FCC Rural Health Care Pilot Program
Texas Health Information Network Collaborative (THINC)
Quarterly Data Report
January 30, 2011

Federal Communications Commission WC Docket No. 02-60

1. Project Contact and Coordination Information

a. Identify the project leader(s) and respective business affiliations.

The Project leaders and their affiliations are:

George S. Conklin, SVP and CIO
CHRISTUS Health
Houston, Texas

Ralph Farr, CIO
University of Texas Medical Branch (UTMB)
Galveston, Texas

David Cantrell, CIO
Texas A&M Health Sciences Center
College Station, Texas

Quang Ngo, Vice President and CIO
Texas Organization of Rural and Community Hospitals (TORCH)

Hank Fanberg
CHRISTUS Health
Houston, Texas

b. Provide a complete address for postal delivery and the telephone, fax, and e-mail address for the responsible administrative official.

The responsible administrative official is:

George S. Conklin, SVP and CIO
CHRISTUS Health
2707 North Loop West
Houston, Texas 77008
713-684-3877 (p)
713-684-3555 (f)
George.conklin@christushealth.org

c. Identify the organization that is legally and financially responsible for the conduct of activities supported by the award.

CHRISTUS Health is legally and financially responsible for the conduct of activities supported by this award.

d. Explain how project is being coordinated throughout the state or region.

Our designated geographic area is inclusive of the entire state of Texas. THINC has conducted and will conduct various activities to coordinate the project throughout the state, including collaboration with the State of Texas through its governor's office.

A project coordinator has been assigned the task of coordinating the state level effort and has reached out to all the named facilities. In addition, we are working with the Texas Hospital Association, Texas Organization for Rural and Community Hospitals, the State's Office for Rural Health. A mail list has been implemented and a web site I under construction.

With the enactment of ARRA, THINC is in discussion with the state of Texas regarding how we might leverage our efforts to coincide with federally mandated actions for states concerning health information technology and health information exchange.

2. Identify all health care facilities included in the network.

a. Provide address (including county), zip code, Rural Urban Commuting Area (RUCA) code (including primary and secondary), six-digit census tract, and phone number for each health care facility participating in the network.
b. For each participating institution, indicate whether it is:
i. Public or non-public;
ii. Not-for-profit or for-profit;
iii. An eligible health care provider or ineligible health-care provider with an explanation of why the health care facility is eligible under section 254 of the 1996 Act and the Commission's rules or a description of the type of ineligible health care provider entity.

Please see the attached list.

3. Network Narrative: In the first quarterly report following the completion of the competitive bidding process and the selection of vendors, the selected participant must submit an updated technical description of the communications network that it intends to implement, which takes into account the results its network design studies and negotiations with its vendors. This technical description should provide, where applicable:

a. Brief description of the backbone network of the dedicated health care network, e.g., MPLS network, carrier-provided VPN, a SONET ring;
b. Explanation of how health care provider sites will connect to (or access) the network, including the access technologies/services and transmission speeds;

c. Explanation of how and where the network will connect to a national backbone such as NLR or Internet2;
d. Number of miles of fiber construction, and whether the fiber is buried or aerial;
e. Special systems or services for network management or maintenance (if applicable) and where such systems reside or are based.

THINC's initial activity as specified in the award is to develop a network design to connect all named entities to the network. The network design RFP has been submitted to USAC and the FCC but has not been made public for bidding. Consequently, we have not completed the competitive bidding process, vendor selection or network build out.

4. List of Connected Health Care Providers: Provide information below for all eligible and non-eligible health care provider sites that, as of the close of the most recent reporting period, are connected to the network and operational.

a. Health care provider site;
b. Eligible provider (Yes/No);
c. Type of network connection (e.g., fiber, copper, wireless);
d. How connection is provided (e.g., carrier-provided service; self-constructed; leased facility);
e. Service and/or speed of connection (e.g., DS1, DS3, DSL, OC3, Metro Ethernet (10 Mbps)
;
f. Gateway to NLR, Internet2, or the Public Internet (Yes/No);
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g. Site Equipment (e.g., router, switch, SONET ADM, WDM), including manufacturer name and model number.
h. Provide a logical diagram or map of the network.

Our network is not yet build nor is it operational. Consequently, no health care provider sites are connected to the network.

5. Identify the following non-recurring and recurring costs, where applicable shown both as budgeted and actually incurred for the applicable quarter and funding year to-date.

a. Network Design
b. Network Equipment, including engineering and installation
c. Infrastructure Deployment/Outside Plant
i. Engineering
ii. Construction
d. Internet2, NLR, or Public Internet Connection
e. Leased Facilities or Tariffed Services

f. Network Management, Maintenance, and Operation Costs (not captured elsewhere)
g. Other Non-Recurring and Recurring Costs

Non-recurring costs related to the network design RFP development have not been incurred. The costs are minimal and adhere to USAC guidelines for these types of costs.

6. Describe how costs have been apportioned and the sources of the funds to pay them:

a. Explain how costs are identified, allocated among, and apportioned to both eligible and ineligible network participants.

Costs have not yet been identified and have not been apportioned. Each facility understands that they are individually responsible for their costs not covered by the rural health pilot program.

b. Describe the source of funds from:
i. Eligible Pilot Program network participants

Eligible participants will provide 15% of the costs of all services they incur

ii. Ineligible Pilot Program network participants

Ineligible participants will provide 100% of all costs for service they utilize.

c. Show contributions from all other sources (e.g., local, state, and federal sources, and other grants).

No changes since our earlier filing

i. Identify source of financial support and anticipated revenues that is paying for costs not covered by the fund and by Pilot Program participants.

Please see the immediate preceding response above.

ii. Identify the respective amounts and remaining time for such assistance.

No changes since our last filing.

d. Explain how the selected participant's minimum 15 percent contribution is helping to achieve both the selected participant's identified goals and objectives and the overarching goals of the Pilot Program.

It is too early for goals of the individual participants to be enabled; we are therefore unable to comment on how their minimum 15% contribution is helping them achieve their goals.

7. Identify any technical or non-technical requirements or procedures necessary for ineligible entities to connect to the participant's network.

Non eligible entities will be required to cover 100% of the costs of connecting to the network. We have not yet addressed requirements or developed policies and procedures for ineligible entities to connect to the participant network.

8. Provide an update on the project management plan, detailing:

a. The project's current leadership and management structure and any changes to the management structure since the last data report; and

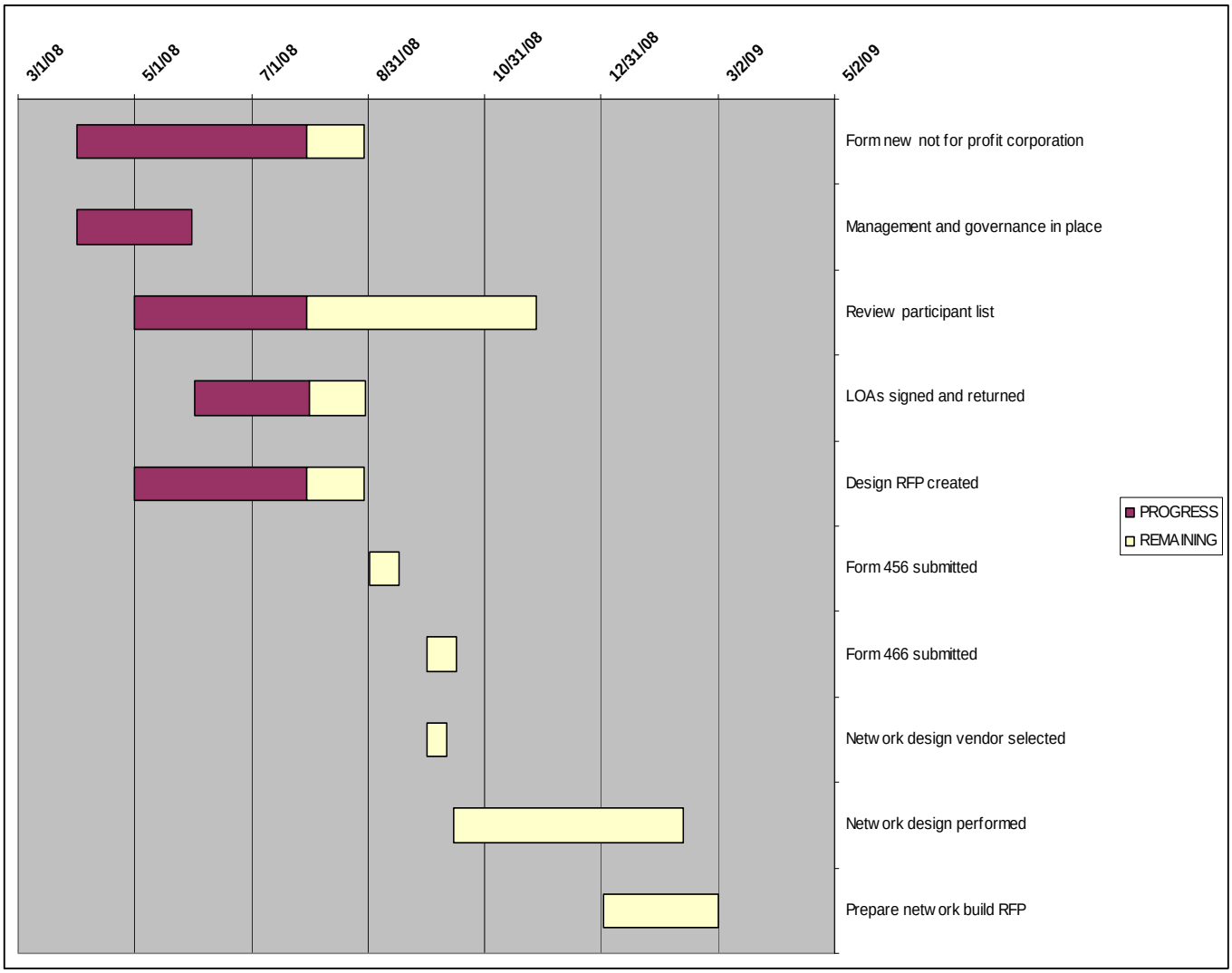
There are no changes to the project's leadership and management.

b. In the first quarterly report, the selected applicant should provide a detailed project plan and schedule. The schedule must provide a list of key project deliverables or tasks, and their anticipated completion dates. Among the deliverables, participants must indicate the dates when each health care provider site is expected to be connected to the network and operational. Subsequent quarterly reports should identify which project deliverables, scheduled for the previous quarter, were met, and which were not met. In the event a project deliverable is not achieved, or the work and deliverables deviate from the work plan, the selected participant must provide an explanation.

As stated above, our design RFP was submitted to USAC and the FCC and has not yet been released. Dates for connecting providers to the network and network operability are best guesses at this time.

ACTIVITY	START	END	STATUS
1. Outreach and add participants			ongoing
2. LOAs signed and returned	05-1-09	06-30-09	review for completion
3. Design RFP submitted for review	07-15-09	TBD	in progress
4. Form 465 submitted	11-15-10	11-15-10	complete
5. Form 465 Attachment submitted	02-15-11	02-15-11	75%
6. RFP for network build released	03-01-11	03-29-11	0%
7. Network vendor selected	04-15-11	04-20-11	0%
8. Contract with service vendor	05-01-11	05-15-11	0%
9. Network build	05-15-11	10-30-11	0%
10. Phase II of program (additional)	04-01-11	04-01-11	50%
11. Bid Phase II	06-01-11	06-29-11	25%
12. Select Phase II vendor	07-15-11	07-31-11	0%
13. Build Phase II	08-01-11	11-01-11	0%

The American Recovery and Reinvestment Act and its HITECH provisions created opportunities to collaborate with state level initiatives around health information exchange, in support of questions 11 and 12 of this report. Part of our delay is attributed to aligning time frames and negotiations with state and federal agencies so that we might align the projects. We are confident moving forward will result in a positive outcome for the rural health care pilot program and allow THINC to contribute to the success of ONC's initiatives.



ORIGINAL HIGH LEVEL PROJECT PLAN – MAJOR MILESTONES TO NETWORK BUILD RFP PHASE

9. Provide detail on whether network is or will become self sustaining. Selected participants should provide an explanation of how network is self sustaining.

The network is not self-sustaining at this time. The plan is for the network to become self-sustaining over time. Costs for building, maintaining, supporting, governance, management and growth of the network are currently unknown. As the project moves forward and costs become more certain, a timeline to self-sustainability will be developed.
The agreed upon methodology for sustainability is that the network will operate as a cooperative. Each facility is responsible for their individual costs while operating costs for the network will be apportioned to each user based upon their volume of services in order to assure fairness is cost allocation.

Sustainability models and assumptions are under review due to the potential impact of our alignment and participation with the state level HIE being planned for Texas.

Our basic tenet remains the same, however. We believe it is important for each facility to contribute to the network. Therefore, each of the more than 500 hospitals and community health clinics and FQHCs within the state will be responsible for their own 15% share of the direct costs. Costs for additional users should be almost exclusively variable and minimal so there will be more users to share in the fixed costs, resulting in lower costs for all users.

The final business model for self-sustaining the network has not been computed; however the primary model is that of a utility cooperative with each member responsible for its share of the costs.

10. Provide detail on how the supported network has advanced telemedicine benefits:

a. Explain how the supported network has achieved the goals and objectives outlined in selected participant's Pilot Program application;
b. Explain how the supported network has brought the benefits of innovative telehealth and, in particular, telemedicine services to those areas of the country where the need for those benefits is most acute;
c. Explain how the supported network has allowed patients access to critically needed medical specialists in a variety of practices without leaving their homes or communities;
d. Explain how the supported network has allowed health care providers access to government research institutions, and/or academic, public, and private health care institutions that are repositories of medical expertise and information;
e. Explain how the supported network has allowed health care professional to monitor critically ill patients at multiple locations around the clock, provide access to advanced applications in continuing education and research, and/or enhanced the health care community's ability to provide a rapid and coordinated response in the event of a national crisis.

Due to the early phase of development and the lack of a network at this time, apart from garnering much interest on the part of many individuals and organizations about the promise of advancing telemedicine through this initiative, there has been no progress to date. We continue to collaborate with the State of Texas and now with ARRA there is much interest in our activities and our progress.

11. Provide detail on how the supported network has complied with HHS health IT initiatives:

a. Explain how the supported network has used health IT systems and products that meet interoperability standards recognized by the HHS Secretary;

While the network is not yet operable, and the core clinical information systems of the founding members are different, three of the four founding members' core clinical information systems meet the interoperability standards recognized by the HHS secretary. The fourth founding member is an association of rural hospitals.

b. Explain how the supported network has used health IT products certified by the Certification Commission for Healthcare Information Technology;

CCHIT certification has been replace by ONC certification although CCHIT is one of the certification bodies for the ONC.

Any and all EMRs and data exchanged via THINC will ONC certified and based upon HHS and ONC promulgated standards.

c. Explain how the supported network has supported the Nationwide Health Information Network (NHIN) architecture by coordinating activities with organizations performing NHIN trial implementations;

THINC participating hospitals are also participating in the NHIN Direct project pilot implementation.

d. Explain how the supported network has used resources available at HHS's Agency for Healthcare Research and Quality (AHRQ) National Resource Center for Health Information Technology;

THINC is aware of AHRQ's resource center but has not made use of it to date. A number of proposed activities and outcomes measures for the network will use the AHRQ National Resource Center as we begin to define our core measures and impact. We have made contact with individuals at AHRQ but have not utilized their services yet.

e. Explain how the selected participant has educated themselves concerning the Pandemic and All Hazards Preparedness Act and coordinated with the HHS Assistant Secretary for Public Response as a resource for telehealth inventory and for the implementation of other preparedness and response initiatives; and

In Texas, health care institutions are experienced in emergency preparations. The participant was ground zero for Hurricanes Rita and Katrina; during Katrina, our hospitals were forced to evacuate and during Katrina, our hospitals received and provided care for thousands of people displaced by the storm. Experience helped inform both state and federal officials as the PAHPA legislation was being drafted. We continue to participate in exercise drills at the local, state and national level.

f. Explain how the supported network has used resources available through HHS's Centers for Disease Control and Prevention (CDC) Public Health Information Network (PHIN) to facilitate interoperability with public health and emergency organizations.

The participant's clinical information system is interfaced with the CDC's Biosense and NEDSS programs that utilize PHIN to enable real time access to reportable events to both the CDC and the State of Texas. Due to the network not being ready, we are not using the network for PHIN reporting. We fully expect the network will be used to support these activities in the future, once it is available.

12. Explain how the selected participants coordinated in the use of their health care networks with the Department of Health and Human Services (HHS) and, in particular, with its Centers for Disease Control and Prevention (CDC) in instances of national, regional, or local public health emergencies (e.g., pandemics, bioterrorism). In such instances, where feasible, explain how selected participants provided access to their supported networks to HHS, including CDC, and other public health officials.

For the past year, THINC has contacted HHS offices including ONC and the CDC and inquired as to the types of actions we can and should take to assure compliance. All of our requests from HHS and ONC staff have either been ignored or unanswered. Formal requests for guidance from the project coaches have also been sought, with no real information forthcoming. We would like to suggest and recommend that a meeting be scheduled that would include all RHCPP project managers, representatives from the FCC, USAC, HHS including ONC and the CDC so we can obtain better guidance than has been provided to dat