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11 CONNECT2HEALTHFCC TASK FORCE
12 VIRTUAL LISTENING SESSION - HEALTH CARE PROVIDER
13 FORUM

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22

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1 P R O C E E D I N G S

2 (1:33 p.m.)

3 OPERATOR: Ladies and gentlemen, thank
4 you for your patience in standing by. Welcome to
5 the Connect to Health FCC Virtual Listening
6 Session Healthcare Provider Forum. At this time
7 all of the participant phone lines are in a listen
8 only mode and later we'll have an opportunity for
9 comment.

10 At this time we'll begin the call with a
11 rollcall. We have the line of Lovisa Gustafsson
12 of the Commonwealth, we have Theresa Mingarell of
13 PAPUC, we have Carey Officer of Nemours
14 Children's, Oliver Spurgeon of NECHC, Jonathan
15 Bailey of Mission Health, Bill Jansen of
16 MetalQuest, Edward Miller of MD Anderson Cancer,
17 Michael Iaquinta from iSelect, Craig Jacobson of
18 Hobbs Straus & Dean, Beth Hahn of Flambeau
19 Hospital, Tracy Hines of CTN, Hank Fanberg of
20 CHRISTUS Health, Sean Grove, BJ Healthcare, Shane
21 Rodebaugh of Baptist Health, Jon Zasada of APCA,
22 and Verné Boerner of Alaska Native Health. With

1 us today from the FCC we also have Dr. David
2 Ahern, Dr. Chris Gibbons, Michele Ellison, Ben
3 Bartolome, Katie Gorscak, Louis Peraertz, Karen
4 Onyeije, and Dr. Kelly Murphy. At this time I'd
5 like to remind you that today's conference is
6 being recorded. If you would like to queue up for
7 a comment at any point in time you can always do
8 so by pressing * followed by 1. I'd now like to
9 turn the call over to our moderators, Dr. David
10 Ahern and Dr. Chris Gibbons.

11 DR. GIBBONS: Good afternoon, everyone.
12 My name is Dr. Chris Gibbons and along with Dr.
13 David Ahern, as you just heard, we will be
14 moderating this session today. Thank you so very
15 much for joining us.

16 The FCC and the Connect2HealthTaskforce
17 are particularly delighted that you decided to
18 join us today. We're really excited because it
19 provides us an opportunity to hear from a group of
20 very important stakeholders from which we don't
21 normally hear. That is the primary objective of
22 today, to hear from you.

1 So, as you will hear, this will proceed
2 largely allowing you the opportunity to comment
3 your thoughts and tell us your thoughts with
4 minimal or no comment. As time permits we may
5 towards the end have time for more open dialogue.
6 If you're not able to say everything that you
7 would like to say or let us know about please
8 email us or contact us. To provide those comments
9 our email is connect2health@fcc.gov. We will also
10 be sending out an email to each of you who
11 registered and are participating on the call
12 today.

13 Once again, thank you. And with that
14 I'll turn it over to my co-moderator, Dr. David
15 Ahern to get us going.

16 DR. AHERN: Thank you, Chris. I will
17 echo Chris' comments. We appreciate you taking
18 the time out of your busy schedules to join us
19 today for the Connect2Health FCC Listening Session
20 for Healthcare Providers. We're very excited to
21 have the opportunity for you to share your
22 experiences in the work that you're doing in your

1 organizations and in your communities.

2 As Chris mentioned, we're really wanting
3 to hear from you. So, the format is to have each
4 of you queue up to share your comments with us.
5 We have about 25 or 26 participants on the call
6 today which is great. That means that we will
7 have to limit though the time that's available to
8 each of you. So, I would ask you to be both
9 concise and succinct with your comments, but as
10 Chris mentioned we want to hear from you in
11 addition in writing if there are other items you
12 want to share with us.

13 With that, I think we can go ahead to
14 see who has queued up first, if we have someone
15 who has joined to speak. If not we'd ask you to
16 do *1, I believe it is, to enter the queue because
17 we're very interested in hearing your comments and
18 your experiences. So, let's see if we can get
19 that process going. You'll get into the queue in
20 sequence and then have an opportunity to speak.

21 Who wants to be first? Hank, I know
22 you're there.

1 OPERATOR: Our first comes from the line
2 of Hank Fanberg of CHRISTUS Health. Your line is
3 open.

4 MR. FANBERG: You beat me to it, David.
5 First, thank you for the opportunity to provide
6 some comments and thoughts for a very important
7 program and need.

8 A little bit of background. CHRISTUS
9 Health is a large Catholic Health System. We
10 operate in six states and three Latin American
11 countries -- but we won't worry about those for
12 the time being -- corporate office is in Dallas,
13 and we have hospitals throughout the state of
14 Louisiana and Texas. Some of you may have a
15 recollection that in about two weeks' time we will
16 be celebrating the 12th anniversary of a little
17 event called Hurricane Katrina. It was in the
18 aftermath of Hurricane Katrina that I had my first
19 interaction with the FCC and USAC because we had a
20 number of hospitals that were directly in the path
21 of Katrina and then Rita three weeks later. Both
22 the FCC and USAC were instrumental in helping us

1 to restore our communications functions.

2 But beyond that, I think there are a
3 couple of things. I've also had the opportunity
4 to be the project coordinator for the FCC Rural
5 Healthcare Pilot Program in Texas which actually
6 started about 10 years ago, it's officially over.
7 I think that provided me some additional insight
8 into the importance of broadband because it really
9 is the forgotten foundation of everything that we
10 want to do. Healthcare is rapidly adopting
11 different platforms, new platforms in terms of
12 delivery, telehealth is becoming more and more
13 prevalent even though there may be some
14 reimbursement challenges still to deliver.

15 And that change is happening very, very
16 quickly, and the rate of change, and how we are
17 providing care, and the tools that we are using to
18 provide care is happening at a faster rate than
19 the regulatory bodies are able to do as well.

20 So, I have a couple of thoughts on a
21 couple of ideas. Number one, we know that from
22 our own experience at CHRISTUS we have geographies

1 where there may not be any broadband available and
2 sometimes that includes cellular in some of our
3 rural and frontier areas in Texas. Number two,
4 actually within your heavily populated cities
5 there are also pockets where access is limited
6 which is probably more of an economic reason than
7 availability. Number three, the needs for speed,
8 broadband speed, circuit speed, has increased as
9 we continue to leverage telehealth to provide
10 initial consultations in emergency departments in
11 the rural facilities where you may be sending
12 images -- not just data but images and video --
13 and T1 lines are totally insufficient for that but
14 the infrastructure to do more than that may be
15 lacking. Number four, we are sending patients
16 home and we are monitoring them post-discharge.
17 This was brought about in part by the need to keep
18 people out of the hospital for the admission rate
19 with CMS and remote monitoring of this type is
20 something which has not really been -- anything
21 into the home has not been something that really
22 has been addressed by the FCC through the

1 Healthcare Connect Program.

2 So, I think it would be a wonderful idea
3 if the FCC could take on some innovation
4 activities and begin to seed some new ways, some
5 innovative ways, of leveraging broadband so we are
6 able to connect provider-to-provider, provider-to-
7 patient and really have an impact by being able to
8 deliver care to where people are. We're becoming
9 a mobile society and we need to follow that. I'll
10 take a breath and stop now.

11 DR. AHERN: Thank you so much. That was
12 really very helpful to us and we appreciate your
13 experiences. I would just take this moment to
14 remind our participants that the questions that
15 you were sent on that two-page document, the
16 Broadband Health Technology Public Notice, any of
17 those questions we're interested in feedback and
18 your experiences, so that's a reference for you.

19 Again, I want to remind the participants
20 that in order to be on the queue to share your
21 experiences you do need to press *1 and we're now
22 beginning to see that which is great. So, let me

1 turn it over to Justin. If you would ask the next
2 participant to identify themselves.

3 OPERATOR: Absolutely. Our next
4 participant is Jon Zasada of APCA. Your line is
5 open.

6 MR. ZASADA: Good morning. My name is
7 Jon Zasada, I am the Policy Director for the
8 Alaska Primary Care Association. We support the
9 operations and development of Alaska's federally
10 qualified health centers. My tact for responding
11 to this was to have a couple of bullet points for
12 each of the questions.

13 A little bit about us. Federally
14 qualified health centers in Alaska, there are 25
15 organizations, 169 sites. Of those 169 sites, 156
16 of them received USAC RHC broadband subsidies to
17 the tune of a requested \$88 million in 2016. It
18 is one of the largest expenses for the health
19 centers that we serve. Alaska's health centers
20 are spread throughout the state of Alaska in
21 communities large and small, tribal and
22 non-tribal.

1 The primary challenges for providing
2 rural and frontier care in Alaska include reliable
3 workforce, small communities, distance of regional
4 health facilities, and a range of others. The use
5 of broadband technology in Alaska's rural health
6 centers includes telehealth visits between small
7 health centers or community-based sites including
8 schools and other facilities, cloud-based
9 electronic health records and prescription
10 systems, use of contracted imaging for sonograms,
11 x-rays, and other services related. We have one
12 health center that provides a virtual emergency
13 room with a dedicated connection to the largest
14 regional hospital in Alaska, based in Anchorage at
15 a distance of 1,300 miles between the health
16 center and the hospital. There is also limited
17 use of in-home monitoring.

18 In terms of the future uses that you
19 requested, the state of Alaska did engage in an
20 omnibus Medicaid redesign in 2016 that has
21 resulted in a relaxing and expansion of licensure
22 and other issues to allow an expansion of billable

1 telehealth services, especially behavioral. I
2 think looking into the future also additional
3 opportunities for patients to do self-monitoring
4 and reporting for care coordination and case
5 management with distant providers.

6 Then, finally, one other future use
7 would be the new VA telehealth initiative that is
8 scheduled to rollout in Alaska later this year.
9 And I personally have some worries that in its
10 rollout many of the potential users might not have
11 the speed of broadband adequacy on their personal
12 devices to take full advantage of that, and I do
13 think it would be a shame if expectations there
14 are not managed.

15 In terms of health providers' technical
16 requirements and needs, right now, I'll be real
17 honest, I think we're very happy with what we can
18 get and are always trying to secure the minimum
19 FCC adequate access of 10 upload 3 download. I
20 will be submitting additional information
21 following this conference with comments from the
22 IT staffs in a number of our health centers.

1 The non-technical issues related to
2 broadband adoption, I would say really the primary
3 impediment at this point in time is a looming
4 sense of financial risk if the subsidies of the
5 RHC Program are not reliable in the future. I
6 think you could see small providers looking twice
7 at the dedicated broadband that they're currently
8 using if they think that they're going to have to
9 pay an increased amount of that cost in the
10 future.

11 All that being said, many health centers
12 in Alaska are fully engaged, have built up their
13 systems based on reliable, dedicated broadband
14 with speeds as fast as they can get in the
15 communities where they are and with the past
16 knowledge that the subsidies necessary have been
17 available.

18 In terms of finally increasing public
19 awareness about the availability of benefits of
20 broadband as they relate to health in rural areas,
21 at least in the state of Alaska I think it would
22 be important for the FCC to help bridge the divide

1 of knowledge between the E-Rate Program and the
2 Rural Health Program. When we speak with Alaska
3 legislators they don't necessarily see the
4 connection between the two programs and how they
5 operate and I think going forward that could be
6 valuable.

7 And I also think that increased outreach
8 between the FCC and municipalities in the state
9 government could be very important. I know that
10 during our last legislative session a group of
11 rural health broadband advocates are working on
12 getting a resolution of support for modernization
13 of the RHC Program, and again, additional outreach
14 from the FCC would be valuable in that process.
15 That concludes my comments. We very much
16 appreciate these listening sessions.

17 DR. AHERN: Thank you, Jon. That was
18 fabulous. We really appreciate you providing
19 responses to all of the questions and obviously
20 very thoughtfully putting the time into that. We
21 particularly liked that you're balancing sort of
22 the challenges and the barriers that you've

1 experienced but also some of the bright spots in
2 Alaska, and I think that's important for us to
3 hear and to document.

4 Again, I would remind our participants
5 that this is an opportunity for you to communicate
6 to us what are some of the important areas that
7 you want us to highlight, what the FCC can do to
8 address some of the challenges that you're
9 experiencing in your particular areas of the
10 country. In order to do that we need to have you
11 do *1 and please tell us your story. With that, I
12 will ask Justin if you would introduce the next
13 speaker.

14 OPERATOR: Absolutely. Next we will go
15 to the line of Jonathan Bailey of Mission Health.
16 Your line is open.

17 MR. BAILEY: Good afternoon, and thank
18 you for allowing us to have this opportunity.
19 It's a great opportunity to not only hear what's
20 going on but to share some thoughts. I appreciate
21 your time.

22 My name is Jonathan Bailey, I serve as

1 the Chief Program Development Officer for Mission
2 Health. We are a seven hospital health system
3 located in western North Carolina and we are
4 headquartered out of Asheville, North Carolina.
5 And we have the unique opportunity of really
6 providing care as the region's only tertiary
7 referral center to both very rural areas that are
8 geographically dispersed as well as metropolitan
9 areas that suffer some areas of lower-income
10 impoverished areas that don't always have the
11 financial means to be able to afford access to
12 broadband technologies.

13 We've taken a very, very aggressive
14 approach into the work of expanding virtual care
15 and telehealth offerings throughout western North
16 Carolina. As we look at the future, as we think
17 about healthcare delivery, our view is that we
18 need to accelerate this and to really help
19 leverage the use of broadband and the assistance
20 of the FCC to continue to help us be able to reach
21 these rural areas, particularly in counties that
22 are anywhere between 0 to 20 percent of coverages

1 for download and upload speeds and to be able to
2 help leverage this health technology so that we
3 can really take powerful impact to lowering our
4 overall cost of the healthcare delivery system.
5 We're currently offering virtual care services in
6 20 different clinical specialties and are touching
7 about 10,000 patients per year. And through
8 audio/video connectivity, we do a lot in
9 behavioral health and some of the higher acute
10 areas, but we know the opportunity out there to
11 touch and impact lives is significantly greater.
12 Just as was talked to by I think Hank, relative to
13 our ability to connect with patients in different
14 locations there are some areas in particular that
15 we believe the FCC could be helpful to enable
16 further reach, and that is in areas such as
17 schools. The ability to reach different school
18 locations and help to ensure the broadband access
19 and the connectivities are there in all the
20 different schools is essential to ensure we can
21 connect with those school-based telemedicine
22 programs.

1 And also really the home. I think in
2 the commentary, in the initial handout, was this
3 "hospital in the home." We believe that's a huge
4 opportunity going forward where patients in the
5 future will be admitted to their home, but that
6 means the home has to have the right kind of
7 connectivity so that we can have the monitoring
8 and the ability to get into that home, to be able
9 to know where the patient is in their clinical
10 recovery basis and that the interventions we're
11 taking are actually making an impact. That's
12 probably I think one of the biggest areas of
13 opportunity where we are struggling.

14 I think number three on there was
15 non-technical issues in promoting broadband
16 adoption. I think there are opportunities for
17 crossover amongst our federal agencies to better
18 enable and remove the barriers that are in place
19 today, in particular the geographic barriers that
20 are in place today through CMS that create a
21 disincentive from a financial reimbursement
22 standpoint when we're trying to connect with

1 patients in these urban areas. While they're
2 urban in nature that doesn't take away the
3 disparities that many of these individuals that
4 live in those areas experience and their struggle
5 to be able to pay for broadband and to be able to
6 access healthcare services.

7 I think just further awareness in
8 expanding the information around how critical the
9 nature is, both to the public and to our various
10 legislators and policymakers is of critical
11 importance. So, with that I'll stop, and, again,
12 thank you so much for this opportunity.

13 DR. AHERN: That's wonderful. Thank
14 you, Jonathan. Just as a follow-up question, if I
15 may for you, particularly around the hospital in
16 the home concept, could you explain a little
17 further about that for our participants who may
18 not be as familiar with that concept?

19 MR. BAILEY: Sure. So, this has been
20 tested out in the EU as well as it's very popular
21 in Australia and it actually made its way to the
22 U.S. Johns Hopkins has done quite a bit in this

1 area. But in essence the concept is instead when
2 a patient may show up to the emergency department
3 or a physician would have otherwise admitted a
4 patient to the hospital for some sort of treatment
5 or observation, enabling that that patient --
6 let's just take a patient that comes through our
7 emergency department, that they would instead be
8 admitted to their home, transferred to the home,
9 and outfitted with the various technological
10 peripherals, the monitoring equipment to be
11 monitored by a central agency, and have frequent
12 nursing visits and they come and check on a
13 patient firsthand, but the physicians and other
14 care providers would be able to remotely connect
15 in with the patient to be able to see what's going
16 on with their physiological monitoring and/or be
17 able to talk with the patient directly using
18 two-way audio/video, and then be able to make
19 interventions and decisions based on that. It
20 will help alleviate the need for the expensive
21 hospital beds that we have so vastly across the
22 country.

1 DR. AHERN: Fantastic. Thank you,
2 Jonathan, really appreciate you explaining further
3 your experience with that concept. If there are
4 other participants when their opportunity to
5 comment comes up they want to talk further about
6 that, that's great. Let me ask Justin if he would
7 again go to the next participant in the queue.

8 OPERATOR: Certainly. We have Beth Hahn
9 of Flambeau Hospital. Your line is open.

10 MS. HAHN: Hi. I am part of a community
11 group that is currently participating in a pilot
12 project through the University of Wisconsin
13 extension broadband expansion. Our pilot project
14 is connected aging communities. We are located in
15 a very rural area of northern Wisconsin. We are a
16 community group comprised of community members
17 from hospital and clinic providers, health and
18 human services including the aging unit providers
19 and our local broadband provider.

20 What we are looking at is ways to get
21 seniors connected. One of the focuses of our
22 group, we have several different focuses but the

1 main one that we're looking at is telehealth,
2 telemonitoring, how can we get seniors connected
3 in northern Wisconsin to their healthcare
4 providers, that might be home health providers
5 trying to monitor patients following a hospital
6 stay or the hospital trying to prevent a hospital
7 readmission has been addressed previously.

8 Connectivity in our area is definitely
9 an issue, reliability and speed from patients'
10 homes and even sometimes with the healthcare
11 providers travelling into the field, and how do we
12 get seniors to want to be connected for health
13 issues or just for social media. We're trying to
14 figure out different ways to get seniors to feel
15 that this would be a valuable service for them to
16 have in their home.

17 Our broadband provider has been trying
18 to expand availability in our local counties by
19 providing more fiber optics and laying more fiber
20 optics but that's always a cost to that provider.
21 So, looking at ways that broadband can be adapted,
22 specifically with my focus on the healthcare

1 settings, and how do we get people connected, and
2 then is there funding availability once we talk
3 them into being connected then how do we get them
4 to be able to utilize the services that we're
5 trying to provide to them.

6 So, it's a totally voluntary community
7 group that's trying to figure out ways to utilize
8 this within our organizations and for the good of
9 the community. I'm hoping that some of the
10 information that I'll receive today on the
11 listening session is some insight into additional
12 funding opportunities that we can continue to do
13 this group after our two-year pilot project is
14 over which is minimal funding. But just trying to
15 get out there and explore opportunities for our
16 seniors and people within our healthcare community
17 as a whole.

18 So, I appreciate the listening session
19 and I've already learned a lot from what I've
20 heard, so very interesting. Thank you.

21 DR. AHERN: Thank you, Beth. Actually,
22 one brief follow-up question, if I may. Of the

1 monitors that you're using to connect seniors in
2 your project do you know if they're wireless?
3 What are the sort of technical communication
4 aspects of it, do you know?

5 MS. HAHN: What we're looking at right
6 now and what we're utilizing is they are not
7 wireless, they are wired just because of the
8 connectivity within patients' homes. We're just
9 doing it by an internet connection. Right now
10 we're also looking at patients being able to get a
11 smartphone or utilize a smartphone or some type of
12 an iPad system if they have availability to
13 wireless within their homes. But right now we're
14 just trying to do it with fixed.

15 DR. AHERN: Thank you, Beth. Appreciate
16 that. Before we move on, we've actually had a
17 number of additional participants join the call
18 since we began. Justin, I wonder if you could
19 introduce those additional participants before we
20 proceed with the queue?

21 OPERATOR: Certainly. We have been
22 joined by Ken Stigen of RCMH, Seva Kumar of WSHA,

1 Jonathan Bailey of Mission Health, and Craig
2 Jacobson of Hobbs Straus & Dean.

3 DR. AHERN: Great, thank you, Justin.
4 Again, for those that have just joined this is an
5 opportunity for you as participants to share your
6 experiences with the Connect2Health FCC Taskforce.
7 The questions that were sent to you, the two-page
8 document, are the questions that we are
9 particularly interested in hearing your
10 experiences about, but any areas that you want to
11 focus on in telling our story to us would be
12 greatly appreciated. In order to do that we need
13 to have you press *1 on your phone so that you can
14 get into the queue. We're trying to see if we can
15 build this queue up to make sure that we have as
16 many participants joining in on the conversation
17 today.

18 I know this is a little bit different
19 than perhaps other calls that you've had where
20 it's been more of a discussion and we will have an
21 opportunity to do that before we conclude our
22 session today. But please do *1 and you'll be put

1 into the queue for you to be able to share your
2 comments.

3 Justin, I do think we have another
4 participant ready to contribute.

5 OPERATOR: Absolutely. Next we go to
6 the line of Michael Iaquinta, of iSelect MD. Your
7 line is open.

8 MR. IAQUINTA: Thank you. I'd like to
9 thank the FCC for allowing us this forum. This is
10 really great and obviously well-attended.

11 Once again, my name is Michael Iaquinta,
12 I'm with iSelect MD. We focus on two areas. The
13 first is delivering telemedicine services either
14 through voice or video utilizing broadband
15 technology to folks in rural areas for either
16 primary care and one of the new things that we've
17 been developing over the last six to eight months
18 is Obnet which is recovery and treatment for the
19 opioid challenges we have. We do that through
20 outpatient-based medication assisted treatment.

21 So, the challenges that we see, first of
22 all the uncertainty whether the Affordable Care

1 Act and obviously repeal and replace, high
2 deductible programs that impact lower-income
3 folks, broadband users in rural areas, and also
4 the looming and physician shortages that we're
5 seeing. So, what I wanted to share was, once
6 again, some of the things that we're doing and how
7 the FCC and healthcare providers that focus on
8 broadband delivery methods can help reduce cost
9 and improve access to areas of care.

10 So, right now, our company has five
11 different wireless carriers that we deliver mobile
12 health services to, and we see a significant
13 decrease in cost directly associated with
14 procedures but also more importantly
15 pharmaceutical costs. Because we are what I refer
16 to as symptom and patient specific, when you go
17 into a setting typically you might be prescribed
18 multiple different medications even though you may
19 have gone in there for an ear infection. So,
20 we're seeing significant reduction in
21 pharmaceutical costs to insurance companies, to
22 patients, subscribers.

1 On the opioid treatment and recovery
2 what we're seeing is in many cases there are
3 two things that really stick out. First of all,
4 in seeking treatment a lot of times with how this
5 has exploded is there's a three- to six-month wait
6 before somebody that recognizes they have a
7 problem can then get in to be treated. Through
8 bidirectional video we can triage those broadband
9 utilizers face-to-face and in real- time, and in a
10 lot cases get them the medications they need to
11 augment the withdrawal they may be experiencing.
12 We treated a nurse the other day that came forward
13 and was able to really get her on the road to
14 treatment and recovery.

15 The second thing is we see that
16 embarrassment aspect where if somebody wants to
17 show up at a physical location they're there with
18 other people in the community. So, we've really
19 created an opportunity for people to have the
20 confidentiality, privacy, and the access to
21 treatment on the opioid issues.

22 The other thing is that a byproduct of

1 this, what we're seeing is a lot of the
2 pharmaceutical players scale back on how freely
3 opioids are getting to the broadband user. What
4 we've done here is we've seen a transition from
5 opioids to heroin and the new drug is now
6 fentanyl, so when the opioids dry up we see them
7 migrate to that.

8 I think there's a number of ways that
9 the FCC through pilot programs and funding can
10 help improve access to care, especially in the
11 rural areas for those two things: Primary care
12 and for opioid addiction treatment and recovery.

13 DR. AHERN: Thank you, Michael. Dr.
14 Gibbons has a follow-up question.

15 DR. GIBBONS: Well, it actually wasn't a
16 follow-up question. I think these have been
17 fantastic comments so I just wanted to reiterate
18 my thanks for you offering them. I know we also
19 have some participants who may not work for
20 provider organizations, hospitals, health systems
21 directly but they work in the area supporting,
22 doing research, doing other things. We'd also

1 love to hear from the perspectives of those
2 organizations, philanthropies, think tanks and
3 others who are on the call telling us what they're
4 doing, what they're seeing, what they're learning
5 as well. So, I just wanted to reiterate that
6 point. Thanks so much.

7 DR. AHERN: Thank you, Chris. On that
8 note, again, I would mention that in order to
9 share your comments we need you to press *1 on
10 your phone and that will put you in the queue.
11 Right now there's a short list so you really don't
12 have to wait long to be able to share your
13 comments. We really would appreciate it if you
14 would do *1. And, again, it can be as long or as
15 short now as you choose, but we're very interested
16 in hearing from you on the call today.

17 Justin, if you would ask the next person
18 to comment.

19 OPERATOR: Certainly. Our next comment
20 comes from the line of Verné Boerner of Alaska
21 Native Health Board.

22 MS. BOERNER: Hello, can you hear me?

1 OPERATOR: Yes.

2 MS. BOERNER: Oh, great. Hi this is
3 Verné Boerner, President and CEO for the Alaska
4 Native Health Board. I want to thank the FCC for
5 the opportunity to participate in these listening
6 sessions. Broadband is quite critical to the
7 Alaska tribal health system overall.

8 The Alaska Native Health Board is an
9 advocacy organization supporting the Alaska tribal
10 health system and supports 229 tribes and over
11 158,000 American Indians and Alaskan natives and
12 thousands more. The Alaskan tribal health system
13 is a critical part of the Alaska public health
14 system, often the tribal health facilities are the
15 only access to care in those rural and frontier
16 communities.

17 Alaska has over 660,000 square miles and
18 a very sparse road system. In many cases we can
19 only reach the communities by air, water, or on
20 snow machine in the winter. So, having access to
21 telehealth has been a critical part of our care
22 and one that has been developed early on, and

1 broadband has become an integral part of that
2 system of care.

3 So, telemedicine has allowed our members
4 to dramatically improve access to care, accelerate
5 diagnosis and treatment, avoid unnecessary
6 medevacs which cost tens of thousands of dollars,
7 and they expand local treatment options as well.
8 Alaska has been quite innovative in developing
9 (inaudible), in partnership, and with the
10 utilization of the Rural Healthcare Program, has
11 been able to also greatly improve medication
12 management, reduce hospital readmittance, increase
13 patient safety, and bring a sense of security for
14 those who manage patients' care. Those are just a
15 few examples of how technology has been leveraged
16 in the state.

17 I also wanted to take a brief moment to
18 endorse and agree with the comments that were
19 already provided by Jon Zasada with the Alaska
20 Primary Care Association. He did a great job in
21 identifying some of the specific uses with x-rays
22 and cloud-based storage and virtual emergency

1 room. Those are just great examples here.

2 One of the challenges that we have seen
3 of recent too in thinking about the sort of
4 non-technical issues is the recent proration of
5 the Rural Healthcare Program. That has acted to
6 destabilize some of our efforts because the
7 broadband is not just part of telehealth, it goes
8 to the total infrastructure of how we provide
9 services. It helps us meet reporting requirements
10 and compliance issues that affect our delivery of
11 care but also our ability to bill and feasibility
12 of our programs overall. Similar to the community
13 health centers, the Indian Health Service just
14 funded facilities are not able to raise our
15 service rates to compensate for any increase in
16 cost due to that proration. So, finding a long-
17 term solution is something that is critical to
18 help support the advances that have been made for
19 providing care in rural and frontier communities
20 overall.

21 As far as increasing public awareness,
22 the FCC doesn't need me to tell it that in many

1 rural areas in Alaska many of the community
2 members and communities themselves lack access to
3 high-speed broadband, upwards of 80 percent and in
4 some cases more. Having that general lack of
5 access to broadband is a barrier to help increase
6 the public awareness of the benefits that it
7 brings. So, thinking about different ways that we
8 can utilize the infrastructures that are already
9 there and maybe underutilized to help increase
10 that access generally is one way to help raise
11 awareness.

12 And then as far as requests for research
13 and case studies, Alaska has 229 tribes and
14 660,000 square miles to offer many, many
15 opportunities for research and case studies, and
16 we would definitely like to be a part of that.
17 Thank you.

18 DR. AHERN: Thank you, Verné. That was
19 very helpful and I appreciate your comments.

20 Are there any other participants who
21 would like to make any introductory comments where
22 we can have the line available to them? We can

1 take a moment to see if anybody else wants to
2 press *1. If not, we can open all of the lines
3 for general discussion and we can begin with a few
4 questions. But this is, again, an opportunity for
5 any of the participants to tell us a bit about
6 your experience in the area you're in with your
7 organization. So, one last request for *1 for any
8 of our participants.

9 Thank you. Justin, if you would go
10 ahead and have our participant be introduced.

11 OPERATOR: Certainly, thank you. We
12 have Carey Officer with Nemours Children's. Your
13 line is open.

14 MS. OFFICER: Thank you so much for the
15 opportunity to speak and tell you a little bit
16 about what we're doing.

17 So, we come from a little bit different
18 perspective from the fact that Nemours is actually
19 an organization fully dedicated to pediatrics. We
20 have two free-standing children's health systems,
21 one hospital in Orlando, Florida, and one in
22 Wilmington, Delaware, and then also service many

1 of the (inaudible) surrounding that area. I agree
2 with a lot of the comments that have been said up
3 to this point. We currently -- my role in Nemours
4 is as the telehealth administrator. We are doing
5 quite a bit in this field. We are serving
6 children who have acute care needs to chronic care
7 needs within the home, within the school, and even
8 on cruise ships. And we're doing quite a bit of
9 work with primary care organizations and also
10 other community hospitals and health systems.

11 One of our biggest challenges is that we
12 do service a large Medicaid population. While we
13 service many urban areas, a lot of these families
14 don't have access due to the cost of the services.
15 So, that's one of our biggest hurdles, if you
16 will, enabling and allowing us to be able to
17 provide the telehealth services into those
18 settings where they may not have access.

19 So, we're excited about the opportunity
20 not only in the urban settings but also in rural
21 settings to begin to think about what we can do
22 and how we can have a better exchange within the

1 home so that our providers can provide these
2 services into those locations. Many of our
3 patients and families travel many miles in order
4 to access this care, so we think it's very, very
5 important and relevant at this point in time to be
6 able to have this discussion today and really
7 think about what we can do in order to improve the
8 connectivity. So, thank you very much for the
9 opportunity to speak.

10 DR. AHERN: Thank you, Carey. We really
11 appreciate your input. One quick follow-up
12 question, if I may. Of the services that you
13 described, how much of it is wireless would you
14 estimate?

15 MS. OFFICER: Probably over 50 percent.
16 We have found that really works better in the home
17 setting and we have found it to be difficult in
18 other settings like schools. So, we're a little
19 bit challenged from a wireless perspective to have
20 that kind of access so we try to go hard wire
21 wherever we can. We have found that the
22 connectivity especially from a video perspective

1 has been better.

2 DR. AHERN: Great, thank you, Carey.
3 Justin, if you could queue up the next
4 participant.

5 OPERATOR: Certainly. Next we'll go to
6 the line of Bill Jansen of MetalQuest. Your line
7 is open.

8 MR. JANSEN: Good afternoon. Thank you
9 for having me. I'll try to be as eloquent as my
10 colleagues and as concise and succinct.

11 When I originally applied for the
12 listening session, what does MetalQuest have to do
13 with healthcare? Such an odd name. Well,
14 actually, one of the big parts of our business is
15 operating as a trustee for bankrupt healthcare
16 providers, whether it's a large urban center, a
17 critical access hospital, or an individual
18 provider. So, we see every day the need for
19 broadband, just connectivity in general,
20 especially in rural areas or areas where people
21 are more economically challenged.

22 So, we deliver historical data and we

1 deliver real- time data, but oftentimes we can't
2 deliver the data for someone who needs to undergo
3 a test. So, if we had that broadband -- whenever
4 the person is educated enough to use -- we can cut
5 costs tremendously across the country in terms of
6 invasive tests, tests of any kind, and just
7 generally the patient would be happier knowing
8 that they can access their data. So, access to
9 data is critical.

10 We also have the same problem with
11 hospitals. Hospitals will call us, or a provider
12 will call us, they need access to data. We may
13 have a lot of imaging data, but we can't
14 effectively deliver in real-time to, say, a rural
15 facility.

16 So, those are the big challenges that we
17 see every day, and there is definitely a digital
18 divide. We especially see this with low-income
19 and we see it with the elderly population; they
20 just don't know how to use the technology to take
21 care of their healthcare needs. So, that's all I
22 have and thank you.

1 DR. AHERN: Thank you, Bill, that was
2 very helpful. I do have a follow-up question. I
3 think there is a major concern among the provider
4 community about some of the uncertainty with
5 coverage and the implications of changing
6 healthcare insurance policies in terms of impact
7 on providers. So, are you seeing more and more
8 risk for providers as a consequence?

9 MR. JANSEN: Absolutely. I had that
10 conversation today. Changing reimbursement has
11 put especially smaller providers, rural providers,
12 at risk. Large urban providers, it puts them at
13 risk. A lot of that is because the population
14 they serve, they're indigent or they're receiving
15 Medicare, Medicaid or their insurance policies
16 just don't pay enough.

17 So, one thing that's kind of
18 interesting..., if you believe the data, there
19 will be 400 rural hospitals closed in the next
20 several years. So whether that's true or not,
21 whether it's 100 or 500 it's still a lot. So not
22 only will the patients be without an acute care

1 facility to attend to their healthcare needs, they
2 won't even be able to get the data to take another
3 provider. So, yeah, we see reimbursement issues
4 every day as affecting the health of the entire
5 provider community. Thank you.

6 DR. AHERN: Thank you. Again, one
7 follow-up question, Bill. Do you see the
8 providers are doing poorly because they try to
9 adopt broadband health services and aren't
10 successful in doing that? Would that be an
11 accurate appraisal of what you've seen?

12 MR. JANSEN: Yes. So, they want to
13 adopt broadband technology but the implementation
14 costs might be too high and/or but probably more
15 importantly is the interoperability just isn't
16 there. So, if you're a large urban center you may
17 have a healthcare exchange and can easily move
18 information. If you're using a large EHR system
19 maybe you can move information between like users
20 of the same EHR. But, yeah, interoperability is a
21 huge stumbling block for providers, especially
22 smaller providers. They want to provide good care

1 and they do the best they can but they could do
2 better with good broadband, whether it's fixed or
3 whether it's wireless and interoperability issues
4 would go away.

5 DR. AHERN: Thank you, Bill. I
6 appreciate your answers to those questions. We do
7 have one remaining participant but there's a
8 chance that we could get another one before we go
9 to open discussion, so don't miss your
10 opportunity.

11 Justin, if you would go ahead and ask
12 our next participant to introduce themselves.

13 OPERATOR: Certainly. It will come from
14 the line of Edward Miller, MD Anderson Cancer
15 Center. Your line is open.

16 MR. MILLER: Thank you, and thank you to
17 the FCC for hosting this call today. My comments
18 aren't too different from the others that have
19 spoken out.

20 We're the largest cancer hospital in the
21 country and in urban areas often have access to
22 specialty care for either oncology or heart or

1 whatever their complex health condition may be.
2 But we've experienced here in Texas, a large
3 state, a lot of rural areas, especially when you
4 get to west Texas, there aren't enough specialists
5 that can take care of the needs of the community.
6 And of course our experience is only with oncology
7 and a lot of these people cannot travel but just
8 because it's rural or it's underserved
9 communities.

10 So, we have been participating in a
11 program that trains primary care providers with
12 specialties to be more attuned to specialty care,
13 they can provide more care than they would have
14 been able to. And we do this through
15 tele-mentoring and other programs like that and it
16 requires broadband to have videoconferences and
17 share data and slides and pictures, etcetera. By
18 doing this it allows patients to be treated in
19 their community at the right time, it doesn't
20 cause delays in care which can end up making their
21 cases much more complex and it can improve
22 outcomes or reduce costs.

1 But the thing we're running into is that
2 there is a severe lack of broadband, or even
3 wireless services in certain areas that are very
4 rural and the faster uptake in those areas we
5 could definitely expect greater outcomes from
6 these health episodes. And, again, it's not just
7 cancer-specific but you could get a lot more
8 specialty care into primary care offices and
9 they'd be more aware of the conditions that do
10 need to go into in-patient settings in a hospital
11 versus being able to stay home and being able to
12 be monitored remotely as many other groups have
13 already expressed.

14 So, I guess that's kind of what our hope
15 would be, just that access would increase and I
16 think that would open up the door for a lot of the
17 other programs. Again, I thank you for hosting
18 the call.

19 DR. AHERN: Thank you, Edward. Really
20 appreciate that input.

21 I think we're at a point now where we
22 can open up all the lines, Justin, and have an

1 open discussion. If we could go ahead and do that
2 I will ask my colleague, Dr. Gibbons, to maybe
3 begin with a question or two to get the
4 conversation going. This is, again, now an
5 opportunity for all of the participants on the
6 call to comment, respond to the questions, and
7 have a dialogue.

8 DR. GIBBONS: Great, thanks, David.
9 Again, thank you everybody. This has been
10 fantastic. It's gone above and beyond what we'd
11 hoped for.

12 I've heard a number of things that I
13 found very, very interesting and fascinating. For
14 one, Hank, in the beginning you were pretty clear
15 about saying that really the need for speed is
16 going up, and you even said that your T1 lines are
17 basically insufficient currently and that's only
18 going to get worse in the future, if I understand
19 you correctly.

20 But at the same time, I think I heard
21 from Jon Zasada that -- and I want to make sure
22 I'm hearing the right thing -- that 10-3 is

1 actually okay for you guys, or were you saying
2 that you'll take it because that's all you can
3 get? I'm wondering in general, not only at Hank
4 and Jon, but I'm wondering across all of the
5 groups if the need for broadband speeds are going
6 up as Hank described, and in particular Jon
7 because you mentioned 10-3.

8 And then there is a second question.
9 I'd love to hear more about the virtual ER
10 program, how that is actually working and if
11 others are doing things like that. Thanks so
12 much.

13 MR. FANBERG: This is Hank. I'll
14 comment that, yes, I think you have it correctly.
15 And the specific example that I can give. So have
16 one of our San Antonio hospitals is a transplant
17 center and they have patients literally scattered
18 across the state of Texas. There is a certain
19 amount of testing that needs to be done ahead of
20 time when you go on the registry for an organ
21 transplant. And in some of these communities
22 where we have these people there is insufficient

1 bandwidth just to conduct a virtual visit with the
2 testing that needs to be done to transfer the
3 information from the rural location into San
4 Antonio. And those connections, all that we have
5 available there right now are T1 lines and we're
6 finding that we can't even get these visits done
7 trying to send what I consider to be relatively --
8 the data that would really need minimal bandwidth,
9 but we're having difficulty with that.

10 DR. GIBBONS: Do you have any sense of
11 what a minimum might be for you guys? If you
12 could choose what the minimum would be, what would
13 you say?

14 MR. FANBERG: Well, it's going to depend
15 upon the location and the area. Someone earlier
16 had referenced the FCC has what they consider the
17 standard minimum which I don't recall the number.
18 But, frankly, when you start talking about if
19 you're sending data, if you're sending the visual
20 (inaudible), i.e., any of your images, you really
21 probably need to start with a baseline of about 10
22 megs, and sometimes during the day that probably

1 will not be sufficient but it's a good starting
2 place. We like to do a minimum of 45 if it's
3 available, but that is not always the case.

4 DR. GIBBONS: I want to clarify because
5 I think you're saying something very important.
6 You're suggesting that, first of all, the need is
7 not a static need, it's not whatever, 100 megs all
8 day long, but it can and does vary throughout the
9 day but to the extent that we don't have the
10 availability when the need is greatest then the
11 entire thing is insufficient. I think if I
12 understand you correctly that's an important
13 insight that we have to think about at the FCC in
14 terms of trying to decide what's adequate. It's
15 more than just some sort of a number, whatever
16 that number is, because the needs vary throughout
17 the day, if I understand you correctly.

18 MR. FANBERG: Yeah, although again,
19 there is a minimum threshold that will be needed,
20 and I think experience says that that minimum --
21 and maybe I'm going back to the Connect America
22 Map which came out with some standards, if a

1 certain amount of bandwidth was available they
2 said you had sufficient bandwidth in the
3 community, and our own experience is that their
4 information is not necessarily correct all the
5 time.

6 DR. GIBBONS: Great. Others?

7 MR. ZASADA: This is Jon Zasada from the
8 Alaska Primary Care Association again. I was
9 actually just trying to get back into some
10 testimony that we provided to the Alaska
11 legislature this spring, and I'd also defer to
12 Verné Boerner, our colleague with the Alaska
13 Native Health Board. We will provide some
14 additional data or information after this meeting
15 regarding speed. But I guess in my personal
16 experience in talking with health center directors
17 they are okay with the speed that they have.
18 There are lags that affect the flow of
19 appointments and the flow of work, but I think in
20 particular very isolated communities understand
21 the limitations of the connections that they do
22 have. I will say also that in communities that

1 don't have dedicated connections the need for
2 speed of bandwidth in a dedicated connection is of
3 vital importance. And I think this goes back to
4 the person that was talking last, in non-dedicated
5 connections, in a very small community it can very
6 quickly take up to four hours to transmit out a
7 single image for review by a distant provider and
8 ties up the rest of the online work that the
9 clinic may be doing.

10 Again, all that being said, we like
11 everyone else are continuing to modernize our
12 EHRs, our electronic health platforms. We were
13 just talking yesterday about expansion of in-home
14 and in-community monitoring and all of those
15 require a constant increase in both bandwidth and
16 speed. Those changes are being developed by the
17 commercial providers here in Alaska but they come
18 at a very, very large cost which to this point has
19 been borne without interruption by the Rural
20 Healthcare Fund and with 7.5 percent proration
21 that we saw in 2016 and the peril of a much higher
22 proration for 2017 and beyond. The modernization

1 of that fund is of the highest priority for both
2 the non-tribal and tribal systems and for rural
3 hospitals here in Alaska.

4 DR. GIBBONS: Great, great. So, again,
5 correct me if I'm wrong but I'm not hearing you
6 say that lower bandwidths are really adequate.
7 You're working with them and you're happy for what
8 you can get but more would definitely be better.
9 That's what I'm hearing, right?

10 MR. ZASADA: Isn't more always better?

11 (Laughter)

12 DR. GIBBONS: Well, yeah.

13 MR. ZASADA: And, again, I think my
14 homework that I'm taking away for you all and for
15 future sessions will be doing a survey with our IT
16 directors to try and flesh out some of these
17 issues in additional detail so that we can share
18 that information with you going forward.

19 DR. GIBBONS: Okay, great. And just one
20 final question. Can you tell us a little bit more
21 about the virtual ER?

22 MR. ZASADA: I can tell you a little bit

1 and then, again, get you more information as we
2 go. So, basically a patient would present in an
3 emergent situation at the community health center
4 that's located in Dutch Harbor, Alaska which for
5 those that don't know is one of the largest
6 fishing communities in the United States. It has
7 an annual influx of tens of thousands of seafood
8 workers that augment its regular population of I
9 want to say 2,000 to 4,000 people. It does not
10 have a critical care hospital so the emergency
11 room does exist in the community health center.
12 Again, the patient appoints, there's a dedicated
13 connection to Providence Alaska Medical Center in
14 Anchorage. The medical staff at the health center
15 use a range of diagnostic equipment that provides
16 direct feed to the hospital and they are guided in
17 the care of the patient until a medevac can be
18 arranged. Just so you know, a medevac can be
19 arranged -- with the weather in the distant North
20 Pacific can sometimes take a number of days in
21 worst case situations and can cost between \$50-
22 and \$100,000.

1 DR. GIBBONS: Wow. Wow. Thank you very
2 much.

3 DR. AHERN: Thank you, Hank and Jon, for
4 your comments. Any other comments on the topics
5 that we've been discussing?

6 MS. BOERNER: This is Verné Boerner with
7 ANHC.

8 DR. AHERN: Yes, go ahead, Verné.

9 MS. BOERNER: Thank you. I just wanted
10 to add a couple of statements in addition to
11 Jon's. Again, I think he's done a fantastic job
12 describing the situation.

13 Some of the other issues that we have
14 seen with regards to speed, not just with the
15 transmission of medical files and records and
16 such, is actually processing and doing the
17 administrative work. A lot of the enrollments and
18 billing that our members have engaged in, they're
19 all sort of online- based and if there's an
20 interruption in the transmission of that or if the
21 speed is too slow it can cut off hours' worth of
22 work that will have to basically be started over

1 again. So, it does affect the overall
2 productivity of our centers as well. So, that's
3 just one addition that I wanted to add.

4 Parity is something that the tribal
5 health programs have really stood for and fought
6 for as well. So, the 10-3 is a good baseline but
7 the problem we have is that it hasn't always been
8 consistent or consistently available or reliable.
9 Again, I do think that there are improvements
10 being made, but again, it really depends on that
11 sort of consistent and predictable support that
12 the tribes, the broadband providers, our partners,
13 and the state have sort of worked together. And
14 as Jon has said, addressing the Rural Healthcare
15 Program fund is of utmost priority for our IT
16 usage and broadband usage.

17 DR. GIBBONS: Great, thank you.

18 DR. AHERN: Thank you, Verné. I think I
19 might at this point take an opportunity to mention
20 that in the two-page document that you were sent
21 with the questions we also have a request for any
22 research or case studies that you might want to

1 share with us. So, as was mentioned in the
2 previous participants, if there is additional
3 information that you want to provide we would be
4 very pleased to receive that at
5 connect2health@fcc.gov. That would be very
6 helpful to us.

7 On that note, I might ask if Lovisa
8 Gustafsson is still on the call from the
9 Commonwealth Fund. Lovisa, I know that the
10 Commonwealth Fund has been working on a
11 breakthrough portfolio and I wondered if there
12 were any projects that you might be able to talk
13 about that would be relevant here in our
14 discussion.

15 MS. GUSTAFSSON: Hi, yes. I think a lot
16 of our work to date has been focused around
17 consumer access to their healthcare data,
18 interoperability, and a lot of those sorts of
19 issues. So, this is a newer area that we're
20 starting to wade into in relation to that sort of
21 work. So, it's really helpful for me to hear a
22 lot of these issues and the problems that

1 providers are bringing up given that we're not out
2 in the field working with providers on a
3 day-to-day basis to help inform us in terms of
4 what our priorities are going to be going forward
5 in terms of how we can be thinking about these
6 issues and how we can potentially be doing
7 grant-making around them to solve some of these
8 problems that you are raising. So, really
9 appreciate the opportunity to hear from all of you
10 and your experiences and any of the problems that
11 you are experiencing today or potentially foresee
12 coming down the road. So, thank you.

13 DR. AHERN: Wonderful. Thank you,
14 Lovisa, I appreciate that. Chris, did you have
15 another question that you wanted to pose?

16 DR. GIBBONS: Yeah, sure. I was
17 thinking about what we've heard and I also found
18 what Bill Jansen at MetalQuest said very
19 interesting. Similar in some ways to Lovisa
20 because these are not provider organizations, yet
21 the work that they do is critical to provider
22 organizations. At one level, it illustrates for

1 us -- if I'm understanding you correctly and you
2 can correct me if I'm wrong -- that when we think
3 about broadband and supporting health and
4 supporting providers we have to think more broadly
5 than just supporting hospitals and doctors and
6 maybe consumers in their homes and there are other
7 types of organizations like MetalQuest that are
8 critical to the healthcare process.

9 I'm wondering if, Bill, you or others
10 might have any thoughts for us about any other
11 kinds of organizations that may not be providing
12 healthcare from a physician or other typically
13 recognized healthcare provider, but are critical
14 in the healthcare process that you think it would
15 be important to have us think about and try to be
16 inclusive of as we strive to develop or inform the
17 development of priorities and other things at the
18 FCC.

19 MR. JANSEN: Hi, this is Bill Jansen. I
20 can think of any number of companies and probably
21 industries that need to be included in the
22 discussions. But one thing that comes to mind

1 easily is just companies that are working on
2 clinical systems and their ability to provider
3 interoperability. So, those kinds of companies
4 really affect not only the provider and the
5 consumer but all the players that are in between.
6 And, of course, you need to have the big carriers
7 involved in it. One of the last things you want
8 to see is limited speeds.

9 And to answer the previous question, I
10 think really your kind of baseline minimum is 10
11 megabits at the very minimum. We can hardly push
12 data out for less than that unless it's highly
13 compressed.

14 But I think that most of these questions
15 are not a question of technology, it's really a
16 question of economics. I mean, we communicate
17 with the Voyager that's beyond our solar system
18 all the time. So, if we can do that on technology
19 built back in the '60s and '70s surely all these
20 other issues can be easily solved.

21 But, again, I think one of the biggest
22 challenges we have are people that are either

1 elderly, they don't understand the technology, and
2 people who are of low income, who don't have
3 access to technology. And, of course, there are
4 people in rural areas who don't have access to
5 technology. But, again, that goes back to if
6 you're a provider of technology do you want to go
7 after three people? You want to go after 100
8 people that live in Alaska or some other far-flung
9 location.

10 So, that's really, I think, maybe at the
11 heart of it. I don't think it's much of a
12 technology issue. It's really a question of what
13 policy do we want to create to help our country
14 move ahead in terms of its health.

15 DR. GIBBONS: So, assuming that to be
16 true -- and I'm not saying it's not, I believe you
17 -- what would your suggestions be for an FCC? I
18 mean, okay, this is not a technology issue or at
19 least not mainly, you say; if that's the case, do
20 you see a role for the FCC assuming that these
21 things would be within its mandate? I'm just
22 really trying to get your perspectives on how an

1 FCC can help address the problems that you see
2 that are impacting utilization of broadband in
3 greater ways to achieve health outcomes. What can
4 we do or what recommendations might you have for
5 an agency if you assume the problem is not a
6 technology problem at its core?

7 MR. JANSEN: Well, I think that this is
8 a very good start, bringing together interested
9 parties and stakeholders with the FCC acting as a
10 facilitator in a policy body that can bring
11 together all these disparate groups and kind of
12 make sense out of it. That's one of the biggest
13 challenges, right? Getting the people together
14 and figuring out some kind of consensus on a path
15 forward. I mean, that's the toughest part.

16 Again, I don't think it's the technology
17 but in this case how do you bring groups together,
18 how do you reach a consensus. I think that's the
19 role of the FCC. Then, of course, once that
20 consensus is reached being able to put out the
21 regulations so we're all playing by the same
22 rules.

1 But, you know, that's tough and with all
2 the changes in technology, technology getting
3 better, of course keeping up with change is its
4 own set of issues. So, it's definitely a big
5 challenge to overcome but it's definitely not
6 impossible.

7 DR. GIBBONS: Great. Thanks so much.

8 DR. AHERN: Thank you, Bill. Chris, if
9 I may, we have another question thinking about the
10 future, and that is certainly part of the question
11 set that we had sent out. If participants on the
12 call have thoughts about current and future
13 broadband- enabled health applications could they
14 comment on that? And what kinds of services are
15 we talking about and what kinds of bandwidths and
16 speeds will be need, thinking about the future as
17 healthcare continues to transform? Do folks have
18 thoughts about that?

19 MR. FANBERG: I think, David -- it's
20 Hank. I'd just like to make a quick comment that
21 I think will touch on your question, but I want to
22 go back to the immediate prior discussion.

1 The FCC sets the regulations as to how
2 we can -- I don't want to say use broadband, but
3 in terms of the programs that it has to subsidize
4 the cost of broadband. And when I talk about the
5 need for speed I'm also talking about the need for
6 speed within the FCC to change its policies. Two
7 years ago I petitioned the FCC to do some of the
8 things that we're talking about today and I'm
9 still waiting for a reply.

10 So, as the policymaker which impacts
11 what we all can do and how we can do it and who is
12 eligible to be a part of it are going back to the
13 pilot program, and I think this rule still stands,
14 where there were prohibitions on being able to
15 share your circuits with non-healthcare providers.
16 These are policies that need to be addressed, that
17 need to be changed, and in my opinion these are
18 regulatory issues and not legislative issues and
19 those are things that need to be addressed in the
20 process also. And if we can address some of those
21 things that will help the innovation and help us
22 get to where we need to go in terms of being able

1 to reach new places, new locations, reach
2 mobility, and provide a variety of services. But
3 it's those underlying policies that need to be
4 addressed.

5 DR. AHERN: Thank you, Hank. Appreciate
6 that. I think the question on the table was about
7 the future and services that we can imagine two
8 years out, five years out. Things are moving very
9 quickly with respect to healthcare reform and
10 digitalization of healthcare which we see every
11 day now in many ways. What are some of the
12 opportunities and solutions that we think are
13 going to emerge for which broadband is going to be
14 critical?

15 MS. OFFICER: This is Carey Officer with
16 Nemours. As we think about what the future
17 entails for the children that we're serving across
18 a pretty wide geographic area, we really foresee
19 remote monitoring and providing care within the
20 home as a critical aspect, predictive, analytic,
21 and really getting to the source before and being
22 proactive before something sets in and a child

1 ends up in our emergency room or ends up as an
2 inpatient in our health system. So, it's really
3 pushing care into the home and if we don't have
4 the right type of connectivity into the home and
5 at a cost point that these families can subscribe
6 to then that will never become a reality.

7 MS. HAHN: This is Beth. Also, to
8 understand that we're all out here trying to do
9 this without any funding. There is no
10 reimbursement for telehealth, telemonitoring, in
11 patients' homes but we're doing this because we
12 know that this is for the benefit of the patient
13 and the care that they need to receive.

14 Our cardiology patients and one care
15 patients, if they have connectivity to their
16 doctor they can save travel of 80 to 100 miles and
17 a two-hour travel to providers where there is a
18 lack of providers and they have to wait weeks to
19 get into a specialty provider sometimes. So,
20 we're all grassroots trying to do what needs to be
21 done behind the scenes with the capabilities that
22 we have and without reimbursement. The medical

1 community isn't supportive because they know there
2 is a lack of providers and that they can't see
3 everybody one-on-one as much as they would like
4 to. We get referrals, "Do you have cardiology
5 telehealth?" Because the providers know that this
6 is what's needed. But we're here in the
7 background scrambling trying to figure out how to
8 provide it to them at our own cost.

9 DR. AHERN: Thank you, Beth. So, one of
10 the barriers, one of the challenges, is obviously
11 the funding and sustainable funding in order to
12 support the development of these initiatives, the
13 deployment, and that's sort of part of the
14 challenge that you face and I'm sure many
15 providers are facing today.

16 MS. HAHN: Yes.

17 MS. BOERNER: This is Verné with the
18 Alaska Native Health Board. I just wanted to --
19 the last three speakers I think really did a great
20 job in addressing some of the in-home care issues
21 and some of the innovations that might occur but
22 the lack of access, again, in rural communities is

1 so incredibly high across the United States and
2 thinking about the regulatory barriers that have
3 impacted the -- I mean, there are efficiencies
4 that are not being tapped into that because of the
5 limitations as to how they can be used is part of
6 that.

7 When you think about non-technical
8 issues, if you look at immunizations and you don't
9 have a critical mass having access to those
10 immunizations they're not effective. And
11 similarly, with broadband if you don't have that
12 critical mass with access to it you're not going
13 to build that sort of awareness of it overall and
14 then these innovative approaches can't get off the
15 ground quite as easily. So, I think that's a part
16 of an artificial barrier that might need to be
17 addressed. Thank you.

18 MS. ZASADA: This is Jon, also in
19 Alaska. I guess I had an experience recently that
20 kind of gave me a little bit of perspective. I'm
21 pessimistic about the increased affordability of
22 rural broadband for residential use and I'm also

1 somewhat pessimistic about how much more
2 affordable cell plans are going to become. I was
3 recently in rural northern Canada, the Yukon
4 Territory and the Northwest Territories, and in
5 response to their desire to lower costs and
6 increase access to in-home monitoring, they
7 actually deployed old school 3G teleconnectivity
8 and monitors that maximize at that level of speed
9 in order to at least have a minimum base of home
10 monitoring available for their patients. I know
11 in talking to them that this is also a model that
12 has been used in other rural countries that have
13 centralized health systems. So, again, I think
14 it's good to get it out on the record as one
15 opportunity that other places are trying.

16 DR. AHERN: Thank you, Jon. I want to
17 be respectful of time for participants. We're
18 near our two-minute mark. Are there any other
19 brief comments that any of our remaining
20 participants would like to make before I turn it
21 over to Chris for final comments? Hearing none,
22 Chris, did you want to wrap up?

1 DR. GIBBONS: Sure, thanks, David.
2 Again, let me on behalf of David and the entire
3 Connect2Health Taskforce and the FCC thank each
4 and every one of you for taking the time out of
5 your busy schedule to give us your critical
6 insights, your findings, and your thoughts.

7 We heard many things and I'll just
8 briefly tick off a few of the top ones that
9 impacted me. The increased need for more speed,
10 problems around access and affordability,
11 reimbursement. But also there are non-technical
12 issues that get in the way and that there is a
13 feeling that the FCC can have a role in overcoming
14 those non-technical issues, if it's coordinating,
15 getting people together, particularly in community
16 is important. And also, as the last caller just
17 talked about, sometimes low-tech technologies can
18 be useful on an interim basis to get through a
19 problem.

20 These are all fantastic. We look
21 forward to continuing the conversation with you
22 again. Please feel free to send us anything else

1 you would like us to know or did not get the
2 chance to tell us. Our email is
3 connect2health@fcc.gov. Thank you, again, for
4 joining us today.

5 DR. AHERN: I would just also thank you
6 all for joining us on the call today. We greatly
7 appreciate the time that you've provided and your
8 input. We will now conclude the session. Thank
9 you.

10 OPERATOR: Ladies and gentlemen, that
11 does conclude the conference for this afternoon.
12 We do thank you very much for your participation
13 and using the Executive Teleconference Service.
14 You may now disconnect.

15 (Whereupon, at 2:59 p.m., the
16 PROCEEDINGS were adjourned.)

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