses. Therefore, savings from telehealth would be even higher if caregivers' savings from lost productivity were accounted for, especially when telehealth has the ability for multiple caregivers to join the same appointment from various geographical locations.

Although telehealth offers considerable cost savings to patients with cancer, it is well documented that telehealth adoption is affected by the digital divide. Factors associated with financial toxicity (eg, age, insurance, race, and education) are also associated with the digital divide.²² Future studies are needed to address inequities in telehealth uptake. Additionally, telehealth requires substantial infrastructure costs and investments from health systems with buy-in from administrators and clinicians to ensure high patient satisfaction.²³

Limitations

Our study has several limitations. This analysis was retrospectively conducted at a tertiary/quaternary referral center, and so roundtrip travel distances may be higher than usual because this is a destination center for cancer care. Our assumption of employment rates and incomes for patients younger than 65 years may vary. Additionally, a percentage of patients on active treatment or following treatment may not be fully employed given their functional status, thus affecting the savings from lost productivity. Because we were unable to accurately capture employment among older adults, patients aged over 65 years were excluded; however, future studies should examine cost savings in this population. Cost savings due to lost productivity assumed that all patients are nonsalaried and the loss due to travel time and hours of visit time could not be made up for. Therefore, the savings in this study might be considered a maximum amount of lost productivity. This study only considered telehealth visits that were completed via synchronous videoconference, and the costs of electronic devices and internet access were not considered. This study also did not assess other factors likely to affect cost savings, such as rural vs urban residences, race, education, or insurance type, all of which should be explored in future studies. Finally, further data are needed if long-term oncologic outcomes with telehealth visits are equivalent to those seen in person, which can change costs of treatment.

Conclusions

Patients with cancer spend a substantial amount of time and money traveling to receive care. Using a large data set, we found that cancer care delivery via telehealth was associated with time, travel, and cost savings for patients with cancer, which may reduce the financial toxicity of cancer care. Future studies should explore other cost savings, such as the savings to cancer caregivers and how these vary for rural and urban patients with cancer.

ARTICLE INFORMATION

Accepted for Publication: November 18, 2022.

Published: January 10, 2023. doi:10.1001/jamanetworkopen.2022.50211

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Correction: This article was corrected on February 9, 2023, to fix a sentence in the Results section of the abstract; in addition, Supplement 1 has been reuploaded to fix a cut-off table.

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Author Contributions: Dr Patel had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: Patel, Alishahi Tabriz, Gonzalez, Wang, Spiess.

Acquisition, analysis, or interpretation of data: Patel, Turner, Gonzalez, Oswald, Nguyen, Hong, Jim, Nichols, Wang, Robinson, Naso.

Drafting of the manuscript: Patel, Nichols.

Critical revision of the manuscript for important intellectual content: Patel, Turner, Alishahi Tabriz, Gonzalez, Oswald, Nguyen, Hong, Jim, Wang, Robinson, Naso, Spiess.

Statistical analysis: Patel, Wang, Naso.

Obtained funding: Patel.

Administrative, technical, or material support: Patel, Turner, Alishahi Tabriz, Gonzalez, Robinson, Naso.

Supervision: Patel, Gonzalez, Jim, Nichols.

Conflict of Interest Disclosures: Dr Gonzalez reported receiving personal fees from Sure Med Compliance and personal fees from Elly Health outside the submitted work. Dr Jim reported being a consultant for Janssen Scientific Affairs and Merck, and reported receiving grants from Kite Pharma outside the submitted work. Dr Spiess reported being the Vice Chair of the National Comprehensive Cancer Network Penile/Bladder Guidelines Panel, President of the Global Society of Rare GU Tumors, and a board member of the Societe of Internationale D'Urologie Journal outside the submitted work; none of these roles are compensated. No other disclosures were reported.

Data Sharing Statement: See [Supplement 2](#).

Additional Contributions: The authors would like to acknowledge the members of Moffitt Cancer Center's Planning and Market Data Analytics Department for their help with data curation and analysis, and April Manna, MS, for administrative assistance. Editorial assistance was provided by the Moffitt Cancer Center's Office of Scientific Publishing by Gerard Hebert, MA, and Daley Drucker, BA. No compensation was given beyond their regular salaries. We would also like to thank donors to the COVID-19 Fund at Moffitt Cancer Center for their generous support, which helped to fund research to improve the quality and cost savings offered through Virtual Health.

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SUPPLEMENT 1.

eMethods

eReferences

eTable. Demographics of Telehealth Visits Seen at Moffitt Cancer Center From April 1, 2020, to June 30, 2021

SUPPLEMENT 2.

Data Sharing Statement

Supplemental Online Content

Patel KB, Turner K, Tabriz AA, et al. Estimated indirect cost savings of using telehealth among nonelderly patients with cancer. *JAMA Netw Open*. 2023;6(1):e2250211. doi:10.1001/jamanetworkopen.2022.50211

eMethods

eReferences

eTable. Demographics of Telehealth Visits Seen at Moffitt Cancer Center From April 1, 2020, to June 30, 2021

This supplemental material has been provided by the authors to give readers additional information about their work.

eMethods:

Study Sample: This was a retrospective cohort study of patients, 18 – 65 years of age, seen at Moffitt Cancer Center (MCC), the only NCI designated cancer center in the state of Florida. Due to COVID-19 pandemic, implementation of telehealth at MCC was accelerated in March 2020. Telehealth was defined as care delivered through a videoconferencing platform in real-time. Starting in April 2020, MCC instituted Zoom platform for their telehealth visits. To determine potential travel savings, time savings and cost savings, data for patients with Florida addresses was used for telehealth visits from April 2020 to June 30, 2021. New patients were completely new to MCC, established patients had received care at MCC previously but were referred to a new sub-specialty for consultation, and follow-up patients were being seen for follow-up care by providers within the same sub-specialty. New patient and established patient visit times were similar and thus these categories were considered same.

Data analyses

Potential indirect cost savings was defined as round-trip cost savings arising from the use of telemedicine, calculated as the difference between the travel costs associated with traveling from the patient's home address to an in-person consultation at the MCC. This included 2 components: 1) cost of travel, and 2) potential loss of productivity due to the medical visit.

Potential time savings was defined as round-trip time savings arising from the use of telehealth, calculated as the difference between the time required to travel from the patient's home address to in-person consultation at the MCC plus the in-person consultation time vs. the time required to attend a telehealth visit from home i.e. time savings = roundtrip drive time + (time for in-person consultation – time for telehealth visit). Previous study has reported an average clinic time of 84 minutes, however there was no distinction between new patients or follow up appointments.¹ To more accurately, determine the potential time savings, institutional in person and telehealth mean duration of each visit types were used. Mean duration for in person visits were determined based on clinic cycle times (patient check in to patient check out) – 96.4 minutes for new/established visits and 58.1 minutes for follow up visits. Additional 30 minutes were added to each of these in person visits for parking. Thus, a new/established visit took 126.4 minutes (96.4 + 30 minutes) for new/established visits and 88.1 minutes (58.1 + 30 minutes) for follow up visits. Mean duration for telehealth visits were determined based on clinician's join time and log out time for the visit – 39.2 minutes for new/established visits and 22.1 minutes for follow up visits. The methodology for determining travel time was based on driving distance between patient's address listed in the chart and MCC (all totals were based on round trip drive time calculations). For patients with Florida addresses, we used the respective patient address as a driving departure point and for a small minority of the patients whose addresses were not available, zip codes were used as a point of origin for travel time and distance calculation. American Census Survey (ACS)² was used to determine census tract level data for hourly median income per year which was divided 2080 hours to determine the hourly wage. The census tract income data was then matched to the patient's address to get more accurate representation of hourly wages.

Potential travel savings was defined as round-trip distance savings arising from the use of telemedicine, calculated as the distance the patient would have traveled for an in-person consultation at the MCC. The methodology for determining the distance was based on patient's address listed in the chart. For patients with Florida addresses, we used the respective patient address as a driving departure point and Moffitt Cancer Center (MCC) as a final destination (all totals were based on round trip calculations). For those patients with postal office as their mailing address, zip code's centroid was used as driving departure point.

Cost of operating a vehicle was determined based on a) Internal Revenue Services' 2020 standard mileage rate of \$0.56/mile³, or b) American Automobile Association standard mileage rate of \$0.82/mile⁴ multiplied by distance travelled for each round trip.

Two different models were generated with a combination of two different mileage rates and hourly wage rate determined via ACS census tract level data.

Driving distance travelled in miles were calculated in October 2021 by Buxton Company (Fort Worth, TX)⁵, an analytics organization that uses Alteryx's⁶ analytic platform to provide geospatial data. Briefly, the locations are geocoded. Distance is calculated between the two geocoded locations by finding the route that results in the least amount of drive time between the two locations. Calculations for different models were conducted using R.⁷

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eTable 1. Demographics of Telehealth Visits Seen at Moffitt Cancer Center From April 1, 2020, to June 30, 2021

	All Patients			Patients under the age 65 yrs		
	NP/EP ^a	FU ^a	Total	NP/EP ^a	FU ^a	Total
Number of unique patients	7350	19 964	23 228	3795	10 049	11 688
Number of visits	8743	40 586	49 329	4525	20 971	25 496
Age (median, IQR)	65.0 (54.0 – 73.0)	65.0 (55.0 – 73.0)	65.0 (55.0 – 73.0)	55.0 (46.0 – 61.0)	55.0 (46.0 – 61.0)	55.0 (46.0 – 61.0)
Sex						
Males	3805	18 817	22 622	1660	8 174	9 834
Females	4938	21769	26 707	2865	12798	15 663
Insurance						
Private	3731	16 392	20 123	3415	15 028	18 443
Medicare	4184	20 572	24 756	420	2824	3244
Medicaid	338	1 808	2 146	319	1709	2028
Others	490	1 814	2 304	371	1410	1781
Race/Ethnicity						
Non-Hispanic Whites	6305	32 084	38 389	3018	15 342	18 360
Hispanic Whites	489	2378	2867	350	1677	2027
Blacks	465	2285	2750	315	1640	1955
Others	1484	3839	5323	842	2312	3154
Clinic Type						
Anesthesia		1415	1 15		887	887
BMT/Malignant Hematology	607	5079	5686	245	2183	2428
Breast	320	2205	2525	229	1482	1711
Cutaneous/Sarcoma	232	2571	2803	118	1318	1436
Endocrine/HN	403	3668	4071	273	2423	2696

Genetics	1766	1075	2841	1152	686	1838
GI Tumor	849	2846	3695	396	1284	1680
GU Oncology	504	3979	4483	196	1467	1663
Gyn	52	734	786	31	441	472
IHM/IM	246	1103	1349	120	539	659
Infectious Disease	63	142	205	33	69	102
Integrative Medicine	43	103	146	28	96	124
Interventional Pain	53	967	1 020	31	547	578
Interventional Radiology	283	257	540	119	75	194
Neuro Oncology	227	1904	2131	134	1284	1418
Rad Oncology	1128	2777	3905	478	1161	1639
Supportive Care Medicine	496	2939	3435	305	2099	2404
Survivorship	455	43	498	235	16	251
Thoracic Oncology	636	2113	2749	240	752	992
Others	379	4667	5046	161	2163	2324

Abbreviations: EP, existing patients referred to a different subspecialty; FU, follow-up patients; NP, new patient; SD, standard deviation.

^aA portion of patients will have both NP/EP and subsequent FU visits.

Renting or selling? Enhance your property value with fiber internet. (Part 1)

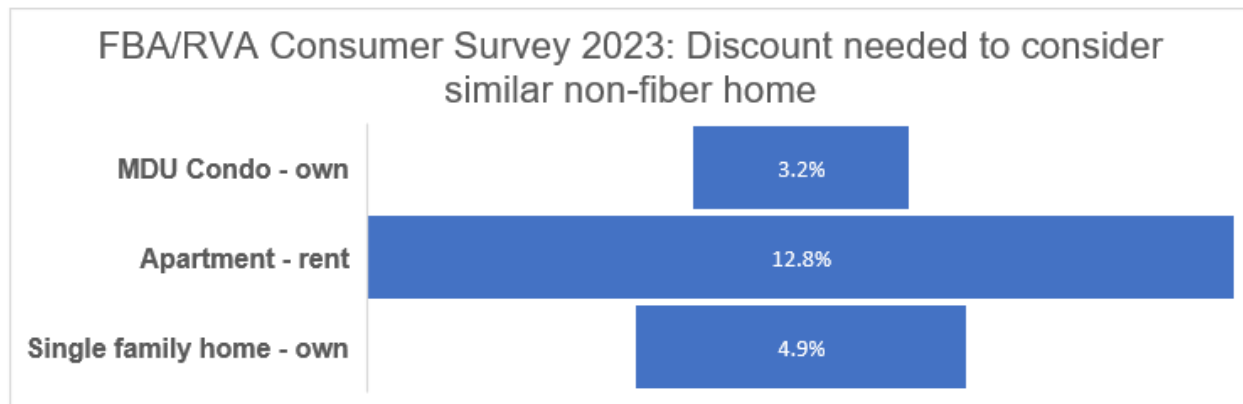
By Alice LaPlante



When it comes to property value, fiber internet—a highly sought-after broadband solution—can make a significant difference, whether fiber-to-the-home or fiber-to-the-unit. Fast connectivity is now an essential requirement for everyday life for most Americans. Whether working, playing games, or streaming, U.S. consumers expect high-speed broadband at home.

According to a 2023 consumer study by [Fiber Broadband Association \(FBA\) and RVA LLC Market Research and Consulting](#), shows that fiber-optic internet is the preferred connectivity technology for almost two-thirds of all internet users, outpacing both cable and wireless.

Not having fiber internet will negatively impact property value, according to additional insights from the same [study by FBA and RVA](#) showing that, on average, U.S. consumers would require a 4.9% reduction in price for a non-fiber-connected house, a 3.2% discount for a non-fiber condo, and 12.8% off for a non-fiber rental apartment.



Additionally, [fiber internet is the second most important feature buyers and renters look for in multifamily communities, according to the study:](#)

1. Laundry room / washer and dryer in unit
2. **High-speed fiber broadband**
3. Hardwood floors
4. Granite kitchens

[A 2023 study on Multifamily Living Trends Report](#) by Allegion, found residents of multifamily communities prefer free WiFi as the number one amenity over affordability and proximity to work and school. And 45 percent said free WiFi was a must-have amenity at their future residency. (Read more about rental income opportunities in [Part 2.](#))

Why is fiber in-demand?

Multifamily community owners and management firms, as well as homeowners understand [fiber's value as a long-term, future-proofed solution](#). Consumers themselves are [increasingly opting for fiber internet because of its ultra-fast speeds and reliability](#).

In fact, consumers who've tried other communications technologies opt for fiber internet as it becomes available in their areas. Of the 17% of consumers who switched internet providers over the past 24 months, **fiber had a net gain of 15 market share points, whereas cable had a loss of 14 share points**, as found by the FBA's report, [Fiber is Preferred by Nearly Two-Thirds of U.S. Consumers According to New Fiber Broadband Association Research](#). This is true even though cable services are two-times more available than fiber throughout most regions of the United States.

The reality is that not all internet connectivity technologies are created equal. [BroadbandNow](#) compares DSL, cable and fiber upload and download speed ranges. These speeds are non-symmetrical and do have an upload speed range of 20 Mbps for DSL and 50 Mbps for Cable. Yet no upload speed reaching 1Gig.

As Zachary Ebner, senior manager of product at [Quantum Fiber](#), explains, "Quantum Fiber offers residents the fast, reliable, and symmetrical internet speeds essential to their lifestyle on

our global fiber network. The term ‘fiber is future-proof’ can be seen in action today as we continue to enable residents to access even [more bandwidth – up to 8 Gig](#) in select locations. And, our fiber network is on the leading edge of what equipment and technology is capable of in the residential space today, and ready for the fast-approaching advancements of tomorrow.”

The latest outlook for the United States’ growing fiber network

Fiber internet deployments are on a sharp rise as the U.S. government, internet service providers (ISPs), and local cities and jurisdictions are determined to bring fiber to homes and offices across the country. Savvy homeowners and community builders will take note if not clued in already.



- In December 2023, the FBA shared the highlights of its [2023 North America Fiber Provider Survey](#), which found that the previous year had set a new record for the fastest annual fiber-to-the-home growth in history.
 - In the United States alone, this represented an increase of 13%, or 78 million homes.
- Billions of dollars are being spent on residential fiber networks.
 - The [Broadband Equity, Access, and Deployment \(BEAD\) program](#) is designed to upgrade “unserved” households and businesses with connectivity speeds of at least 100 Mbps.

- [A paper published in 2023 by the SSRN Journal](#) pointed out that the U.S. government has recently been pushing a fiber-first infrastructure policy across all 50 states, devoting \$42.45 billion to that effort.
- This move to fiber will inevitably increase the value of homes, [according to the SSRN Journal paper](#).
 - Estimates show that, nationally, the aggregate increase in housing value from fiber will add up to more than \$36 billion by the end of 2024.

Fiber is a gift that keeps on giving at rental communities. To find out how installing fiber-optic broadband can specifically improve community property rental income, read [Part 2](#).

Renting or selling? Enhance your property value with fiber internet. (Part 2)

By Alice LaPlante



Fiber-optic broadband is a boon for community property homeowners and builders. In [Part 1](#) we discuss how property value and fiber demands of consumers are on the rise. The expansion of fiber network infrastructure in the U.S. is fueled by fiber's future-proof capabilities, significant reliability, and durability.

What about landlords, property managers, and rental agents? Can they capitalize on fiber internet? The answer: A big affirmative. And even though the rental market has softened considerably in recent months. [According to Buildium's 2024 Property Management Industry Report](#), property managers still plan to increase rental revenues in the short term, despite a declining pool of qualified renters and an increasing supply of vacant properties.

Here are five ways they hope to do it:

1. 62% say by increasing rents/resident paid fees
2. 48% say by leveraging technology to drive efficiency
3. 40% say by expanding service offerings
4. 39% say by making value-add updates to properties
5. 38% say by increasing rates/client-paid fees

Investing in fiber-optic high-speed broadband plays a part in each of these rent-boosting tactics says Dan O'Connell, vice president of mass markets for Quantum Fiber.



"Community managers can hit all of these revenue-raising strategies with just a single action—choosing Quantum Fiber for end-to-end services. This starts with securing a bulk agreement for deploying fiber and pre-installing equipment to every home or unit to provide ongoing resident connectivity."

-Dan O'Connell, vice president of mass markets for Quantum Fiber

[A 2023 study on Multifamily Living Trends Report](#) by Allegion, found residents of multifamily communities **want free WiFi as the number one amenity** over affordability and proximity to work and school. And 45 percent said free WiFi was a must-have amenity at their future residency.

This means that installing fiber is one of the easiest—and most cost-effective—ways for property owners, HOAs, and management firms to add value to homes and apartments, both for sale and for rent.

The many ways fiber adds value to multifamily community properties

Consumers who've tried other communications technologies opt for fiber internet as it becomes available in their areas. Of the 17% of consumers who switched internet providers over the past 24 months, **fiber had a net gain of 15 market share points, whereas cable had a loss of 14 share points**, as found by the FBA's report, [Fiber is Preferred by Nearly Two-Thirds of U.S. Consumers According to New Fiber Broadband Association Research](#).

Here are some of the reasons why fiber-connected dwellings command a premium:

- **Functionality.** A home's communications infrastructure must support residents' increasing digital requirements—whether due to work, leisure, healthcare, education, or other lifestyle considerations. [Fiber's high symmetrical speeds](#) enable multiple household users to stream high-definition video, download and upload large files quickly, and easily work and play from their homes.
- **Reliability.** [Fiber internet is reliable](#). That's because fiber is buried underground, protected from damage against weather and other surface risks. Further, Quantum Fiber is built on a 99.9% reliable, based on network uptime or availability.
- **Low latency.** Latency is how long it takes for a packet of data to travel from one point to another. [Fiber internet has very low latency](#). This results in little lag when uploading large files, streaming video, or playing online games.
- **Sustainability.** [The Fiber Broadband Association estimates](#) that the performance of fiber-optic internet makes it possible for more people to work from home, resulting in a carbon-footprint savings equivalent to taking 11 million cars off the road every year. [With approximately 35% of Americans being offered the opportunity to work remotely](#) as of 2024, fast, secure, and reliable internet has become a must-have home amenity.
- **Future-proofed.** Currently, what fiber can do for consumers is limited based on today's technology of TVs, computers, laptops, and smart-connected devices. But as technology advances, fiber networks will be ready and capable of carrying more data at even faster speeds.

Fiber is a gift that keeps on giving, whether owning property in a multifamily community or a rental property. For more information about what Quantum Fiber can do for sales and rental values in your community, [contact a Quantum Fiber Connected Communities expert](#) to learn about connectivity solutions tailored to your multifamily community.

Check out these related resources:

- [Renting or selling? Enhance your property value with fiber internet. \(Part 1\)](#)
- [Why choose fiber internet for retrofitting commercial real-estate into residence](#)
- [Learn how WiFi 7 is a leap into next-gen community living.](#)



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Para presentar una queja en español, llamar al:
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[Consumer Complaints at the FCC](#)

Internet Form - Descriptions of Complaint Issues

If you have questions about a problem you are having with your Internet service and want to read more about common Internet issues raised with the FCC, see our [consumer guides](#).

If our consumer guides do not address your issue, another option is to file a complaint.

If you are having issues with your provider involving the Affordable Connectivity Program (ACP), please see additional information [here](#).

Please look carefully at the list of issues available on the complaint form. If you already know what issue you'd like to file a complaint about then:

[Start your complaint with the FCC](#)

Internet Issues on the Complaint Form

Availability

Services are not available in your area, issues with coverage areas or coverage maps.

Billing

Issues with your provider about advertised rates, service charges, taxes, fees, surcharges, lifeline.

Equipment

Issues with your modem, router, or other Internet equipment and related equipment.

Interference:

Issues with interference.

Privacy

Your personal information has been breached.

Speed

Issues with your Internet speeds, including not receiving advertised speeds or latency, issues.

[Start your complaint with the FCC](#)

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Chapter 7.16 RCW
CERTIORARI, MANDAMUS, AND PROHIBITION

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- 7.16.020 Judgment, motion, and order defined.

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IN GENERAL

- 7.16.330 When writs may be made returnable.
- 7.16.340 Rules of practice.
- 7.16.350 Appellate review.
- 7.16.360 Inapplicability to action reviewable under Administrative Procedure Act or Land Use Petition Act.

Rules of court: *Writ procedure superseded by RAP 2.1; special proceeding RAP 16.1 through 16.17.*

Camping resorts, writ of mandamus authorized: RCW 19.105.470.

RCW 7.16.010 Parties, how designated. The party prosecuting a special proceeding may be known as the plaintiff and the adverse party as the defendant. [1895 c 65 s 1; RRS s 999.]

RCW 7.16.020 Judgment, motion, and order defined. A judgment in a special proceeding is the final determination of the rights of the parties therein. The definitions of a motion and an order in a civil action are applicable to similar acts in a special proceeding. [1895 c 65 s 2; RRS s 1000.]

CERTIORARI

RCW 7.16.030 Certiorari defined. The writ of certiorari may be denominated the writ of review. [1895 c 65 s 3; RRS s 1001.]

RCW 7.16.040 Grounds for granting writ. A writ of review shall be granted by any court, except a municipal or district court, when an inferior tribunal, board or officer, exercising judicial functions, has exceeded the jurisdiction of such tribunal, board or officer, or one acting illegally, or to correct any erroneous or void proceeding, or a proceeding not according to the course of the common law, and there is no appeal, nor in the judgment of the court, any plain, speedy and adequate remedy at law. [1987 c 202 s 130; 1895 c 65 s 4; RRS s 1002.]

Intent—1987 c 202: See note following RCW 2.04.190.

RCW 7.16.050 Application for writ—Notice. The application must be made on affidavit by the party beneficially interested, and the court may require a notice of the application to be given to the adverse party, or may grant an order to show cause why it should not be allowed, or may grant the writ without notice. [1895 c 65 s 5; RRS s 1003.]

RCW 7.16.060 Writ, to whom directed. The writ may be directed to the inferior tribunal, board or officer, or to any other person having the custody of the record or proceedings to be certified. When directed to a tribunal the clerk, if there be one, must return the writ with the transcript required. [1895 c 65 s 6; RRS s 1004.]

RCW 7.16.070 Contents of writ. The writ of review must command the party to whom it is directed to certify fully to the court issuing the writ, at a specified time and place, a transcript of the record and proceedings (describing or referring to them with convenient certainty), that the same may be reviewed by the court, and requiring the party, in the meantime, to desist from further proceedings in the matter to be reviewed. [1895 c 65 s 7; RRS s 1005.]

RCW 7.16.080 Stay of proceedings. If a stay of proceedings be not intended, the words requiring the stay must be omitted from the writ. These words may be inserted or omitted, in the sound discretion of the court, but if omitted the power of the inferior court or office is not suspended or the proceedings stayed. [1895 c 65 s 8; RRS s 1006.]

RCW 7.16.100 Service of writ. The writ may be served as follows, except where different directions respecting the mode of service thereof are given by the court granting it:

(1) Where it is directed to a person or persons by name or by his or her official title or titles, or to a municipal corporation, it must be served upon each officer or other person to whom it is directed, or upon the corporation, in the same manner as a summons.

(2) Where it is directed to a court, or to the judges of a court, having a clerk appointed pursuant to law, service upon the court or the judges thereof may be made by filing the writ with the clerk. [1895 c 65 s 10; RRS s 1008.]

RCW 7.16.110 Defective return—Further return—Hearing—Judgment. If the return of the writ be defective, the court may order a further return to be made. When a full return has been made, the court must hear the parties, or such of them as may attend for that purpose, and may thereupon give judgment, either affirming or annulling or modifying the proceedings below. [1895 c 65 s 11; RRS s 1009.]

RCW 7.16.120 Questions involving merits to be determined. The questions involving the merits to be determined by the court upon the hearing are:

(1) Whether the body or officer had jurisdiction of the subject matter of the determination under review.

(2) Whether the authority, conferred upon the body or officer in relation to that subject matter, has been pursued in the mode required by law, in order to authorize it or to make the determination.

(3) Whether, in making the determination, any rule of law affecting the rights of the parties thereto has been violated to the prejudice of the relator.

(4) Whether there was any competent proof of all the facts necessary to be proved, in order to authorize the making of the determination.

(5) Whether the factual determinations were supported by substantial evidence. [1989 c 7 s 1; 1957 c 51 s 6; 1895 c 65 s 12; RRS s 1010.]

RCW 7.16.130 Copy of judgment to inferior tribunal, board, or officer. A copy of the judgment signed by the clerk, must be transmitted to the inferior tribunal, board or officer having the custody of the record or proceeding certified up. [1895 c 65 s 13; RRS s 1011.]

RCW 7.16.140 Judgment roll. A copy of the judgment signed by the clerk, entered upon or attached to the writ and return, constitute the judgment roll. [1895 c 65 s 14; RRS s 1012.]

MANDAMUS

RCW 7.16.150 Mandamus defined. The writ of mandamus may be denominated a writ of mandate. [1895 c 65 s 15; RRS s 1013.]

RCW 7.16.160 Grounds for granting writ. It may be issued by any court, except a district or municipal court, to any inferior tribunal, corporation, board or person, to compel the performance of an act which the law especially enjoins as a duty resulting from an office, trust or station, or to compel the admission of a party to the use and enjoyment of a right or office to which the party is entitled, and from which the party is unlawfully precluded by such inferior tribunal, corporation, board or person. [1987 c 202 s 131; 1987 c 3 s 3; 1895 c 65 s 16; RRS s 1014.]

Intent—1987 c 202: See note following RCW 2.04.190.

Severability—1987 c 3: See note following RCW 3.70.010.

RCW 7.16.170 Absence of remedy at law required—Affidavit. The writ must be issued in all cases where there is not a plain, speedy and adequate remedy in the ordinary course of law. It must be issued upon affidavit on the application of the party beneficially interested. [1895 c 65 s 17; RRS s 1015.]

RCW 7.16.180 Alternative or peremptory writs—Form. The writ may be either alternative or peremptory. The alternative writ must state generally the allegation against the party to whom it is directed, and command such party, immediately after the receipt of the writ, or at some other specified time, to do the act required to be performed, or to show cause before the court, at a specified time and place, why he or she has not done so. The peremptory writ must be in some similar form, except the words requiring the party to show cause why he or she has not done as commanded must be omitted and a return day inserted. [2011 c 336 s 165; 1895 c 65 s 18; RRS s 1016.]

RCW 7.16.190 Notice of application—No default. When the application to the court is made without notice to the party, and the writ be allowed, the alternative must be first issued; and if the application be upon due notice and the writ be allowed, the peremptory writ may be issued in the first instance. The notice of the application, when given, must be at least ten days. The writ cannot be granted by default. The case must be heard by the court, whether the adverse party appear or not. [1895 c 65 s 19; RRS s 1017.]

RCW 7.16.200 Answer. On the return of the alternative, or the day on which the application for the writ is noticed, the party on whom the writ or notice has been served may show cause by answer, under oath, made in the same manner as an answer to a complaint in a civil action. [1895 c 65 s 20; RRS s 1018.]

RCW 7.16.210 Questions of fact, how determined. If an answer be made which raises a question as to a matter of fact essential to the determination of the motion, and affecting the substantial rights of the parties, and upon the supposed truth of the allegation of which the application for the writ is based, the court may, in its discretion, order the question to be tried before a jury, and postpone the argument until such trial can be had, and the verdict certified to the court. The question to be tried must be distinctly stated in the order for trial, and the county must be designated in which the same shall be had. The order may also direct the jury to assess any damages which the appellant may have sustained, in case they find for him or her. [2011 c 336 s 166; 1895 c 65 s 21; RRS s 1019.]

RCW 7.16.220 Applicant may demur to answer or countervail it by proof. On the trial the applicant is not precluded by the answer from any valid objections to its sufficiency, and may countervail it by proof, either in direct denial or by way of avoidance. [1895 c 65 s 22; RRS s 1020.]

RCW 7.16.230 Motion for new trial, where made. The motion for new trial must be made in the court in which the issue of fact is tried. [1895 c 65 s 23; RRS s 1021.]

RCW 7.16.240 Certification of verdict—Argument. If no notice of a motion for a new trial be given, or if given, the motion be denied, the clerk, within five days after rendition of the verdict or denial of the motion, must transmit to the court in which the application for the writ is pending, a certified copy of the verdict attached to the order of trial, after which either party may bring on the argument of the application, upon reasonable notice to the adverse party. [1895 c 65 s 24; RRS s 1022.]

RCW 7.16.250 Hearing. If no answer be made, the case must be heard on the papers of the applicant. If the answer raises only questions of law, or puts in issue immaterial statements not affecting the substantial rights of the party, the court must proceed to hear or fix a day for hearing the argument of the case. [1895 c 65 s 25; RRS s 1023.]

RCW 7.16.260 Judgment for damages and costs—Peremptory mandate. If judgment be given for the applicant he or she may recover the damages which he or she has sustained, as found by the jury or as may be determined by the court or referee, upon a reference to be ordered, together with costs; and for such damages and costs an execution may

issue, and a peremptory mandate must also be awarded without delay. [2011 c 336 s 167; 1895 c 65 s 26; RRS s 1024.]

RCW 7.16.270 Service of writ. The writ must be served in the same manner as a summons in a civil action, except when otherwise expressly directed by order of the court. Service upon a majority of the members of any board or body is service upon the board or body, whether at the time of the service the board or body was in session or not. [1895 c 65 s 27; RRS s 1025.]

RCW 7.16.280 Enforcement of writ—Penalty. When a temporary mandate has been issued and directed to any inferior tribunal, corporation, board or person upon whom the writ has been personally served and such tribunal, corporation, board, or person has without just excuse, refused or neglected to obey the same, the court may, upon motion, impose a fine not exceeding one thousand dollars. In case of persistence in a refusal or disobedience, the court may order the party to be imprisoned until the writ is obeyed, and may make any orders necessary and proper for the complete enforcement of the writ. [1957 c 51 s 7; 1895 c 65 s 28; RRS s 1026.]

PROHIBITION

RCW 7.16.290 Prohibition defined. The writ of prohibition is the counterpart of the writ of mandate. It arrests the proceedings of any tribunal, corporation, board or person, when such proceedings are without or in excess of the jurisdiction of such tribunal, corporation, board or person. [1895 c 65 s 29; RRS s 1027.]

RCW 7.16.300 Grounds for granting writ—Affidavit. It may be issued by any court, except district or municipal courts, to an inferior tribunal, or to a corporation, board or person, in all cases where there is not a plain, speedy and adequate remedy in the ordinary course of law. It is issued upon affidavit, on the application of the person beneficially interested. [1987 c 202 s 132; 1895 c 65 s 30; RRS s 1028.]

Intent—1987 c 202: See note following RCW 2.04.190.

RCW 7.16.310 Alternative or peremptory writs—Form. The writ must be either alternative or peremptory. The alternative writ must state generally the allegations against the party to whom it is directed, and command such party to desist or refrain from further proceedings in the action or matter specified therein until the further order of the court from which it is issued, and to show cause before such court, at a specified time and place, why such party should not be absolutely restrained from any further proceedings in such action or matter. The peremptory writ must be in a similar form, except that the words requiring the party to show cause why he or she

should not be absolutely restrained, etc., must be omitted and a return day inserted. [2011 c 336 s 168; 1895 c 65 s 31; RRS s 1029.]

RCW 7.16.320 Provisions relating to mandate applicable. The provisions of this chapter relating to writ of mandate, apply to this proceeding. [1895 c 65 s 32; RRS s 1030.]

IN GENERAL

RCW 7.16.330 When writs may be made returnable. Writs of review, mandate, and prohibition issued by the supreme court, the court of appeals, or by a superior court, may, in the discretion of the court issuing the writ, be made returnable, and a hearing thereon be had at any time. [1971 c 81 s 29; 1895 c 65 s 33; RRS s 1031.]

RCW 7.16.340 Rules of practice. Except as otherwise provided in this chapter, the provisions of the code of procedure concerning civil actions are applicable to and constitute the rules of practice in the proceedings in this chapter. [1895 c 65 s 34; RRS s 1032.]

RCW 7.16.350 Appellate review. From a final judgment in the superior court, in any such proceeding, appellate review by the supreme court or the court of appeals may be sought as in other actions. [1988 c 202 s 4; 1971 c 81 s 30; 1895 c 65 s 35; RRS s 1033.]

Severability—1988 c 202: See note following RCW 2.24.050.

RCW 7.16.360 Inapplicability to action reviewable under Administrative Procedure Act or Land Use Petition Act. This chapter does not apply to state agency action reviewable under chapter 34.05 RCW or to land use decisions of local jurisdictions reviewable under chapter 36.70C RCW. [1995 c 347 s 716; 1989 c 175 s 38.]

Finding—Severability—Part headings and table of contents not law—1995 c 347: See notes following RCW 36.70A.470.

Effective date—1989 c 175: See note following RCW 34.05.010.