Before the

FEDERAL COMMUNICATIONS COMMISSION

Washington, D.C. 20554

In the Matter of

Actions to Accelerate Adoption and Accessibility of Broadband-Enabled Health Care Solutions and Advanced Technologies	))))	GN Docket No. 17-46

Comments of

The National Congress of American Indians and
The National Indian Health Board

Brian Cladoosby
President
National Congress of American Indians

Vinton Hawley
Chairman
National Indian Health Board

May 24, 2018

Marlene H. Dortch,
Commission Secretary
Office of the Secretary
Federal Communications Commission
12th St. SW., Room TW-A325

RE: Comments in Response to GN Docket No. 16-46:

Dear Secretary Marlene H. Dortch:

On behalf of the National Indian Health Board (NIHB)[1] and National Congress of American Indians (NCAI)[2], we write in response to the Federal Communications Commission's (FCC) request for comments and data on *Actions to Accelerate Adoption and Accessibility of Broadband-Enabled Health Care Solutions and Advanced Technologies*.

As national organizations, NIHB and NCAI advocate for Tribal Nations throughout the United States on issuing impacting tribal communities, including broadband deployment and health care issues and ensuring that the trust responsibility is upheld when federal agencies create policies that impact tribal nations.

Tribal Nations are part of the constitutional structure of government. Since the formation of the United States, hundreds of treaties, statutes, executive orders, and numerous court decisions have recognized that the United States adheres to certain trust fiduciary standards in its dealing with Tribes.[3]

The FCC has recognized its obligation to consider, and consult with, Tribal Nations when it develops policies impacting Indian Country. In 2000 when the Commission released its

[1] Established in 1972, NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/AN). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-68, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

[2] NCAI is the oldest, largest and most representative organization of Tribal Governments in the United States. Founded in 1944, NCAI advocates for Tribal Governments in all areas of policy making. Because of Indian Country's rural and remote landscape, promoting the deployment and adoption of telecommunications technology is a priority of NCAI. NCAI's Telecommunications and Technology Subcommittee convenes the leaders of Tribal Telecom twice a year to discuss the telecommunications priorities across Indian Country.

[3] *See, e.g., U.S. v. Mitchell, 463 U.S. 206 (1983).*

Statement of Policy on "Establishing a Government-to-Government Relationship with Indian Tribes" The FCC "recognized that certain communities, particularly Indian reservations and Tribal lands, remain underserved, with some areas having no service at all." While the FCC has made great progress on its Government-to-Government relationship with the Tribes since 2000, there is room for improvement within all offices of the FCC.

The Federal Government's Role in Indian Health Care

The Federal Government carries out its trust responsibility to Tribal Nations by providing healthcare to members of Federally Recognized Indian Tribes through the Indian Health Service (IHS) and other federal programs. The Indian Health Service, an agency within the Department of Health and Human Services is a healthcare provider that serves American Indian and Alaska Natives. IHS is a health service delivery system for approximately 2.2 million American Indians and Alaska Natives who belong to 567 federally recognized tribes in 36 states.

Many Federal agencies and offices outside of the Indian Health Service have worked towards the same goal of providing for better health outcomes in Indian Country. Agencies include the US Department of Veterans Affairs (VA), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Administration for Children and Families (AFC), Administration for Community Living (ACL) and US Department of Agriculture Rural Development. Upholding treaty and trust obligations for Indian health is not just a responsibility of IHS, but a trust obligation of all federal agencies that provide health care or implement health related programs, including the FCC's Rural Health Program and the Connect2Health Initiative.

It is imperative that the FCC consider the needs of tribal nations and citizens in carrying out the Rural Health Program and the Connect2Health Initiative.

Lack of Broadband Infrastructure

The FCC understands the difficulties in deploying broadband in rural Tribal communities and has addressed this in many of its USF programs. As the FCC noted in its 2016 Broadband Progress Report, 68% of rural tribal communities lack access to broadband[4]. The Commission has made efforts to address the digital divide that persists in Indian Country, but the lack of broadband deployment in Indian Country continues to affect Indian Health.

Approximately 75% of IHS sites are located in areas defined as 'rural' by the FCC. These rural sites pay a higher percentage of their operating budget than urban locations on monthly circuit costs. When bandwidth upgrades are required, rural IHS sites are frequently asked to fund the capital costs of these upgrades. These projects can take years to complete. In some cases, telecommunication providers are not able to offer any upgrade options for IHS locations.

[4] 2016 FCC Broadband Progress Report

At rural IHS sites, circuit outages and restoration times are above industry averages, due to outdated equipment and small regional telecommunication providers covering large geographical areas with long travel times and limited staff. This creates challenges and risks in relying on network connectivity to provide clinical services. During 2016, IHS upgraded network bandwidth at over 50 locations. Furthermore, IHS is moving away from slow speed circuits such as T1 lines (1.5 Mbits) to Ethernet circuits which offer bandwidth in the 10 to 100Mbits range. To help fund the monthly recurring circuit costs associated with these upgrades, IHS is increasingly leveraging the financial support provided by the Healthcare Connect Fund (HCF). The HCF is an FCC program to provide rural healthcare providers with financial support for bandwidth charges.

However, large numbers of IHS facilities do not currently have sufficient bandwidth to offer telehealth and related services. Approximately 50% of the IHS sites are still depending on circuit connections based on one or two TI lines (3 Mbits). Their circuits are constantly saturated with staff experiencing slow response times when using traditional IT applications. The addition of telehealth and mobile health services is not an option at these locations. Services like this are critical in rural communities where recruitment and retention of medical professionals is continually a challenge.

In addition, over 1.5 million people living on Tribal Lands lack access to broadband. According to the FCC's 2016 Broadband Progress Report, 41% of Americans living on Tribal Lands and 68% of people living in rural Tribal Lands lack access to high speed internet, compared to the national average of 10%.

Some states with the largest telehealth potential have the lowest rates of broadband adoption on Tribal Lands.

Lack of Broadband Access on Tribal Lands by State

Data is specific to populations living on Tribal Lands

State	People without Broadband	Percentage of Population	State	People without Broadband	Percentage of Population
Arizona	162,382	95%	Wisconsin	13,042	33%
Alaskan Villages	128,638	49%	Minnesota	12,047	33%
New Mexico	108,604	80%	Colorado	11,875	87%
Montana	40,944	65%	North Carolina	8,910	99%
Oklahoma	36,739	42%	Nevada	7,563	72%
California	29,052	51%	Nebraska	6,393	85%
Idaho	27,666	95%	Oregon	5,517	64%
Utah	24,919	78%	New York	5,472	41%
North Dakota	19,295	80%	Kansas	4,955	100%
South Dakota	19,261	32%	Michigan	4,265	13%
Washington	17,104	13%	Mississippi	2,895	38%
Wyoming	13,202	48%	Florida	1,762	51%
National Average	**33.9 million**	**10%**	**All Tribal Lands**	**1.5 million**	**41%**
All above data sourced from the Federal Communications Commission's 2016 Broadband Progress Report-Appendix G					

The lack of broadband does not only impact healthcare providers' ability to support telehealth and telemedicine, it inhibits a patient's ability to research his/her own health. For 1.5 million people living on Tribal Lands, searching the internet for symptoms, doctors or insurance benefits is simply not an option.

While 90% of Americans enjoy the benefits of high speed internet, 68% of Americans living on Tribal Lands do not. The FCC and its individual offices like the Rural Health Care Program should partner with the Office of Native Affairs and Policy to tackle this issue in Indian Country.

Health Disparities in Indian Country

Across almost all diseases, American Indians and Alaska Natives are at greater risk than other Americans. American Indians and Alaska Natives are 520 percent more likely to suffer from alcohol-related deaths; 207 percent greater to die in motor vehicle crashes; and 177 percent more likely to die from complications due to diabetes. Recently, a report has come out stating that American Indian and Alaska Natives are also disproportionately affected by the hepatitis C virus (HCV). Furthermore, Natives have the highest HCV-related mortality rate of any US racial or ethnic group – resulting in 324 deaths in 2013. And, most devastatingly to our Tribal

communities, suicide rates are nearly 50 percent higher in American Indian and Alaska Natives compared to non-Hispanic whites.

Although the statistics highlight the severity of health disparities that American Indians and Alaska Natives face, behind each statistic is the story of an individual, a family and a community lacking access to adequate behavioral health and health care services, traditional healing practices, and traditional family models that have been interrupted by historically traumatic events. Devastating risks from historical trauma, poverty, and a lack of adequate treatment resources continue to plague Tribal communities. American Indians and Alaska Natives have a life expectancy 4.8 years less than other Americans. But in some areas, it is even lower. For instance, in South Dakota, for white residents the median age is 81, compared to only 58 for American Indians.

The Indian health care delivery system faces significant funding disparities, as evidenced by the per capita spending between the IHS and other federal health care programs. In 2014, the IHS per capita expenditures for patient health services were just $3,107, compared to $8,097 per person for health care spending nationally. With the funding gap already reaching upwards of $25 billion, even if 100% of these were recouped and put into services, the large budget gap and associated health disparities will remain. It is crucial that resources from across the federal government be used to address the health disparities and underfunding of the Indian health delivery system. As a result, investing in telehealth programs in Indian country could have significant impacts.

Increasing access to telehealth and tele behavioral health services in Tribal communities could help in combating the transportation and financial challenges that prohibit many American Indians and Alaska Natives from accessing necessary healthcare services.

Existing Telehealth Programs in Indian Country

Indian Country has seen a very successful utilization of a variety of telehealth technologies and services, especially regarding behavioral health. However, these successes were achieved on a largely regional basis, driven by visionary leaders in particular communities, with various and not reliably sustainable funding sources. As outlined above, the IHS has not yet been systematically resourced to establish either a sustainable telehealth infrastructure or governance program that would prioritize resources in accordance with identified need, establish and promote best practices, and formally evaluate and report on successes and issues.

Telemedicine has allowed Tribal Nations to dramatically improve access to care, accelerate diagnosis and treatment, avoid unnecessary medivacs and expand local treatment options. Program managers have noted that when communities adopt tele health programs, their patients like it and the community wishes to expand telehealth to other programs.

IHS Tele-Behavioral Health Center for Excellence

The IHS Tele-Behavioral Health Center of Excellence (TBHCE) was established in 2008 to provide behavioral health services across the country through real-time (synchronous) video connections.

TBHCE program managers report the following benefits:

1. Patients are 2.5 times more likely to keep their tele-psychiatry appointments than in-person psychiatry sessions;
2. in FY2013, IHS patients avoided more than 500,000 miles of travel, which translated into over $305,000 in savings for them; and
3. in FY2013, patients saved an estimated 16,450 hours of work or school that would otherwise have been missed to travel for appointments.
4. Native Veterans are more likely to participate in tele behavioral health programs at their local IHS clinic rather than tele health or in person treatment at the closest VA clinic[5]
5. Increased access to specialists and Emergency Services

The TBHCE is operating in 9 IHS Service Areas and at 25 sites. Program managers have reported great successes in the Oklahoma Area for behavioral health and wound care in addition to dermatology and nutrition success in the Phoenix area. However, there are 12 IHS Services Areas and over 300 different sites in the Indian health system – meaning, there are a significant number of Tribal Nations who are unable to access the services provided by the TBHCE. A further expansion of this program, as well as an expansion of broadband and telehealth infrastructure as a whole, is greatly needed to improve access to quality and culturally appropriate behavioral health services for all American Indians and Alaska Natives.

One major impact Telemedicine can have on the Indian Health Service is the benefit of recruiting and retaining professional healthcare staff. The Indian Health Service has historically seen difficulties in recruiting and retaining qualified professionals due to the rural and remote locations of IHS facilities. With Telemedicine, IHS professionals who already understand the health issues of a particular community can stay connected to that community if they move away or relocate. Telemedicine allows for an innovative new way to keep qualified professionals connected to Tribal Communities.

IHS Telehealth Contract in the Great Plains Region

In 2016, the Indian Health Service awarded $6.8 million in telemedicine services to Avera Health to serve American Indian and Alaska Native patients in the IHS Great Plains Area[6].

[5] Native Americans have served in the U.S. Armed Forces in greater numbers per capita than any other ethnic group in the United States.

Because of the vast landscape and remote nature of Tribal communities in the Great Plains Area, emergency services are much more difficult for IHS clinics to address. This contract is providing additional emergency medical services as well as allowing for patients to see specialists in behavioral health; cardiology; maternal and child health; nephrology; pain management; pediatric behavioral health; rheumatology; wound care; ear, nose and throat care; and dermatology.

The outcomes of this program have been positive, however the limited funding has not yet allowed for the Great Plains region to reach its full telehealth potential. Additionally, while this necessary investment to address urgent quality of care issues in this particular Service Area is beneficial, we urge that equal investments be made across Indian Country. Other Service Areas suffer similar issues of poorly resourced facilities and lack of capacity to implement telehealth services.

USDA Rural Utility Service

The Rural Utility Service within the US Department of Agriculture administers telecommunications telehealth grants through two major programs: the Distance Learning and Telemedicine (DTL) Program and the Community Connect Program. Federally Recognized Tribes are eligible for funding under these grants, and many non-tribal recipients do allocate small portions of funds to neighboring Indian Communities. However, the RUS programs that address telehealth in Indian Country do not sufficiently fund or address the potential for telehealth on Reservations. The FCC should consider the lack of sustainable tele health opportunities for Indian Country within USDA and HHS when considering the future of Connect2Health and the Rural Healthcare Program.

Successful Tele Health Programs in Indian Country

Alaska Federal Health Care Access Network

The Alaska Tribal Health System (ATHS) has relied on telehealth programs to deliver care for more than 20 years. The largest program, the Alaska Federal Health Care Access Network, has been operating since 2001 and has been installed in 250 sites in Alaska. Almost two-thirds of these sites are staffed by Community Health Aides/Practitioners in small Native villages. When first implemented in 2001, internet connectivity was largely unavailable in these village clinics. The Alaska Federal Health Care Access Network created new, innovative technologies that would capture images and patient data for transmission and consultation at other distant sites. Now, the clinical staff, the primary care doctors and specialty doctors can see in real time what is

[6] Indian Health Service awards $6.8 million telemedicine services contract to Avera Health, Press Release, https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/IHSPressRelease_Telehealth-Award_09202016.pdf

being entered into the patients' medical record. This has greatly improved medication management, reduced hospital re-admittance, increased patient safety and brings a sense of security for all who manage the patients' care.

Additionally, in Alaska, the use of telemedicine for audiology and ear, nose and throat (ENT) services not only cut down wait times for Alaska Native patients, it saved consumers and estimated $8-10 million in patient travel costs. [7] The FCC's Universal Services Fund (USF) subsidy program was a large contributor to the expansion and development of telehealth in Alaska Native villages.

Care Beyond Walls and Wires: Telemedicine Home Health Monitoring Program

The Care Beyond Walls and Wires program at Northern Arizona Healthcare, is a telemedicine-based, home-health monitoring program that has significantly improved the health of most participating patients, reduced emergency room visits and hospital admissions and readmissions, and decreased the length of stay for those who still require hospitalization. This program originated in 2011 through a pilot program through the National Institutes of Health Office of Public and Private Partnerships. Northern Arizona Healthcare agreed to conduct a pilot project involving 50 patients that targeted individuals who lived in Supai, a Tribal community located at the bottom of the Grand Canyon, or on a mesa on the reservation. Patients were each given a scale, blood pressure monitors, and pulse oximeters as well as smart phones and solar powered chargers, as many of the participants did not have electricity within their homes. The relationships and sense of security many of the participants developed were reported to have improved health outcomes and reduced unnecessary hospital visits because patient coordinators could monitor and prevent complications while patients were at their own homes.

[7] The Success of Telehealth Care in the Indian Health Service, American Medical Association Journal of Ethics December 2014, Volume 16, Number 12: 986-996. Howard Hays, MD, MSPH, Mark Carroll, MD, Stewart Ferguson, PhD, Christopher Fore, PhD, and Mark Horton, OD, MD

Recommendations

We ask the Commission and the Connect2Health Taskforce to consider Indian Country when addressing rural health and moving forward with this notice. To better serve the health needs of Indian Country, and to fulfill the Commission's trust responsibility, we recommend the following policies:

Memorandum of Understanding between the Federal Communications Commission and the Indian Health Service

NCAI and NIHB recommend that the FCC enter into a Memorandum of Understanding with the Indian Health Service to coordinate Health IT and telehealth efforts to best utilize government resources. To advance both departments' trust responsibility to Indian Tribes, both the FCC and IHS should keep an open dialogue and work together. For example, the FCC Office of Native Affairs and Policy could coordinate with the IHS Telebehavioral Health Center for Excellence to find common goals, provide outreach to Tribal communities on telehealth opportunities and collect and share data on telehealth in Indian Country. An MOU between these two agencies will provide for more efficient use of funds and a better approach to solving health disparities in Indian Country.

Tribal Set Aside in FCC Health Funds

NCAI and NIHB recommend that the FCC create at least a 5% Tribal set aside for all healthcare related funding that the FCC and USAC distribute. To reach a set aside of at least 5%, we consider the FCC data in the 2016 Broadband Progress Report. There are 1,573,925 people living on Tribal Lands who lack access to broadband out of 33,981,660 people who do not have access nationally. This equates to 4.6%, and rounding up to 5% for the increased costs associated with deployment on the rural and rugged terrain in Indian Country. Many other federal agencies and programs create at least 5% of set aside funding for Tribal programs.

Establish a formal Telehealth Working Group to Address the Needs of Indian Country

NCAI and NIHB also encourage the FCC to establish a Tribal Telehealth Working Group to address the unique needs of health in Indian Country. The working group should work directly with senior Commission staff and the Chairman to advance the FCC's health related goals in Indian Country.

Conclusion

We thank you for the opportunity to provide our comments and recommendations and look forward to further engagement with the FCC. Please contact Maria Givens, Policy Analyst for NCAI at mgivens@ncai.org or NIHB's Director of Federal Relations, Devin Delrow at ddelrow@nihb.org if there are any additional questions or comments on the issues addressed in these comments.