Health Information Exchange of Montana

March 1, 2010

VIA ELECTRONIC FILING

Marlene H. Dortch, Secretary
Federal Communications Commission
445 12th Street, S.W., Room TW-B204
Washington, DC 20554

Re: Docket No. GN 09-51

Madam Secretary:

On behalf of the Health Information Exchange of Montana (HIEM), we write to respond to a written ex parte presentation made by the Montana Telecommunications Association (MTA) in the above-captioned docket, filed on January 11, 2010 and oral ex parte presentations made by their Executive Director, Geoff Feiss, on January 27 and 28, 2010 to reinforce these comments. In both cases Mr. Feiss chose to use HIEM as a negative example of a Rural Health Care Pilot Program (RHCPP) participant – in one instance calling us "ugly".

HIEM takes exception to several of Mr. Feiss' misleading or uninformed comments, and wishes to set the record straight.

Our vision is to establish a secure, dedicated network with sufficient bandwidth and essential connectivity between each HIEM member and qualified end-user to more readily support high bandwidth healthcare applications. This vision is consistent with the RHCPP goal "to stimulate deployment of the broadband infrastructure necessary to support innovative telehealth and, in particular, telemedicine services to those areas of the country where the need for those benefits is most acute." See, Rural Health Care Support Mechanism, FCC 07-198 (Nov. 17, 2007 at para. 1).

MTA has made the following accusations regarding HIEM:

- HIEM's allegations that bandwidth is unavailable to HIEM members are misleading at best.
- The need for GigE, or even 100 Mbps bandwidth, is questionable.
- The intentional circumvention of existing network facilities has been repeated throughout the HIEM project.
- Building, operating and maintaining a telecommunications network is not a core competency of HIEM's health care provider partners.

Kip Smith, Executive Director 310 Sunnyview Lane, Kalispell MT 59901 (406)752-1724

- The other Montana RHCPP project, Frontier Access to Healthcare in Rural Montana, will spend less than 10 percent of the HIEM project, while interconnecting more health care providers.

HIEM provides the following responses:

Bandwidth is unavailable to HIEM members:

While it is correct that HIEM members had some access to bandwidth prior to the RHCPP, in many areas access was limited and costly, making expansion to a high-speed connection demanded by today's healthcare environment unaffordable and unsustainable. Prior to submission of the HIEM's RHCPP application, HIEM commissioned a reputable telecommunications consulting firm to conduct a survey of current carrier network capabilities. They found that some HIEM communities had no or limited fiber and that many critical microwave relays were at capacity. In addition, the monthly cost for expanded bandwidth from telecommunications providers was beyond the reach of many of our small rural healthcare providers.

Need for GigE or even 100 Mbps bandwidth is questionable:

This claim fails to recognize the scope of HIEM member services, the difference between standard videoconferencing and high resolution data transmission, and the reality of developing medical technology here in the 21st Century.

100 Mbps has already proven to have limitations. For example, two HIEM members previously sharing a 100 Mbps connection experienced significant and unacceptable latency while exchanging very basic healthcare information, necessitating an upgrade to 500 Mbps. The opportunity for HIEM members to significantly expand their broadband connection in a cost effective way and thereby eliminate these delayed transmissions is critical to providing appropriate diagnosis and intervention within the "treatment window" and ensuring real-time access to physician specialists in our rural/frontier area.

The regional picture archiving and communication system (PACS) network operated by our anchor facility, Kalispell Regional Medical Center, notes that *single* radiology exams currently being performed can require anywhere from 12 Mbps to over 400 Mbps and future technology bandwidth requirements could easily increase by 10, 20 or 30 times with the advent of perfusion imaging, breast tomosynthesis, 4d ultrasound, etc. Future-proofing the HIEM network today is not only a wise investment of RHCPP funds but will insure these rural health care providers will have affordable, cost-effective recurring costs for many years to come. Put simply, HIEM does not envision building a network that could be obsolete in a year or two.

Intentional circumvention of existing network facilities has been repeated throughout the HIEM project:

All RHCPP awardees are required to comply with the FCC's competitive bidding process to select a service provider for their proposed project. As part of this requirement, HIEM must certify to USAC that the service provider it chooses is, to the best of the applicant's knowledge, the most cost-effective service or facility provider available. See, Rural Health Care Support Mechanism, FCC 07-198 (Nov, 17, 2007 at para. 78).

The HIEM has consistently followed these requirements, posting all RFPs on the RHCPP website for the minimum 28 days, distributing the RFP directly to any known potential vendor and accepting bids from all interested parties. For our first RFP, Whitefish to Conrad, Montana, we only received one proposal, from Burlington Northern Santa Fe Railway, which was subsequently awarded.

On the second RFP, Kalispell to Libby, Montana, we received four proposals including a joint submission from Frontier Communications and CenturyTel (now CenturyLink), which became a semi-finalist. However, their proposal was not selected for a number of reasons, including but not limited to, higher cost, lower throughput, restrictions on use, and the offering of a lease that would leave HIEM with nothing when project funds ran out.

What we find interesting is that MTA's National Broadband Plan recommendations include prohibiting the construction of "duplicate" broadband facilities where sufficient bandwidth exists or can be obtained without new network construction. Yet, the proposal that Frontier/CenturyTel submitted in response to our RFP included construction of new redundant infrastructure, despite the fact they have existing dark fiber along part of this route. Adoption of the MTA recommendation would appear to have disallowed the Frontier/ CenturyTel proposal in the first place.

In an effort to explore all opportunities to collaborate with existing telecommunications providers, HIEM proposed leasing excess capacity from its portion of the Kalispell-Libby link to CenturyTel/Frontier, which would increase CenturyTel/Frontier's commercial capacity while assisting HIEM in sustaining its network. Even the possibility of discussing how to collaborate in furtherance with the Commission's policies was immediately rejected as "outside company policy".

Despite these experiences, HIEM has continued to have encouraging discussions with other telecommunications cooperatives within the region to develop dedicated fiber connections to participating healthcare providers and identify ways to work together, while maintaining an arms length relationship as required by the FCC. These discussions will continue and we intend to pursue collaborative relationships whenever possible.

Building, operating and maintaining a telecommunications network is not a core competency of HIEM's health care provider partners:

This statement is true as far as it goes – HIEM is comprised of health care providers and not telephone companies. That said, HIEM members rely on experienced professionals to carry out many mission critical tasks, none of which could be considered a "core competency." For example, there are professionals who fly helicopters, manage IT networks, maintain physical plant, negotiate contracts, and construct buildings.

Our core competency is creating and managing an environment that is conducive to high-quality health care. Whether it is buying hardware and software to implement new patient electronic health record requirements or contracting with experienced telecommunications contractors to install fiber, we are perfectly capable of efficiently and effectively managing the project.

If anything, we've learned that there's nothing about building or maintaining the physical plant that is any more difficult than other similar tasks we routinely take on in the course of operating health care facilities.

Frontier Access to Healthcare in Rural Montana (FAhRM) will spend less than 10 percent of the HIEM project, while interconnecting more health care providers:

HIEM is a participating member of the FAhRM project and has been involved in the development and selection of their broadband vendor.

The FAhRM project in fact will connect only six healthcare network hubs with maximum 1Gig connections (initially limited to100Mbps of bandwidth). FAhRM's RHCPP investment, while significant, will provided limited bandwidth for 3 years after which the six hubs will need to sustain these costs as well as provide more funding when additional bandwidth is desired. HIEM, on the other hand, will begin with connections to eight hospitals, two community health centers, and one Indian Health Service clinic with access to up to 12 pairs of fiber providing virtually unlimited bandwidth for the next 30-50 years – a truly future-proofed network that will in the long run prove to be far more cost effective than MTA has portrayed it to be.

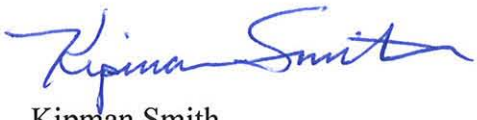
HIEM has also formed a partnership with the University of Montana to expand access to healthcare education throughout the region and plans to establish connection points for professional health care instruction at Flathead Valley Community College, Blackfeet Community College and Salish-Kootenai College when our network is fully implemented.

FAhRM and HIEM are two entirely different projects and MTA's unfortunate and inappropriate apple to oranges comparison compels this response.

In summary, The Health Information Exchange of Montana is excited about the development of our dedicated healthcare broadband network and the support received through the Rural Health Care Pilot Program. We look forward to working with the FCC, willing telecommunication vendors, and an expanding membership of eligible healthcare providers during the next 16 months to see our vision become a reality and to "examine how RHC support mechanism funds can be used to enhance public and non-profit health care providers' access to advanced telecommunications and information services." See, Rural Health Care Support Mechanism, FCC 07-198 (Nov. 17, 2007 at para. 15).

If you have any questions about the Health Information Exchange of Montana or our RHCPP-funded project, please contact me at kipsmith@krmc.org or 406-751-6687.

Sincerely,



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Executive Director

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