



**Rural Wisconsin Health Cooperative**  
**Further Comments on Rural Healthcare Support Mechanism NPRM**

By Louis Wenzlow, Director of Health Information Technology  
Contact at [lwenzlow@rwhc.com](mailto:lwenzlow@rwhc.com)

RE: RWHC comments relating to the matter of the Rural Healthcare Support Mechanism (WC Docket No. 02-60 and DA 12-1166)

**Organization Description**

The Rural Wisconsin Health Cooperative was founded in 1979 in Sauk City, Wisconsin. Owned and operated by 35 rural, acute, medical-surgical hospitals, RWHC brings a large number of Wisconsin community hospitals (as well as their affiliated physician clinics, pharmacies, and long-term care facilities) under a single loose-knit organizational umbrella. RWHC's emphasis on developing an integrated network among freestanding entities distinguishes it from alternative approaches.

Here at RWHC we have long worked to assist our member hospitals to implement health information technology (HIT) and electronic health records (EHRs). In 2003 RWHC established the RWHC Wide Area Network (WAN) that was developed in response to the significant challenges and cost inequities rural providers face when trying to connect to the Internet and other facilities. The value philosophy of the WAN is that providers pay for one connection that gives them access to numerous trading partners, rather than paying for multiple point-to-point connections. Most RWHC WAN participants utilize the current rural support mechanism, and RWHC staff provides them with assistance navigating the USAC application process.

In 2005, a RWHC-led group of stakeholders received an AHRQ planning grant for developing a collaborative EHR infrastructure for Wisconsin hospitals. This planning work eventually led to the establishment of the not-for-profit RWHC Information Technology Network (RWHC ITN), which provides a shared datacenter, electronic health record applications, and 24/7 system support to four freestanding Wisconsin critical access hospitals (CAHs) and their affiliated physician clinics. **RWHC ITN is a participant in the FCC Rural Healthcare Pilot Program.**

The commentary in this response will therefore reflect a first hand knowledge of Pilot Program, Universal Service Fund, electronic health record implementation and support, and rural HIT related issues. Our overarching principle in addressing the NPRM is to ask whether the proposed changes in

fact further the goals of providing equitable broadband facilities (consistent with the legislative intent of the Telecommunications Act) to rural healthcare providers.

### **Comments on Topics Identified in the Notice**

#### **I.a. Consortium application process**

We agree that submitting LOAs later in the process, with the Form 466-A, would be appropriate, since the decision to participate cannot be finalized until pricing is known and considered.

#### **I.b. Post-award reporting requirements**

We believe that the Quarterly reports required in the Pilot Program are a reasonable way to monitor how the funding is being used. They are not overly burdensome particularly if certain administrative costs are covered, as was proposed in the NPRM for the Infrastructure Program.

#### **I.c. Site and service substitution**

Our experience is that existing network participant broadband needs may change periodically with the introduction of a new teleradiology or EHR system or use case and that it is critical there be flexibility to allow network participants to make a service substitution to meet the broadband requirements of the new use case, whether or not the new or upgraded service was included in the original RFP.

Additionally, we believe that it is critical to allow the networks to grow to meet the evolving needs of existing participants. For example, if an existing network member has an immediate information exchange use case with a non-member, there needs to be an expedited process to allow the non-member to join the network, so the use case can be realized. Whether the non-member is an eligible provider utilizing the USF program outside the consortia, an eligible provider not utilizing the USF program, or a non-eligible provider that needs to pay their fair share, there needs to be an expedited mechanism for adding new members that were not identified in the original RFP.

#### **II.a.b.d. Proportion of urban and rural sites in consortia/Limiting percentage of funding available to urban sites/Impact on network design**

We agree with the importance of including urban referral centers in the rural broadband networks, and we support expanding funding to non-rural healthcare providers participating in rural broadband networks to the extent that (1) the funding used for non-rural providers is excess funding under the \$400 million cap and not at the expense of rural provider access to funding that is by statute dedicated for rural purposes and (2) the program continues to be structured in a way that supports the voice and influence of rural providers in the broadband network.

We therefore believe that the Commission should adopt specific rules to ensure that the major benefit of the program flows to rural HCPs and rural patients.

We believe the right approach is to limit the percentage of funding available to urban sites. This will provide the rural networks with more flexibility than the alternative of limiting the percentage of urban

sites that can be part of the consortia. Some consortia may have good reasons that benefit the rural participants for having over 35% of urban members. By limiting the percentage of funding available to urban sites, such consortia would still be required to spend the significant majority of their funds in the rural locations (that have higher cost of broadband), while the urban locations (that have significantly lower cost of broadband) would benefit only up to a 35% maximum. Urban spoke membership is much more likely to be driven by the value of the network, rather than moderately reduced cost for what will likely be an affordable connection. Our only concern about the 35% funding limit is whether 35% in all cases would be sufficient to appropriately fund an urban hub. The hub is essentially a shared resource between all participants, and if it is located in an urban area (which is common) the equipment, network design, administrative, and management costs associated with the hub may in certain circumstances exceed the 35% threshold. Granting consortia some limited flexibility to allocate portions of the urban hub shared resource to the rural participant percentage may be desirable.

#### **II.f. Grandfathering of urban sites already participating in Pilot projects**

We believe that the Commission should grandfather existing Pilot Program urban sites, but only for so long as the urban site is a member of a consortium with rural HCPs.

#### **III.a. Point-to-point connectivity**

To the extent that the term “point-to-point” artificially limits reasonable network connectivity options, including services that will become available over time, we believe the term should be omitted and the definition of connectivity options in the Broadband program should be more general.

#### **III.b. Eligible non-recurring costs**

We strongly believe that equipment eligible in the Pilot Program (including “servers, routers, firewalls, and switches” but also other equipment eligible in the Pilot Program, such as network management equipment) should be funded. We also believe that recurring costs for network management (as allowed in the Pilot Program) and administration (as proposed for the Infrastructure Program in the NPRM) should be funded for Broadband Program consortia.

#### **III.c. Limited Funding for Construction of Facilities in Broadband Services Program**

We agree that it would be appropriate for an applicant that can demonstrate that self-provisioning the last mile is more cost effective than procuring the last mile from a commercial service should be allowed to do so.

#### **III.d. Ineligible sites and treatment of shared services/costs**

We agree that there are many good reasons that ineligible participants should be allowed to be part of the consortia, since their participation can strengthen the consortia and satisfy various network use cases of the eligible participants. We believe that the methods of allocating cost should be left to the consortia and be based on “reasonableness.”

#### **IV.a. Competitive bidding process**

Having been through the RFP process, we are comfortable with it and believe that the process allowed us to get good pricing. However, it was a time-consuming process that took significant resources to complete. If administrative costs were funded for the Broadband Program (as proposed in the NPRM for the Infrastructure Program), then we believe it would be reasonable to require all consortia applicants to prepare an RFP. If administrative costs are not funded, we believe the RFP process will be a significant challenge particularly for predominantly rural consortia without RFP writing experience, and in such cases we believe that exemptions such as the \$100,000 example should be considered.

#### **IV.b. Requirement to obtain competitive bids**

We agree that there are HCPs that do not seek or lose USF support because of the administrative burden of the program. We support flexibility to reduce the administrative burden of the competitive bidding requirement in those circumstances where competitive options do not exist.

#### **IV.c. Multi-year contracts**

We support the NSTN's recommendation that a "true" evergreen provision be applied to HCPs with multi-year contracts and believe that the proposed 3 year period between 467 filings is reasonable.

#### **IV.e. Eligible service providers**

We agree that the current definition is too narrow. We believe the definition should be "a telecommunications carrier, a qualified broadband access service provider, or an information technology service or equipment provider that provides services and equipment related to telecommunications or broadband services."

#### **V.a. Telemedicine**

It is our understanding that over 80% of rural hospitals utilize teleradiology services.

Our network of hospitals utilizes a shared PACS system that serves up images to participants over 20 MG network connections. This level of broadband is functional but not optimal and for some PACS vendors it would not even be functional. We believe 100 MG of bandwidth would be sufficient, and 1000 MG would be optimal. One factor that will cause bandwidth needs to grow is larger studies from for example the next generations of CT scanners.

It is our understanding that a reasonable bandwidth level for telehealth applications that require video-conferencing is 756k per connection.

#### **V.b. Electronic health records**

Our network of hospitals utilizes a shared EHR system by which EHR data is accessed from a shared datacenter, and several participants have achieved meaningful use. EHR data in structured form is generally a relatively low bandwidth consumer. In our experience, scanned images and large pdf files

are the highest EHR consumers of bandwidth. The bandwidth impact of HIEs will become dramatic when the HIE begins to exchange radiology images.

#### **V.c. Other telehealth applications**

It is our understanding that a reasonable bandwidth level for telehealth applications that require video-conference is 756k per connection.

#### **V.d. Service quality requirements**

High service quality and redundancy is critical particularly to EHR related applications, since high availability can affect patient care. In use cases where caregivers depend on patient information to make point of care decision, downtime needs to be kept to a minimum with redundant telecommunications connections. Other quality of service impacts (jitter, latency) can dramatically impact end user experience depending on the vendors being used.

Redundant connections can be lower bandwidth, so they do not need to significantly increase cost. Redundant equipment (firewalls, routers, etc.) configured in high-availability configurations can double the cost.

#### **V.e. Cost savings from broadband connectivity**

When we began our Shared EHR project, we determined that it would cost 20% less for participants to implement collaboratively over the network rather than individually. Cost savings were due to server and infrastructure (datacenter) sharing, as well as volume discounts from vendors due to economies of scale.

Thank you for considering our comments.