

**REMARKS OF
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WORKSHOP
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Good morning. Thank you, Velinda Stevens, for that kind introduction. Thank you for everything you do to make Kalispell Regional Healthcare such a dynamic institution—and thank you for hosting this event.

It's great to be in Montana. It's pretty glorious to be in Kalispell, too. Because in Washington, I assure you we've got nothing like the views you have in your backyard of Glacier National Park.

It was 105 years ago this month that three nurses ventured from Iowa to see those mountains and to help establish the hospital here in Kalispell. As the story goes, shortly after arriving by train, they sat down to lunch. But their meal was interrupted. A call came in from the local doctor. There was a sick patient with typhoid fever. Those nurses took on the patient—and the hospital was launched. Twelve days and \$28 dollars later, he was discharged.

Things were simpler back then. Less expensive, for starters.

But fast forward to the here and now. Kalispell Regional Healthcare is a hospital system that serves a geographic area the size of six New England states. It handles more than 20,000 emergency room visits, over 10,000 surgeries, over 200,000 outpatient visits, and over 600 newborn deliveries every year. So if anyone here from the hospital gets called away this morning, I will understand.

Kalispell Regional Healthcare is also a leader in telehealth. I will get to that in a moment. But first, in a room with so many health care experts, I feel duty-bound to begin by offering my credentials. I come from a family teeming with physicians. Count my father, father-in-law, brother-in-law, and sister-in-law among them. I am the lowly lawyer in the bunch. So over holidays when the table turns to talk of hospitals and HIPAA, I listen politely. But I can admit it's not my realm. Because I know in their mind, somewhere I took a wrong turn, headed for the legal life, and wound up in Washington.

But as good fortune would have it, I wound up at the Federal Communications Commission. That means day-in and day-out I have the privilege of a front row seat at the digital revolution. The opportunity to see the networks that are remaking our civic and commercial lives. The opportunity to see the connectivity that is changing the ways we reach out around the corner and across the world. It also provides a prime vantage point to witness the ways that broadband and telehealth are revolutionizing healthcare.

I'm privileged to say that I've been able to see this up close—in urban Washington, in suburban California, and in remote Arctic villages in Alaska. And now in rural Montana.

Everywhere I visit looks different, feels different, and treats different populations. But everyone I encounter on these visits has something in common: sheer optimism about the power of telemedicine.

I share their optimism. The numbers show that lots of others do, too. More than half of hospitals now use telemedicine to interact with their patients remotely. Two-thirds of health care professionals use some form of telemedicine today or plan to do so soon.

But it's not just professionals—it's patients. Roughly two-thirds of Americans are interested in having video visits with their doctor. Consider the tens of thousands of mobile health applications available on smartphones that one in five users regularly access—and you quickly get the picture.

Of course, one kind of patient deserves special mention. Our rural communities send more than their fair share of young people to the military. We owe them the best care we can provide. Increasingly, it's telehealth that makes that possible. And key programs—like telemedicine outreach for post-traumatic stress disorder—are showing even better results for veterans than those enrolled at traditional in-person facilities.

But for veterans—and everyone else, the best is yet to come. Imagine the world of the Internet of Things bringing tens of billions of connected devices by the end of the decade—so much more than the wrist bits and watches we know today. Imagine telemedicine aggregating patients with rare diseases and linking them to specialists for treatment and participation in clinical trials. Imagine how it can facilitate the connection of patients to doctors who can provide specialized language or cultural needs. Imagine how it can help keep local bonds strong in rural communities by fostering aging in place.

With all of this promise, then, the question becomes what can we do to expand the opportunities for telemedicine and telehealth success? The answer is lots. So let me talk about what we are doing at the FCC.

I'll start with the obvious. Telehealth solutions require access to high-capacity broadband networks. That's where the FCC comes in. It might surprise you, but this idea is not new or novel. In fact, Congress charged the FCC with assisting with deployment to rural health care providers back in the Telecommunications Act of 1996. Remember 1996? I called the Internet the “information superhighway”—and maybe you did, too. It was nearly two decades ago and broadband was in its infancy. Dial-up was our online destiny. So let's credit Congress with being ahead of the curve—and understanding that better networks can mean better care.

In the years following passage of this law, the FCC had a rural health care support system in place. It provided a handful of remote hospitals and clinics with funds for advanced communications. The program was small. The demand for support was weak. Over time we tweaked the rules at the margins, adjusted the filing requirements. But demand simply did not budge. The agency knew telemedicine was powerful—and Congress had given us a job to do. So back to the drawing board.

In time, we came up with the idea that we should test big changes in this program with a small pilot program. And Montana, true to form, showed up early and with bold ideas. Those ideas became the Health Information Exchange of Montana, which was brought to life through a \$13.6 million FCC grant.

Now many of you here are familiar with the Health Information Exchange of Montana because Kalispell Regional Healthcare is a key part of this network. But if you're not, you should know that it is a consortium that has deployed high-capacity fiber connections to non-profit health care providers across remote areas of northwest Montana. Those providers now have scalable access to a 10 Gigabit fiber backbone, which has expanded health care capabilities in remote communities throughout the network—on both sides of the Continental Divide. That means the transmission of medical images, patient records, and other data now takes place at broadband speed. It facilitates real-time consultations and distance learning. It helps create a virtual medical community in a region that is vast and beautiful but not always easy to travel.

That's good stuff. But it's the day-to-day applications that really make a difference. X-rays now get expert review remotely in a matter of minutes. That used to take an hour or more, jeopardizing local decision-making and patient care. On a daily basis, physicians say that the speed of the network saves them an hour—time that used to be spent waiting for computer systems to load and transfer can now be spent on patient care. Plus, the network has brought the ability to transmit higher resolution images, which supports the Kalispell Regional Healthcare mobile mammography program. The network also facilitates interactions with local colleges that are training the next generation of Montana health care professionals.

In many ways, the FCC pilot program that helped create this network was a sandbox. We studied what you did, sifted through your experiences, and learned from your experiments. Then we turned around and made the pilot program permanent.

As a result, the FCC now has a Healthcare Connect Fund, which provides up to \$400 million annually to help rural providers get the connectivity they need for modern medicine. Under the program, eligible health care providers can apply to receive funding to cover 65 percent of the cost of either broadband services or health care provider-owned networks. Consistent with the law, the focus of the program is on rural areas. But both rural and non-rural health care providers are eligible for support if they apply as a consortium with a majority of rural health care providers. This makes good sense. After all, linking rural and urban providers

means more access to specialists. It means lower cost broadband services through bulk buying. And it means less administrative expense.

This program is in its early years. But it builds lock, stock, and barrel on the success of the pilot program and what you have done here in Montana. So your network was not only an early experiment, like a true Western Pioneer, you led the way.

To ensure this program is effective, we are coordinating. After all, more than 20 federal agencies and departments have a role in shaping telemedicine. So for example, the Affordable Care Act and the Health Information Technology for Economic and Clinical Health Act both emphasize the use of electronic health records. As a result, our Healthcare Connect Fund includes support for broadband connections to off-site administrative offices and data centers, which will in turn support cloud-based electronic health records.

But there's more that can be done to expand the power and reach of telehealth. So let me conclude by briefly venturing out of the FCC's authority. But it's an issue that comes up in every single visit I have made to a major telemedicine facility—including here in Montana. So here it goes.

We can strive to do great things with telemedicine, but we will cut its promise short if it is fenced in by state borders and old rules premised on local paperwork. States have played a large role in the regulation of our health care system and physicians. Indeed, today as many as 70 jurisdictions are involved in the licensing of doctors in the United States. Before the advent of telemedicine, the diagnosis, treatment, and care of patients almost always happened face-to-face. But what if it doesn't? After all, with telemedicine patients may receive treatment across state borders. This means medical professionals typically must comply with different licensing requirements in multiple jurisdictions. It's time to fix this—by law or through simple state reciprocity arrangements—because we should not have analog-era paperwork limit the possibility of telemedicine in the digital age.

But licensing rules are only part of the story. State by state, insurance reimbursement through Medicaid and private insurance companies vary based on state requirements. Moreover, malpractice laws also vary, so malpractice insurance must be procured at the state level. The added cost of compliance with so many individual state requirements can hinder the development of relationships across state lines. This can cut patients off from regional networks that can be both valuable and cost-effective. It can mean that however good and smart programs are, like those at the FCC, they will never reach their full potential.

But even with these challenges ahead, I am an optimist. Because I've seen what you've done here in Kalispell and the connectivity you've brought to health care in remote Montana. Because rural residents deserve first class health care—and telemedicine can help deliver it. Because digitization, cloud computing, broadband ubiquity, and new wireless services are combining in such a potent way. And I am confident we can seize this mix, save lives, enhance

patient care, improve outcomes, and lower costs. I even think my many relatives in medicine would agree—and I know I'd like the FCC to help make it happen.

Thank you.