



BEFORE THE FEDERAL COMMUNICATIONS COMMISSION

WASHINGTON, D.C 20554

To: The Federal Communications Commission, Washington, DC 20554

Reference: Docket No. 02-60 and DA 12-1166

Comments of: Hospital Sisters Health System (HSHS), HSHS Division (Western Wisconsin), HSHS Division (Eastern Wisconsin), HSHS Division (Southern Illinois), HSHS Division (Central Illinois)

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Date: August 17, 2012

Re: Comments for the FCC Wireline Competition Bureau on Issues in the Rural Health Care (RHC) Program Reform

Dear Chairman Genachowski:

On behalf of our 13 hospitals and three integrated physician networks in Wisconsin and Illinois, Hospital Sisters Health System (HSHS) appreciates the opportunity to comment on the FCC Wireline Competition Bureau on Issues in the Rural Health Care (RHC) Program Reform (WC Docket No. 02-60) released on July 19, 2012.

In addition to providing feedback to the FCC through Rural Health Care (RHC) Pilot outreach calls, through St. Joseph's Hospital (Chippewa Falls, WI), HSHS wishes to comment on the specific questions below.

SUMMARY AND STATEMENT OF INTEREST

HSHS has been a leader in proceedings designed to enhance the availability of Internet access and other broadband facilities to health care providers. We support the Commission's efforts to offer financial support for telecommunications services necessary to expand health care services into rural areas and to assist communities and healthcare providers with developing and deploying their own broadband networks in collaboration with other public and private stakeholders (such as the Community Area Network or CAN model). Through St. Joseph's Hospital (Chippewa Falls, WI), we have also participated

with the FCC's existing Rural Health Care Pilot Program as one of 50 active pilots¹ (out of 69 original participants), which has given our organization as an important source of lessons and insights which can inform the proposed changes.

Advancing Care Integration: As you know, broadband plays a critical role in supporting applications that benefit rural America. Hospitals in rural and urban areas need broadband that is:

- **Fast**—100 megabits (Mbps) to one gigabits per second (Gbps)
- **Accessible**—to even the most remote areas
- **Reliable**—with redundant links to assure mission critical applications are available 24/7 without the risk of downtime that could interrupt applications like telemedicine
- **Affordable**—to bend the cost curve

Underserved areas where traditional commercial providers have not deployed broadband are especially disadvantaged. Broadband applications are especially critical to the healthcare sector since the industry is reacting to an economic marketplace imperative. New delivery models need to be created that are far more integrated and connected if the \$2.6 trillion healthcare industry is to successfully transform itself. Broadband investment that includes remote medical facilities will support Care Integration, telehealth, greater efficiencies, and improved access to clinical expertise and health care information. The Commission should do everything within its power to encourage expanded and affordable broadband coverage in rural areas.

Eliminating Distance as a Barrier to the Best Possible Health Care: In medical emergencies, fast and reliable access to health care professionals, health records and diagnostic images—using technology connected by advanced broadband—can be decisive factors that save lives and improve outcomes. Advance broadband networks in rural areas are foundational to health care integration because they remove the distance between caregiver and patient. Not only does advance broadband expand health care access, it expedites treatment, improves quality and reduces costs through enhanced communication, coordination, and efficiency across providers and settings. Advanced broadband allows the whole person to be cared for by a whole health care community throughout the continuum of care settings: hospitals, clinics, physician offices, rehabilitation and skilled nursing facilities, hospice and home. It breaks down barriers by supporting and coordinating patient and provider relationships with a free flow of critical information between providers. Broadband expands relationships to allow organizations to share medical technologies to link patients, providers and care facilities. Its connectivity helps bridge the “digital divide” between urban and rural hospitals and helps caregivers reach vulnerable populations (low income, minorities, older adults, and individuals with disabilities or who need chronic care). The result is improved care coordination, superior value through the elimination of variability, and innovative solutions that can address shortages of health care professionals. Advanced broadband also increases patient and provider satisfaction.

Linking Patients and Providers: HSHS has produced four case studies to illustrate the Care Integration benefits of advanced broadband to rural and urban health care ([link](#)). To summarize these and other benefits, advanced broadband supports:

¹ WC Docket No. 02-60 (July 6, 2012), §3

- **Telemedicine** for interactive face-to-face physician examinations of patients to speed stroke, heart attack and other emergency treatments where minutes count and to reduce the need for patients to travel long distances for care
- **Faster emergency and trauma care** by physician telepresence in emergency rooms & ambulances
- **Improved health care access** to reduce disparities in rural areas & vulnerable populations
- **New solutions to alleviate shortages** of health care professionals by allowing centrally located clinicians to expand “on call” coverage
- **Development of statewide health information exchange (HIE)** networks in Illinois and Wisconsin
- **Shared applications** to:
 - Coordinate and expedite patient care through unified medical record file sharing including MEDITECH, EPIC, SoftMed Electronic Health Records (EHR), Picture Archiving and Communications System (PACS), and CT and MRI diagnostic files
 - Reduce costs through shared software applications (common telephone, paging, voice mail, email, & file storage and sharing)
 - Support a [Tele-Radiology Image Hub](#) at Sacred Heart Hospital (Eau Claire, WI) to allow images to be sent or viewed between 43 healthcare facilities across western Wisconsin and eastern Minnesota using [Chippewa Valley Inter-Networking Consortium \(CINC\)](#) fiber, a Community Area Network (CAN).

Advanced broadband is needed to link urban and rural providers, clinics and nursing centers. It facilitates dynamic partnerships to enable key players in the health care equation to seamlessly work together. It allows:

- Improved timely physician communication and coordination for better patient care
- Enhanced working partnerships between hospitals and universities
- Expanded distance continuing education opportunities and other continuing education

COMMENT

I.6(a) and (b) Application & Reporting

We are concerned that a program that is too administratively burdensome will be unable to provide support where it is most needed, particularly to rural hospitals that have less administrative support to manage a federal project. According to the American Hospital Association (AHA), previous experience with the Rural Health Care Pilot Program and the current Rural Health Care Internet Access Program provides ample evidence that heavy administrative burdens limit participation. For example, in 2009 only \$60.7 million was spent, out of the \$400 million available.

St. Joseph’s Hospital suggests letters of authorization (LOAs) be required later in the administrative process to ensure consortium members have a clear understanding of projected costs associated with participation. Moving this requirement at the 466-A stage would increase efficiencies for consortium members and USAC. St. Joseph’s Hospital supports the Commission’s requirement for the consortium to provide details in any request for services because this streamlines the invoicing process. The Commission should only require the lead entity to certify that the support provided will be used for eligible purposes to ease the administrative burden of the program. Additionally, the Commission should adopt the reporting requirements of the Pilot Program. However, the Commission should also change the

frequency of the reporting requirement to an annual submission to reduce the administrative burden. Finally, the Commission should adopt a site and service substitution policy for the Broadband Services Program. Our experience in the Pilot Program has reflected the need for service and site changes because organizations and healthcare delivery locations can change over the life a program.

II.8(a) (b) and (c) Inclusion of Urban Sites in Consortia

The FCC's inclusion of urban sites under the Pilot Program was a step in the right direction. Requiring consortia members to report out and define more than the Pilot Program's *de minimis* standard will only increase the administrative burden on participants and USAC. Rural healthcare is delivered through the collaboration of rural and urban sites. If the FCC chooses a percentage restriction, the requirement needs to be clearly defined and be as simple as possible. The challenge is determining percentage of benefit of a rural to urban connection between two locations and or entities. Clearly the patient in the rural area receives 100% of the benefit.

II.8(d) Funding Limits for Urban Sites

Reimbursements for telehealth are inadequate under the existing CMS regulations. HCPs invest in telehealth services to better serve patients despite the current reimbursement models. If funds are limited for rural sites that have less access to capital and limited CMS reimbursement, rural partners will struggle to sustain broadband efforts without the support of urban HCP. Excluding urban sites from funding under the Broadband Services Program would severely limit the program's effectiveness to improve the quality of our nation's healthcare delivery system in rural America.

II.8(e) Roles of Urban and Rural Sites

Rural communities do not have the administrative overhead to manage federal programs. To participate in a federal program, rural partners often depend upon larger health care organizations, often located in urban areas, to provide support. If funds are limited for urban sites, or a ceiling is established to limit urban involvement, the critical administrative oversight for rural partners is also limited. The Commission should support urban organizations that make investments in broadband for rural partners and support profitability and sustainability that will enable improved patient care and Care Integration. St. Joseph's Hospital is concerned that a program that is too administratively burdensome will be unable to provide support where it is most needed. According to the American Hospital Association (AHA), previous experience with the Rural Health Care Pilot Program and the current Rural Health Care Internet Access Program provides ample evidence that heavy administrative burdens limit participation. For example, in 2009 only \$60.7 million was spent, out of the \$400 million available.

II.8(f) Funding for Urban Sites

The Commission should create urban incentives for those that are proactive. This policy would not exclude some health care organizations that did not have the resources to invest at the program's beginning. By incentivizing urban investments to benefit rural partners, the Commission "floats all boats."

III.10(a) Connectivity Solutions

The Commission should support a wide variety of connectivity solutions to achieve network designs that allow for flexibility and adaptability required by a healthcare delivery process that continually advances innovations. To do this, the list of eligible connectivity solutions should be expanded. For example, using

a MetroE, MPLS or public/private fiber networks may be the most cost effective approach to connect multiple urban and rural HCPs. Moreover, the Commission should also support connectivity to existing Community Area Networks (CANs). CANs provide an alternative to high cost leased services where communities have maximized economies of scale across multiple government, education and other non-profit sectors to obtain broadband capabilities and connectivity that is not available from traditional telecommunication providers. The Commission should support a wide range of connectivity solutions.

III.10(b) Non-Recurring Costs (NRCs)

The Commission should continue to include non-recurring costs as supported in the Pilot Program and extend the definition to the Broadband Services Program and Health Infrastructure Program at the very least. St. Joseph's Hospital recommends that the Commission expand its list of non-recurring costs eligible for reimbursement to mirror those expenses that have been deemed eligible under the Department of Commerce's National Telecommunications and Information Administration (NTIA) Broadband Technology Opportunities Program (BTOP).

III.10(c) Funding Limits for Construction of Facilities in Broadband Services Program

Flexibility is needed for both "ownership" and "leasing" models as proven in the Pilot Program. St. Joseph's Hospital (Chippewa Falls, WI) used both fiber construction and leasing options to serve its HCPs. Projects need the option of constructing their own facilities when no service provider is willing (or able) to construct broadband facilities and lease them to project participants, or when the bids a project receives for leased services are higher than the cost of construction. Both open and closed fiber network architectures should be encouraged. There is no need for the Commission to dictate contract terms for any infrastructure project because a "one size fits all" description will be a poor fit to accommodate the variety of health care provider circumstances. Health care providers generally should be given wide latitude to choose the broadband services, including the level of redundancy and reliability required for their individual needs. In some rural areas, economic models may not exist for traditional telecommunication services providers to provide the broadband connectivity to anchor institutions, thus there is a need to support construction. The competitive bidding process would serve as a mechanism to determine the most cost effective option between leasing services and construction. Cost comparison analysis estimates over a given time period could be used to evaluate the options. As these options provide the most cost effective approach, the Commission should not cap the funding for construction unless the Commission also caps the funding for leased services. It is important that overall program caps are established so that programs can be sustained. However, imposing caps on construction projects will delay the expansion of broadband services to rural HCPs where the need is greatest.

III.10(d) Expand Sharing and Access of Network Capacity Needed

Providers may wish to enter into cooperative arrangements with other providers that are funded, in order to create local and regional health care networks. By acting together, providers are more likely to receive lower pricing and a wider array of services to meet their health care needs. If the Commission requires a "fair share" comparable to the Pilot Program, it should be defined in such a way as not to create a heavy administrative burden. This administrative burden in the Pilot Program discouraged many organizations from participating. Additionally, construction costs are fixed in the equation because they will occur regardless, but they are not Community Area Network (CAN)-friendly. The Commission should further define reasonable "fair share" cost methodologies to reduce the administrative burden demonstrated in the Pilot Program. Using a percentage of initial construction or monthly service costs are not often reasonable

cost allocations between eligible HCP and potential ineligible consortium members. Program participants could be given the flexibility to determine reasonable “fair share” costs between members.

For profit providers should be included. In developing infrastructure and planning broadband network connections, providing access to for-profit health care providers can be a key element to project success. The health care community as a whole will benefit by permitting for-profits to be part of the consortia.

IV.11(a) Competitive Bidding

A competitive bidding process is necessary to reduce the potential for fraud, waste and abuse. As with the Pilot Program, the Commission should include non-traditional service providers in the Broadband Services Program and Health Infrastructure Program. Healthcare consortiums should be given the flexibility to create an evaluation matrix to evaluate service options so that cost is not the only determining factor in service selected. Healthcare networks are inherently complex and the need to fit into existing infrastructure is necessary for the long-term viability of maintaining reasonable ongoing support costs. Submitting a RFP and using a competitive bidding process ensures that non-traditional service providers have an opportunity to bid on services that may have been served by one traditional service provide. The market space for broadband service offers flexibility when non-traditional providers are able compete to provide services to HCPs.

The State of Wisconsin has no specific competitive bidding requirements for schools and libraries participating in the Schools and Libraries Universal Service program. Hence, applicants use the "Open and Fair Competitive Bidding Process" as outlined by the Universal Service Company at:

<http://www.universalservice.org/sl/applicants/step02/competitive-bidding.aspx> .

The Commission must have a comprehensively modernized focus to ensure that rural areas have access to broadband infrastructure and services. As the Program is redesigned, HSHS supports the inclusion and full participation of nontraditional stakeholders. HSHS also supports the requirement to make interconnected points and backhaul capacity available so that unserved high cost communities would be able to deploy their own networks. Supporting dark fiber among community anchor institutions, and then connecting these community anchor institutions into the network, is a proven method of expanding broadband services to areas and communities that do not have the volume of subscribership necessary to support the traditional wired or wireless service providers. Traditional support programs limited participation to service silos (i.e. public safety, government, education, and healthcare). This limitation made aggregated collaboration and the build out of advanced broadband community owned networks difficult if not impossible. By supporting a broad program with non-traditional partners, the Commission will be a catalyst for the creation of an infrastructure based on networks of networks that would help facilitate application and data sharing.

We encourage the Health Care Broadband Infrastructure Fund to help create affordable and sustainable broadband connectivity to unserved rural areas in America without creating silos that exclude stakeholders. This action and funding would produce alignment and sustainability for an infrastructure to support cost-effective and equitable health care in rural areas. This Fund is a significant step toward reaching the nation’s health care objectives and our advancement of a Care Integration strategy to better serve patients and advance the Three Aims of “better patient experience, improved population health, and reduced per capita costs.”²

² Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health Aff.* 2008;27(3):759–69.

IV.11(c) Evergreen Status

Evergreen status should be coupled with a multi-year ward to reduce the administrative burden. St. Joseph's Hospital (Chippewa Falls, WI) suggests the Commission consider the allowance of five-year contracts.

IV.11(e) Eligible Service Providers

The Commission should broaden its definition of “eligible service providers” to include non-traditional stakeholders as defined in the Pilot Program.

We strongly encourage the FCC to include community anchor institutions and Community Area Networks (CANs) in its Technology Opportunities Program funding. FCC funding to these groups would facilitate fiber infrastructure to bring broadband to rural areas. In addition, CANs composed of many stakeholder anchor institutions (city, county, schools, libraries, public safety, universities and hospitals) are able to create economies of scale for more extensive expansion of broadband to rural areas by utilizing an open fiber architecture. In our experience, CANs have been extremely successful in expanding fiber infrastructure to rural unserved areas by connecting anchor institutions. CANs are uniquely equipped to build infrastructure in unserved rural areas and to collectively manage shared resources for long-term sustainability.³ As articulated in the NPRM, the Commission's focus should be on:

- The promotion of connectivity
- Coverage that represents a spectrum which is optimally allocated and managed
- The enablement and development of urban/rural oriented wireless medical devices

HSHS believes it is essential over the next six to seven years to focus on and aggressively support rural fiber infrastructure to support universal broadband. In the immediate future, clinics, hospitals and other health care partners must become robust in building mobile data capabilities to ensure that rural patients have access to state-of-the-art diagnostic tools.

The Commission should allow tradition and non-traditional organizations to leverage economies of scale to expand broadband in rural areas. In America today, a fragmented healthcare delivery system limits coordination across providers and health care settings and an outdated broadband infrastructure further impedes communication. Dense files of medical information cannot be shared in a timely and coherent fashion using low-capacity broadband. Commercially-provided private broadband—often analogous to a narrow two-lane road—cannot accommodate the advanced data exchange needs of hospitals at the current pricing structure.

Essential applications such as accessing a Picture Archiving and Communications System (PACS) diagnostic file or sharing Electronic Health Records (EHR) require advanced broadband speeds of 100 megabits (Mbps) to one gigabits per second (Gbps). These speeds are seldom available at any price in rural areas due to a lack of fiber optic infrastructure. Advanced broadband networks, such as dark fiber community area networks that are open networks as opposed to the traditional closed networks offered by traditional broadband providers, allows health care organizations to intentionally link patients, providers and care facilities. The result is superior value and improved care coordination, enhanced efficiency with reduced costs, and increased satisfaction for patients and providers.

³ Ostrom E. *Governing the commons; the evolution of institutions for collective action*. Cambridge University Press, 1990.

V.12(a) Telemedicine

The need for data grows exponentially each year driving up the consumption of broadband. Every HCP is at various stages in the continuum of broadband need. The FCC should not impose limitations or set bandwidth minimum connectivity speeds. Furthermore, as state HIE and market-driven exchanges develop and mature, HCPs needs for connectivity and broadband services will increase. The Commission's Health Infrastructure and Broadband Services Programs need to support the flexibility for HCPs to easily upgrade service during a funding year if needed.

V.12(d) Service Quality Requirements

Open and closed networks provide access to fiber bundles. It is critical that the Commission allows partners to set up highly secure point-to-point entities with more control by the health care entity.

CONCLUSION

Advanced broadband allows the whole person to be cared for by a whole health care community throughout the continuum of care settings: hospitals, clinics, physician offices, rehabilitation and skilled nursing facilities, hospice and home. It breaks down barriers by supporting and coordinating patient and provider relationships with a free flow of critical information between providers.

Broadband expands relationships to allow organizations to share medical technologies to link patients, providers and care facilities. Its connectivity helps bridge the "digital divide" between urban and rural hospitals and helps caregivers reach vulnerable populations (low income, minorities, older adults, and individuals with disabilities or who need chronic care). The result is improved care coordination, superior value through the elimination of variability, and innovative solutions that can address shortages of health care professionals. Advanced broadband increases patient and provider satisfaction.

Thank you for the opportunity to provide comments. We believe that by addressing these concerns, the newly designed Health Care Broadband Infrastructure Fund will subsidize network deployment for HCPs to provide better patient care in rural areas.

Sincerely,

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