Brief Facts

on the
[Federal Communications Commission Staff Report](#):
Evaluation of Rural Health Care Pilot Program

Background:

In 1996, Congress passed the Telecommunications Act which:

- Directed FCC to establish "an affordable rate for the services necessary for the provision of telemedicine and instruction relating to such services." (p. 8-9).

- Defined 7 types of eligible health care providers (p. 9)

In response to this directive, FCC developed the rural healthcare telecomm program in 1997 in an effort to contain costs for rural providers so they matched their urban counterparts. In 2003, FCC developed the Rural Health Care Internet Access program which provides a 25% discount for monthly internet access for eligible rural providers. Together, these two programs are referred to as the Primary Program.

In 2006, the Rural Health Care Pilot Program was established to fund up to 85% of broadband deployment for rural healthcare providers. Originally intended to be a 3 yr program with evenly distributed funding, the program has taken longer than expected to lay groundwork for contracting and procurement. The goals of the Pilot Program are

1) "to bring 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." (pg. 6-7)

2) "lay the foundation for a future rulemaking that [w]ould explore permanent rules to enhance access to advances services for public and non-profit health care providers." (p. 7)

Since 2006, developments in HIT have increased the need for rural broadband access. FCC continues to work toward rural broadband deployment. In 2010, the agency proposed reforms to the Primary Program. The Notice of Proposed Rule Making (NPRM) is currently pending, and GAO recommended that FCC execute a performance evaluation for current programs in order to best design new programs in the NPRM. This staff report recounts the result of that performance evaluation process.

Pilot Projects – Quick Facts:

- Each pilot project is a consortium of individual health providers or health systems
    - Projects include sites in 38 states and three territories\
    - Most include urban providers, often serving as the network hub, but the pilots are comprised mostly of rural
    - Many are statewide or include multi-state regional networks (p 21)
- Projects vary in size
    - One third of active projects include fewer than 10 providers
    - One third of active projects include 11 to 50 providers
    - One third of active projects include at least 50 providers
- There are only 11 states without projects
    - Five of these states are totally urban (Maryland, Delaware, New Jersey, Rhode Island and Connecticut)
    - Two didn't apply and one was not awarded (Oklahoma and Idaho; Massachusetts)
    - Two withdrew (Kansas and Florida
    - 2 missed deadlines (Mississippi and Washington)
- As of Jan 2012, a total of $217 million of pilot project funding was committed by all the projects. This amounts to roughly $100,000 per participating health care provider.
- As of Jan 2012, a total of $100 million had been disbursed. This amount to about half the amount for which pilot projects had received funding commitments
- Most projects (up to 80% of project funding) use third party services rather than building and owning their own broadband network, but some projects had to construct "last mile" connections where there was no competitive alternative

Quality Improvement and Cost Reduction:

The Pilot Program has helped to create local, regional and state-wide networks, resulting in improved access to specialists and other services, such as telemedicine, that enables patients remain in their communities rather than travelling great distances for care. (p. 41) Using these networks, rural providers have been able to exchange electronic medical records, as well as achieve adoption of many telemedicine/telehealth applications (p 42). The most common applications include:

- tele-psychology/tele-psychiatry
- tele-radiology
- tele-echocardiology

- tele-stroke

Additional examples of broadband enablement in the use of telehealth/telemedince include:

- Pre-natal care (fetal medicine specialists, genetic counseling, etc)

- Tele-trauma

- Two-way video for e-ICU

- Telepharmacy (has enabled some systems to meet MU Stage 1 requirements)

- Tele-dermatology

- Development of HIE using pilot program enable connections (p. 44)

The FCC reports that telemedicine is popular with patients and providers, and has positively impacted the recruitment and retention rates of rural providers. In addition, pilots report improved care outcomes as the result of EHR adoption, which enables care coordination (care that follows the patient from provider to provider).

Further, pilot projects have demonstrated a public health use as they are now able to track communicable diseases, perform syndromic surveillance and environmental health reporting. One of the many benefits of this public health impact is reduced response times in cases of suspected outbreaks

Cost Reduction

Pilot projects have reported that the use of telemedicine applications has reduced cost for patient care by:

- Limiting admissions and wait time for patients who simply need access to a specialist

- Providing immediate consults for strokes, saving lives (p. 45)

- Reducing or eliminating travel time that is costly for patients, while simultaneously reducing no-show rates and improving outcomes

  - Example: high risk mothers make their appointments and avoid complications

- Reducing turnaround times for radiological imaging, allowing faster interventions and reduced stays at the hospital

Further, broadband has helped providers capitalize on the benefit of telemedicine technology by providing faster connections, thereby reducing turnaround times for various clinical processes. Broadband also provides better quality audio/video for video collaboration during consultation or treatment. Access to a reliable connection ensures that patients and providers enjoy reduced travel time and distance, even in the case of specialized treatment. In fact, telemedicine applications reportedely saved one network $1.2 million in transfer costs.

Moreover, operating costs for facilities implementing various health IT applications were significantly reduced. In one example, the use of tele-psychiatry saved $18 million in Medicaid spending. The savings came from reduced wait times for consults, during which time a patient would be held in the hospital ER for their safety. In another example, one facility reported reduced turnover for transcriptionists as a result of home access to clinical and financial information over broadband. As a result, the network saved $20,000 per FTE as turnover rate dropped from 50% to 0%.

Finally, the use of broadband enabled applications allow rural hospitals to retain desperately needed revenue and even create new revenue streams because telemedicine applications allow patients to remain in rural hospitals rather than being transferred to urban facilities.

Observations and Conclusions:

The FCC report identifies a few key observations, which include:

Opportunities and benefits

- The consortia approach, mandated by FCC, was beneficial as it simplified the application process and provided significant cost savings for networks who could share cost and administrative burdens of applying and participating in the pilot program. This approach also created purchasing efficiencies that resulted in high bandwidth and better service quality.
- Patients experienced improved access to health care, particularly specialty care, through telemedicine applications
- The inclusion of urban providers was a benefit to rural providers and to the projects as a whole by providing:
    - Access to specialists
    - Cost savings using telemedicine for services
    - Resources for technical expertise and training in telemedicine, EHR, and other health IT applications
    - Financial resources and consortia leadership: urban participants absorb most of the administrative cost of participation, which allows small, rural practices to participate
- Most networks chose not to own and operate their own broadband networks, but rather to purchase services on a multi-year basis. This shows that "dedicated health care networks do not require *ownership* of those networks."

Challenges

- Administrative costs are not eligible for reimbursement through pilot project funding and some projects have expressed frustration with this
  - Some have gotten state grants to cover costs and some have charged participating hospitals a fee to cover the administrative expenses (65)
- Long-term sustainability is required, but many projects are finding that sustainability is difficult to predict
- Many sustainability plans indicate reliance on government and private organization grants as well as participating healthcare providers. In addition, many of the plans cite the opportunity to redirect funding from cost savings and/or new revenue as a result of using telemedicine and other health IT applications. However, most programs also cited continued reliance on FCC support through the Primary Program.

Lessons for Future Reform

- The pilot projects have successfully fostered the creation of broadband networks and demonstrated the value of broadband connections for healthcare providers, particularly those in rural areas
- The flexibility of the pilot program has allowed 50 pilots to produce varying types of networks, all moving toward full implementation
- The consortium approach has proven successful and beneficial by reducing administrative cost and burden, realizing purchasing efficiencies, creating economies of scale and connection rural and urban providers. This approach should be continued.

For more information, please contact Katie Boyer, HIMSS Manager of Federal Affairs, at 703-562-8872.