

1 of the oldest and largest Native run health organizations in
2 the nation. It is a consortium of 20 Native communities,
3 providing health services for Tlingit, Haida, Tsimshian, and
4 other Native people in Southeast Alaska.

5 This panel, like the panel before, have received several
6 questions, basically focusing on the use of advanced services
7 to telehealth, what the impediments are, how their organization
8 has used these services and cooperated with others to be able
9 to advance these services in their regions, and basically to
10 comment on how this is impacting health care delivery.

11 Again, I'd like to provide to each of the panel members
12 five minutes to address these questions, and then to allow us
13 to have time for exchange. Maybe we'll go in the opposite
14 direction this time and start with Tom? Dr. Nighswander, would
15 you like to.....

16 DR. NIGHSWANDER: Yeah, Tom Nighswander. And I'm
17 facilitating the Telehealth Advisory Group. It is -- just to
18 tell you that it is made up -- we look at telemedicine at the
19 60,000 foot level, we have major -- the major players involved
20 in policy development, so that -- Tom Posey, for example, I
21 represent Tom and Ron Duncan from the telecommunication
22 industry, plus the Alaska Telephone Association. The CEOs of
23 the major -- the hospitals here in town. Provider groups, the
24 Nursing Association, State Medical Society, I represent it. So
25 that's the group, there's a few more involved with it.

1 And it is around policy development. It was organized
2 really at the request of Senator Stevens, and it was originally
3 chaired solely by the Commissioner of Health, Karen Perdue, now
4 co-chaired by Karen. And the issue was this infrastructure
5 cost, one of the -- is to get everyone on the same page. That
6 in this state we're not going to be able to compete, as opposed
7 to larger population groups, and we were going to have to share
8 infrastructure, we're going to have to share software
9 development, and the competition in the health care industry
10 would really be around services. So when you punch the button,
11 you're sitting in Nome or Kotzebue, the button you push is
12 dependant on the services that you'll get from the other end.

13 The comments I'd like to make are very apropos to the --
14 actually the first panel, because those are the same issues
15 that we are facing. The most successful applications probably
16 thus far have been teleradiology, and we are transmitting both
17 the public and the private sector teleradiology images from the
18 rural areas and they're being read centrally. There are a
19 number of e-mail applications, and it's -- and using kind of a
20 store and forward technology. That's the good news. The bad
21 news is they're not reimbursed. And right now insurance
22 companies and states around the country in Medicaid are not
23 reimbursing for -- or Medicare, reimbursing for store and
24 forward technology. And that's a real problem for us in
25 Alaska.

1 They are reimbursing for real time telecommunication
2 capacity, and the best clinical example I can give you of this
3 is -- and you would be surprised, is in telepsychiatry. I
4 believe there is a telepsychiatry application here, done by
5 Corrections. And they can, with very little technology, POTS
6 lines and videophones, do some monitoring of patients and
7 follow up and immediate assessment of prisoners as -- which is
8 required by state law to be evaluated after they are
9 incarcerated.

10 However, if you take one of our greatest needs in this
11 state, which is adolescent and child psychiatry, that really
12 requires observation of the group setting of the child, and
13 that's going to be -- that's got to be real time and high
14 bandwidth capacity. And that -- so as you go up bandwidth
15 capacity, we can really do more around the state than low
16 bandwidth, and that's what we're pushing for.

17 The big issue, as they've all mentioned, and we've all
18 seen -- I was in Fort Yukon a few weeks ago, and it's the issue
19 of multi-use of these -- of the bandwidth. That's got to be
20 where it's at, and I think in pretty creative ways, with
21 partners we're not typically used to working with. And I'll
22 stop there, Lieutenant Governor.

23 LT. GOV. ULMER: Great, thank you very much, Tom. Bob.

24 MR. CITA: Hi, my name's Bob Cita, and I guess one of our
25 questions was to share an innovative and effective use of

1 advanced services to provide health care. And I think the one
2 thing I'd like to share is a project that's run out of the
3 Alaska Native Medical Center, and it's a project called Multi-
4 Facility Integration. And it's a system in which all the
5 tribal organizations without -- throughout the state of Alaska,
6 as well as the public health nurses in the various communities,
7 can share visit information, health record information, amongst
8 ourselves.

9 I think there's a lot of travel throughout the state. For
10 instance, in Sitka there's a state boarding school that we get
11 kids from all over the interior down. And through this
12 program, multi-facility integration, their health information
13 that's stored, say, up in the hospital in Bethel can be
14 accessed by the hospital in Mount Edgecumbe and Sitka. If that
15 kid comes in with a -- needs a suture, we can look to see if
16 they've received a booster shot recently.

17 The other big -- the big bonus of this project, as I'd
18 mentioned, the public health nurses. We're interconnected with
19 that organization, and they provide a lot of the immunization
20 shots out in the rural part of the state. And so as the kids
21 travel, if they come out of a village to come in and do some
22 shopping, and stop and want to get some shots as well, we can
23 through the system determine if they've received -- you know,
24 which shots they have received.

25 It's kind of a low tech system in a lot of senses, and for

1 me I think that's it's beauty. I think through some of the
2 programs such as Universal Service Funds, that the rural health
3 -- I kind of see the fog's kind of lifting in the state. And
4 we're, for the first time, I think able to look out and ask
5 some questions and look at some more innovative and perhaps
6 higher tech solutions to meeting some of our health needs in
7 the smaller communities. And I just would like to share our
8 excitement over this project, and like to see it continue.
9 Thank you.

10 LT. GOV. ULMER: Rebecca?

11 MS. GRANDUSKY: I'm Rebecca Grandusky, Chief Information
12 Officer in YKHC, and I also chair the AFHCAN Telemedicine
13 Steering Board. And that is a major telemedicine project
14 that's going on around the state right now. It was funded
15 through the generosity of Senator Stevens, and it includes all
16 of the federal agencies in the state, as well as the state
17 public health nurses are a part of that project.

18 And what we see from telemedicine, and in looking at the
19 HIPAA regulations that are out there floundering right now, and
20 we don't know where they're going, but the strength of HIPAA,
21 it sounds like that the telemedicine is going to be a wide area
22 network that is -- has many protection and security layers.
23 And so whether that can be done over the internet right now is
24 questionable, and may require us to have a stand-alone
25 telemedicine network in the state.

1 And we're watching the regulations real closely because of
2 that. It will allow us to have internet access, but we will
3 have to make sure that we have really tight portals to the
4 internet access. And in fact, that's what YKHC is doing right
5 now. We have one internet access portal and we monitor that
6 tightly. We are able to transmit that across our wide area
7 network to health aides in the villages using a proxy server.

8 And as far as the questions that you put out, I think that
9 for us, telemedicine is going to help us really to provide
10 services locally, which is what our patients want. It will
11 give also our health aides access to peer support, and our
12 other providers. We're in very -- our providers work in really
13 isolated areas, and they feel sometimes professional isolation
14 as well as personal isolation. And telecommunications will
15 really provide an easier forum for them for their referrals,
16 and for looking for information both on the internet and from
17 other providers.

18 We hope that what it will do for us is to lower our
19 provider burn out rate, and maybe help with our provider
20 turnover. And believe it or not, health aides have as high of
21 a turnover rate as providers in our area because of the stress
22 level put on them due to their isolation. We also hope that it
23 will help patients to become more educated in their own health
24 care.

25 I think the most important thing for YKHC is asynchronous

1 transmission, or store and forward technology. There's really
2 two main reasons for that. Number one is the barrier of time.
3 We're talking about busy providers. We're not talking about
4 doctors who have time to schedule a two-way interactive
5 videoconference with a patient and a health aide, we're talking
6 about people who have minutes in their day to spend reviewing
7 charts. And by having store and forward technologies,
8 physicians and health aides can review charts at their
9 convenience rather than trying to have everybody scheduled
10 together. So time, I think, is a big barrier to us.

11 And the second barrier is transmission quality, and you
12 heard that earlier in the discussion about the latency delays
13 in the satellite. And that's just going to be a fact of life,
14 we already know that, but the store and forward technologies
15 really give us the ability to clean up that jerkiness and
16 fuzziness and all the junk that comes across the satellite.
17 And we can put in software to clean it up, so that at the
18 provider end it's a very fast, easy connection when they
19 finally get to look at the picture. And it makes a big
20 difference when your day is already hectic.

21 I think the most significant impediment for us is cost.
22 When you look at the cost of broadband access in Anchorage at
23 \$900 a month recurring cost, and in Bethel at \$13,000 per month
24 recurring cost, there's no comparison. So until there's some
25 kind of equity in the rural costs, whether it's a ground or a

1 satellite transmission, you aren't providing equal service to
2 the State of Alaska communities.

3 The final thing I'd like to say is that I think there's a
4 really great opportunity here for reduction in costs with
5 satellite transmission because we can integrate voice and data
6 now, and that's going to make a big difference to us. When we
7 look at YKHC, we right now are paying over \$2 million annually
8 in telecommunication costs, which is almost three percent of
9 our budget. And that's just our recurring use of satellite
10 time, including long distance. That number could be greatly
11 reduced for us by integrating both voice and data. So I think
12 that long-term, the change in technology will move towards a
13 voice and data integration. Thank you.

14 LT. GOV. ULMER: Thank you, Rebecca. Hazel, would you
15 like to add anything else?

16 MS. JULIUS: No.

17 LT. GOV. ULMER: Okay. Thank you very much to our panel.
18 Commissioner Ness, do you have some comments or questions?

19 COMMISSIONER NESS: Thank you very much. When I visited
20 Bethel and your region back in 1997, I think this was at a
21 point where we were first beginning to write our rules for
22 rural health care. And the first set of rules were too
23 difficult to apply, and indeed what we saw, looking at the
24 rules and looking at the use of the rural health care funds,
25 that there -- it was obvious that the users were not finding

1 them particularly helpful, and so we revised our rules. And we
2 seem now to have hit a better tone on those rules. Can you
3 comment -- is there anything at the moment, from a regulatory
4 standpoint, that restricts you from providing better service
5 and using the rural health care provisions of Universal Service
6 more efficiently?

7 MS. GRANDUSKY: I think this year the rules really changed
8 incredibly, to make it more efficient. What's going to happen
9 now are the HIPAA and the HCFA regulations, which are going to
10 probably still prevent us from sharing this bandwidth unless we
11 come up with really tight security mechanisms for the health
12 corporations, so -- and that's going to be the issue. Right
13 now we could most likely efficiently share the bandwidth with
14 the schools, from the regulatory side -- FCC side. It's going
15 to be now whether HCFA and HIPAA regulations will really let us
16 do that.

17 COMMISSIONER NESS: Thank you.

18 MR. CITA: I'd like to add, it's difficult for us to plan
19 for infrastructure development. I think the Universal Service
20 Fund is a great way for us to build this infrastructure, but
21 there's a certain amount of capital expense at each facility
22 that we need to obviously take on ourselves. And without
23 having any kind of a long-term sense for the project, for
24 Universal Service Funds, it's a kind of difficult business
25 decision. If we need to invest 100 or 200 or 300,000 on

1 network infrastructure, with the hopes that Universal Service
2 Funds will be out there in three, or five, or beyond years, so
3 that we can, you know, realize return on that investment. So
4 our perspective in Southeast, I think if we had a little more
5 vision -- or a little better idea to help us with the planning.

6 COMMISSIONER NESS: Points well-taken.

7 DR. NIGHSWANDER: My biggest concern, from where I sit, is
8 this issue of sustainability. After -- for example, in this
9 particular project, in five year it goes away. I know that
10 Providence Hospital has been the -- really the most active, I
11 think, private partner in the state, and they've invested out
12 of their own funds tremendous resources. And the issue is, is
13 this going to last.

14 And it -- around the country, as you've probably heard in
15 telemedicine, there's been these really compelling telemedicine
16 and successful projects that have lasted as long as the grant
17 has lasted, then they've disappeared. I mean, it's a litany
18 across this country of projects that have folded because of
19 cost issues. And so recurrent costs, cheaper transmissions,
20 and people -- in village costs -- you know, when you talk about
21 transmission costs are annualized 12, \$13,000 a year, one or
22 \$2,000 a month, it doesn't sound like a lot unless you're
23 sitting in Shaktoolik, and then it's really a barrier.

24 COMMISSIONER NESS: Even by D.C. standards, it's a lot.

25 DR. NIGHSWANDER: Is it?

1 LT. GOV. ULMER: Anything else, Commissioner Ness?

2 COMMISSIONER NESS: No, thank you.

3 LT. GOV. ULMER: Okay. Commissioner Thompson, in addition
4 to whatever questions you might want to ask, you might want to
5 share the stitched cheek example, for those who are in the
6 audience might find it an interesting case study.

7 CHAIR THOMPSON: We saw -- it was an example of store and
8 forward technology. When we were in the hospital -- Maniliq
9 Hospital in Kotzebue, they -- we saw a couple of good things
10 there, and stitch -- the cheek one was once. But they were
11 trying to show us how it was -- how this technology was used,
12 and how it was important to have these very good, high quality
13 video pictures so you could diagnose it. And the pictures were
14 kind of gross, but they showed how -- it was a puncture wound.
15 And I think that one was from Selawik, I don't remember which
16 village it came in from. But they showed us the pictures that
17 the doctor had reviewed, and how the doctor had been able to
18 use those to diagnose the patient.

19 And in that particular case, I believe that the -- because
20 of the severity of the injury, and the need to have it closed
21 up soon so it would heal quickly, the doctor in Kotzebue kind
22 of walked the person in the village through stitching the cheek
23 up. And it looked fine, we saw it again later, much better.
24 So it was a good example.

25 The other fascinating thing we saw at that, to me, was the

1 difference in connections. We -- they showed us -- they had
2 one T-1 sent to Selawik from that hospital, and we saw an
3 example of the type of transmission over a T-1. And then they
4 turned around and did a connection to Anchorage, the main
5 office of this AFHCAN project. And the difference was quite
6 dramatic. You see the kind of blurry image, and blocking in
7 the picture, and it was very apparent to me the difference in
8 quality, and the physician's ability to use this as a
9 diagnostic tool was greatly limited when the connection wasn't
10 as good. I couldn't imagine doing something like a
11 telepsychiatry assessment, or even a good assessment of wounds.
12 And the clarity over the T-1 connection was wonderful.

13 We had the village health aide put her hand down on the
14 counter somewhere, and the camera was able to foc- -- the
15 doctor from Kotzebue was able to focus in on it. And we got a
16 really good picture of skin condition. It's a very powerful
17 tool to deliver advanced medical training to areas where you
18 have a village health aide. And it was something that was --
19 it was great to see.

20 I wanted to ask a follow up question of Bob Cita, if I
21 could, which is about the medical records centralization. I
22 wanted to know more about the scope of the project, and where
23 you are in the process of deploying it, and how that project
24 was funded as well.

25 MR. CITA: It's a project that originally started with the

1 Indian Health Service, and it's managed and operated at the
2 Alaska Native Medical Center. And I'm sure Rebecca can
3 probably help me. It's throughout -- almost the entire tribal
4 -- almost every tribal site in the state of Alaska, as well as
5 all the public health nurses are connected to the system.
6 Interestingly enough, the organization I work for is not, and
7 we are the last remaining tribal agency that's not connected.
8 And it also includes the hospital here in town, too, the
9 Alaska Native Medical Center as well. So being the main
10 referral hospital for most of us in a tribal site, it's
11 important that when our patients come back home to our villages
12 that we're able to get access to those -- the visits and the
13 information that was -- the health care that was provided to
14 them while they were in Anchorage. And the project's up and
15 operating. It's been really going up -- it's been fully
16 implemented for several years.

17 MS. GRANDUSKY: In fact, the federal government was so
18 impressed with the MFI (ph) project, that they are starting a
19 project called GCPR, Government Computerized Patient Record.
20 And Alaska has been chosen as the alpha site for that. We're
21 going to test between the Indian Health Service, the VA, and
22 the Department of Defense. (Indiscernible) are already using
23 it. And it's a little bit like a credit card, it has a minimal
24 data set for patients on it, and it just tells where your
25 record is stored and what kind of a visit you had. So when you

1 look at the record on this patient, it just helps the doctor to
2 clarify where he needs to go for the record. It doesn't
3 actually transfer the records.

4 LT. GOV. ULMER: Kathy, do you have any questions?

5 MS. BROWN: Could I ask what would be the sort of
6 practical human problems of having to also coordinate, say,
7 with the education side of things here in the state? Suppose
8 we acted on this notion that we need to aggregate demand and
9 get to capacity. You know, having been in many communities,
10 and with communities, I know the practical problems of sitting
11 down with two kind of disciplines to come up with ways of using
12 it. What do you think, can we do it? Can it be done?

13 MS. GRANDUSKY: Well, we do it now to some extent. We
14 were just talking about this earlier today, or last night
15 maybe. Our health aides that float from village to village a
16 lot of times either have to stay in the clinic overnight
17 because they don't have a place to stay, or they will spend a
18 lot of time in the evening in the clinic. And they can take
19 courses on line right now. In fact, we have people from Bethel
20 doing that, too. We allow them to stay after work if they are
21 taking college courses on line. So through the health
22 corporation we're doing that. I don't know the schools. That
23 would be something you'd have to -- maybe this afternoon it'll
24 come up in the schools.

25 MS. BROWN: Well, I'm going to ask them, too, but I'm

1 asking you, of the two professions, is there a way to talk to
2 each other so that -- what we hear from the satellite folks is
3 yeah, the capacity's there, but we need folks to use it, and we
4 need them to use it more efficiently.

5 MS. GRANDUSKY: It definitely has to come from the village
6 level, I believe. I think that village communities will take a
7 firm stand and do that. We saw that in Toksook Bay where we
8 started working on this project. In fact, Hazel's from
9 Toksook. And we actually saw schools and community people come
10 together. And today I've hired one of the school people from
11 Toksook who -- or students, who is now my web designer. And he
12 does the work in Toksook Bay for us.

13 MR. CITA: I would say it's definitely a challenge,
14 because we don't really have strong relationships right now.
15 One of the gentlemen earlier -- earlier panelist had mentioned
16 that through the E-Rate and Universal Service Funds, there's
17 not a lot of incentive to, you know, combine these services.
18 And perhaps from a regulatory perspective, if there was some
19 type of initiative -- he'd mentioned that he was also a local
20 exchange carrier in those communities as well. And perhaps
21 some kind of incentive on that end where they could perhaps
22 design and build the infrastructure that would allow the two
23 organizations to connect, say, in their facility and then we
24 would, from there, share.....

25 MS. BROWN: Well, I had a similar thought. If the

1 industry itself was incented (sic) to provide services to its
2 customers, you, in a way that it was sharing those services
3 with its other customers, say the school community, would that
4 then bring you all to the table to think about how that could
5 be done?

6 MR. CITA: I think we would be more than open to, you
7 know, looking at that kind of approach. See, Rebecca had
8 mentioned earlier, too, I mean I think we do have some privacy
9 issues. Our business, we really try to, you know, defend and
10 protect patient records, and their privacy. It's very critical
11 for just about any type of infrastructure that we develop.

12 MS. BROWN: But I was hearing that even the simple
13 application of e-mail is crucial. And that seems to me maybe
14 not the whole thing, but a step that's the right way to go.
15 And if we're sitting with a capacity in our school, and our
16 health aides can get on the e-mail, it seems to me that we can
17 at least start to make incremental steps toward this.

18 MS. GRANDUSKY: I think probably in the Delta we have all
19 of the -- 100 percent of the health aides and the school
20 districts on the same e-mail network. It's called first class
21 e-mail, and it was started through the Distance Delivery
22 Consortium, you'll probably hear more about that later, but I
23 think it's a big boon to allow students direct access to a
24 health aide in case they have a private question they want to
25 ask. The problem that we see, though, is that we have to come

1 up with some better ways to encrypt that, because it's a health
2 care record.

3 DR. NIGHSWANDER: In the next panel you'll hear about a
4 distance delivery education commission that's very -- it's
5 modeled on what we've done with telemedicine. It's shared by
6 the president of the University, Mark Hamilton. And so at the
7 state level, we -- and those of us who have been involved with
8 this think that there will be a melding of interests, and
9 there's a lot of very similar, common, and vested interests.
10 There's some special applications, obviously, in medicine and
11 also in distance delivery education, but we anticipate here
12 that we'll -- at that level -- again, this is the 60,000 foot
13 level, that we'll see a coming together probably of those two
14 groups eventually, because there's so many similar issues. And
15 the big one is being accessing capacity.

16 LT. GOV. ULMER: Even though there are different
17 organizations, in a sense structurally, organizationally, that
18 make decisions and that run these programs and that process the
19 requests, I was thinking about it as we were in Kotzebue, in
20 the Maniliiq region, even though the health care is run out of
21 Maniliiq, and of course the schools are run by the school
22 district, which is an elected school board, you have many of
23 the same people who sit on both the Maniliiq board and the
24 school board. And they both, you know, are responding to the
25 same villages and the same community of interest, and serving

1 the same constituents who say they want better internet access
2 and they want advanced services from both their educational
3 system and their health care system. So it becomes very
4 possible in rural Alaska, where you have so many of the same
5 leaders in a sense of these organizations overlapping.

6 The challenge then is I think, back to your question,
7 whether or not the regulatory system or the revenues, the
8 system of subsidy, can somehow be the extra little incentive
9 that gets these groups to come together and say let's put aside
10 our separate entities and come to the table in a consortium to
11 make it work for all of the organizations and all of the
12 constituents we serve. And I think that there certainly is a
13 way in which the FCC can be a player in providing that
14 incentive.

15 MS. BROWN: Just to add there, not that our industry are
16 economic development agents, but in a sense they are. And to
17 the extent that they -- the industry is willing to sit down and
18 provide and make services available that are perhaps different,
19 and thought about differently, then that also brings people to
20 the table. And so I think from the government perspective,
21 maybe we should think hard about how to create those
22 incentives. And from the industry, private perspective, to
23 think about this as serving customers, and what the industry
24 needs from us to be able to do that better. So I think this is
25 very useful to hear this kind of input.

1 LT. GOV. ULMER: Other panel comments on any of this
2 discussion? I would like to ask if, Rebecca, you would spend
3 just a few moments talking about AFHCAN. You mentioned it in
4 your opening comments, but I think for people here in Anchorage
5 who don't know very much about it, either in terms of where
6 it's at right now or what its goals are in terms of the state
7 program, if you'd be willing, I think that would be useful.

8 MS. GRANDUSKY: I'll try. The State of Alaska federal
9 agencies received about \$30 million over a four or five year
10 period to put telemedicine equipment into 235 rural sites.
11 Most of those sites are Indian Health Service sites. There are
12 also, I believe, four Department of Defense sites, two VA
13 sites, and seven PHN sites that were on that list.

14 The telemedicine equipment is -- you saw an early version
15 of that equipment in Hazel's demonstration. It is a PC based
16 system that allows a video oto ophthalmoscope, a derm scope for
17 skin, and a heart monitor, EKG, to do wave patterns from
18 monitoring. Those three pieces of equipment will be available
19 to every one of the sites, and that -- it will also allow them
20 to purchase equipment to connect to the telemedicine network
21 that I spoke briefly about. And the telemedicine network will
22 be a joint effort. In fact, I think it's got -- already a co-
23 location in AT&T and GCI, with a across-town ATU link between
24 the two, is that correct? It's.....

25 UNIDENTIFIED VOICE: Uh-huh.

1 MS. GRANDUSKY: Oh, okay. I'm not sure what the telco
2 side has in it, but it's trying to be a telco independent
3 network so that hospitals and clinic can have their choice of
4 access to the network. The federal sites, everybody has to
5 come up with their own recurring costs to join up to the
6 network. They can only -- the grant will only purchase the
7 equipment. So that's why when we were talking about
8 sustainability earlier, and the cost of telecommunication,
9 that's going to be critical to the project if we are going to
10 continue that project beyond its grant inception. And it will
11 allow also private practices and hosp- -- private hospitals to
12 join up to the network. They do not receive equipment, however
13 they are free to join up, and anyone will be able to transmit.
14 It will allow the transmission of radiology images, and then
15 the other images that I described to you earlier.

16 LT. GOV. ULMER: Any further questions?

17 CHAIR THOMPSON: Given the opportunity, I wanted to follow
18 up with this panel and find out what their vision is for the
19 future of telemedicine in this state. As a policy-maker, it's
20 helpful to know, you know, where you want to be in five or 10
21 years as opposed to just where you are now. And what we've
22 seen and heard is a couple of exciting projects that are just
23 starting. But if you could get where you want to be in five or
24 10 years, where should we be targeting?

25 DR. NIGHSWANDER: Can I start, Nan? I think that

1 different communities are going to need different capacities,
2 depending on the -- it's going to be tailored, it's not going
3 to be one size that fits all.

4 Let me give you a real practical example. Right now the
5 Family Practice Residency program has all the equipment to do
6 continuing medical education on Thursday afternoons out in
7 Bethel to the Bethel physicians. Rebecca does not -- her
8 \$13,000 a month line is absolutely full, and she has no
9 capacity. And clearly it's a system that's all ready to go,
10 it's -- and we are dead in the water in making it happen. So
11 if you take a regional center like Bethel or Kotzebue, clearly
12 we're going to need much higher bandwidth capabilities.
13 There's no question about that. And we need it -- actually, we
14 need it today.

15 As you go -- then -- and the Lieutenant Governor
16 mentioned, our communities under 1,000. But there's some
17 regional centers. If you take people at places like McGrath,
18 and Galena, and Fort Yukon, that have -- for example, have x-
19 ray equipment, there we're going to have a tailored -- what we
20 need is kind of a tailored capacity for what is available
21 locally. I think the big promise -- the big promise, of
22 course, is services closer to home for our patients.

23 Frankly, I'm not planning on saving any money on this
24 system. You know, I think that we have all said that we're
25 going to reduce transportation costs, and that it's going to be

1 cost neutral, and I've -- I hope I'm wrong on that. I don't
2 expect to use that as an argument. I think that we can bring
3 services closer to home, but I -- in terms of capacity tailored
4 to the community, and where we want to be, I think we want to
5 have the flexibility. But the big deal is to make it
6 reimbursable and make it so it's financially sustainable, and I
7 think that's our biggest challenge frankly.

8 LT. GOV. ULMER: Thank you, Tom. Bob?

9 MR. CITA: Well, I really -- my sense is that we're really
10 on the verge of seeing telemedicine explode in the state of
11 Alaska. I would think -- and probably Tom's got a better sense
12 of this than I do, but most of the providers throughout the
13 entire state recognize potential benefits and the need. I
14 completely concur with the comments about costs. These
15 systems, at least from my perspective, I don't see a saving of
16 any costs, but I do see us improving health care, improving
17 access to health care.

18 A point Rebecca made earlier about providing support out
19 in the villages, you know, it must be a terrible thing to see a
20 trauma come in, to a health aide in a village, that it's 20
21 below zero and the wind's blowing 40 knots, and there's just,
22 you know, no chance for getting any type of support for that
23 person other than perhaps some type of a telemedicine project.
24 So I really see a lot of enthusiasm throughout the state.

25 We haven't mentioned it, but there was a federally funded

1 teleradiology project that's gone through most of the state.
2 You know, computed radiography is going to be really big, it'll
3 allow us to be able to do more x-rays out in the villages
4 without requiring high end radiology technicians to be doing
5 the shooting of the film. So I think we're -- I think
6 culturally we're really ready to probably join the rest of the
7 United States on this.

8 MS. GRANDUSKY: If I had to say where I wish we'd be in
9 five years, it might really be out there, but I'll try anyway.
10 First of all, I think we have to have cost equity in our
11 telecommunication satellite use between rural and urban areas.
12 If that doesn't happen in the next five years, urban -- the
13 digital divide is going to become a chasm that nobody can
14 cross. And we have to have 100 percent convergence of voice
15 and data to do that. That's the only way it's going to become
16 cost effective for us.

17 And then from the health care side of it, I think we need
18 access to our patient records, no matter where they are. Are
19 they in a village clinic, are they in Anchorage at the ANMC,
20 wherever they're at our physicians need access to those patient
21 records the same way our health aides do in the village.

22 And from the security standpoint, where I hope we'd be is
23 in the use of biometrics. If we can do fingerprint access, or
24 voice recognition, or face recognition access, I think maybe
25 we'll meet the security requirements that HIPAA is asking for

1 us.

2 And then finally, nobody's mentioned this yet today, but
3 -- and it falls outside of the FCC, but I have to say it
4 anyway. I think that there's going to be an increased
5 availability of spread spectrum wireless radio technologies.
6 And for some areas of the Delta, that might really be
7 beneficial for places -- if our doctors want to go out to the
8 river fishing, and it's just a little too far to reach the
9 network. But with spread spectrum, I could possibly put the PC
10 on their boat or something. I mean, there's -- you know, I
11 don't know what the issues are going be, I know.....

12 DR. NIGHSWANDER: We don't want it.

13 MS. GRANDUSKY: I know all our health aides want to spend
14 the summer in fish camp, and if we can hit the fish camp with
15 spread spectrum. So I think those are the technologies that I
16 hope we see in five years, and I hope is where we're at at YK.

17 LT. GOV. ULMER: Hazel, you get the last word.

18 MS. JULIUS: More distant communication.

19 LT. GOV. ULMER: That sums it up. Well, if there aren't
20 any other questions, or any other comments by this panel, I
21 want to thank you all very much for sharing your expertise this
22 morning and also for what you are doing to bring telehealth to
23 Alaskans. We really appreciate your work. We are actually
24 early.

25 I know this is unusual, but it will give you all an

1 opportunity to get out and get lunch and be back here. We do
2 plan to start at 1:00 p.m. with our distance education panel,
3 so we hope you will join us for this afternoon as well. With
4 that, we are adjourned for the morning. Thank you very much.

5 (Off record - 11:10 a.m.)

6 1780

7 (Tape change)

8 Tape 3

9 0015

10 (On record - 1:10 p.m.)

11 LT. GOV. ULMER: Please take your seats, and we'll go
12 ahead and begin.

13 Our panel this afternoon on distance education I'm really
14 looking forward to hearing from you all. I know that there are
15 many exciting things happening all across Alaska, and it is
16 really true that if you scratch the surface in one region, and
17 then you go to the next region and scratch the surface, you are
18 just -- I'm always amazed about how much really is happening.

19 Having said that, there's still much work to be done. And
20 it is our hope that our panel this afternoon on distance
21 education will both tell us about the many exiting and
22 wonderful things that are underway already in rural Alaska, but
23 can also give us a vision of what -- where it's possible, what
24 some of the barriers are, and what some of their suggestions
25 are for both federal and state level of governments.