UNITED STATES FEDERAL COMMUNICATIONS COMMISSION

CONNECT2HEALTHFCC TASK FORCE
VIRTUAL LISTENING SESSION -
RURAL AND CONSUMER ISSUES FORUM

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P R O C E E D I N G S

OPERATOR: Ladies and gentlemen, thank you for your patience in standing by. Welcome to the Connect2Health conference call. At this time all of our lines are fully interactive for a brief rollcall. We do ask that you use the mute button when not speaking so we can ensure the best audio quality. Also, just a reminder, today's conference is being recorded.

Do we have the line of Connie Beemer with Alaska State Hospital and Nursing Home Association?

MS. BEEMER: Hi, I'm here.

OPERATOR: Thank you. Do we have the line of Daniella Dean of National Conference of State Legislatures?

MS. DEAN: Yes, I'm here.

OPERATOR: And Darryl Cooper with FCC Disability? Darryl Cooper, do we have your line?

MR. COOPER: I'm here.

OPERATOR: Thank you. David and Nikki with CSD Communications for the Deaf?

MS. SOUKUP: Yes, we're here.

OPERATOR: Douglas Waite, Children's Village?

MR. WAITE: Yes, I'm here.

OPERATOR: And Elaine Gardner with the FCC?

MS. GARDNER: Yes, I'm here.

OPERATOR: Everette Bacon with National Federation for the Blind?

MR. BACON: Here.

OPERATOR: Haley Nicholson of State Legislators?

MS. NICHOLSON: Here.

OPERATOR: Jon Zasada with APCA?

MR. ZASADA: I'm here, thank you.

OPERATOR: Joshua Seidemann of NTCA-Rural Broadband?

MR. SEIDEMANN: Present.

OPERATOR: Margaret Nygren of AAIDD? Margaret Nygren, do we have your line?

Do we have Michele Ellison with Connect2Health FCC?

MS. ELLISON: Yes.

OPERATOR: Preston Wise of the FCC?

MR. WISE: I'm here.

OPERATOR: Ryan Hutchinson of CSD?

MR. HUTCHINSON: Yes, I'm here.

OPERATOR: Thank you. Do we have the line of Suzy Singleton from FCC?

MS. SINGLETON: Yes, I'm here. Hi.

OPERATOR: Do we have the line of Tracy Brewer of Altacare.

MS. BREWER: I'm here.

OPERATOR: And Verné Boerner of Alaska Native Health Board? Ms. Boerner, do we have your line?

Thank you. Now I would like to turn the conference call over to our host, Ben Bartolome.

MR. BARTOLOME: Greetings. Thank you very much, Justin. My name is Ben Bartolome and I serve as Special Counsel on the FCC's Connect2Health Task Force. I will be moderating today's virtual listening session which is focused on rural and consumer issues. On behalf of the

Task Force, thank you all for joining this virtual listening session, which is related to the Commission's April 24, 2017, Public Notice on Broadband Health Technology.

As we previously stated, among other reasons, these sessions are being held to better accommodate non-traditional stakeholders and those based outside the Washington, D.C. area by providing them as well as any interested parties an opportunity to provide immediate input and comment on the issues raised in the Broadband Health Public Notice. I think we've accomplished that objective today. We're thrilled to attract a large and diverse group of stakeholders, at least in terms of the RSVPs. We have folks who are already on the phone or may be in the process of calling in from as many as 16 different states across four different time zones, and representing a variety of stakeholder groups. So, thank you all for taking time from your busy schedule to join this session.

Let me now provide you with a brief

overview to serve as a level set for today's session and also go over some basic ground rules for this call before we proceed with the questions and your comments and input. As we previously informed you, and as Justin reminded us, this session is being recorded and the recording will be transcribed. The transcript, once completed, will be made publicly available on our website, www.fcc.gov/health. It will also be a part of the official record in GN Docket No. 16-46, which is the FCC's Broadband Health docket.

I'm hoping that all of you had an opportunity to read the April 24th Public Notice or at least have read the summary of the notice that we previously sent you. Through the public notice and these virtual listening sessions we are seeking input as well as data on a broad range of regulatory, policy, and infrastructure issues related to broadband-enabled health technology, solutions, and services, and ways in which we can foster their availability and adoption, especially for those living in rural and remote areas and on

Tribal lands.

Among other things, the public input we receive -- and that means your input today and anything you submit in writing in the docket -- will be used by the Task Force in making recommendations to the Commission, and they will also serve to inform the Task Force with respect to future initiatives we might pursue. So, it's really important that we hear from all of you today to get your input on some very important issues.

In terms of format, we will proceed with me asking questions, and I will be asking most of the questions that we sent you in advance. After each question is stated I will open up the floor, if you will, for comments from you. Again, this is a listening session and we're here to take notes and listen to you on the issues.

If you wish to make a comment, as Justin mentioned, in response to a question, please press * and then the number 1 on your phone and that will put you in queue and our AT&T operator will

announce the next person in queue and then open their line to speak. When it's your turn to speak, it would be great if you can tell us -- when you're speaking for the first time during the session -- from which state you are calling and perhaps a little bit about your company or organization, or if you're not affiliated with any feel free to just tell us about your interest in the issues that we're discussing today.

Please be aware that we have a sign language interpreter on this call to assists a couple of our participants who are deaf, so please make sure to speak clearly.

At any time during this session if you experience any technical difficulties, as a reminder please press *0 to reach an AT&T operator for assistance.

After we go through the list of questions I will then open the session to anyone who has any additional comments or statements they wish to make. It could be a reaction to any of the comments made by other participants, it could

be comments or thought unrelated to any of the questions raised, but basically we want to make sure that we provide all of you an opportunity to speak and provide input.

If time permits, we will open the lines to allow for some free-flowing discussion between and among participants and myself. During that segment, I may also be directing specific questions to some of you.

So, let's begin. As I mentioned, earlier this week we sent you a list of proposed questions for this session related to the six areas we want to cover for this session. I will basically follow the same topic organization which I'm hoping will allow us to maintain an organized and focused discussion. The six subject areas of topics are, number one, broadband health availability and accessibility; two, broadband health adoption; three, the FCC's Rural Healthcare Program; four, accessibility issues for people with disabilities; five, broadband health projects and initiatives at the state and local levels as

well as on tribal lands; and six, a focused or further discussion on telehealth and telemedicine.

So, we'll discuss each of these topics in turn. Although these topics are related, please do your best to focus your comments on the specific question or questions raised at the time so that we can maintain a clear record that's easier to follow, particularly for those parties who cannot join the session but plan to read the transcript.

So, topic 1, broadband health availability and accessibility. As you know, closing the digital divide, including in broadband health, is a key focus of the Commission, especially given the reality as many medical and other experts have informed the Task Force that the future of modern medicine is increasingly reliant on connected health. As such, we want to engage in efforts that will better ensure that broadband-enabled healthcare technology, solutions, and services, such as telehealth, telemedicine, electronic health records, remote

sensor monitoring, mHealth technologies, wireless-based medical devices, et cetera, are available and accessible to everyone.

So, as an initial matter we want to hear from you and learn, based on your experience and perspective, about the variety of issues, whether they be technical, non-technical, legal, environmental, cultural, anything unique in your particular area, et cetera, that are impeding the availability and accessibility of broadband health technologies, and especially in rural and remote areas of the country and on tribal lands.

In addition, we would like to know do you have any suggestions or recommendations with respect to any actions or initiatives that the FCC and/or its Task Force could pursue to address any of these issues? Or do you think perhaps some of these issues are best addressed at the state or local level or another federal agency?

With that, please press *1 now to get in queue to provide your comments with respect to this subject area and the questions raised.

OPERATOR: It looks like the first person here in queue is the line of Dr. Douglas Waite of Children's Village. Your line is open.

DR. WAITE: Hi, thanks for hosting this. I appreciate you initiating this as a physician and pediatrician. There are so many kids that have developmental issues that are not being able to be served because of their location, and that certainly includes kids in the tribal areas, especially in fetal alcohol spectrum disorders. I think the main thing as a physician is having available a platform that has some standardization and also complies with HIPAA and various confidentiality concerns. Those are the main things I would highlight.

MR. BARTOLOME: Dr. Waite, at least based on your experiences, what sort of challenges have you found with respect to using telemedicine with the patients you're serving in these underserved communities?

DR. WAITE: I think a lot of it is access on the other side, although more and more

people have computers. I guess the other piece is just getting suitable platforms to do this with. A lot of times it ends up being something simple like just facetime just because people don't necessarily have access.

MR. BARTOLOME: I see. Do you have any additional comments with respect to this subject matter that we're focused on at the moment?

DR. WAITE: That's it for now.

MR. BARTOLOME: Thank you very much, Dr. Waite. Justin?

OPERATOR: Our next line is Tracy Brewer with Altacare. Your line is open. Tracy Brewer, your line is open. If you could please check your mute button here for us.

The next questioner here in queue for comment, we have the line of Joshua Seidemann from the NTCA-Rural Broadband. Your line is open.

MR. SEIDEMANN: Thank you very much, and thanks for convening this call. This is of special importance to us. Just as an introduction to NTCA-The Rural Broadband Association, we have

about 850 members who are facilities- based broadband communications providers living in rural areas. Our companies average anywhere from 5,000 to 20,000 customers in population densities of about one-and-a-quarter person per square mile. 87 percent of our members are able to offer speeds of 10 meg and above to at least part of their customer base and 10 to 13 megabits per second is really what you want for streaming video which is useful in telehealth.

I think that, for us, when we look at this and we look at our members, some of the issues we see of course are the needs for federal policies to support network and infrastructure development and deployment and maintenance, but then also the issue of getting the medical community to support this and I think that support is growing. And I think particularly in rural areas what we have from our members is that many of the patients they still need to be convinced of this. They still need to understand that this is really -- we've reached the inflection point where

I think everyone in the medical community and policymakers understand that this is the next wave of medicine and maybe there's a point where we don't talk about telemedicine anymore because now it's just medicine. But we've got to bring the patients along as well. Thank you.

MR. BARTOLOME: Joshua, if I may, you mentioned 80 percent at 10 meg. Let me ask you about broadband speed. Are all of your member rural carries providing the current 25/3 standard that the Commission announced a year ago?

MR. SEIDEMANN: No. That's actually what I would call a thorny policy hurdle to get over. The interesting thing is that the Commission has defined broadband as 25/3, but for purposes of demonstrating that you're in compliance of obligations when you receive high-cost funding from the Commission, you are only required to provide 10/1. That risks almost setting up by design a rural infrastructure that won't be as robust as the Commission has defined at 25/3 standard.

MR. BARTOLOME: Okay. And for those rural carrier members that actually provide services for healthcare systems or other healthcare facilities, do you know what broadband speeds they are requesting or are requiring in order to be able to provide the variety of broadband-enabled health services that they're offering their patients?

MR. SEIDEMANN: Most of the case studies that we have accumulated from our members that are actively engaged in telehealth are probably using a fiber deployment. But, again, with these they've got such things as connected health carts in schools that connect to retail medical facilities, they're doing elder care. Again, the sky is the limit on this stuff, we just need the network there to be the baseline for it.

MR. BARTOLOME: I guess one final question for you, at least for now, because it's really helpful to get your perspective on behalf of a lot of the rural carriers because there's still some gaps in terms of infrastructure and

services in rural areas. So, from your perspective do you think that consumer health needs can serve as a sufficient market incentive for telecommunications companies to build and provide broadband service, and therefore enable the availability of broadband health technologies and services in currently unserved areas?

MR. SEIDEMANN: I'll answer that with a phrase I only learned recently, and we always look for silver bullets but I think sometimes we need to recognize the usefulness of silver buckshot. We are encouraging our members to look at telehealth and we encourage them to look at this not just as a revenue stream for their own market needs but also to better their community and to make sure that their customers have what they need. I think that telehealth can be an incentive to deploy the network.

Do I think it is the only be-all incentive, no. But I do believe that between the Veterans Administration and Health and Human Services and the Federal Communications Commission

there are so many federal bodies that have a real interest in this topic. I think that we can use this to push forward a collection of polices that will enable better broadband and better medical care.

MR. BARTOLOME: Great, thank you very much, Joshua. Justin, can you please announce the next participant in queue?

OPERATOR: Certainly. Next for comment or input we have the line of Danielle Dean who is the Policy Director at National Conference of State Legislatures. Your line is open.

MS. DEAN: Hi, thank you. So, a little bit about the National Conference of State Legislatures. We represent all 50 states and the territories, the state legislators and legislative staff. We have reached out to legislators who are very interested in this topic and this legislative session introduced legislation specifically around rural access. We came up with a few points that are commonalities from the responses that we received.

The first is understanding who is impacted by the digital divide and where legislators should focus resources. The mapping programs have been something that every single legislator has brought up. The National Association of Regulatory Utility Commissioners just came out with a report in June that highlighted that all 50 states and D.C. have created broadband maps under NTIA's program, but the study shows that many of the broadband mapping programs expired with the end of the BTOP funding.

So, for example, Oregon has looked at the -- Mississippi state has a digital divide index that looks at county level index scores with which communities are not receiving internet access. And in Georgia they held a series of public hearings. And so you're finding legislators who still need access to that information but looking at other ways of finding basically who are these people that need the access and how they can focus their resources more efficiently.

Another thing that has come up is looking at rural area decline. For example, 115 of Georgia's 159 counties are underserved by broadband, and all but one of those 115 counties are rural. As south Georgia continues to lose population, hospitals in those areas are continuing to close.

Another issue that we're seeing is what does telehealth mean and how is it currently being used? I thought it was interesting, our Georgia representative has held -- he serves on the Rural Development Council and he held five sets of two-day public meetings throughout rural areas in Georgia. They were specifically looking at lack of adequate broadband, and what they found was that even though there is a community health center in every county in Georgia and every one of those centers have broadband connectivity and equipment, some of the healthcare professionals were using the term telehealth and telemedicine but in reference to old technologies like doing telephone consultations, faxing files, or scanned

photos.

Also, and what I would like to echo from what I heard a previous participant say, you really need to look at access in an individual patient's home. We see a lot of resources getting spent at getting broadband access in anchor institutions like schools and libraries and hospitals and not so much on an individual's home. When you look specifically at telehealth, the legislator's vision of what that means is a healthcare professional from his or her office consulting with and diagnosing patients over the internet in a person's actual home.

I think that's where I'll stop right now. I also have a bunch of research of state legislation, but for now that's where I'll stop. I also have a bunch of research on state legislation.

MR. BARTOLOME: That's very helpful. Thanks very much, Danielle. Whatever research that you think would be helpful to us for any other information please feel free to send it to

us in the docket or email it to us and we'd be happy to receive it. Thanks very much.

Justin, can you please announce the next person in queue?

OPERATOR: Certainly. Next we'll go to the line of Connie Beemer, Director of Alaska State Hospital and Nursing Home Association. Your line is open.

MS. BEEMER: Hi, can you hear me?

MR. BARTOLOME: Yes. Hi, Connie.

MS. BEEMER: Great. Thanks for taking time to hear from us today. I appreciate the opportunity. First, the Alaska State Hospital and Nursing Home is an association, we represent

of the 28 hospitals in the state of Alaska. We've been around for 60 years. Seven of those hospitals are tribally-owned facilities. I serve on the Alaska Collaborative for Telehealth and Telemedicine and also on our state Health Information Exchange Board of Directors.

We have at ASHNHA been advocating for adequate funding of the Universal Services Support

Rural Healthcare Fund that is critical to our members and to our state. Alaska, I believe, receives about 25 percent of that funding, and the funding hit the cap this year. Right now I believe in the regulations Alaska is designated as rural and there may be potential to change it as a nation to frontier. Many of our facilities are not accessible via road so the only way to get in is either via plane or a boat. Many of them are off the road system once you get outside of the Anchorage bowl. So, it's really a lot more rural than some of the places in the lower 48.

Telehealth is used in our state. We have a robust tribal network. But it will only work if we continue to have adequate access to these funds. So, I just wanted to express our members' concerns with the proration and the capping and the uncertainty that these funds will not be available in the future. I think that's all I have for now.

MR. BARTOLOME: Thank you very much for your comments, Connie. We'll further explore the

issues or any concerns with respect to the Rural Healthcare Program as part of our third topic for today. But thank you.

MS. BEEMER: I also want to mention that our state through our Medicaid redesign -- just released a Medicaid redesign telehealth stakeholder workgroup report that gives a pretty good snapshot of where we're at in the state of Alaska in terms of telemedicine and the barriers that we're facing. That might be good for the workgroup to have. Thank you.

MR. BARTOLOME: Thank you very much.

OPERATOR: Next we have Verné Boerner, President and CEO of Alaska Native Health Board. Your line is open.

MS. BOERNER: Thank you. My name is Verné Boerner, I'm the President and CEO for the Alaska Native Health Board. We serve the Alaska Tribal Health System as an official involuntary agreement between the tribes in Alaska, serving under a single compact that has referral patterns from the village level to regional hubs to the

state level, including over 180 village clinics and regional hospitals. Then we also work with the broader healthcare network in Alaska as a whole. We have over 158,000 American Indians and Alaskan natives that we serve, and even beyond that the Alaska Tribal Health System is a critical component of the Alaska public health system.

In many cases the Tribal Health System is the only point of access to care in the communities, so we have a number of duly funded programs through HRSA and through the IHS. We also have tribal sharing agreements set with the Alaska Veterans Affairs providing access to care for both native and non-native veterans alike. So, we serve a large component of the Alaska healthcare system overall.

The broadband health availability and accessibility is something that is certainly a challenge within the state of Alaska. In many cases we do not have access to broadband and are utilizing satellite and microwave technology in order to have the connectivity. The FCC's own

reports have indicated that 81 percent of rural Alaska do not have access do not have access to highspeed broadband, so that does impact the overall adoption of utilization of broadband in health and healthcare management.

One of the points that I had raised before was if you don't have the critical mass -- in many cases our programs are required to provide patients with access to their own records, but on the one side of the fence the access and the systems are being developed but the patients themselves have a lack of access to care. So adopting those technologies in the home, as had been shared by others providing comments, that is one of the barriers to overall adoption, is getting the broader community involved. They have found that if you're able to access care at earlier stages you have better outcomes and lower costs overall.

With regards to the Rural Healthcare Program I would like to thank Connie Beemer for her comments and state that the Alaska Tribal

Health System and the Alaska Native Health Board are in support of the comments that she had shared overall. The state of Alaska has over 650,000 square miles and over 300 villages in towns that are defined by the Census counting system. I think it was only 61 had a population greater than 1,000.

As someone else had stated, in most rural areas we are similar as a state as a whole where we have about 1.21 person-per-square mile in the state. But in the vast majority of the state, we have less than 1 person per square mile. So, the Rural Healthcare Program is critical to our operations.

Some of the challenges that we see are the slower connectivity that we have with the different types of technology transmitting data has also different reliability levels as well, so being able to transmit EKGs and radiology data requires a great deal of bandwidth. The biggest problem that we have from our tribal health providers is latency issues, and often

interrupting transmission requires a restart of sending the data. And that's not just for telehealth itself or those sort of commonly thought of issues with radiology or EKGs but it even goes beyond to operations where a lot of our billing programs require manual data entry inputs. There are a number of different systems that don't necessarily communicate with one another, especially if a facility is dually funded. So, a lot of the data is manually inputted which requires a great deal of time. If there's an interruption in that process in many cases the individuals have to begin at the start as well so it affects that.

There are the compliance issues that had been mentioned before as well. That, again, goes more to operations not necessarily thought of. If you're not able to be compliant then you're not able to provide the services or be reimbursed for the services, and if you're not able to be reimbursed for the services it limits access to care overall.

So, there are just a number of issues with regard to having that access. And the Rural Healthcare Program has been a way to help bridge the digital divide that we have experienced, and it also has encouraged investment into developing infrastructure systems. If you have that stability and predictability that the program provides overall then you're more willing to be able to attract investment to help support and build the capacity of the overall program.

The proration of the cap has done a great deal to destabilize that and it threatens our operations and our ability to provide care overall. So, we really hope that we can work towards answering this issue from a sort of multidisciplinary level from the providers to the tribes, the communities, and the internet providers overall.

Some of the other initiatives that have been discussed are promising. But one thing that I wanted to point out that we've heard is while the 5G technology seems great in Alaska without

the overall connectivity and investment in the infrastructure, you wouldn't be able to get all the benefit out of the 5Gs unless a holistic approach is taken towards building that infrastructure overall.

MR. BARTOLOME: Verné, just one quick question for you before we move on to the next participant. You mentioned satellite as a platform being used by some of your healthcare facilities. Have they found satellite to be sufficient in providing the variety of broadband-enabled services like telehealth with respect to their patients using satellite as a platform?

MS. BOERNER: It has been utilized as a backup so when microwave is not available then they revert back to satellite. So, yes, it has helped but it is not the number one choice.

MR. BARTOLOME: Okay, got it. Well, thank you very much for your comments, Verné, we really appreciate it. Justin, could you please announce the next participant?

OPERATOR: Certainly. Next we have Eric Brown, President of California Telehealth Association. Your line is open.

MR. BROWN: Good afternoon. So, it's California Telehealth Network. I just wanted to comment on your question with regards to whether or not consumer health needs are going to provide sufficient incentives to drive broadband deeper into underserved areas. My observation about that is here in California where we serve over 350 clinics and hospitals, many of them in rural areas, most of the rural broadband providers, in particular the smaller ones like the gentleman who spoke earlier that are serving rural areas, remember they're not participating necessarily in the clinical side of service delivery related to telehealth; they're providing broadband. That is not their business line. Many of them quite frankly are a little wary of it because of the HIPAA requirements and that kind of thing. So, they're just trying to figure out how to come up with a business model that makes sense to deploy

broadband deeper into rural and unserved areas.

So, to answer the question, I don't think that's the solution. I do think the solution, based on what we've seen in rural California, in our many communities that remain unserved from a broadband standpoint, is when we have the capability to aggregate the needs of the safety net intuitions in those rural communities -- by that I mean not just the healthcare but also the schools and libraries, the public safety facilities, et cetera -- then we begin to see a business model that makes more sense.

So, I would encourage the Commission, from a policy standpoint, an approach that specifically for rural begins to breakdown some of the silos around the funding sources. As an example, the Connect America Fund in California has only three providers that can access those funds. They're all big providers. That's not to disparage them but, again, for a lot of these communities that have very rural and small providers it's not an option for them.

The last thing I'll say and then give up the mic is as people have been hinting in their previous comments there is no one-size-fits-all solution but to fill in the gaps that are not being served by these commercial providers -- and I used to be one -- I think it's going to take either local consortia or regional consortia or non-profit oriented entities because if the for-profit folks were going to serve, the chances are it would have been served by now. So, in order to come up with the right solution, the right hybrid networks that look at wireline and wireless and 5G and all those kinds of things, it's difficult to do that when everybody's got a profit motive involved with the initiative.

MR. BARTOLOME: Great. Thanks very much, Eric. Justin?

OPERATOR: Next we have the line of Everette Bacon, President of the National Federation of the Blind. Your line is open.

MR. BACON: Can you hear me?

MR. BARTOLOME: Yes, we can, Everette.

Thank you very much for joining us.

MR. BACON: I'm actually a board member with the National Federation of the Blind. I'm the President of the Utah affiliate. We have a national organization out of Baltimore, Maryland. We are the largest and oldest consumer advocacy organization of blind people for blind people. We have affiliates in every single state as well as chapters and members all over the country.

We estimate there's 1.4 million blind/low-vision individuals across the country in rural areas. The biggest things, challenges we are facing, are definitely with regards to accessibility. With regards to accessibility for telehealth some of the things that we're noticing are patient portals that people need to access. The problem is that they are not accessible to a screen reader, they have not gone through any kind of regulations. We do recommend that the web accessibility 2.0 guidelines be used. These guidelines have been in place for quite some time through the world wide web consortium, but there's

actually no regulations in place to have those guidelines be enforced or used. And that's part of the problem. So, blind individuals that might have the ability, have a computer or a phone that's accessible, they can't access the patient portals, it doesn't read to them.

The other issue is devices. Medical devices that are needed for blind people, things like CPAP machines, things like blood glucose monitors, and things like that, those have digital displays, digital readouts that, again, have not been made accessible, so a blind individual cannot get that information themselves. The thought that we notice that people seem to have is that blind people readily have a spouse or some kind of caregiver that can read this information to them or can help them with this information, and that's simply not the case in many instances. And it's also not the case that blind people want to be able to access that information themselves, it's important to them, it's their privacy.

So, we would implore that you consider

the accessibility in how you look at this in the future. We thank you for your time and thank you for this opportunity.

MR. BARTOLOME: Absolutely. Thank you very much, Everette. Justin, is there anyone else in queue for the first topic? If not, we can move on to the second.

OPERATOR: We have no one further in queue at this time.

MR. BARTOLOME: Great. It looks like there may be some new participants on the phone. Can you please announce them if you're able to?

OPERATOR: Certainly. It looks like we have now been joined by the line of Sherita Kennedy of the FCC, Elaine Gardner as well from the FCC, and Jon Windhausen of the SHLB Coalition. I don't show any further late entries here for us.

MR. BARTOLOME: Thank you, Justin. So, let's now move on to the next topic on broadband health adoption. On this we would appreciate your input as to how we can further promote and foster broadband health adoption and close the divide.

Some of the participants have already touched on this topic, but I want to make sure there's an opportunity for others who may have additional comments to make with respect to this topic to do so now.

So, with this in mind, please press * then 1 to queue up if you have any comments. The question is do you have any suggestions as to how the FCC and its Task Force can further increase consumer awareness in adoption of broadband health technology solutions and services generally, and specifically for certain population groups that a lot of experts contend continue to experience digital divide issues and are medically underserved, for example the economically disadvantaged, seniors, people with disabilities, native Americans, and veterans. We'd appreciate any comments from any of you on this topic.

OPERATOR: It looks like first we have the line of Dr. Doug Waite, Medical Director of Children's Village. Your line is open.

DR. WAITE: I'm not sure if this fits

into the previous topic or this one, but I really forgot to mention one of the biggest things for physicians is cross-state licensure. The American County Pediatrics and multiple telemedicine organizations have brought this issue up and I'm not sure if the FCC is the person to do this, but this is something that probably would have to take place at the federal level, and maybe as an exemption specific to telemedicine as long as the physician is licensed in one of the states. When we begin to talk about specialty services as multiple people have mentioned it's not always possible for someone in a single state to see a specialist, especially for something that is not well-known to a lot of physicians like fetal alcohol spectrum disorders and developmental disabilities. So, I just wanted to put that plug in.

MR. BARTOLOME: Dr. Waite, actually while I have you on the phone I think I recall from the bio that you sent us that you've

initiated telemedicine clinic with the National Organization for Fetal Alcohol Syndrome. I wanted to ask you how telemedicine could actually be used to help address fetal alcoholism particularly on tribal lands. Can you comment on that please?

DR. WAITE: This is in its infancy. I'm working with NOFAS, a national organization for fetal alcohol syndrome on this because as we know these kids are not being diagnosed. A lot of them are in foster care and adopted. We get calls all the time of people desperate, really from across the United States, to just get their kid diagnosed because no one has been able to diagnose them and they've not been able to get services, no one is understanding what's going on with their kid.

In tribal lands I would say this is even more critical because of the lack of providers, and probably also lack of access is another piece of this. This would be a very easy thing to do because a lot of times we can get school reports with psychological testing, we can interface with the people themselves, the exams. While initially

it was a big deal for fetal alcohol syndrome we now know that the physical exam findings are a small component of the greater neurological neurodevelopmental disabilities. So, it really becomes something more like the kind of diagnosis that a psychiatrist might make.

MR. BATOLOME: Great. Thank you again, Dr. Waite. Justin, can you please announce the next person in queue?

OPERATOR: Certainly. Again we'll go to the line of Verné Boerner of Alaska Native Health Board. Your line is open.

MS. BOERNER: Thank you so much. I apologize for misunderstanding the overall format.

MR. BATOLOME: No problem, Verné.

MS. BOERNER: I did want to add one thing to the adoption issue as far as having general community access. I had mentioned that

percent of rural Alaska does not have access but there is underutilized capacity, and perhaps there's some sort of way to utilize the underutilized capacity which regulations prohibit

currently outside of the actual health program. If that is made available during off hours or some other way we might be able to increase community involvement and therefore adoption of broadband in rural communities.

MR. BARTOLOME: Great. Thank you very much, Verné. Go ahead, Justin. Announce the next person in queue please.

OPERATOR: Certainly. Next we'll go to the line of David and Nikki with CSD, Communications Service for the Deaf. Your line is open.

MR. SOUKUP: Just one moment please.

MR. BARTOLOME: Sure, not a problem.

MR. BAHAR: Hi. Just to let everyone know, the connection between the interpreter and myself is a little choppy so I'm going to do my best here to communicate our thoughts.

This is David Bahar and I actually had my hand raised for the previous topic. I did want to respond to the point that was made about the thorny policy issue that we need to address, and

that being funding for broadband converge and the costs of funding that only requires 10m down, 1m up if everyone follows there. Unlike the FCC's definition of broadband which is 25/3 and which is sufficient for deaf and hard of hearing people to be able to participate in group video chats which really are necessary for things like telemedicine and telehealth applications where you can video in an interpreter, a medical professional, and the deaf or hard of hearing person. 10/1 does not meet the requirement for that type of telemedicine applicability.

So, by continuing to require only 10/1 connections for the high-cost funding that really leaves out a number of service options quite frankly for deaf and hard of hearing people who live in more rural areas across the country. So, I do think it is crucial for accessibility purposes to look at upping the requirements to meet the FCC standard for broadband and that would be at 25/3.

In addition, I would also like to

discourage the FCC from revising that standard of 25/3 downward. It really is imperative that it's maintained. The moment that you reduce the speed requirements you are risking harm being done to the availability of services and the communication options for deaf and hard of hearing people who rely on the video connection for the use of their native language. That really is my comment to address that first topic.

Moving on to the topic that we're currently discussing, the second question that was posed, I do have some comments regarding how we could increase the adoption of telemedicine specifically in rural areas among deaf and hard of hearing people. There was some years ago a program under the National Telecommunications Information Association that allowed individuals that connected, low-income, rural deaf and hard of hearing people who were not able to afford broadband or were not able to afford mobile devices to be able to access broadband. And in that program which was run for three years it's

entirety they made over 13,000 with members of the deaf and hard of hearing community throughout the United States and they provided subsidized broadband services to them and devices as well that they could use in order to access it, one example being iPads. At the end of that program they surveyed all of the participants in the program and they found that a higher percentage than was expected did have access to broadband. You did not expect that result but that was wonderful.

So, I guess it's kind of a mixed bag there because many of them did have broadband and they were paying for services that they couldn't necessarily afford. However, because of the communication requirements requiring internet to make the video calls in sign language they were essentially having to prioritize certain services over the other and that really isn't applicable to increasing adoption of these types of things when it comes to telemedicine and telehealth programs specifically. There is something similar, a

lifeline program and another that are actually crucial and they're doing what they can to make sure we are increasing the access given to deaf and hard of hearing individuals in rural areas.

In regard to adoption specifically, we have found that there is one very specific challenge was an incredibly low number in the digital literacy of said individuals, specifically deaf and hard of hearing people in rural areas, that we had surveyed. It was much, much higher than we had expected. And that we realized does prevent a number of them from using the internet connection that they might have or use that internet- connected device that was given to them as a part of the program. So, for example, they're being handed a device but then don't know how to use it. And we think that that really is a barrier to the adoption of services and that could lead to another barrier in accessing the medical services as well.

We do know we've come a long way and a lot has been done to improve the adoption of

telemedicine and health in the deaf and hard of hearing community, but to make sure that it happens we need to make sure that those providers are trained and make sure that we are training the deaf and hard of hearing users as well on how they can use those types of systems. That really does need to be emphasized in my view.

MR. BATOLOME: Great. Thank you very much, David, for your comments, and thank you Madam Interpreter. Justin, is there anyone else in queue for topic number 2?

OPERATOR: At this time we have no one further in queue.

MR. BARTOLOME: Thank you, Justin. We'll now move on, ladies and gentlemen, to our third topic. Some of you have already commented on this, and it's the FCC's Rural Healthcare Program.

Just briefly for those participants who may not be familiar with the Program, the Program provides funding to eligible healthcare providers for telecommunications and broadband services

necessary for the provision of healthcare. The underlying goal is really to provide the quality of healthcare available to patients in rural communities by ensuring that eligible healthcare providers have access to telecommunications and broadband services. Currently funding for the Program is capped at $400 million annually and we're certainly aware, and as some of you have commented, that demand for funding under this program is increasing.

So, we'd like to hear from you now. Anyone interested please comment on this topic, especially for those of you who have participated in the Program. I'll pose the following question: Do you think the FCC's Rural Healthcare Program as a whole, including its regulatory framework and the manner in which it is administered, remains effective and is keeping pace with the changes in the delivery of healthcare and technological developments? If not, what actions or changes would you recommend that the FCC make to the RHC Program and potentially other universal service

programs given its authority? Please press *1 now to comment on this question.

In particular if John Windhausen with the Schools, Health & Libraries Broadband Coalition is on the line we'd appreciate your comments on this question. But it looks like we have several folks. Justin, can you announce the next person in queue?

OPERATOR: Absolutely. Next we go to the line of Hank Fanberg of CHRISTUS Health. Your line is open.

MR. FANBERG: Thank you. And thank you for the opportunity. Let me also extend that I, technically, was the Project Coordinator for the FCC Rural Healthcare Pilot Program in Texas. Just a couple of general comments to the question.

The Rural Health Program I think is a very important and critical program, but the pace of change and technology in general in the adoption of technology by healthcare facilities and the need now to send simultaneously data, video, needs for bandwidth that are increasing,

that I would characterize the greatest need is in flexibility with the Program and with the regulations of the Program. There needs to be flexibility in contracting; not all the time does it make sense to have a multiyear contract with a particular service provider. So, there needs to be some flexibility and new thinking in how best to provide contracting with service providers in different situations, perhaps even some of the situations that were discussed by the people representing different needs and different entities earlier.

There needs to be a flexibility in the funding, I think everyone would agree. Since the requests for funding exceeded the amount last year we're all still kind of waiting to see how much the requests were for this fiscal year now. So, there needs to be flexibility in the funding to increase the funding.

There needs to be flexibility in how we are able to use the broadband. I think USAC has been doing really a good job with what I perceive

to be limited resources over the past probably 12 months, but I think the FCC has more regulatory authority to make changes than it's been willing to accept, in my opinion, up until this point in time. So, flexibility is the key.

MR. BARTOLOME: Great. Thank you very much, Hank. Justin, can you please announce the next person?

OPERATOR: Absolutely. It looks like we have Verné Boerner again of Alaska Native Health Board. Your line is open.

MS. BOERNER: Hi, there, thank you again. I just wanted to respond to your questions that you had posed in addition as to the value as a whole and is it keeping pace. So, the answer as far as the Alaska Tribal Health System is concerned is an absolute yes. I think it's been a great example of partnership between the tribes and the FCC, so that definitely is yes.

Then keeping pace. One of the things that I would say is not keeping pace is the cap has been implemented, it's not congressionally

mandated, and that it has not changed since it's been implemented although the eligibility has been broadened and there's a broader use or broader access to the funds but the funds themselves have not changed pace with either inflation or increased eligibility for that. Those are my additional comments. Thank you so much.

MR. BARTOLOME: Thank you very much, Verné. Go ahead, Justin.

OPERATOR: Next we have the line of Eric Brown with the California Telehealth Network. Mr. Brown, your line is now open.

MR. BROWN: Thank you. I think the comments I would leave with you with regards to the Rural Healthcare Program are number one, I think it is clearly time to revisit the amount of allocation, the $400 million. The folks that I've talked to historically have indicated that there wasn't a strong justification for arriving at that number in the first place, but whether or not there was I would certainly be in favor or taking a fresh look at what should the allocation be

given the realities of today's healthcare landscape and the number of healthcare providers, et cetera, because the current situation where we're managing through the cap with funding windows and so forth, as has been said, is creating a lot of uncertainty. We're finding that that is becoming problematic with regards to getting the sites for whom the program is most intended to participate. They simply can't wait to try to figure out what the discount is going to be.

I also think that per the comments that SHLB, John Windhausen, and that group of which we're members and others have filed in the past, there really needs to be another look at the discount rate itself as it relates particularly to rural America versus the non-rural sites. When we look at what the subsidy amounts are in comparison to, for instance E- Rate, again it would suggest that maybe there is something that needs to be done there even if we had to come up with a tiered system for higher rates in rural communities

versus urban communities.

Those would the top comments. We love the Program, we just think it's time for it to be updated and enhanced.

MR. BATOLOMTE: Understood. Eric, just one quick question for you before we move on to the next participant. Setting aside the monetary cap for the Program, do you have a suggestion as to how we can better ensure that the rural areas of your state and other states that have significant health issues and have significant need for connectivity solutions get funding?

MR. BROWN: Well, I'm reminded that when you apply for grants or funding -- I know these aren't grants, these are subsidies -- usually it's either based on merit or on competition. This seems to be a little bit of both now because of the funding cap. I think that what I would like to see, certainly with regard to rural communities, is I've got a half dozen rural communities in California that we've been trying to -- these are critical access hospitals, tribal

health facilities, rural health clinics, that we've been trying to get fiber-based broadband to so that they could do telemedicine, do duplex video communication for seven years. And we haven't been able to do it because even with the Healthcare Connect Fund had a 65 percent subsidy.

Again, standing on its own, we can't make it pencil out. So, I go back to my comments earlier around maybe if there's the ability to use the funds in conjunction with other federal funding for schools, libraries, public safety, et cetera, I could see us in at least half of those cases coming up with a viable solution.

MR. BARTOLOME: Thanks very much, Eric. Justin, will you please announce the next participant?

OPERATOR: Certainly, thank you. So, next we'll go to the line of Eric Brown of Telehealth Network.

MR. BARTOLOME: I think that was just Mr. Brown.

OPERATOR: I apologize. Next we have

the line of John Windhausen who is with the SHLB Coalition.

MR. BARTOLOME: Great, thank you, Justin.

MR. WINDHAUSEN: Hi, this is John. Thanks for having me on. I have four points that I'd like to make which I'll do as quickly as I can.

First, in response to your questions, the first question was in the Program valuable. Yes, it's enormously valuable, in fact it's a shame that it's the smallest of the four universal service funded programs when arguably the healthcare program should be at least equal in size to the other three universal service fund programs. So, it's enormously important.

I would also add that I fully support the comments from our friends in Alaska, but this is not just an Alaskan issue. We've heard from California but we also have rural telehealth networks in Utah, and New Mexico, and New England, and Arkansas, and other places around the country

where this rural health connectivity is vitally important to extending both the quality of care and the cost of care is much cheaper if you use a telemedicine solution which is increasingly important as we face this critical shortage of hospitals in rural areas. So, I'd say this is a national problem that's critically important for the FCC to address.

You asked a question about whether the Program has kept up with the changes in the marketplace in demand. Absolutely it has not. The obvious point being that it's 20 years since the cap was set at $400 million and just inflation alone would argue that the cap should be $700 to $800 million. But there are other changes that have taken place as well. The addition of stilled nursing facilities by Congress means that there are additional eligible applications for this Program and that's wonderful and very worthwhile but it does add stress to that $400 million cap.

The other change that I just learned about a couple of hours ago today that I didn't

appreciate until I went to this ATA briefing on Capitol Hill. They talked about the increase in bandwidth demands that has been required because of electronic health records, and the fact that the 2009 stimulus bill encouraged all providers to adopt electronical medical records. Those really began to take off in the rural markets between 2013, 2015. So, just one provider gave an example that the average bandwidth demand per site grew from 7 megabits per second in 2013 to 317 megabits per second in 2015. So, just in two years the bandwidth demands just exploded. So, that's another example of why the cap really needs to be raised and the percentage taken a look at.

In response to your other question to Eric about the priority for rural areas, I think we're all in agreement about the needs for rural areas. One idea that I'll just throw on the table, I can't say we necessarily endorse this yet but it ought to be looked at, as whether you could provide some sort of a guarantee or priority funding for the rural health clinics and their

connectivity. So, that would help to provide some certainty going forward and would help these telehealth networks with their planning purposes, whatever the percentage is, and probably should be increased for those rural providers. But also if they could be accompanied with a priority system or guarantee that that funding will continue to flow, that I think would help, as I said, the certainty and also provide some stability going forward.

Now, obviously that leaves the question, well, the second priority, what happens to them? And that's still something that needs to be thought through. So, I'm not necessarily wholeheartedly endorsing the idea yet but I think it is something worth talking about. Thank you.

MR. BARTOLOME: Thank you, John. Just one quick question for you. Is the SHLB Coalition, would it prefer some sort of priority mechanism as opposed to the current pro rata approach with respect to available funds?

MR. WINDHAUSEN: Well, that's exactly

what I'm putting on the table for discussion. I know there was a priority system in place for the E-Rate Program and then the FCC moved away for that once it found more funding. So, if we can fully fund the Program, and doubling the amount of money I think is a reasonable place to look at doubling the Program. Maybe you don't need any kind of a priority system at that point because then the funding would be there. But if the funding is not available to fully fund it at the $800 million and you're stuck with the $400 million cap maybe there needs to be a priority for the rural connections.

MR. BARTOLOME: Great, thank you very much, John. Justin, would you please announce the next participant?

OPERATOR: Certainly. Next we'll go to Jon Zasada with APCA. Your line is open.

MR. ZASADA: Good morning, and thank you for this opportunity. I'm with the Alaska Primary Care Association. We support the activities of Alaska's 26 federally qualified health centers

that operate at 179 sites throughout the state. I really don't want to belabor the points that have been made by my colleagues, Connie Beemer and Verné Boerner, or those made by John Windhausen.

Again, we have found great value in the Rural Health Program. It has until 2016 largely kept up with changes that our rural clinics have experienced. The state of Alaska has largely built its medical system on the promise of affordable high-speed dedicated internet at sites throughout the state through a variety of different technologies.

It became inadequate in 2016 when fears of proration came to reality. We have providers that are looking for lower-cost redundant backups, potentially cutting the types of imaging referrals that they send out, and even looking at different types of backup for their electronic health records if they were to not be able to afford the internet that they are using.

In regards to the regulatory framework of the Program, I know there have been some

conversations regarding whether the application process is too onerous or too easy and what the ramifications could be if it was made more easy and potentially more folks would apply for the available funds. It's a difficult situation for our providers. Most of them do not use consultants in their application process and we provide technical assistance in order to make sure that they are fully compliant heading into any given year. So, it would be a benefit if it were less onerous but at the same time we want to make sure that there is adequate funding for the safety net in frontier providers of which we are.

I think that pretty much concludes what I had to say. Again, we absolutely support an increase to the fund. We've also heard conversations that there could be an effort to seek additional funding of RHC potentially through the Department of Health and Human Services. We're wary of that approach. We currently believe that the universal service charge is a good way to fund this Program. We fear that seeking

additional funding through Health and Human Services could put additional pressure on the range of programs that they currently fund. So, that's one other thing that we've been starting to hear about here just in the last two weeks. With that I'll conclude my comments, thanks.

MR. BARTOLOME: Great. Thank you very much, Jon. Justin, please announce the next person in queue.

OPERATOR: Certainly. Again, we'll got to the line of David and Nikki with CSD Communications for the Deaf. Your line is currently open.

MS. SOUKUP: Hi, everyone. This is Nikki speaking. I am with CSD Communication Services for the Deaf. I want to talk specifically about what the FCC could add to their current requirements and considerations going forward.

Maybe you know that CSD was originally founded in South Dakota several years ago. South Dakota is largely rural. Since that time CSD has

grown to provide services for deaf and hard of hearing consumers all across the nation and even internationally providing a number of different needs, a lot of them being specifically in rural areas. Those rural areas sometimes have no access to communication, specifically interpreting services. One area that the FCC can really do is to make sure that the RHC providers and caregivers have training about how to provide services to people with disabilities, specifically providing interpreting services when they are requested. Not all small clinics do, and we know that it is a critical need for the patients in that moment, for them to have access to good healthcare especially for people with a wide variety of disabilities. Providing training to the folks who have disabilities themselves as well will also benefit this Program.

Also, FCC could think about providing resources, and we would be happy to share a number of resources that the RHC providers could use to really increase their ability to provide quality

services to patients with disabilities and who are deaf and hard of hearing specifically.

When it comes to funding for this Program of course we want to do what we can to conserve the fund because the costs of providing these types of services -- it can become very costly.

Any information that is provided to patients in a visual way should be provided in their native language as well. It would be beneficial to the patient. The point being that we need to be more considerate of people with disabilities and to ensure that they are receiving effective care and are fully aware of what's happening.

MR. BARTOLOME: Terrific. Thank you very much, Nikki and Madam Interpreter. Justin, can you please announce the next person in queue?

OPERATOR: Certainly. Next we'll go to the line of Joshua Seidemann, Vice President of Policy of the NTCA-The Rural Broadband Association. Your line is open.

MR. SEIDEMANN: Thank you. I just wanted to follow up on something that John from SHLB noted. I so appreciate his mentioning the need for resources and the question of why certain programs might not have an inflationary factor built into them so that we're looking at the same sort of resources that were allocated 20 years ago, yet inflation has caused every (inaudible) to increase.

So, just commenting on that, and this is more sharing than anything else, I mentioned before that there's going to be a need for almost a multi-agency push for certain policies. By the same token, on the other side of the fence I think there's benefit for all of us thinking about the proposition that very often policymakers will see the logic and the intuitive goodness of a position, and yet sometimes it takes certain data points and demonstration that there's an actual return on an investment to push certain decisions over the finish line.

So, to the extent that this is useful

for anyone on this call, NTCA published about six months ago a paper that begins to quantify the positive economic benefits of rural telemedicine deployments. They are attached to the comments that we filed in this proceeding in May. Just, again, to the extent that that helps the people on this call develop their policy and advocacy, I just wanted to make that known.

MR. BARTOLOME: We certainly appreciate it. Thank you very much, Joshua. Justin, is there anyone else in queue?

OPERATOR: At this time we have no one further in queue.

MR. BARTOLOME: Thank you. I'm trying to be conscientious of the available time we have and time sure has flown very quickly. Our next topic is about accessibility of broadband-enabled health technologies for people with disabilities, and it's been fantastic that Everette, David, and Nikki have provided comments with respect to the topics we're discussing as they concern people with disabilities. If anyone else has anything to

add with respect to really the Commission's interest in ensuring that people with disabilities are able to access the variety of broadband-enabled services we'd like to hear from you now. In particular if Dr. Nygren is still on the phone with the American Association on Intellectual and Developmental Disabilities, if you have any sort of comments concerning folks with cognitive disabilities or impairments with respect to broadband technology we'd appreciate hearing from you.

So, if anyone has any additional comments with respect to this current topic please press *1.

OPERATOR: Now we'll go to the line of Margaret Nygren. Your line is open.

DR. NYGREN: Hi, this is Margaret Nygren with AAIDD on the line. Thank you for the opportunity to comment.

It's really quite challenging because people with intellectual disabilities are on a range, a whole gamut, of capacity and may or may

not have co-occurring conditions that probably are more on point with accessibility than their diagnosis of intellectual disability. So, it's just too broad and diverse a constituency to make a single comment on, but thanks for considering that.

MR. BARTOLOME: Right. Thank you, Dr. Nygren. Justin, anyone else in queue for this topic?

OPERATOR: Now again it looks like we have the line of David and Nikki of CSD Communications for the Deaf. Your line is open.

MR. BAHAR: Hello, this is David again, specifically to talk about people with disabilities. There are several considerations that should be included and taken into account. First off, we have found that within the deaf and hard of hearing community there is an overwhelming preference to access broadband via mobile devices as opposed to through fixed computers or things of that nature. So, for the deaf and hard of hearing communities specifically who do prefer to use the

mobile broadband we do think that there are several things that are really critical for the FCC to consider in rulemaking.

Number one is that it is really crucial that the data caps for mobile broadband have some type of consideration for people who are deaf and hard of hearing and also who are going to use more data purely because they are using video communication as opposed to voice communication. If there is to be a widespread use of telemedicine and video medicine specifically then there will be a lot of those types of services that could be done with two gigabytes a month, or rather that would not suffice. It would be incredibly limiting.

So, that would need to be increased, the use of data for deaf and hard of hearing people on a monthly basis. That would be one example. It can be very expensive for them to try to access the different broadband health services from their mobile phones because of the way in which they're going about doing it.

Also, we need to think about the reliability of it, the telemedicine through mobile means. It would need to be standardized for mobile broadband in the same way that it has been standardized for the current landline broadband programs, the 25/3 as was mentioned before.

So, those two things really are crucial to be considered in order to help deaf and hard of hearing users really access telemedicine through the devices that they prefer to engage with it.

Moving on, I would also like to add the previous comments about RHCs, I do think that it really is important that there be some consideration made thinking about the connections to funding that the different entities might receive to really ensure that they are providing training and outreach to people with disabilities who use those services, to really teach them how they can use the broadband-enabled telemedicine application and different types of services that might be offered in their area.

So, beyond that deaf and hard of hearing

people can use broadband telemedicine services in one of two ways if we break it down. Speaking specifically for video connections, they would be connected to a sign language interpreter which provides them with access to the medical professional through sign language, their native language. However, we would prefer that they receive services directly from medical professionals who are fluent in American sign language to the extent that the FCC can do so under their authority. We would like to encourage some sort of education to the medical organizations that provide the broadband health services to just really let them know that they can provide medical professionals who are fluent in sign language, that there really are cost incentives and benefits for them to really reduce the expenses that they would need for interpreting services, for example, in one way. So, that's something we would want to encourage not just because of the cost, because of the quality of service being enhanced as well as a result. Thank

you.

MR. BARTOLOME: Great. Thank you very much for those comments. Ladies and gentlemen, it looks like our time is up, but we can certainly extend the session for a little bit longer. I want to make sure that anyone who has not had an opportunity to provide comments have an opportunity to do so now. So, this is your opportunity. Does anyone else on the line have any additional comments which he or she wishes to make before I make some concluding statements? If you do please press *1 right now.

OPERATOR: First it looks like we have the line of Hank Fanberg with CHRISTUS Health. Your line is open.

MR. FANBERG: Thank you. I just wanted to actually give a shout out to the Program. One of the major users of the subsidies, the pilot program, is a mental health, behavioral health provider in south Texas. The state of Texas outsources mental health services to different agencies; every single county in the state is

covered. We have one provider that covers eight rural counties and they were able to expand their broadband business director because of the Program providing very critical service to eight counties in Texas. So, to me it demonstrates the importance of the Program, the potential impact that this Program can have, and for all the good reasons that the other people have spoken out as to why, we need to continue moving this Program forward. Thank you.

MR. BARTOLOME: Thank you, Hank. Justin?

OPERATOR: Next we have again the line of Danielle Dean, Policy Director at the National Conference of State Legislatures. Your line is open.

MS. DEAN: Thank you. I will be submitting formal comments with all of the state legislation. I just wanted to quickly conclude by saying this is an issue that state legislators are very passionate about, they're very concerned about it. There have been a lot of activity on

looking at universal service funding, incentive programs through grants and tax incentives. There has been a lot of conversation about the role of municipal broadband and looking at larger broadband strategies and communicating with their governors, the executive leadership, on how to get the information that they need in order to service this population.

So, I just wanted to conclude with that and say that we are excited to give you the information that we have on this topic.

MR. BARTOLOME: Fantastic. We very much look forward to receiving it. Thanks very much, Danielle. Justin, is there anyone else in queue?

OPERATOR: No one further in queue at this time for us.

MR. BARTOLOME: Thank you. So, it looks like there are no additional comments, and since our time is up I just wanted to thank all of you for participating today. This was an outstanding session and we really appreciate very much the input you provided. If you wish to provide any

additional input or comments please consider submitting written comments on this matter. Last Monday we sent you sent you some instructions for how to file written comments so you can use those or you can just contact us if you need some guidance. If you have any questions in the future or need to contact us please just send us an email at connect2health@fcc.gov.

Again, thank you all very much, and thank you very much Justin for your assistance. Have a great afternoon everyone. Justin, can you please conclude the session?

OPERATOR: Absolutely. Ladies and gentlemen, that does conclude the conference for this afternoon. We thank you very much for your participation and for using our executive teleconferencing service. You may now disconnect.

(Whereupon, the PROCEEDINGS were adjourned.)

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