September 10, 2018

Secretary Marlene H. Dortch

Federal Communications Commission

Washington DC 20554

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RE: Response to FCC NOTICE OF INQUIRY

Promoting Telehealth for Low-Income Consumers

WC Docket. No. 18-213

Dear Secretary Dortch and Members of the Commission:

The Cherokee County Health Services Council (CCHSC) appreciates the opportunity to respond to the Federal Communication Commission’s Notice of Inquiry regarding “Promoting Telehealth for Low-Income Consumers”, WC Docket No. 18-213. CCHSC is a coalition of local leaderships aiming to serve the needs of Cherokee County, Oklahoma. CCHSC was created by an interlocal cooperative agreement between Cherokee Nation, Northeastern State University, Tahlequah Hospital Authority, and the Board of County Commissioners of Cherokee County, Oklahoma on February 25, 1999 under the provisions of 74 O.S. 1981, S1004, Oklahoma Statutes. The primary purpose of the council is to enhance the health status of Cherokee County citizens.

Cherokee County, Oklahoma, is a federally designated rural county by the U.S. Census Bureau,[[1]](#footnote-1) and is one of 14 counties located in the rolling hills of Northeastern Oklahoma that constitute Cherokee Nation, the largest Native American tribe in the United States.[[2]](#footnote-2) The land area for Cherokee County in square miles is 749.41 and the population per square mile according to the 2010 census was 62.7.

Within its boundaries, Cherokee County has about 20 U.S. census “places”[[3]](#footnote-3) with the largest 12 having a population between 495 and 15,753. Tahlequah (population 15,753) is the county seat and largest city within the fourteen surrounding counties. It is also the capital of Cherokee Nation. Residents receive health care services from one of three institutions in the area—Northeastern Heath Systems is the city/county hospital, Cherokee Nation Health Services (hospitals and clinics), and Northeastern Oklahoma Community Health Centers is a federally qualified health center. Northeastern State University, a four-year institution of higher learning, is in Tahlequah and was originally the Cherokee Female Seminary, established in 1847 and the first school of higher learning for women west of the Mississippi. The primary industries in Cherokee County are agriculture and mining.

In regards to broadband providers, Tahlequah is largely served by two wired providers: Cablelynx Broadband and AT&T Internet. Both of these providers offer wired internet service to large parts of Tahlequah. Lake Region Technology & Communications provides fiber optic services to just over 5,000 homes in Cherokee County and covers some smaller areas of Tahlequah with its wired residential service.

Should an RFP develop from this Notice of Inquiry, CCHSC intends to submit a proposal for FCC’s consideration in partnership with Cherokee Nation Health Services System (includes Hospital, outpatient clinics, and behavioral health), Northeastern Health Systems (Hospital and specialty services) and Cherokee Nation Business (Home Health Agency). These entities work together to provide primary care, home health services, hospice care, behavioral health care, transportation and medication delivery to all low-income community members of Cherokee County of all races—including about 3,500 veterans, and have unique access to the American Indian population in the area. To support broadband efforts we will also partner with the three providers in the area-Cablelynx Broadband, A T & T, and Lake Region Technology & Communications.

This proposal would focus on increasing Remote Patient Monitoring to veterans and low-income rural residents to reduce the incidence of rehospitalizations, emergency room visits, hospital length of stay, morbidity and mortality by monitoring health indicators of patients afflicted with diabetes and hypertension. CCHSC would partner with Connected Home Living to place patient kits in the homes of individuals referred by the medical provider for monitoring. This service providers 24/7/365 internet .access to care coordinators and a team of providers to address medical events immediately and in the most cost effective manner. As a criteria of service delivery, broadband services would be installed in those homes currently without services. Activities would be assessed through increased acceptance and utilization of technology as treatment for health conditions and improved physical well-being of residents reflected by lower A1C scores, reduced hospitalizations, improved quality of life, and willingness to engage in further technology-based treatment modalities.

The lack of broadband connectivity is a serious problem to the residents of rural Cherokee County Oklahoma, the government seat of the Cherokee Nation and home to many American Indians and Alaska Natives, actively serving in the military, retired military, or in the military reserve. The vision and efforts of the Commission to address the needs of this population in a Notice of Inquiry speaks to the critical needs regarding access to broadband.

17-27 Goals of the Proposed Pilot Program

The need for broadband access is great in rural areas. Many places do not have access to broadband or experience VERY slow or spotty access. Providers have a service delivery model that rolls out services in phases and is dependent upon having a percent of households in the area signing up to receive services. Service development to more sparsely populated areas are to come at some future time. The role of internet access today is similar to having telephone lines in the past. It functions as a critical utility in order to communicate and compete in today’s world. It should be the role of the government to ensure equal and equitable access to all.

Having a comprehensive plan to broadly cover rural and less densely populated areas would greatly aid rural communities. In our area, there is limited telehealth services focusing on behavioral health and these employ a hub and spoke model, wherein individuals must travel to a central site to access the equipment for the telehealth appointments.

The interest in telehealth is growing but the infrastructure does not allow for agencies to take full advantage of the many benefits proffered through broadband access.

A pilot program focused on improving health should not be restricted to specific conditions, but rather, should address the needs of the targeted community, and should include programming for pediatric services.

Emphasizing trends towards direct-to-consumer models of care would push providers to integrate services more quickly resulting in quicker outcomes for community members and lowering costs. In our envisioned program, we would have a patient kit with monitors on-site with the patient and 24/7/365 access to a medical provider who could immediately address concerns and alleviate emergency room visits, ambulance rides, and hospitalizations—expenses that could be minimized or totally avoided.

To maximize the benefit and reduce duplication, we believe there should be a partnership component to the pilot program that requires groups to identify and work with others in the community who are offering or considering telehealth.

The expansion of broadband into rural and less populated communities appears to be dependent upon the marketing plans of various providers. Unless an area meets minimum ROI standards, the area is unserved. The roll of the FCC should be to require providers to present plans, timelines, and deadlines that will ensure full coverage for all residents in the United States in the next two to three years, and provide funding toward that end. Support for internet providers to participate in pilot programs is a start.

Adoption rates are low because of the cost of installation and maintenance of broadband services. Low-income families cannot afford monthly fees of $50 or more a month – the typical charge in Cherokee County.

28 - Structure of the Program

The current pilot suggests a limit of 20 medical providers and one hospital and it is unclear why there are restrictions on the number of medical provider participants. The eligibility criteria for health care providers in our project would be their willingness to have their patients be monitored via telehealth.

Further, infrastructure needs in rural areas are great and the costs of installation are high. It can cost in excess of $4,000 per home to build a broadband network in rural areas and the cost for our county to become connected is projected to be $70,000,000.  We recommend that the budget be at least $10 million.

The selection criteria should be aimed toward applicants that have both health care and broadband partnerships and that are actively expanding broadband and homebased health care to the rural areas in their community. In our project, the broadband providers would be chosen or eligible if they were in the process of constructing fiber optic broadband internet services, to consumers in medical need. Again, we believe that it should be funded for 5 years at $10,000,000 with quarterly drawdowns from the federal financial system.  We recommend 10 providers at $10,000,000 each.

29 – 30 Budget

Factors to consider when determining a budget include the extent of existing services and the level of need for new services. Areas with greater access may have less costs associated with developing and implementing a pilot program. Access and current coverage should be a consideration for funding with priority given to states with lower coverage.

31-33 Application Process and Types of Pilot Projects to be Supported

CCHSC believes that priority should be given based both on geography and health condition.

34-36 Eligible Health Care Providers

CCHSC suggests allowing all health care providers to participate and limit services to those patients meeting the pilot’s criteria—low income, rural, and/or veteran. Further, federal definitions exist for “rural” and “urban” and their use would minimize confusion and the need for creating definitions. If the emphasis is expanding fiber optic infrastructure and promoting telehealth, the proposed project should prioritize hospitals that have yet to fully implement telehealth.

37-38 Partnering with Facilities-Based Eligible Telecommunications Carriers

We concur and have no comments.

39-41 Eligible Low Income Subscribers

In Oklahoma, we did not expand Medicaid so have residents who would be Medicaid-eligible if living in another state. Rather, the criteria should be income based using Federal Poverty Level Guidelines.

The pilot program should focus on low-income individuals/veterans who do not currently have broadband but should not restrict participation. In some areas, residents have access to broadband but do not use it due to costs or fear of change. These residents could be made aware of the FCC Lifeline Program that provides subsidy for low income households that can be used to reduce phone or internet service costs.

This pilot should cast a broad net in order to collect data and information for future planning. In our proposed program, we have daily monitoring and monthly check-ins. Service is delivered in 60-day increments, thereby greatly reducing the need for recertifications of income or eligibility status. In other programs, eligibility is determined on a bi-annual basis.

42-48 Supported Services

We concur the program should support fixed services and should consider 4G or 4G LTE bandwidth.

The RPM equipment should be provided by the RPM service and included as a component of the budget. Further, the pilot program should fund mobile health applications (the wave of the future) selected by the health care providers.

49-50 Number of Pilot Projects Selected, Support, Amount, and Disbursement

As a pilot, there should be cohorts of similar programs across a varied geographical background, e.g. 3 Tribal Programs; 3 rural frontier programs; 3 rural Midwest programs, etc. with a range of $5 TO $10 million based upon costs and number of clients served. There could be inter and intra comparisons to see how funding needs to be disbursed. In California, costs are higher than in Mississippi, so having a set cap may not allow for equal and equitable comparisons. Rather, funding based on annual costs of clients served may make more sense, with costs for infrastructure as a separate line item.

51 – Duration

Further, the pilot should be for a five-year period to allow time for infrastructure development that may be needed prior to delivery of patient services.

52-Compliance

There should be no barriers to delivery for CCHSC in that we would be paying for the services directly and insurance providers would not be billed at present. It is anticipated that billing will be allowed and should be implementable by project end.

53-54 Ensuring effective fiscal responsibility

The Commission may ensure pilot program funding is appropriately spent by prohibiting co-mingling of funds, requiring separate accounting. Annual program reports, including fiscal reporting would also support fiscal responsibility.

To ensure appropriate client utilization, the programs should collect and report data as part of a quarterly reporting schedule.

55-56 Patient Confidentiality

All staff should be trained on HIPPA, all partnering organizations should have confidentiality policies in place and all staff should sign confidentiality agreements. Further, any providers or subgrantees providing direct services should supply this documentation to the administrative agency.

57 – Lessons Learned

CCHSC generally concurs with the recommendations of the 2006 Rural Health Care Pilot Program Staff Report, particularly in regards to the effectiveness of consortiums, bulk purchases of bandwidth from local providers and the ability to acquire faster data transfers.

58-67 Measuring Effectiveness of the Program

The administrative agency should be the entity ultimately responsible for data collection and reporting requirements. A general set of key metrics should be collected from pilot programs that include: numbers served, hospital readmissions (avoided), changes in health condition (reductions in symptoms) and impact of quality of life. Local evaluations can report on key measures relevant to their programs. For example, in our pilot we target people with diabetes and hypertension, so would measure the number of people acquiring broadband, changes in A1C and blood pressure, number and acuity of medical events, types of services needed (hospital admissions), and impact of quality of life and acceptance/willingness to use technology for future medical care. Most grants require bi-annual progress reports and project officers could request more frequent reporting in needed.

63- CCHSC does not recommend the requirement of a control group. This would place an undue burden, particularly on small and rural programs. The requirements and costs accompanying a research study could vary widely depending upon the type of program the pilot is providing. In our case, it would be difficult to find a comparable control group of rural American Indian individuals unless services are withheld from a segment of our population, thereby reducing the numbers of people acquiring broadband and access to telehealth services – counter to the overall goals of the project. Further, each tribe is sovereign, and accessing data about another tribe’s health is prohibitively difficult.

64-Measurement of savings could be done on both the macro and micro levels. Savings related to reductions in emergency room visits and hospitalizations can be calculated based on electronic health records. Reductions in office visits and time spent in waiting rooms can be calculated by comparing past and current events, and savings to the patients can be computed through reports from patients about the personal costs (time, money, lost wages, transportation, childcare, etc).

65-66. To track success, in our program we would work with the broadband providers to gather information on number of clients served and a map of the area pre and post the program to demonstrate the increase in services to rural populations as a result of this project.

67. In rural areas, broadband adoption may be greatly desired but unaffordable, particularly in high areas of poverty. Consequently, a measure of services delivered may not be a measure of services sustained over time. At best, the pilot could measure intention to retain broadband and seek to find support for very low income individuals who have been successful in their efforts to improve their health and have been discharged from the patient monitoring program. The advantage of having a 5-year program would be the ability to track all patients (active and in-active) over time to determine how they have integrated broadband into their lives and health care plans.

68-Procedural Matters

Cherokee County Community Health Services Coalition shall not be making a presentation.

END OF COMMENTS

1. www.census.gov/population/www/metroareas/metrodef.html [↑](#footnote-ref-1)
2. http://cherokee.org/About-The-Nation/Frequently-Asked-Questions [↑](#footnote-ref-2)
3. A **census** designated **place** (CDP) is a concentration of population identified by the United States **Census** Bureau for statistical purposes. CDPs are delineated for each decennial **census** as the statistical counterparts of incorporated **places**, such as cities, towns, and villages. [↑](#footnote-ref-3)