

TRANSCRIPT OF PROCEEDINGS

BROADBAND HEALTH TECH FORUM:)
)
Leveraging the Power of)
Broadband to Address)
Disparities, Drive Health)
Innovation and Spur)
Entrepreneurship)
)
Connect2HealthFCC,)
Wayne State University,)
TechTown Detroit)

MORNING SESSION

Pages: 1 through 122
Place: Detroit, Michigan
Date: October 28, 2015

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FEDERAL COMMUNICATIONS COMMISSION

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 Connect2HealthFCC,)
 Wayne State University,)
 TechTown Detroit)

iBio Center
 Wayne State University
 6135 Woodward Avenue
 Detroit, Michigan

Wednesday,
 October 28, 2015

The parties met, pursuant to the notice, at
 9:17 a.m.

PARTICIPANTS:

Dr. M. Roy Wilson, President, Wayne State
 University

Mignon Clyburn, Commissioner, Federal
 Communications Commission

Doug Skrzyaniarz, MHSA, Associate Vice President
 Government Affairs and Adjunct Instructor,
 Wayne State University School of Medicine

Paul Riser, Managing Director, Technology-Based
 Entrepreneurship, TechTown Detroit

Dr. David Rosenberg, MD, Professor and Chair,
 Department of Psychiatry & Behavioral
 Neurosciences, Wayne State University and the
 Detroit Medical Center

Marc Hudson, Co-Founder and Chief Executive
 Officer, Rocket Fiber LLC

PARTICIPANTS: (Cont'd)

Jamal Simmons, Co-Chair, Internet Innovation Alliance

Silas Buchanan, Chief Executive Officer, Institute for eHealth Equity

Dr. Adam Perzynski, Ph.D., Assistant Professor of Medicine, Center for Health Care Research and Policy, MetroHealth and Case Western Reserve University

Dr. Herbert Smitherman, Jr., MD, MPH, FACP, Assistant Dean of Community and Urban Health, Associate Professor of Internal Medicine, Karmanos Cancer Institute, Wayne State University School of Medicine

Dr. Kimberlydawn Wisdom, MD, MS, Senior Vice President, Community Health & Equity and Chief Wellness and Diversity Officer, Henry Ford Health System

P R O C E E D I N G S

(9:17 a.m.)

1
2
3 MR. SKRZYNIARZ: Good morning. I'm Doug
4 Skrzyniarz, Associate Vice President for Government
5 Affairs for the Wayne State University School of
6 Medicine. We're delighted that all of you are here in
7 the audience and online through the FCC.gov live
8 webcast today to participate in the Broadband Health
9 Tech Forum: Leveraging the Power of Broadband to
10 Address Disparities, Driving Health Innovation and
11 Spur Entrepreneurship.

12 This event is hosted by the Federal
13 Communications Commission's Connect2Health Task Force
14 under the leadership of Michele Ellison, and in
15 partnership with us at Wayne State University, and our
16 good friends at TechTown Detroit which is located next
17 to this new iBio Building.

18 We have an exciting program for you today
19 and have assembled distinguished senior leaders and
20 experts in health care and technology. As you will
21 see in the program handout, our focus this morning
22 will be on how broadband technology could be leveraged
23 to reduce health disparities in urban settings such as
24 here in Detroit and on the provocative and new
25 question as to whether broadband adoption is a social

1 determinant of health.

2 During the afternoon, starting at 1:00, our
3 program will continue at nearby TechTown and will be
4 led by Paul Riser, its Managing Director and focus on
5 innovation and entrepreneurship and health technology.

6 During the afternoon program, you will hear from
7 successful innovators, entrepreneurs about their
8 experiences and lessons learned in developing health
9 technology.

10 And then there's a lightning round
11 discussion with an impressive panel of luminaries to
12 discuss very important issues such as the impact of
13 digital literacy on health technology innovation and
14 on methods to energize diversity, innovation and
15 entrepreneurship in broadband health technology space.

16 So just a fantastic program, and we're
17 thankful to FCC's Connect2Health Task Force for
18 bringing this event here in Detroit. Just a couple
19 notes. During this forum, we encourage you to tweet
20 using the hashtag #C2HFCC. You may also submit
21 questions to session participants via Twitter, again
22 at #C2HFCC or email at livequestions@FCC.gov and we'll
23 entertain your questions as time permits.

24 Now it's my privilege to welcome the
25 President of Wayne State University, Dr. Roy Wilson,

1 to provide opening remarks. Dr. Wilson became the
2 12th President of Wayne State University on August 1,
3 2013. Prior to joining Wayne State, President Wilson
4 served as Deputy Director for Strategic Scientific
5 Planning and Program Coordination at the National
6 Institute on Minority Health and Health Disparities of
7 the National Institutes of Health.

8 Previously, he was Dean of the School of
9 Medicine and Vice President for Health Sciences at
10 Creighton University, amongst other roles. President
11 Wilson's research has focused on glaucoma and
12 blindness in populations from Caribbean to West
13 Africa. He is a member of the Institute of Medicine,
14 and might I add as many of you know, Detroit is
15 experiencing a renaissance, and Wayne State is a very
16 large part of that. And we're very excited to have
17 President Wilson part of our family at Wayne State
18 University, to help lead not only the renaissance here
19 at our University, but also help lead the renaissance
20 of Detroit here in Midtown. So without further adieu,
21 President Wilson.

22 (Applause.)

23 MR. WILSON: Thank you, Doug. Good morning,
24 everyone. I thank Commissioner. Good morning to you.
25 Thank you for being here, glad we're able to host you.

1 You know, this is great being in this
2 building and in this room. This is, I think, the
3 first time that I've been in this room. Just a couple
4 of weeks ago, we opened this building up officially,
5 and it was a very nice celebration.

6 And what we're hoping happens in this
7 building is that interdisciplinary teams get together
8 and try to solve one of society's perplexing problems,
9 which is the issue of health disparities. To try to
10 look at it from different perspectives, and come at it
11 from different points of view, and work together to
12 try to deal with this issue.

13 So I think that there's really a great fit
14 between what goes on here, all the time now hopefully,
15 and the innovations this forum is striving to achieve.

16 And that's why I think this is really a perfect place
17 to hold this forum.

18 You know, as a surgeon and a researcher -- I
19 guess I should say past surgeon and researcher; my
20 particular passion has been in addressing health
21 disparities. And in fact, in many ways, my life's
22 academic work has been in this field. Whether it's
23 good or bad, health should not be determined by where
24 you live or your income or your race or any other
25 variable access to good health. And it just seems to

1 me that it's perplexing, and certainly unacceptable,
2 that this is still an issue in today in this country,
3 one of the most wealthiest and developed countries in
4 the world.

5 But we still do understand the realities,
6 and we understand the need to change those realities.

7 And that's particularly why this building and what
8 goes on in this building is going to be very
9 important, and that's partly why we're all assembled
10 here today.

11 So broadband connectivity can serve as the
12 backbone of a new, more effective and efficient health
13 and care ecosystem; and Michigan is a key focus state
14 in this context with significant health disparities
15 and connectivity gaps. According to the 2014 Census
16 Bureau's American Community Survey, 20 percent of
17 households in Michigan report no broadband connection
18 at home; and in the urban center of Detroit, and I'm
19 sure in many urban centers throughout this country,
20 the percentage of households without high speed
21 internet connectivity increases to 38 percent.

22 And this is important, because broadband
23 technology can help transform access to health care
24 services; despite time, and distance, and other
25 factors that may post barriers to patients needing

1 care. And one of the things that's been intriguing to
2 me as I glanced at this program is this whole issue of
3 connectivity being a social determinant of health.
4 And I must admit I never really thought of it in that
5 context, but it certainly makes a lot of sense.

6 And, you know, I'm going to say something
7 which probably you think, well, everybody says that.
8 But you know, I really wish that I had the time to be
9 here, to listen to this really; because I think it's a
10 fascinating topic. Unfortunately, I am already late
11 to another place I have to be. You might have heard,
12 there's a big announcement this morning about a big
13 donation in a building that's going to be going up
14 downtown. That was not supposed to happen until
15 Friday, and so I'm trying to do a lot of damage
16 control here because somebody's leaked something to
17 the press. So I've got to get going and do some
18 damage control.

19 (Laughter.)

20 But I do wish, and I sincerely say this,
21 that I could be here to participate in this discussion
22 because I think it's fascinating. So have a great
23 productive day. Thank you very much.

24 (Applause.)

25 MR. SKRZYNIARZ: Thank you, Dr. Wilson,

1 appreciate you having some time for us this morning
2 and kicking things off.

3 Now I have the absolute privilege to
4 introduce a distinguished guest, the Commissioner of
5 the FCC, Commissioner Mignon Clyburn.

6 Commissioner Clyburn served with distinction
7 as Acting Chairwoman of the FCC following her
8 appointment by President Barack Obama. As such, she
9 became the first woman ever to serve in that capacity.

10 She joined the Commission in 2009 and was sworn in
11 for a second term on February 19, 2013. And after her
12 renomination by the President, she was confirmed by
13 the United State Senate.

14 Prior to her current distinguished federal
15 service, Commissioner Clyburn spent 11 years as a
16 member of the Public Service Commission of South
17 Carolina, and she served as its Chair from July 2002
18 through June 2004. As a long-time champion of
19 consumers and a defender of the public interest,
20 Commissioner Clyburn considers every Commission
21 proceeding with an eye towards how it will affect each
22 and every American.

23 She is a strong advocate for enhanced
24 accessibility and communications for disabled
25 citizens. And she has fought to promote strong

1 competition across all communication platforms,
2 believing that the more robust and competitive the
3 market place is, the less need there is for
4 regulation.

5 She is also an outspoken champion for smart,
6 targeted regulatory action. She has pushed for
7 affordable universal telephone and high speed internet
8 access, great broadband deployment and adoption
9 throughout the nation and transparency in regulation.

10 She has taken a leadership role in ensuring
11 that broadband and advanced technologies are available
12 to all Americans, particularly given the critical role
13 they will play in the future of health care. Please
14 join me in welcoming Mignon Clyburn.

15 Commissioner?

16 (Applause.)

17 COMMISSIONER CLYBURN: Thank you so much.
18 It's such a pleasure for me to join you on this
19 beautiful Chamber of Commerce Day. My dad always
20 calls it liquid sunshine. So we need to look at this
21 as a positive, because if it were not for the rain and
22 the other elements, what would we have? Probably, a
23 clearer day, but that's another time.

24 (Laughter.)

25 It is really an honor for me to join you

1 today, here at this beautiful setting. This is the
2 ideal place, time, and city for these conversations to
3 occur.

4 Again, you are here today because you
5 recognized that broadband, as President Wilson
6 mentioned, is a social determinant of health. And if
7 we look at it in that way, and if we look at what we
8 are speaking about and addressing in an empowering
9 way, then I think the chronic problems that we know
10 the stats -- all of us know the statistics. If you
11 don't know them, but better or for worse, you have
12 them in your packets. We know the challenges.

13 But through technology and the commitment of
14 all of you, we know that we can solve this. And we
15 need to look at it in that framework. If we truly
16 believe, as our chair says, that broadband is not
17 about broadband but what it enables, it enables us to
18 do and deliver better. So again, I'd like to thank
19 our President Wilson, Ned Staebler and of course Dr.
20 Skrzyniarz and Dr. Yancey for allowing us to assemble.

21 I understand that both the University and
22 TechTown have left no stone unturned for all of us to
23 make sure that our time is valuable. You see the
24 names of the panelists for our first round. So you
25 know we will have a comprehensive and interactive

1 conversation today.

2 We really appreciate all of your hard work,
3 and what you will contribute to our Connect2Health
4 effort, as you hear more about -- that really, our
5 main goal at the FCC is not just about helping those
6 companies with affordability in terms of getting the
7 infrastructure in the ground.

8 We recognize that we can't just say, "We
9 will build it and they will come." If the other
10 elements are not there in terms of affordability;
11 relevance; and all of us recognizing that if there is
12 true ubiquitous connectivity that we will have a
13 healthier population and we can do so more affordably
14 -- if we don't recognize that, then honestly, you
15 know, our pathway will be in vain.

16 But I don't have to worry about that today.

17 We recognize that, the importance of this. And we
18 recognize that we have to look at this in terms of our
19 communities, each of our individual talents,
20 connections and all of the elements that we bring to
21 the table -- that we recognize, if we do this
22 collectively, that our outcomes again will be optimal.

23 So I will yield the rest of my time, as we
24 say in D.C., to -- oh, goodness, I'm taking someone's
25 job. I was going to say to Paul Riser, but I am going

1 to ahead and yield back to Dr. Skrzyniarz, because he
2 is the MC today. I'm just showing off. Thank you
3 very much.

4 (Applause.)

5 MR. SKRZYNIARZ: Thank you, Commissioner.

6 And so before we delve into the substance of
7 our program, I'd like to call up Paul Riser, the
8 Managing Director of Technology-Based Entrepreneurship
9 at TechTown Detroit, and a terrific partner of this
10 event to say a few words.

11 And just really quick on TechTown, you look
12 at Midtown Detroit here, which is helping drive the
13 renaissance of Detroit. It didn't look like this a
14 decade ago. And TechTown, in partnership with Wayne
15 State University, has really rebuilt this area of the
16 City in Midtown. And so we're really excited to have
17 Paul and TechTown to be our partner today and today's
18 program. Paul?

19 MR. RISER: Thank you. Good morning,
20 everyone. I am Paul Riser, again TechTown Detroit
21 Managing Director of Technology-Based Entrepreneur
22 Programs.

23 It has been truly a delight and a joy in
24 working with the FCC over the past couple months to
25 deliver what we have here today. I thank Commissioner

1 Clyburn, Chairman Wheeler and the Connect2Health Team,
2 Chris Gibbons, Deborah Klein; and the others who I
3 have had the pleasure of being in contact with, in
4 order to afford TechTown and Wayne State and our
5 partners the opportunity to deliver what we have
6 today.

7 When the topic was actually brought to me or
8 I was informed of the topic, I not only said wow, what
9 an interesting topic, but I said TechTown has got to
10 be involved. And I felt that Detroit was the perfect
11 city -- not to put any pressure on anyone today, but
12 -- to figure out all of the answers to these questions
13 that we have.

14 Because, a unique diverse set of
15 characteristics our city represents, but a great
16 intellectual capital and group of people that I think
17 can really contribute to some solutions today. And
18 that's what we charge and ask of our audiences both
19 this morning and the afternoon sessions to think
20 about.

21 And so being at TechTown, and even before
22 TechTown, a lot of my work -- and whether it be
23 schools or even with the medical device company in the
24 specific space of dentistry and regenerative medicine
25 -- I've noticed what the impact of broadband and

1 technology can have on solutions, and the value of
2 those solutions. Dentistry not being quite an
3 industry to adopt technology so quickly, but I was
4 granted and fortunate enough to be with a very
5 innovative and forward thinker, who really leveraged
6 technology-strong, or in an impactful way.

7 And so that has actually brought me to where
8 I am today. And being in TechTown and in today's
9 events, not only is it important obviously about
10 equitable access that was talked about; but also
11 affordability; but also meaningful use. And that's
12 the training, it's the education, it's the literacy.
13 It's closing those gaps that are also important, to
14 ensure that everyone has a fair and equal chance; and
15 that we are able to compete not only domestically, but
16 nationally and globally.

17 And so this is a topic that I think is so
18 germane to all of us, it transcends what broadband
19 transcends health. It transcends education. It
20 transcends employment, and it leads to so many things
21 that are so important to our lives.

22 And so for TechTown specifically, we are in
23 the business of building great entrepreneurs and great
24 companies, both tech start ups and place-based
25 lifestyle businesses. But broadband plays an

1 important role in us being able to not only help
2 deliver great solutions with our entrepreneurs, but
3 also to attract and retain the best talent from around
4 the world, right here in the City of Detroit in
5 Southeastern Michigan.

6 And so without any further ado, I want to
7 just note that TechTown is committed, not today but
8 moving forward to this movement, and to this
9 conversation; and the work that needs to be done in
10 partnership in unison with the FCC. We look forward
11 to it, and we know that this is important to foster
12 competition, connect communities and also provide
13 equity for all in a digital economy.

14 So thank you. I ask you that you join us
15 later this afternoon across the street from 1:00 to
16 3:00 p.m. Thank you so much.

17 (Applause.)

18 MR. SKRZYNIARZ: Thank you, Paul. You got a
19 little appetizer --

20 (Laughter.)

21 MR. SKRZYNIARZ: -- a taste of what this
22 afternoon's program is going to be. So I would expect
23 everybody's going to want to be at TechTown this
24 afternoon.

25 Well, we begin our program this morning with

1 two important presentations that will serve to provide
2 context and ground our important discussions. First,
3 we have a presentation by Dr. David Rosenberg, who is
4 the Chair of Psychiatry and Behavioral Sciences at
5 Wayne State University School of Medicine. Dr.
6 Rosenberg is going to speak about the variety of
7 health disparities in Detroit, and how broadband based
8 technology is incorporated to address them.

9 And then we'll hear from Marc Hudson, the
10 Co-Founder and CEO of Rocket Fiber to provide a
11 presentation on the state of broadband connectivity
12 here in Detroit. And may I just add with Dr.
13 Rosenberg, first that the Department of Psychiatry and
14 Behavioral Sciences here at Wayne State University
15 really provides very critical services across Wayne
16 County. Wayne County and the City of Detroit is one
17 of the larger community mental health regions in the
18 country, and Dr. Rosenberg helps lead a lot of
19 providers here in Wayne County to provide much needed
20 mental health services.

21 So, he's very well informed on this area. I
22 look forward to hearing his comments. Dr. Rosenberg?

23 (Applause.)

24 DR. ROSENBERG: Thank you, Doug. It's
25 wonderful to be here. This is such an exciting place

1 at the iBio; having the FCC, TechTown work with you.
2 And just let me say that the School of Medicine, the
3 University, the Department of Psychiatry; we're all in
4 and want to partner and help all of you in any way we
5 can.

6 The Wayne State University Department of
7 Psychiatry has a unique and historic relationship to
8 the mental health community in the Detroit
9 Metropolitan area. We believe strongly in our
10 leadership role in providing access and the highest
11 quality of care to those most at risk, most vulnerable
12 populations and doing so through innovative approaches
13 that both increase access, improve outcome; while at
14 the same time reduce costs.

15 To give you some background in why broadband
16 is so critical in new approaches, new technology,
17 Wayne County is the most populous county in Michigan,
18 over 1.6 million people with a minority population of
19 45 percent, and 25 percent live below poverty. Now in
20 the entire state of Michigan, we have 1,314
21 psychiatrists. That means four psychiatrists for
22 every 100,000 people.

23 The circumstances are even more dire,
24 though, in Wayne County; because the average age of a
25 psychiatrist is 63 years old. So if only a small

1 portion retire or cut back, we're looking at a
2 devastating crisis in terms of mental health care and
3 our ability to intervene.

4 I'm also a child and adolescent
5 psychiatrist. There are only 218 child and adolescent
6 psychiatrists in Michigan. So it's not surprising
7 that children and adolescents are diagnostic and
8 therapeutic orphans, because in a system dominated by
9 the politics of who will pay the bills, those without
10 votes get short shrift. Thus, we have Medicare rather
11 than Pediticare, and literally millions of children
12 with mental health problems without adequate access to
13 mental health care treatment.

14 And that's where technology, telemedicine,
15 smartphones, apps is a game changer. Because what we
16 know, is that the reality is that primary care
17 practitioners are seeing most of the mental health
18 problems -- either primary mental health problems,
19 schizophrenia, bipolar disorder or the many mental
20 health co-morbidities with diabetes.

21 We know that teenagers with diabetes are at
22 a markedly increased risk for depression. And guess
23 what? So are their first degree relatives, their
24 brothers, sisters, mothers and fathers. How well can
25 an insulin level or a glucose level be maintained, if

1 the patient himself or herself is depressed, and the
2 mother who's supposed to be watching over the father
3 who's watching over is depressed?

4 Asthma. We know that in African Americans,
5 asthma is increasing at an astounding rate,
6 particularly in children -- about 50 percent increase.

7 One in six children suffer from asthma. The death
8 rate from asthma, over twice as high in minority
9 populations than in Caucasians.

10 Mental health, co-morbidity, can impact all
11 of this. And what we know is that when we integrate
12 care -- medical behavioral care, we don't separate
13 below the neck from above the neck -- we treat the
14 whole person, and we use smart technology. We also
15 know that not only is it a game changer as I've said,
16 but we can create a virtually connected medical and
17 behavioral health plan; that integrates care, meets
18 the needs in a way that we haven't been able to do.

19 So we have to think multi-dimensionally. We
20 have to think globally. And what I'll show you today
21 are a few snapshots of how -- when this works -- what
22 it means to patients, families and the primary care
23 providers that we work with. Can I have the first
24 video, please.

25 (Video begins as follows.)

1 SENATOR STABENOW: And David Rosenberg, Dr.
2 Rosenberg is Chair of the Department of Psychiatry at
3 the Wayne State School of Medicine. And so many
4 people, all of you who work in the area of behavioral
5 health, members of the law enforcement community,
6 students, community members, thank you so much for
7 coming together today.

8 I want to congratulate everyone at Wayne
9 State who's involved in the face-to-face inpatient
10 diversion program. Because this really is a model for
11 what we can do in mental health reform, and shows how
12 important it is to have a central psychiatric
13 emergency service available, for people struggling
14 with mental illnesses and substance abuse.

15 That's part of, requirements we put in this
16 new certification plan for federally qualified
17 behavioral health clinics. And frankly, it's one of
18 the reasons that we have such strong support from the
19 law enforcement community across the country, to be
20 able to meet forward in this way. So that we can make
21 sure people are getting the emergency care that they
22 need in an emergency psychiatric setting; rather than
23 in jail, or in the emergency room of a hospital.

24 And we know that if this is done right, we
25 can keep people out of long-term care in hospitals and

1 give them the support that they need; the medication
2 and treatment to be successful, and go on, and live
3 healthy lives.

4 (Video ends.)

5 DR. ROSENBERG: So that's Senator Debbie
6 Stabenow, the Senior Senator in Michigan. Doug
7 Skrzyniarz has had her here at Wayne State several
8 times, most recently over the Summer. She gave
9 another talk about mental health.

10 She was all in, in terms of new technology,
11 mobile crisis, telemedicine, increasing access,
12 improving outcome. And what you've heard here, is
13 when you do that correctly, you can actually keep
14 patients and people out of the emergency room, out of
15 inpatient hospitalization, help those in primary care
16 to begin to determine what is an emergency, what needs
17 to be referred, what can be done at home and the like.

18 And what I would say is that she has, with
19 her Republican colleague, Roy Blunt, cosponsored the
20 Excellence in Mental Health Act. And that is now a
21 law, and eight states are going to be chosen who will
22 get \$25 million for each state to look at new
23 approaches. And we hope that we here in Michigan will
24 be one of those states. Michigan has received the
25 pilot of a little less than a million dollars to begin

1 looking into this particular approach.

2 What I would tell you, is that this is
3 personal to the Senator. And she's very open about
4 this, but her father suffered from bipolar disorder.
5 And she talks about what a difference it made to her
6 and her whole family, her father, when he was properly
7 diagnosed and treated.

8 And as an aside, since we're talking about
9 smartphone technology broadband, there's a company in
10 Italy that has developed a mood regulation sensor. In
11 bipolar disorder, manic-depressive illness, there's
12 considerable mood dysregulation highs and lows. And
13 patients can wear this smartphone app and get a sense
14 of, oh, my mood is changing and that can be connected
15 and communicated to the physician.

16 Why is that so important? Well, recent data
17 suggests that if you can treat and intervene in
18 bipolar disorder in the middle of a cycle; when
19 they're becoming depressed, as they're about to become
20 depressed, as they're about to become manic before
21 waiting for an appointment, before waiting several
22 days, hours, what have you; if you can do it at that
23 particular point in time, the prognosis increases
24 markedly.

25 And we also know that the longer you wait,

1 every month that you're not treated properly for
2 bipolar disorder, the long-term prognosis goes down 10
3 percent. So the stakes are very high. If I could
4 have the next slide, please.

5 I have the honor and privilege of chairing
6 the Tenet Behavioral Health Advisory. Tenet owns the
7 Detroit Medical Center. They're the hospital system
8 that we at Wayne State partner with. And David
9 Hickman, one of the quality managers in Dallas, came
10 and visited our programs here, saw what we were doing,
11 and said that the Detroit Medical Center's Emergency
12 Department Psychiatry Programs and Crisis Center
13 should be seen and used as the model for how these
14 programs should be organized across the Tenet System.

15 So, they have hospitals across the system.
16 And we had a long discussion yesterday about how to
17 implement that with Tenet's Chief Behavioral Officer,
18 all emanating from here in Detroit. And a big part of
19 it is because we've been, as I'll show you in a
20 moment, using smartphone technology, telemedicine,
21 telepsychiatry, increasing access, improving outcomes.

22 Next slide, please.

23 Well, in our audience, we see two of the
24 authors, Alireza Amirsadri and colleagues. We
25 published an evidence-based paper about this program

1 in the emergency room, that resulted in a 94 percent
2 reduction in inpatient hospitalization and repeat
3 emergency room visits of behavioral patients. It
4 improved outcome, and in a single year saved Michigan
5 State Medicaid \$7.6 million. Since that program has
6 been implemented, it saved the State of Michigan
7 Medicaid over \$70 million. Next slide, please.

8 We've now translated that into children, and
9 using what we call hybrid mobile crisis; that is,
10 using behavioral specialists who've been trained by
11 us, not psychiatrists, typically social workers, some
12 nurse practitioners, masters level psychologists and
13 combined with telemedicine, telepsychiatry; we in the
14 Childrens Hospital of Michigan Emergency Room,
15 completed turned something around that had been a
16 crisis, was unacceptable.

17 So, before we implemented this program,
18 before 2013, 82 percent of children with behavioral
19 problems coming into the emergency room at Children's
20 Hospital were going into an inpatient hospital
21 afterwards. By the time 2014/2015 rolled around here
22 right now with the Mobile Crisis Program, access to
23 telemedicine, telepsychiatry; what we see here is the
24 20 percent of patients are being hospitalized. Eighty
25 percent are being kept out of the hospital and in the

1 community.

2 Next slide, please.

3 This just shows the range of our
4 consultation with telepsychiatry, mobile crisis
5 outreach programs. The programs that I talked to you
6 about at the Children Hospital of Michigan Emergency
7 Room, were so successful that we've now been asked to
8 provide these telemedicine, mobile crisis services to
9 every emergency room in Wayne County. Good for the
10 taxpayer, good for the patient's families. The
11 children are back in school, back in the community,
12 avoid unnecessary hospitalizations.

13 I'm not bashing hospitalization. We need
14 hospitals for certain things. But there are too few
15 beds in Michigan and most states, and we just want to
16 make sure those children and adults who go into the
17 hospital, really need to be in the hospital. And by
18 the way, the programs that we have here, the mobile
19 crisis telemedicine programs, they are so effective
20 that for those children, those adults who do go into
21 the hospital, they spend less time in the hospital.
22 There's a significant decrease in the length of stay
23 in the hospital.

24 I talked to you about the Pediatric Asthma
25 Clinic and providing mobile crisis services to asthma

1 patients, families, others, diabetes families. We can
2 say that the case of the mother who smokes, but not
3 around the children; so she doesn't think that that's
4 affecting her son's asthma -- but wait a second.
5 Education has helped somewhat, but with access to
6 broadband telepsychiatry, cartoon training vignettes;
7 suddenly she begins to understand and you can train in
8 real time that the secondhand smoke, the smoke in her
9 clothes, other environmental triggers, it's a game
10 changer.

11 We've worked with the federally qualified
12 health centers' adult foster care homes. We have done
13 training sessions for these workers who may not be
14 mental health providers. And the rule of thumb, often
15 in the adult foster care home; was that if something
16 happened at night, just bring them down to the
17 emergency room, "we don't want to take a chance." Now
18 with telemedicine, we have a similar decrease in those
19 events happening.

20 And in a single year we saved \$15.6 million.

21 So there's real money that can be invested in
22 programs, invested in access to smartphones. And by
23 the way, patients' families are doing better.

24 Diabetes, example. Obesity, there's a huge
25 epidemic here in the Detroit Metropolitan area,

1 particularly in children and adolescents. There can
2 be many psychiatric behavior co-morbidities. Working
3 together in this virtually integrated telemedicine
4 center, we create an integrated care medical care
5 home.

6 Now I'm not here to say that telepsychiatry,
7 telemedicine is the answer for everything. And I've
8 gotten some pushback, some from legislators and
9 others, "How can that be with the psychiatric process,
10 don't you have to be in a room together." What I'm
11 telling you is that the stakes are so high, and we --
12 the status quo isn't working.

13 There are not enough psychiatrists. There
14 probably won't be enough that we train with ACGME
15 cuts. Mental health, other providers, we have to
16 every tool in our tool kit. And telemedicine is one
17 of those studies. And I will tell you that there's
18 data in Montana and out West in large populations,
19 thousands of patients with, who receive telepsychiatry
20 or traditional psychiatric intervention. And in the
21 head-to-head comparison that's been published in the
22 peer-reviewed journal, no significant difference.

23 But guess what happened that was
24 interesting? They did some simple neuropsychologic
25 testing, memory for what happened in the session

1 attention, and the group that telepsychiatry ended up
2 doing significantly better.

3 Now, the authors didn't know exactly why,
4 but one of the suggestions is; maybe when we're
5 looking at a television screen or a monitor or
6 smartphone, that we're trained to look and just focus.

7 Whereas, if I'm in this room and somebody walks in
8 the room, I'm a little distracted. Oh, okay, I'll get
9 back to my attention. They're not replacing one
10 versus the other. We're expanding our outreach.

11 And I'll tell you one other anecdote. That
12 we have a psychologist, Steven Ondersma; who's working
13 with our team to make better use, with telemedicine
14 smartphone apps with the waiting room.

15 Because instead of wasting time reading old
16 outdated magazines, looking at a TV show or just
17 sitting there bored, we can put that to work and begin
18 screening. And then help the primary care physician
19 and the family answer a really decisive question:
20 What do I do with this scale that suggests that there
21 might be depression? Do I need to refer them to a
22 psychiatrist? Is this significant? Is it not? What
23 is the intervention? All of that, through broadband
24 technology, becomes accessible.

25 Next slide.

1 And these are just some things that we can
2 talk about, more in the discussion about whether
3 they're smartphones, desktop, other ways that we can
4 do things. We have a technique we call "hybrid
5 telemedicine" where we include and incorporate both
6 behavioral specialists who may be embedded in a
7 clinic, a social worker, for example, trained by us;
8 with telemedicine capacities. Sometimes it's just
9 straightforward telemedicine without that behavioral
10 specialist.

11 We have found that the outcome, combining a
12 behavioral specialist embedded in a particular place
13 or with mobile crisis, can improve the outcome. Next
14 slide, please.

15 And I just want to show you an example.

16 (Video begins as follows.)

17 WOMAN IN VIDEO: I have tried home care that
18 has been for evaluation. He has a few problems. He
19 needs some help. So I was wondering if you could
20 possibly give him some medication. He has a history
21 of this for a while. So hopefully he can have you
22 come in and say, and --

23 (Video ends.)

24 DR. ROSENBERG: Okay. So that's, what I'm
25 just saying, I don't know how well that came out here.

1 But with the resolution, usually it's a bit better
2 here.

3 But what we have had here is an example
4 where there's one of our screeners who is, for
5 example, a social worker who's with the patient at the
6 clinic, or wherever they may be. And then they're
7 communicating with the psychiatrist in real time.
8 Again, in the way that things were done previously, it
9 would often take people months maybe to get a
10 psychiatrist or a follow-up visit.

11 And the rule of thumb in large urban centers
12 has been typically that of the patients referred,
13 you're lucky if 15 percent of them ever follow up at
14 all. And of those who follow up, one and sequentially
15 goes down.

16 Here, by having that access at the time of
17 the appointment, and not just at the time of the
18 appointment. Our people, our teams through
19 telemedicine, through texting, follow up with the
20 patients and families afterwards. That's one of the
21 reasons that they don't come back to the emergency
22 room. Their compliance with outpatient treatment is
23 so much higher.

24 So I think I only had ten to twelve minutes.

25 So with that, I'm going to stop, and happy to

1 entertain questions if there's time. Thank you.

2 (Applause.)

3 MR. SKRZYNIARZ: Thank you, Dr. Rosenberg.
4 So you just heard the future of medicine. Now we get
5 a chance to listen to the future of the civilization
6 as we know it. So Dr. Rosenberg had a great
7 presentation, and now we're going to have a millennial
8 come up.

9 People wonder, who are these millennials?
10 Well, here's an opportunity to hear from Marc Hudson.
11 He's the Co-Founder and Chief Executive Officer of
12 Rocket Fiber. I encourage you to read his bio in the
13 program. But Marc's going to talk here about his
14 reflections on this topic. But Marc is truly helping
15 build the future of Detroit in terms of our technology
16 base, and I look forward to hearing him talk this
17 morning. Thanks, Marc.

18 (Applause.)

19 MR. HUDSON : I'm supposed to have support
20 switching presentation.

21 MR. SKRZYNIARZ: This one right here?

22 MR. HUDSON: Yep.

23 MR. SKRZYNIARZ: There you go.

24 MR. HUDSON: Thank you so much.

25 My name is Marc Hudson. I'm a co-founder

1 and CEO of Rocket Fiber. We're a brand new gigabit
2 internet service provider in Detroit headquartered
3 downtown.

4 For those of you who don't know what a
5 gigabit is, it's really fast internet. It's roughly
6 100 times faster than the current residential average
7 today. So it's really a game-changer in terms of
8 speed. We've always made the analogy, it's like going
9 from dial up to cable and DSL. It's that same type of
10 generational leap forward.

11 Today I'd like to give a brief presentation
12 on the state of broadband in the City of Detroit, a
13 lot of things going on across the city and varying
14 things that we see in terms of infrastructure, access
15 and adoption. Before we even get in the broadband
16 piece, though, I know we have folks watching online
17 and some folks that are from out of town but may not
18 be familiar which is kind of the brief history of
19 Detroit.

20 So I just wanted to touch on that really
21 quick because it is relevant to how we got to where we
22 are today in terms of infrastructure. The City of
23 Detroit is 143 square miles, pretty big city. Our
24 population peaked at 1.85 million people in 1950.
25 Today in 2015, we're down to 680,000 people. Our

1 median household income is just \$25,000. Pretty low,
2 almost -- we're right at the poverty level.

3 How did we get here? There's a lot of
4 different reasons, and we could spend a whole day just
5 talking about that. But real briefly, the loss of
6 manufacturing, seeing the auto industry export jobs
7 out of the State of Michigan and overseas. Deep
8 racial inequality led to all sorts of problems in the
9 city.

10 The advent of the highway -- which was
11 actually invented, the first highway, here in Detroit
12 -- and widespread automobile ownership made it very
13 easy for people to move out of the city and out to the
14 suburbs.

15 So as our population flight continued,
16 things got pretty dire in Detroit. By 2012, half of
17 our street lights were out. Our water system was
18 facing a massive budget shortfall. We had the water
19 crisis, you know, well-documented Detroiters without
20 water. Widespread, blatant crime.

21 Today, we've kind of turned a corner. We're
22 not there yet, but things are looking up. The Detroit
23 Public Lighting Authority is on-pace. It's actually
24 ahead of schedule to relight all the lights in the
25 city by the end of 2016, and the Regional Water

1 Authority has been established. So the water system
2 has seen a lot of improvements.

3 There's a lot of other things going on.
4 Again, we could talk about that all day. But I really
5 just wanted to set the stage for infrastructure. We
6 also see the redevelopments that are going on in
7 Downtown and Midtown, and the blight -- the Motor City
8 Mapping Project, which was a huge win, for the first
9 time went out and mapped 80 parcels last year to put
10 together a comprehensive plan for eliminating blight
11 in the city.

12 So now that we see some of the issues that
13 have been addressed, the one that we don't talk about
14 enough in the City of Detroit and I think is really
15 crucially important to our forward progress, is
16 broadband access.

17 So in the City of Detroit, we have a massive
18 digital divide. We have 40 percent of all the
19 residents in the City of Detroit have no internet
20 access of any kind at home. That's 100,000
21 households. When we talk just fixed-line broadband
22 access, that's almost 60 percent of the households in
23 the City of Detroit. So the delta between those two
24 numbers is cell phones and mobile hotspots.

25 Education; seventy percent of the Detroit's

1 school-aged children have no internet access at home.
2 That's a really big deal as we move to more of an
3 e-curriculum nationally and locally.

4 So when talking about the digital divide and
5 digital adoption, there's really two main reasons we
6 see in Detroit. Number one is affordability.
7 Affordability of broadband in the city is a major
8 problem. We know that some of the incumbent providers
9 have crafted programs to address that issue, but
10 they're not all-encompassing.

11 One of the more popular ones, the Internet
12 Essentials, requires participants to be in the
13 national school lunch program, or to be a family that
14 has a child in the National School Lunch Program. So
15 we'd leave a huge percentage of the population out --
16 seniors, disabled persons. So we have to create other
17 programs or else we're going to leave a whole
18 generation behind.

19 The other area is training and relevance.
20 We've seen a lot of projects in the city to address
21 digital divide issues, that have struggled because
22 they've failed to establish relevance to the people
23 that are going to use the technology. So, doing basic
24 digital literacy training; how to use a computer, how
25 to use the internet, how to find a job online. Those

1 are all things that we need to address, or solving the
2 internet and the access problem means nothing.

3 I just wanted to touch briefly on the
4 competitive provider landscape in the city.
5 Obviously, I mentioned Rocket Fiber. But there's a
6 number of other providers in the city. Michigan Bell,
7 or better known as AT&T provides residential DSL and
8 TV services and commercial fiber services downtown.
9 And, actually, I want to talk about downtown first
10 because I'm going to contrast that first with the rest
11 of the city.

12 Comcast, which is another very well-known
13 provider, provides internet and TV. A little history
14 of Comcast in the City of Detroit. Comcast actually
15 acquired Barton Cablevision, which was the exclusive
16 provider of cable TV in the City of Detroit. They won
17 a citywide RFP to become the first cable provider in
18 the City in 1982. By 1986, they had raised
19 \$100 million to wire the city and provide access to
20 roughly 120 thousand households. So at that time,
21 that was a third of the city.

22 A hundred million in today's money is
23 \$230 million to wire the city and provide access. So
24 one of the questions that we've gotten at Rocket
25 Fiber: what's the cost to wire the entire city?

1 Well, that \$230 million it's probably in the ballpark,
2 if we were going to try and wire the vast majority of
3 Detroit.

4 We have at least a dozen commercial wireless
5 fiber and copper internet service providers downtown,
6 so a pretty good mix. There's a lot of competition
7 going on in downtown. And now Rocket Fiber, which I
8 mentioned at the beginning, we're a brand new gigabit
9 fiber ISP and just the third cable TV franchisee in
10 the City of Detroit. So we just received our permit
11 from the City to go and provide cable TV services.

12 Everywhere else. So, outside of the
13 downtown core, we're looking at very limited options
14 from a competitive provider standpoint. Most areas
15 have a combination of Comcast or AT&T or just one.
16 That's not a healthy competitive environment. We
17 really need three or four providers, in my opinion.
18 So, again, one of the missions of Rocket Fiber is to
19 provide a more competitive environment in the City of
20 Detroit; so that cost and speed are improved for
21 residents.

22 So our goal is not only to improve the
23 quality of service in Detroit, but also to improve the
24 speed which I mentioned. So gigabit internet, why
25 it's important, and why it's important in context of

1 why digital health and telemedicine is, it enables a
2 whole brand new set of technology. Some that are just
3 getting off the ground, some that haven't even been
4 invented yet, that we're confident will be invented.

5 So on the residential side, wiring homes
6 with gigabit internet that they can then do a -- we
7 talk about -- Dr. Rosenberg talked about the
8 consultations occurring in the hospital. We can now
9 do those in the home, because the resident has fast
10 enough internet to do a high-quality videoconferencing
11 scenario with a doctor.

12 On the small business and entrepreneurship
13 side, gigabit internet is going to attract
14 entrepreneurs to the City of Detroit. We know that's
15 happened in other gigabyte-enabled cities like Kansas
16 City and Chattanooga, and we're confident that a whole
17 slew of innovation is going to happen on that
18 infrastructure.

19 Right now you can get gigabyte internet in
20 some areas of the city -- again, downtown, midtown,
21 but it's very cost prohibitive for a small business.
22 So this is one of the things that we're doing to
23 change with Rocket Fiber.

24 Again, the attraction of business.
25 Chattanooga, Tennessee, probably the prime case study

1 that exists today; wired the entire city in 2010 with
2 something like 70,000 homes passed.

3 A lot of similarities to Detroit, we got a
4 chance to go down there in July -- widespread blight,
5 a lot of disinvestment had occurred in the city. And
6 just five years since the launch of their network,
7 their entire downtown has been rebuilt, and the
8 stories that we hear in terms of the way that that
9 city turned the corner when their fiber network came
10 online were just incredible to see.

11 So lastly, I'm going to leave us with just
12 some thoughts. How do we promote digital inclusion in
13 the City of Detroit? We know it's a massive problem.

14 There's massive infrastructure problems across the
15 board that remain. But want us to think about four
16 ideas. Are we pooling our resources? Are we working
17 together? There's a lot of different efforts around
18 the city to work on digital divide, digital inclusion
19 issues. Are we maximizing all of our talents and
20 skills and resources together?

21 Are we maximizing existing policies and
22 programs? Are we using e-rate? Are we using BTOP?
23 Are we using -- are we going to use some of the new
24 rules that we talked about yesterday with the Lifeline
25 broadband program? And are we advocating for new

1 policies and programs? Are we using our voice? Are
2 we talking to our legislatures to make sure that
3 Detroit is well represented, in what is a very
4 important national conversation?

5 And finally, are we focusing on what, again,
6 I believe are the two most important barriers in
7 Detroit which is affordability of access and digital
8 literacy training and relevance.

9 Thank you very much.

10 (Applause.)

11 MR. SKRZYNIARZ: Thank you, Marc, for that
12 presentation. And as you can tell from my earlier
13 remarks, Commissioner Clyburn indicated that robust
14 competition is going to lead to improvements in the
15 marketplace, and here's a great example about how
16 increased competition and the key being innovation.
17 How innovation can really spark the possibilities in
18 the competitive marketplace.

19 So now that we have a good understanding of
20 the interplay between health, advanced technology and
21 broadband; now we can start our panel discussion. In
22 this session, we'll discuss the strategic and
23 practical implications of considering broadband
24 connectivity as an unrecognized social determinant of
25 health.

1 In this session, we'll be moderated by
2 Commissioner Clyburn and Jamal Simmons. Jamal is a
3 Co-Chair of the Internet Innovation Alliance, and I
4 also understand Jamal's also a TV star.

5 (Laughter.)

6 And so if I could invite the panelists to
7 come up, your place -- there's a placecard indicating
8 where -- like I said, I know Dr. Smitherman will be
9 joining us as well.

10 So our distinguished panelist experts are
11 Silas Buchanan, Dr. Chris Gibbons, Dr. Adam Perzynski,
12 Dr. Smitherman and Dr. Kimberlydawn Wisdom. And I am
13 now going to hand it off.

14 MR. SIMMONS: All right, I think I will get
15 it started. Welcome, everyone. I've got a couple of
16 mics on. So I'm not sure which one is working. So
17 bear with me a little bit on the technical side. Can
18 you guys hear me? Okay, there we go.

19 So welcome, good morning to this wonderful
20 home. I grew up here over on Dexter and Davidson and
21 went to Cass Technical High School. So I spent a lot
22 of days in my life making it to school in weather just
23 like this. So, it's like it's a welcome home for me,
24 too.

25 Many of you may have met my or saw my

1 brother yesterday who spoke a little bit, Kwame
2 Simmons. He spoke about education and innovation, and
3 we come from a family that's been here for a long
4 time. So it's a pleasure and, really, a pleasure to
5 be back here, but it's also amazing to watch the
6 transformation taking place in the city. And we just
7 want to make sure everybody gets a chance to
8 participate in it.

9 So I spend a lot of my time focused on these
10 issues of broadband inclusion both as the Chairman of
11 the Internet Innovation Alliance, which is a policy
12 group focused on making sure that there's more access
13 and more broadband for more people, and also as the
14 co-founder of a new website and social media platform
15 called the CRVIII.com of which we did an app launch
16 here.

17 You may have read about it in the Free Press
18 a couple weeks ago. We took over a corner of the
19 neighborhood over in the Valley on the East Side, and
20 we put a wifi hotspot in there and took over -- we
21 did, you know, it was like a shipping container crate
22 that we painted and turned into a whole place for kids
23 to come and sit. Microsoft brought Surface tablets.

24 And the most amazing thing that happened
25 during that experience, which really kind of frames my

1 interaction here, is this woman who brought her six-
2 year-old daughter and her three or four-year-old son
3 over to the shipping container to use the internet.
4 And her daughter whipped out her tablet and started,
5 you know, on the tablet Microsoft brought, and started
6 going through it, finding websites and checking it.
7 And the mother looked amazed.

8 She was sitting there kind of, you know,
9 really engaged. I said to her, you look like you're
10 really into this. She said, "I've never seen my
11 daughter use a computer before." She says she has
12 computers at home, but we don't have -- "she has
13 computers at school, but we don't have the internet at
14 home."

15 And so we think of this being this
16 ubiquitous resource, and it just came really flashing
17 back to us how important this is. So I'm glad that we
18 talked about this because not only is it important for
19 education but also for health care. And I want to
20 thank my co-host here, Commissioner Mignon Clyburn.

21 COMMISSIONER CLYBURN: Down here at the end
22 of the table, thank you.

23 MR. SIMMONS: We're a tag team.

24 COMMISSIONER CLYBURN: Right.

25 MR. SIMMONS: I just want to say, she's a

1 leader who's really focused on the gaps that exist
2 between communities and access to what is really the
3 greatest social, entrepreneurial, economic force
4 really on the planet right now. Which is this amazing
5 technology that we have.

6 And I know that she had a big win last week
7 when we were just talking about this earlier around
8 dealing with rates for families or for prisoners who
9 are in jail, and being able to talk to their families
10 without having to pay huge rates on phones. We've
11 talking about Lifeline; I think you guys talked about
12 it yesterday.

13 But she's really been at the forefront at
14 the FCC of making these changes in our
15 telecommunications policy real for families, at every
16 level of the income and social spectrum. So thank you
17 for having me, Commissioner Clyburn, and thank you for
18 pulling this whole event together.

19 COMMISSIONER CLYBURN: Jamal, thank you so
20 much for joining and helping the Connect2Health Team,
21 which a lot of you got to meet. They stand at the
22 rear; but, trust me, they are the wind beneath this
23 effort for us to really take down and eliminate
24 longstanding barriers when it comes to connectivity
25 and what it enables.

1 Jamal, truly when you gave that example, it
2 just reinforces why and what. You know, why we are
3 here and what the possibilities are, and what needs to
4 be addressed if we are to move to the next level.
5 That mother seeing that child. And what, you know,
6 technology could do to better her attitude and her
7 access and her ability to be on a better, if not equal
8 if not exponentially ahead, by way of footing, that's
9 possible.

10 Because in too many of our communities,
11 let's face the facts. I'm off script now. Let's face
12 the facts.

13 MR. SIMMONS: Me, too.

14 COMMISSIONER CLYBURN: That, there are a lot
15 of challenges to hope and opportunities in our
16 communities. And if we don't recognize that and the
17 reinforcement that technology can bring in terms of
18 access. That child might not be able to go, you know,
19 over to Belle Island or wherever -- other places
20 around town. But they can be zoomed there literally
21 through technology, and show and get reinforced, you
22 know, what is possible beyond the walls of their --
23 assuming the walls are not peeling, you know, beyond
24 their current existence.

25 So I really appreciate all of you for

1 spending or choosing or opting, knowing how important
2 it is to spend a part of your morning with us to talk
3 about these most important topics.

4 The Connect2Health team, as it's been said,
5 has been hard at work over the past several months
6 thinking about the future of health in this instance
7 in health care; and the intersection of broadband and
8 other technologies. We have been challenging
9 ourselves in coming out and seeing and talking to you,
10 to think about how the future of health, and what is
11 truly possible when broadband and technology are at
12 the epicenter of all of this.

13 You've heard the talk about a psychiatric --
14 that the state and that we need to continue to work on
15 in terms of our psychiatric experience when it comes
16 to the delivery of care. And what technology can do
17 to beam us up, to be just light-years ahead; in terms
18 of having that personalized immediate exchange or
19 interaction. How important that is to be able to help
20 with the stigma that exists in too many communities
21 about seeking care.

22 If you can do in the confines of your own
23 home or wherever you're comfortable, having that
24 exchange with that medical professional, then we could
25 address some of these issues. And when you heard the

1 doctor, you mentioned about that gap in terms of
2 receiving care immediately -- that can be virtually
3 eliminated through technology.

4 So I am really happy that we have the
5 opportunity to further explore with this impressive
6 panel, a role that we each have to play, in order to
7 improve the lives of our citizens, and to reinforce
8 how significant technology is at the epicenter.

9 Jamal?

10 MR. SIMMONS: So we know the impact of
11 poverty on health has been known for centuries. Over
12 the last 15 to 20 years, however, growing evidence
13 suggests that certain non-medical factors are really
14 playing a part, and are related to where and how
15 people live, and profoundly impact the health and
16 systems.

17 These social determinants of health are
18 often grouped into what are called downstream factors.

19 You know those factors, for those of you who are in
20 that space -- things like health knowledge, attitudes,
21 beliefs, behaviors, diet, smoking, exercise, etc. And
22 upstream factors, such as education and public policy
23 that shape the opportunities and realities that are
24 experienced by individuals in these communities.

25 COMMISSIONER CLYBURN: So Jamal talked about

1 the incredible innovation; what's going on in Detroit.

2 You've heard it all, and you have a lot to be proud
3 of. But it's really going to, you know, take a team
4 of us -- innovators, consumers, providers, all of us
5 to truly make a difference.

6 So we're going to spend some time, again,
7 you know, talking about how better Detroit can be, in
8 changing some of these significant challenges and
9 moving ahead in some very fundamental ways. These
10 changes will require us to think more about those
11 social determinants that we've been hearing so much
12 about, and that we know exists when it comes to
13 health. And expanding and really addressing them.

14 Take, for example, that as we move
15 increasingly into this digitally connected universe
16 that we have, more and more of our lives are being
17 played out online. Not all of us are happy about all
18 of our lives and others' lives being played online.
19 But that's a current reality. Anyway, I had a
20 flashback of a couple of cats and a couple of
21 entertainers, and it wasn't a pretty picture. But
22 we've got a chance to paint an even better picture.

23 And so, you know, let's talk a bit more
24 about this power and how we can truly address this,
25 and we've got some experts. Feel free to agree,

1 disagree, challenge and affirm; because they're ready
2 for you. So we're going to get started with what
3 again will be as I teed up earlier, an interactive
4 part of this program. It is not going to be
5 worthwhile, it is not going to be engaging if you do
6 not take part.

7 So you've got some questions that I know you
8 walked in the door with. They're going to stimulate
9 you so you will have more questions. So you know,
10 please again at the appropriate time when the panel
11 makes their opening comments. You know, after that
12 we're all in, in terms of making this a conversation
13 that we can take away from, and affirm our charge to
14 really better be stewards and partners in our
15 communities' uplift.

16 MR. SIMMONS: So I could spend an hour
17 reading biographies of everybody who's up here, and
18 then we could all get up and leave.

19 (Laughter.)

20 MR. SIMMONS: But I bet that wouldn't get us
21 any interactive conversation that the Commissioner
22 just talked about. So what we're going to do, just as
23 a matter of form is we will have each person begin to
24 speak. If you want to take a minute just to say what
25 you do for a living or why it is you're here and what

1 your expertise is, and then we can get started with
2 your response on the panel and make your statement.

3 I want to initially go to Chris Gibbons, and
4 have Chris just do a little scene setting for us about
5 broadband as a determinant of health and get us
6 started.

7 DR. GIBBONS: Okay. Thank you, Jamal. My
8 name is Chris Gibbons. I am a physician by training,
9 and some of you know the FCC is full of lawyers. So I
10 break out in a rash every morning. But I love --

11 (Laughter.)

12 DR. GIBBONS: It's just a joke; I love what
13 you're doing.

14 COMMISSIONER CLYBURN: Very bad joke.

15 (Laughter.)

16 DR. GIBBONS: So I trained in surgery and
17 preventive medicine at Johns-Hopkins. I've been on
18 the faculty of Johns-Hopkins for 23 years; until this
19 past July, where I joined the FCC full time as their
20 Chief Health Innovation Officer working with the Task
21 Force and the FCC.

22 And our goal today is not to have just the
23 same old discussion again. You know, these topics are
24 not new to some of you. To some of you, they are new.
25 But we really want this to be different. So let me

1 just take a couple minutes to help you see and think
2 about it in a different way.

3 It's clear that broadband and the internet
4 are changing everything. They're changing how we
5 live, how we shop, how we bank, how we even elect our
6 presidents; right? And so at the Connect2Health Task
7 Force, we have been spending a lot of time thinking
8 about these things, talking with experts, with people
9 and even with consumers. We've done focus groups in
10 Miami with Latino consumers as well as others.

11 I personally have done hundreds of focus
12 groups with hundreds of inner city African American
13 seniors, the group most unlikely to be online. And I
14 tell you, what I've learned from them would surprise
15 you. It's not what the party line always is. But we
16 can talk about that later.

17 And we've been listening. We've been doing
18 a lot of listening and thinking about the
19 implications. A few things are clear. People rely on
20 more than just doctors, nurses and hospitals to get
21 well and stay healthy. But I'm a doctor, right? I
22 want you to rely on me. So I get it. But the reality
23 is, they rely on much more than that.

24 And when the doctor's office is closed, or
25 they can't get there, they have to do other things.

1 That's one of the reason Dr. Google is so popular,
2 okay.

3 (Laughter.)

4 DR. GIBBONS: It's true. The number one
5 search topics on Google are about health now. It used
6 to be pornography, but it is what it is.

7 But it's about health now, and there's a
8 reason for that. They value what the docs and the
9 health care system say, but they can't get to them.
10 Or they have to take off time from work, or lose a
11 job. And these realities of the health care system
12 today, too many of them don't fit in to the realities
13 of real people.

14 But we're also living in a time of great
15 provider shortages. It's already been estimated that
16 by 2020 there could be as many as 90,000 doctors that
17 are needed to meet the needs, and almost 800,000
18 nurses. So if we don't have enough today, all right,
19 and we're going forward, how are we going to solve
20 these problems.

21 We're in the middle of a population
22 explosion. As of the last census, 318 million people.
23 Today, it's closer to 320 million. Plus, right.
24 Think about it. There's about 400,000 primary care
25 doctors, 2.6 million nurses, 320 million potential

1 patients in this country. The numbers just don't add
2 up to give everybody enough face time when they want
3 it over the course of their lifetime, with an in-
4 person live provider. It just becomes increasingly
5 impossible to see how that's going to work.

6 And finally, increased numbers of
7 minorities, immigrants and others; who already the
8 health care system is challenged with working with.
9 So if we don't fix this and get it right, the problems
10 could get even bigger. It's clear that broadband is a
11 disrupter. And if other sectors are an example and
12 what we know is true, the future of health and health
13 care is going to look very, very different than it has
14 when I went to medical school and in the past and even
15 now.

16 And so we at the FCC have been doing a lot
17 of time -- spending a lot of time thinking about what
18 we must do, to ensure that these opportunities accrue
19 to every single consumer. Not just those who can pay,
20 not just those who live in certain parts of town, not
21 just the opportunity to participate, but the
22 opportunity to benefit from all of these things. It's
23 also clear that as we live more of our lives online,
24 it is the way connections are being made and
25 maintained. Connections between family members and

1 friends, but also increasingly connections between
2 professionals. You know, not only providers but for
3 jobs and education and everything else.

4 And so if that's true, the ability to be
5 connected through broadband, is actually and will
6 increasingly shape the ability to live satisfactory
7 productive and healthy lives. And we haven't even
8 talked about "the internet of things." You've heard
9 of that, right? Smart car, smart city, smart homes,
10 smart devices driven by artificial intelligence and
11 contextualized algorithms; which can do things to the
12 environment without the input, the direct input of a
13 human.

14 This is not the future. This is already
15 happening. I'll give you a couple examples. They
16 already have on the market -- patients are already
17 using glucometers, devices that can test your blood
18 glucose and tell you what it is so you can know how
19 much insulin to take. They have some on the market
20 right now that automatically test your blood glucose,
21 know what it is and then give you the amount of
22 insulin you need, without you or your doctor doing
23 anything. It's already happening.

24 So we're not talking about Star Trek a
25 hundred years from now. This stuff is already

1 happening.

2 Or what about a person with asthma that -- I
3 have two friends that were in high school. They died
4 because they had asthma and couldn't get to their
5 inhalers fast enough. But in the future; when our
6 smart homes are connected to our smart cars, which are
7 connected to our smart health care systems and smart
8 devices; maybe when a patient starts to have increased
9 work of breathing, something that happens even before
10 you have an asthma attack, the smart home detects that
11 and then raises the humidity level in the house to
12 perhaps decrease the risk of that person going into a
13 full-blown asthma attack.

14 That's what the nebulizer treatment
15 essentially is when you go to the emergency room.
16 It's humidified air with some medicine in it, and then
17 out of the vents of your heater you get that puff of
18 Albuterol even before the patient even knows they're
19 going to get an asthma attack and before they've left
20 their home. That's the future. That is the future,
21 and it's almost possible today.

22 So how do we ensure that everybody can
23 participate? It's shaping being able to treat, not
24 only behaviors but the environments in which people
25 live.

1 So let me close by saying, you know, it's
2 the environments, the social and environmental
3 realities; that powerfully determine behaviors,
4 opportunities and outcomes for health and in health
5 care. And we have over a decade now of disparities
6 where the National Health Care Disparities Report,
7 we've been measuring it at the national level for over
8 ten years.

9 How many disparities are getting better?
10 Anybody know? How many are getting worse? It's all
11 over the place. One year, some get better; the next
12 year, those same ones get worse. We're making no
13 systematic improvements, in any of the disparities
14 that are being measured over a ten-year period. And
15 international; Europe and others have had longer
16 experience with this.

17 So let me just say President Wilson said it
18 right. He said he never thought about thinking about
19 broadband connectivity in this way. That's exactly
20 what we're trying to do here today, to get you to
21 think differently about some things.

22 And I want to challenge you to think
23 differently about, in the world of disparities, what's
24 possible. Too many people I come in contact with
25 think it's going to be here forever, and there's

1 nothing we can really do about it. But we've got to
2 pretend -- okay, I'm not politically correct -- but
3 think differently about what's possible, and think
4 differently about what might work. And if we do, we
5 just might surprise the world with what we're able to
6 accomplish. Thank you.

7 MR. SIMMONS: So I have one other question,
8 and I'll let Commissioner Clyburn come in. Dr.
9 Perzynski, you are a data scientist, right? You deal
10 with data for a living. You're at Case Western
11 Reserve. Tell us a bit about that. But tell us; how
12 do we isolate broadband from a research perspective to
13 determine its impact on health. What's the social
14 science?

15 DR. PERZYNSKI: Sure. Well, first I'm
16 really humbled to be here with the rest of you. I
17 come from Case Western Reserve in Cleveland. I was
18 born in Toledo. I feel at home in Detroit. I work in
19 a center called the Center for Health Care Research
20 and Policy, and I'm a sociologist there.

21 And in terms of your question about data,
22 the data that we have looked at recently at Metro
23 Health focused on our patients over the past three
24 years. All of them. And in that period we looked at
25 which patients are using the personal health records.

1 It's the software that most health care systems have
2 now where you can check and see things about your own
3 health. You can actually go in and schedule an
4 appointment with your doctor.

5 Not just schedule an appointment; I mean,
6 you can literally see every minute of their schedule
7 and compare that to yours and then say, "oh, I want,
8 I'm going to go here." I don't know how many of you
9 have used the phone system to see the doctor lately,
10 but it can be a lot more difficult than that.

11 Maybe if you have lots of kids and you're
12 trying to schedule dental appointments and eye
13 check-ups and well child visits for all those kids;
14 and, you know, doing that over the phone might take
15 you hours and you may not actually have success.
16 Versus the ability to just open a browser from the
17 comfort of your home, not have to wait on hold and
18 click to the schedule, is pretty amazing. So that's
19 one of the features of that sort of software.

20 So what we looked at, we used data from the
21 Federal Communications Commission Form 477 that
22 describes the amount of internet coverage in a
23 person's neighborhood for all of the 300,000 patients
24 that we saw at Metro Health in the study period.

25 And we found that the patients who lived in

1 neighborhoods that have very low broadband coverage.
2 So, if they live in a neighborhood and 40 percent or
3 less of the folks who live in that neighborhood have
4 internet; then those folks are about -- they have
5 about 50 percent of the rate of use of that technology
6 of using the web browser to communicate with the
7 health care system, to be able to schedule an
8 appointment and to look at their labs.

9 And so, I think of this sort of as a walled
10 garden. So that, if there could be all kinds of
11 wonderful things going on inside of a walled garden --
12 rose bushes, tomato plants, all kinds of wonderful
13 things that you might be able to enjoy. But if you
14 can't gain admission to that walled garden, then none
15 of that is for you.

16 And I see that as what we found in some of
17 our data in Cleveland. I was talking to my dad this
18 morning before I left Cleveland. And I said, you
19 know, to me I feel a little bit like -- if we think
20 about 911 service, right, which we view as completely
21 an essential service; right? everybody has access.

22 Even if you don't have a plan on your cell
23 phone, it will work so that you can call 911. And
24 then, what if we had all kinds of technologies that
25 were so good, that could make you so healthy that you

1 wouldn't need to call 911 for half the stuff that
2 people call 911 for? But what we did, was we made it
3 that people can't use -- some folks can use those
4 technologies. There's a barrier because, so unlike
5 the way a phone works there's no emergency service;
6 right? There's no way to do that.

7 So I think things like the Lifeline Program
8 are absolutely essential. Other programs like that,
9 I'd like to give one more real positive data story. I
10 have a project with another organization in the
11 Cleveland area called Health Span.

12 Health Span patients have access to a
13 diabetes prevention program that's offered in
14 connection with the YMCA. And one of the things that
15 they found is that the participants in the program --
16 some of them, particularly racial and ethnic
17 minorities and lower-income folks -- were having
18 trouble completing the program and getting through
19 week 16. It's a 16-week program that's shown to
20 reduce people converting over to having diabetes. So
21 they may not get it if they participate in the
22 program.

23 So together with this team at Health Span,
24 we rolled out a project where we used non-immersive
25 virtual reality. Which, made short, is an Xbox Kinect

1 in your living room.

2 (Laughter.)

3 DR. PERZYNSKI: And via Xbox Kinect you can,
4 from your living room, get in those extra exercise
5 minutes. In Cleveland, when it's a day like today;
6 there's just no chance that you're going for a walk.

7 (Laughter.)

8 DR. PERZYNSKI: So in that program, we have
9 about -- it's a pilot program. We have about 20
10 participants enrolled. And what we found is that
11 those folks have lost on average about 5 percent of
12 their body weight in 12 weeks, or 9 percent. Which is
13 the same as what we see when we run the diabetes
14 prevention program among commercially-insured,
15 high-income folks in sunny Southern California.

16 So I think -- but that technology, I would
17 note, and I think this overlaps a lot with what Chris
18 was saying about: "the future is here;" right? The
19 future is here, and it's working. But that
20 technology, non-immersive virtual reality for diabetes
21 prevention, does not work if you do not have internet
22 in your home. And so we can halt the spread of
23 diabetes among racial and ethnic minorities and poor
24 folks in our country. But there are some fundamental
25 things that we need, to do that; and broadband I feel

1 is one of them.

2 MR. SIMMONS: Commissioner Clyburn, this has
3 been brought up twice here. I'm not sure everybody
4 was around yesterday and they're familiar. Can you
5 tell us about the Lifeline Program and some of the
6 reform ideas that you have in the microphone.

7 COMMISSIONER CLYBURN: Can you hear me? I
8 think I'm showing off with a wireless.

9 MR. SIMMONS: So if you just give us a
10 little background.

11 COMMISSIONER CLYBURN: Right. The Lifeline
12 Program is one that's been around for 30 years. It
13 was started under the Reagan Administration. And what
14 it does, it recognizes that affordability has been
15 chronically a factor when it comes to communication
16 services in this nation.

17 So, that has been, since the Reagan
18 Administration, a program that at this time
19 contributes \$9.25 per month toward the provisioning of
20 voice telephone services. Now you know, especially
21 those who have children and those adults who I think
22 we have forgotten about the spoken word, we are not
23 talking as much. We're texting and communicating in a
24 digitally, you know, enhanced ecosystem no matter what
25 our income is.

1 So what that has not kept up with -- meaning
2 the Lifeline Program -- is how we're communicating
3 today. So what we've been talking about over the last
4 several months, and what is teed up at the FCC today
5 that the Chairman has committed to have a final
6 decision on within the next four months; is the
7 probability of making that program directly support
8 broadband. Because all of the things that we're
9 speaking about, we know that that is going to be the
10 key to connecting and enabling people in the 21st
11 century.

12 Now that's not going to come without
13 friction. There are some detractors. But these are
14 the things that we need to put on the table, and I am
15 not fearful about really having conversations about
16 what we need to -- I'm in favor, personally, of
17 overhauling the current program; but keeping the
18 fundamentals intact. Meaning that it is a bridge to
19 connectivity. It can be a positive conduit and
20 enabler when it comes to what we're speaking about.

21 And we know that affordability, particularly
22 from where we sit, is a major factor for communities
23 and households to be disconnected. How do we bridge
24 the gap? And this is one of those times you hear the
25 opposite, that this is one of those times where money

1 can fix it.

2 MR. SIMMONS: Great, thank you. And now I
3 want to go to one of the best-named people in life,
4 Dr. Wisdom.

5 (Laughter.)

6 MR. SIMMONS: Dr. Wisdom was the first
7 Surgeon General here in the State of Michigan, and is
8 focused on community health. And talk a little bit
9 about how you see broadband playing into the community
10 health issues.

11 DR. WISDOM: Absolutely. Can you hear me?

12 Okay. For one, thank you so much for this
13 invitation. It just thrilled me when I learned about
14 it because this is actually the work that I do at
15 Henry Ford Health System, one of the things that truly
16 keeps our team up at night; the connectivity elements
17 of how we address particularly our under-served
18 communities.

19 I do want to say first that we believe that
20 health is more than health care. We're of course part
21 of a -- Henry Ford is a high quality, you know,
22 quaternary care, integrated health care system that
23 sees people from all over the world. And truly if you
24 need a transplant or something of that nature, you
25 don't want to -- you want to go to the best place.

1 They're always the best health care.

2 But if you truly want to address health, we
3 need to understand those social determinants of
4 health. And health occurs when we live, learn, work,
5 play and pray. And all of those social determinants,
6 whether it's transportation, education, jobs, access
7 to health care; those all determine your overall
8 health outcome. And I think that is just so key.

9 So just in terms of -- I really appreciated
10 the Rocket Fiber, sharing about how expansive Detroit
11 is; and I'm going to talk about how we will be at the
12 neighborhood level. But Detroit, the 143 square miles
13 that -- the footprint of Detroit, actually Boston,
14 Manhattan and San Francisco, all three of those cities
15 fit within Detroit's footprint. And that represents
16 about three million people. Of course, you know,
17 Detroit is about 687 thousand.

18 So we know that connectivity is actually so
19 key, because that transportation issue is actually
20 magnified in a city that has such a large footprint.
21 However, not as many players within that footprint.

22 So we certainly understand that place
23 matters, and that your zip code is often times a
24 better predictor of your health outcomes than your
25 genetic code. So that's why we have elected to work

1 very deeply within the neighborhoods, and we're
2 actually working very collaboratively with other
3 competing health systems. So, DMC, Oakwood, Legacy
4 Oakwood as well as HR Providence in addressing a
5 particular effort.

6 So I'm going to just give a little detail, a
7 little specificity around what we're doing and why it
8 does truly keep us up at night. In the City of
9 Detroit, we have a -- we see about 150 or 200 infants
10 that die before their first birthday every year. We
11 call that our infant mortality rate. It's higher than
12 developing countries like Slovenia. It's just
13 unconscionably high. Considering that we have so many
14 health resources within our community, we still have
15 an appallingly high infant mortality rate.

16 So what we've done collectively as the
17 various health systems and public health departments
18 and other community-based partners is we have
19 identified a way to address that. One way that we've
20 addressed it is through what we call transforming
21 communities or transforming neighborhoods. So we're
22 working in three of the very under served
23 neighborhoods: Osborne on the East Side; Brightmoor
24 on the West Side; and Southwest Detroit, the CHASS
25 economy neighborhood.

1 So we have engaged community health workers
2 to help us transform those neighborhoods and help
3 level that playing field. So that's one element, the
4 human element. We also are working very closely with
5 our providers in terms of translating what these
6 patients are experiencing.

7 But thirdly, and what relates to this
8 initiative, is that we are talking about transcending
9 place which means we can't relocate people. We can't,
10 you know, contract Detroit, make it smaller, provide
11 access. I mean, we've got the M-1 Rail. We're making
12 progress certainly. But this is not going to happen
13 very instantaneously.

14 However, with connectivity and digital
15 access and broadband access, we can transcend
16 neighborhoods. So rather than people trying to
17 travel, you know, using three busses to get to a
18 doctor's appointment -- or to get to an emergency
19 department, you know, for themselves or their children
20 -- we are very much looking at how we can connect
21 people to resources that connect them to information
22 through this element of connectivity.

23 So what we've done in our efforts, and it's
24 called WIN Network with Detroit. WIN Network was
25 inspired -- WIN Network Detroit. There's a website.

1 There's information there. As we're trying to find
2 greater and greater ways to -- we're doing text
3 messaging. We realize a lot of the under-served
4 women, they do have smartphones, but they do not have
5 internet access.

6 So the ability to easily make appointments,
7 to have a telemedicine visit is much more challenging.

8 Of course, you can do some on your phone. But to
9 have that internet access would just be amazing.

10 One of our neighborhoods that we work with,
11 the Osborne neighborhood at some point and I don't
12 know a lot of the detail, but maybe some years ago
13 they received some grant funding. This is to make to
14 human services. They were able to get some kind of
15 neighborhood hotspot to provide connectivity. But I
16 don't think it was a long-term effort.

17 So we know in terms of if we're truly going
18 to transcend place and make Detroit very, very much
19 connected; I think that the answer's right here, and
20 that's why I was so excited to participate this
21 morning.

22 COMMISSIONER CLYBURN: Dr. Wisdom, you bring
23 up something that I think is a perception gap. It is
24 a problem, and a challenge for all of us. A friend of
25 mine who's a Commissioner in a city that I better not

1 mention because there seems to be a state rivalry
2 here.

3 (Laughter.)

4 DR. WISDOM: Okay, that's good, good. Good
5 advice.

6 COMMISSIONER CLYBURN: Is that just because,
7 you know, the presence of a device, African Americans
8 and Latinos -- over-index, is the term we use -- when
9 it comes to smartphone, you know.

10 They, proportionally, they have the highest,
11 you know, they buy the most smartphones. But that
12 does not necessarily mean, as you just reinforced,
13 that there is ubiquitous -- there's connectivity
14 across all platforms. And so, he says that -- and
15 this is not in the case with most -- that, you know,
16 there are some people that some -- it might be -- it's
17 connectivity from a voice or text, a little bit of
18 status. But not necessarily the enabling internet
19 access that goes here.

20 So I really appreciate you putting that
21 forth, because there are a lot of community leaders
22 that think that the problem is solved when it comes to
23 the infrastructure side. Because people, we've got
24 90-plus percent of -- the most cell phones of people
25 in this nation. But that does not necessarily mean

1 that that smartpone is equipped to meet these
2 critical needs. So I really am glad that you brought
3 that up.

4 DR. WISDOM: Great. Thank you.

5 MR. SIMMONS: So I'm going to bring in Dr.
6 Smitherman and stay with the physicians for a second.

7 Herbert Smitherman who is here, and I want to say --
8 and this is piggybacking on what the Commissioner just
9 said.

10 We talked about smartphones. But one of the
11 things people are using to monitor their health are
12 wearables, right, so Fitbits and now Apple Watches.
13 But if you're struggling to get a hold of a
14 smartpone, getting ahold of a wearable and paying
15 that money may be another barrier.

16 So let's talk a little bit about the barrier
17 of the devices, and how the devices interact with
18 health. You know, like what happens with the
19 physician when you get that data. And, whether or not
20 focusing there or on some of the other health issues
21 in the community like diet, food deserts also are
22 things -- are places we should be spending our time
23 on.

24 DR. SMITHERMAN: First of all, thank you --
25 I hope you can hear me. Can you hear me through this?

1 Can you hear me?

2 MR. SIMMONS: There we go.

3 DR. SMITHERMAN: You can hear me? Okay.

4 First of all, thank you for having me. I got in here
5 a little late. So I didn't hear all of the
6 conversation. But I just have a few little comments,
7 and then I'm going to kind of get to your question.

8 First of all, I would say the overall issue
9 that I see as a practicing physician in the United
10 States, is that we as a country are not investing in
11 scientific research and development, period. We have
12 cut the NIH by at least 20 percent. We are not doing
13 the kind of science and STEM programs for our kids in
14 school. They are not -- most -- almost 33 percent or
15 40 percent of urban black and brown kids don't have
16 any science being taught to them in school.

17 So let's not -- we're talking about
18 technology and all this stuff. I'm saying, we don't
19 even have basic science being taught to kids. And
20 we're -- my father was a physical organic chemist, a
21 Ph.D and he worked at Miami Valley Labs at P&G, and
22 one of the things he said -- he passed. One of the
23 things he said a long time ago is that we as a nation,
24 both at the public and private sector, are starting to
25 divest in our research and development. And what

1 we're living on today -- this technology is the
2 investments we made 50 years ago.

3 So I'm saying we as a country, if we are
4 going to stay in front of technology, in front of the
5 development of the new thing; we've got to have that
6 investment. With respect to my patients, I can tell
7 you, they aren't waiting for us.

8 MR. SIMMONS: Right.

9 DR. SMITHERMAN: Okay? So I'm in a meeting
10 -- I was in a meeting with one of my colleagues, and I
11 get a text on my phone of a person's skin rash. Or I
12 get a -- I had a -- I was -- my text -- and my phone
13 came up, and all of a sudden I see their pharynx.
14 Like, their mouth is open, and I see all kinds of
15 stuff leaking out.

16 (Laughter.)

17 DR. SMITHERMAN: And there are body parts
18 that I don't even want to share on this panel that are
19 being texted to me. And so people are going, "I can't
20 wait. My life is so busy," that -- "and you guys
21 aren't ready," because I can tell you the EMRs today
22 are, we're not ready for prime time. I mean, I think
23 it was -- I think the ACA did a lot of things. It was
24 an excellent plan. It was appropriate for the
25 coverage of this country. Disparities in health are

1 real, and they are fatal.

2 DR. Satcher did a landmark study and was
3 published in the Journal of Health Affairs in 2005
4 which said that if we calculated in the year 2000
5 alone; we had almost 84,000 African Americans who died
6 in the United States then, that would not have died if
7 they were European American. That's 84,000 additional
8 African American deaths just because of the disparity.

9 So these are real. But patients are out
10 there -- are drowning. So they're saying, "I'm sick.
11 I'm a blue collar worker. I'm on the line. If I
12 leave, I lose money."

13 MR. SIMMONS: That's right.

14 DR. SMITHERMAN: "Dr. Smitherman, look,"
15 they take a picture of something, they text it and
16 say, "what's going on."

17 Now, it's not the most effective way, but
18 you know, I can see a lot. And so, you know, we don't
19 have the kind of telemedicine that's blanketed. They
20 don't have computers. Computer deficits are rampant
21 in my community. So, people are using what they have.

22 And they're essentially going around the technology
23 deficits that we have.

24 And so, all I can say is that from a
25 technological part standpoint; if we don't end this

1 divide, disparities will continue to worsen.
2 Preventive services, regular sources of care will not
3 be there for this community. I say, the other thing
4 is that there's a lot of data out there.

5 Even the Heckler Report, one of the biggest
6 things it did was provide basically data. It didn't
7 provide solutions. It just said, hey, we've got a lot
8 of health disparities in the country, and all of those
9 disparities have worsened.

10 So the scientists have data. The
11 policymakers have data. The legislators have data.
12 The people who don't have the data are the patients
13 and the community and the public. Those are the -- I
14 mean I have never met a person that came to my office
15 that said, "you know what, Dr. Smitherman, I'm here
16 because I want to die." They come to my office
17 because they want to live.

18 But they have so much misinformation that
19 they're making poor choices. And we don't have the
20 technology to get them the right information. When we
21 do -- we had a program here which we had federal
22 dollars.

23 It was a Beacon grant. These are high-tech
24 monies that we got to this community. What we were
25 trying to do, is form a community repository where all

1 the health systems put their data in a central place.
2 Where we could share: someone came to my emergency
3 room at the Detroit Medical Center, and they also next
4 time they went to Henry Ford; we, between Henry Ford
5 and I, we'd be able to share that data.

6 There was a lot of fighting amongst the
7 health systems with respect to who owns that data, and
8 we don't really want to share that data. So we have
9 problems -- and I think that the ACA did a great job
10 at saying: we need to have interconnectivity and
11 share data. But I think the challenge that they had
12 is they didn't have any mechanism to enforce it. They
13 said we're going to do a laissez-faire. We're just
14 going to do a Darwinistic system. You know, whatever
15 happens, happens.

16 And it wasn't a mandate: "In order for you
17 to play in this game and get reimbursement, you guys
18 have to both have electronic systems and all the
19 systems have to be able to be interconnected and share
20 data." Right now, we are in the 1950s with respect to
21 our ability to simply share information at a clinical
22 level, on life and death situations in the United
23 States. And that to me is a crime. We have got to do
24 better there.

25 MR. SIMMONS: Well, Silas Buchanan, I want

1 to bring you in here. Tonight in Colorado, we're
2 going to see -- I don't know how many Republicans are
3 left running for president.

4 (Laughter.)

5 MR. SIMMONS: But a whole room full of our
6 Republican friends talking about, I don't know, Donald
7 Trump's hair and bragging and stuff.

8 COMMISSIONER CLYBURN: Now, now.

9 MR. SIMMONS: But the question is you don't
10 hear this whether it's on the Democratic stage or the
11 Republican stage. You don't really hear these
12 conversations about: how decisions that are being
13 made at the federal level are impacting individual
14 citizens in how they live and how they take care of
15 themselves. You've been working on that in the
16 private sector, public sector, nonprofit, serial
17 entrepreneur, doing a variety of things. Tell us, how
18 does this really play out where the rubber meets the
19 road with individual citizens?

20 MR. BUCHANAN: So first of all, I'm not a
21 physician and I happen to be a Buckeye. So --

22 (Laughter.)

23 MR. BUCHANAN: The objectives are stacked
24 against me a little bit. But I'm with the Institute
25 for eHealth Equity. We are a Cleveland, Ohio based

1 501(3)(c), very focused on finding ways to leverage
2 technology to reduce health disparities, concerned
3 about an exacerbation of health disparities because of
4 technology.

5 Your young lady that you shared an example
6 of; we see some of those folks actually in McDonald's,
7 right, so it dovetails back to the social determinants
8 of health. Where there is internet access after the
9 libraries close, right, because they're in the
10 library. And when the library closes, they show up at
11 McDonald's where you've got to buy at least one
12 something; right?

13 So you've got to buy some fries or you've
14 got to buy a beverage which you can refill as much as
15 you want, right. And so we're having some real issues
16 there.

17 As the rubber meets the road, we've got a
18 bit of funding from Aetna Foundation not too terribly
19 long ago, to run a pilot. The pilot is now sunsetted.

20 But it was a text-based pilot, text for wellness.
21 And the protocol -- and I'll make this long story
22 relatively short, but the protocol was text wellness
23 was to be delivered and was delivered through trusted
24 community facing organizations -- faith-based
25 organizations.

1 And the pastors had to agree to chat a
2 little bit about health from the pulpit, right, and
3 then ask folks to do something completely counter
4 intuitive -- take your cell phone out in church and
5 text health to a short code at the end of services.
6 And because they were reticent to do it, you know,
7 beginning of service.

8 So when they did that, we asked a series of
9 questions; right? Race, age, ethnicity, gender, zip
10 code. "How do you rate your own health? Do you
11 smoke?" And, "are you insured?" And we got a 72
12 percent response rate to that trench of questions,
13 right.

14 Over the course of the pilot, we had some
15 add-on funding, which we used for ten dollar gift
16 cards redeemable for a healthy snack at Farmers
17 Markets. Now, the pilot was in Columbus, Atlanta and
18 Dallas. The church in Dallas had a Farmers Market --
19 their own farmers market; right. So we were able to
20 give them the money, buy the gift cards from them to
21 give to the community members to redeem at their own
22 farmers market. So the rubber can meet the road in
23 some interesting ways, and I think some impactful
24 ways.

25 We chose texting as a training-wheel kind of

1 way to get people comfortable sharing and receiving
2 information electronically. Because we know that
3 there's going to be an exacerbation of disparities
4 because of technology as we begin to introduce people
5 to connected health devices and wearables and tools
6 and trackers and applications.

7 The question becomes, you know, will there
8 be -- the messenger is as important and not sometimes
9 more important than the message; right? And so as
10 these tools and trackers and applications and devices
11 are spun up, are they made culturally appropriate?
12 Because as we go to the rose garden, right, the garden
13 that Dr. Perzynski, my fellow Buckeye, you know,
14 mentioned.

15 (Laughter.)

16 COMMISSIONER CLYBURN: I know you're taller
17 than me, but --

18 MR. BUCHANAN: As he mentioned, you know,
19 can we get people to, you know, smell the roses if
20 they're not comfortable? If they're not designed, you
21 know, with everyone in mind.

22 MR. SIMMONS: At this point, I think I'd
23 love to hear from the audience if there are any
24 questions from the folks in the room. There's the
25 microphones.

1 COMMISSIONER CLYBURN: So let's enable that
2 -- maybe we'll take one. But Roger is here with a
3 microphone. And if anybody has a question, if you
4 could raise your hand. We're going to do it by the
5 notecard approach, but we're family here. So --

6 MR. SIMMONS: I think we see one over here.

7 COMMISSIONER CLYBURN: So, questions. If
8 you can identify yourselves, we'd appreciate that.
9 Anybody with a question -- oh, okay.

10 MR. SIMMONS: There.

11 AUDIENCE MEMBER: I'm Patrick Gossman. I'm
12 here at Wayne State University. And I, you know, a
13 little bit -- how we fund, people fund some of these
14 efforts. I'm curious if we can't take some of the
15 discussion from Dr. Rosenberg. So, what, we save \$15
16 million here, \$7 million there. Any chance we can get
17 some of those savings to come back into the programs
18 that generate those savings?

19 DR. WISDOM: I think that's a wonderful
20 point. We are -- whenever you do get grant funding,
21 of course, the funders are already asking, "do you
22 have a sustainability plan; what are you going to do
23 long term?" So in all the grants that we write, we
24 try to think about that plan.

25 So let me give you a specific example where

1 we're trying to use that particular approach that you
2 mentioned. For community health workers, our newer
3 provider type, at least in this country -- promotoras,
4 village health workers, that sort of thing. Of
5 course, internationally, they've been in existence for
6 a very long time. So we're kind of little late in
7 this game also.

8 But community health workers, by and large
9 have been funded through grants. And we know that
10 they're a key provider type in terms of addressing
11 health disparities and mitigating a lot of the
12 barriers and challenges that we see.

13 So what we're trying to do now is find
14 creative ways to incorporate community health workers,
15 and begin to show that we -- sort of a return on
16 investment, so to speak. So that ultimately after
17 these grants are over, then the additional revenue
18 generated can actually fund their salaries.

19 So that approach is just very key. And I
20 think more and more around these health disparities
21 efforts, developing that business case of how we can
22 sustain these efforts. So that, you know, we're not,
23 you know, so dependent on these, you know, novel
24 grants. Of course, you know, grants have their place.

25 But I think they're wonderful for R&D, but we need to

1 find ways to integrate the learnings into daily
2 processes and systems.

3 COMMISSIONER CLYBURN: I really appreciate
4 the question. Because I think as you talk about the
5 messenger and the messaging, a lot of the information
6 that we already have is not being widely disseminated.

7 And I say that the FCC for a number of years has been
8 issuing grants. Particularly with a rule focus -- not
9 100 percent. If it's 51 percent of the benefits of
10 the footprint, it's in a rule setting. Then of course
11 that means 49 percent including the epicenter that
12 could be the flagship medical center in the state,
13 could be the primary in terms of delivering of care.

14 And what we've seen in my home state since
15 we're doing a little state of South Carolina; is the
16 Medical University of South Carolina was the hub for
17 about \$7.2, \$7.4 million. And at the 18-month point
18 when they issued one of their first reports; we found
19 that in the telepsychiatry portfolio alone, that \$18
20 million was saved with our -- to our state Medicaid
21 fund.

22 So those are real dollars that were saved
23 from that investment, and you can do the math. And
24 you know, what that shows is -- I don't think that
25 that information has been widely disseminated. And

1 part of the frustration I have, that I know people
2 continue to work towards getting rid of; is the fact
3 that we're not talking about what has been enabled and
4 the costs that are avoided.

5 Eighteen million dollars for that one, you
6 know, a million dollars a month, that's real money,
7 real time, real savings, you know. That's targeted.
8 Those are people keeping their appointment because
9 you're delivering in a way in which they're most
10 comfortable. That is making a real difference in the
11 community.

12 And I don't think we're doing as good a job
13 as -- and I'll say, you know, maybe we need to do --
14 maybe we should widely publish that report. But these
15 are things that are happening in silos. They're
16 happening through our efforts and your efforts, and I
17 really think that that needs to be better socialized.
18 So people will know that this is not science fiction
19 for entertainment. These things are making a real
20 difference in our communities, and the investment --

21 Not every investment is going to pay
22 financial dividends, but just about every investment
23 is going to pay some dividends when it comes to health
24 empowerment and the like. When you talk about that
25 child, that example you gave, that wasn't -- a

1 possible educational and psychological uplift. But
2 think about that in the different portfolios including
3 health care when you feel more enabled, where you
4 don't ignore that sign, when you can uplift that - I
5 just had very uncomfortable images when you described
6 that.

7 (Laughter.)

8 COMMISSIONER CLYBURN: But you're able to
9 address that because it would be more uncomfortable if
10 it's not addressed. These are types of things that we
11 need to be better prophets, as a Southerner of just
12 really making known, you know, what is possible
13 through that integration, that merging of health and
14 technology.

15 DR. GIBBONS: Could I just add to that,
16 Jamal? So I think it's fantastic. I appreciate what
17 the Commissioner said and Dr. Wisdom. I agree with
18 both. When I talk about technology, I'm not talking
19 about it at the exclusion of humans, actually. We
20 have to have the human element. But I think it can
21 even make the human element even better or do more or
22 accomplish more.

23 And to her point specifically, I started and
24 ran a community health worker program at Johns-Hopkins
25 for over a decade, continuously funded all by grants.

1 It's tough work. It's tough to keep it, but it can
2 be done. But it's not a great long-term strategy.

3 And I also had -- we had one program, we had
4 an infant mortality reduction program. Eight hundred
5 women went through the pilot. Our preliminary
6 evaluation showed that it saved the hospital over \$2
7 million, just with 400 of those women going through
8 the process.

9 But when we presented that data -- and I'm
10 not trying to talk negatively about my former
11 institution. I'm just talking about the realities and
12 the challenges of the system. You know, we were told,
13 yeah, that's great, that's nice. But those cost
14 savings, they're not coming to the doctors. They're
15 not coming to us.

16 You know, hospitals lose money when beds
17 aren't filled; right? And the primary care docs or
18 the OBGYNs who were providing the care didn't see a
19 penny of that \$2 million that was saved somewhere. So
20 that argument didn't really work that well.

21 And so it got me thinking -- I didn't like
22 it. But it's a reality. So it got me thinking even
23 more about it. And I think, the other way technology
24 is an opportunity, is that as -- part of the reason I
25 agree with Silas that if we don't do this right -- and

1 Dr. Smitherman -- it's not just that disparities are
2 going to get worse because they're getting worse; we
3 are going to make them worse faster.

4 COMMISSIONER CLYBURN: Exactly.

5 DR. GIBBONS: Because some populations will
6 be able to benefit, and others, how do we fix that?
7 By getting those populations involved who are
8 experiencing these things that have better ideas about
9 solutions; than the experts sitting in the ivory
10 towers who think they know -- and I include myself in
11 both worlds; right? Because I think I know something
12 about patients. But when I ask them, I inevitably
13 learn something, too.

14 COMMISSIONER CLYBURN: Exactly.

15 DR. GIBBONS: But when we get them involved
16 in the innovation ecosystem. Developing tools,
17 developing solutions, participating solutions and they
18 work, somebody will pay for them. They're become
19 profitable, and these are ways of realizing income
20 that don't come from cost savings but from real
21 business models behind him. And that's how we have to
22 start thinking.

23 COMMISSIONER CLYBURN: So, again, please
24 raise your hands if you've got questions. Doc, you
25 made me think about my old life.

1 For the first 11 years of my regulatory
2 experience, I was at the State Commission. And one of
3 the things that we were faced with when we talked
4 about energy, particularly when it comes to natural
5 gas -- which I know, you know, you know in terms of
6 that particular portfolio -- what we were forced by
7 reality to do is that, when things got more efficient
8 in that particular portfolio, the earnings, the return
9 for the company went down.

10 Now, how we addressed that was we put on a
11 sort of an adder. I can't remember what it's called
12 right now, because I've been gone too long. But that
13 we allowed them to share in that savings. So they got
14 a boost for being more efficient. So the dollars went
15 to the avoided -- the dollars that were realized from
16 efficiencies, we allowed them to share in that. And
17 you've got to have the right incentive to get to the
18 ultimate point.

19 MR. SIMMONS: Absolutely, absolutely.

20 COMMISSIONER CLYBURN: And if there's not a
21 sharing in that, if there's not going to be any upside
22 benefit, then you're right. The profession as a whole
23 is going to be resistant to the types of changes that
24 we need. And so we really need to -- and that's going
25 to be hard to sell. But we're going to have to be,

1 you know, part of making that a part of the
2 conversation. If not, we're going to be stuck, you
3 know, where we are.

4 And you're right, doctors. It's going to
5 get even wider, and we don't want all of this
6 investment and this excitement when we talk about the
7 benefits of technology to just be further -- my gosh,
8 that will make our communities worse. And, honest
9 with you? Communities are more resentful of what the
10 -- all of the excitement that they see on television
11 and all the big beautiful buildings going up, and
12 you've got people whose lives are worse. That's not a
13 good picture that we want to paint.

14 MR. BUCHANAN: And Dr. Smitherman, I want to
15 kind of pick up on something that you mentioned;
16 right? Which was the STEM school. So around the
17 country -- and in fact Adam and I participated in an
18 ideation and innovation event in Cleveland not long
19 ago. But we got incubators that are popping up all
20 over the country, right. There's Rock Health, Start
21 Up Health, Blueprint Health. And you name it; they're
22 all over the place. And they're bringing in
23 entrepreneurs and helping them to ideate and innovate
24 pretty interesting interventions to manage all sorts
25 of chronic disease, right.

1 When we look at, you know, the entrepreneurs
2 that are being, you know, placed into those classes,
3 we see very few entrepreneurs of color, right.

4 DR. SMITHERMAN: That's what I'm talking
5 about.

6 MR. BUCHANAN: And when Adam and I just
7 participated in one, it was the Cleveland Medical
8 Hackathon just a couple of weeks ago. You know, yet
9 again that played out.

10 But what I do see is STEM programs all over
11 the country would have -- what would have made this
12 one, I think, really interesting would have been: if
13 at least one STEM student was placed inside of each
14 one of those teams that was ideating and innovating
15 over the course of those couple days on these
16 interventions, to better manage chronic illnesses that
17 communities of color are disproportionately impacted
18 by.

19 And so that's just maybe one small fix.
20 I'll just add one more thing. The project that we're
21 doing with Text for Wellness, like most things that
22 are foundation-funded: the funding goes away; the
23 program goes away. And we're thinking now about: how
24 do you make this a sustainable model, you know. How
25 do you use SMS to have a hypertension awareness

1 prevention self-monitoring sort of campaign; on one
2 side. On the other side, perhaps it's around
3 medication adherence. And when you do that, you're
4 dropping the number of people that show up in the
5 emergency room, right.

6 You know, value accrues to both peers and
7 providers, and thus they should support this. So I'll
8 leave it there.

9 MR. SIMMONS: You mentioned the Hackathon
10 ideas as one of events you had done. Howard
11 University runs a start-up middle school in
12 Washington, D.C., and about a year ago I went to see
13 some of the students pitch their start up ideas. And
14 it's amazing what you get when you open up the process
15 and you let them participate.

16 One of them, which I thought was really
17 amazing, was a couple of young guys who wanted to put
18 sensors into garbage cans so that the City would know
19 when garbage cans were full. So the garbage cans in
20 the neighborhood wouldn't be overflowing, and it'd cut
21 down on the rats in the alley, and it would save money
22 and they had this whole idea about how they would do
23 that; which is not something you would think about if
24 you're a 26-year-old Stanford graduate living in San
25 Francisco.

1 DR. SMITHERMAN: Exactly. That's exactly
2 right.

3 MR. SIMMONS: You know? And then the other
4 one that I thought was just heartbreaking but it just
5 tells you where people are; was a young black girl,
6 maybe about 11 or 12 years old, who had this idea
7 about turning Twitter -- she had a Twitter app she
8 wanted to do that would turn Twitter into a Amber
9 Alert for girls of color. Because nobody talks about
10 when black or brown girls go missing; right? And she
11 wanted to be able to get that immediately out to the
12 communities, to let people know using Black Twitter
13 hits.

14 So I think just opening up that process
15 really is important, and all that's health care.

16 DR. SMITHERMAN: Yep, absolutely.

17 DR. WISDOM: Exactly, and that just speaks
18 so clearly to the importance of diversity, and how
19 it's important to really engage and plot early on,
20 agencies like CMS or agencies like these
21 entrepreneurial organizations. In a way where you can
22 request that they, when they're offering these, or
23 picking out these RFPs; that they have to have a
24 certain amount of diverse peoples that are going to
25 receive the grants, diverse people that are part of

1 the thought process, up front.

2 And I just think at Henry Ford, I think
3 about our supplier diversity program. We have a major
4 effort around minorities and women, in terms of
5 awarding contracts as vendors. And we look for places
6 that have minority employees that have even, you know,
7 their second tier, you know, employ minorities.

8 So I think an appropriate same way for these
9 entrepreneurial, if we could work with them, I mean
10 sort of move further upstream, you know, with them; in
11 terms of ensuring that we have a system where we can
12 ensure that the diversity will be represented at the
13 table.

14 Also CMS, you mentioned the Heckler Report
15 and 30 years of the Heckler Report just September of
16 last year -- of this year. So several of us were
17 invited to talk to CMS in terms of how we could
18 address health disparities now. And I think we need
19 to find ways to engage them up-front so when we show
20 that there are millions and millions of dollars worth
21 of savings, guess who's getting the savings? CMS.

22 So we need to figure out a way to work with
23 them; so when they get the evidence, they say, "okay,
24 now we can fund this and fund that," because the
25 savings are being attributed to the place that is

1 realizing the savings. Because the docs aren't, and
2 that's kind of that push back.

3 So you've got your own internal systematic
4 barriers -- you know, we're not talking about
5 external, but we're talking about internal systematic
6 barriers that are not going to drive what we need to
7 see happen when to get rid of these disparities.

8 So we need to figure out: how do we align
9 incentives, and work with the partners that actually
10 can pull the trigger to make funds fall, and make it
11 happen.

12 MR. SIMMONS: We've got a question.

13 COMMISSIONER CLYBURN: Is there a question?

14 MR. WILLIAMS: Yes. My name is Joe
15 Williams. I'm a software developer and I work with
16 the certified medical record. And the reason I'm here
17 is because I'm interested in one of the quotes that
18 was mentioned "where the rubber meets the road." I'd
19 like to know from the panel's perspective what things
20 are really needed, particularly from a health care IT
21 perspective, that actually makes sense now and today.

22 Dr. Smitherman mentioned about speed of
23 text, which is what we might call primitive technology
24 or technology that's been out there for years, that
25 quite frankly works.

1 And if it were really expanded upon and
2 really easily could be, if people that actually
3 develop that, were kind of blocked at the forefront.
4 I guess what I'm thinking about, is that there's a lot
5 of independent software developers out there; but they
6 don't get the attention of people like yourselves,
7 where they could bring real simple solutions, cost
8 effective solutions that quite frankly could help your
9 bottom line right where you're at.

10 As an example, the meeting for youth
11 scholars that were given to providers for -- to get
12 these medical records. Had many of the providers
13 looked at smaller developers, they could have had that
14 same certified record for probably half or one-third
15 of what they paid the major players. I can tell you
16 that you wouldn't be ending up in a messenger, and now
17 many of these records are not really functioning until
18 you agree that you guys really need it to function for
19 you.

20 Small developers generally can ask what you
21 want and then give it to you, without taking it
22 upstairs ten or twelve times before they can even
23 begin to start on the program. So if I had any word
24 of encouragement, my advice would be to begin to look
25 at those independent developers who could bring some

1 real value to the table in some affordable ways.

2 I'd like to end it by saying that I am very
3 interested in dealing with disparities, and that's
4 really the reason I'm here. And so I'm making the
5 audience and, certainly, the panel aware that I'm
6 personally interested in working with those that have
7 an interest in disparities, particularly in the IT
8 arena, to make something happen that's affordable and
9 doesn't take ten years to happen.

10 DR. SMITHERMAN: One quick -- I think it's
11 an excellent comment. I'd just like to piggyback on
12 the issue of the STEM students, just to say one thing.

13 When we marginalize 33 percent of our public that is
14 black and brown people, the cure for cancer could be
15 in there. We're talking about the cure for myocardial
16 replacement cells, neuro replacement cells so we
17 aren't in there stenting hearts. We're actually
18 replacing the heart muscle.

19 I mean, these kind of solutions are out
20 there. And when we marginalize this population, and
21 those innovations are in that creativity in those
22 communities, we're stifling a lot of our innovation in
23 the country.

24 With respect to your direct question, I
25 would say if you talk to most physicians today, we --

1 physicians have always been on the forefront of
2 embracing technology -- always. I mean if you look at
3 health care in medicine, we are the frontier.

4 But -- and so people were saying, "Well, you
5 know, doctors aren't really embracing the EMR."
6 Because they were poor. They were not ready for prime
7 time. You could not as a practicing physician, our
8 thought was you're going to have an EMR, and I'm
9 actually going to be more efficient and effective at
10 getting patient information into this database, and
11 it's going to make my life better. It actually
12 expanded my time working with the chart by about a
13 hundred fold so that we're now doing charts at home.

14 So -- and we are now considering ourselves
15 data entry folks. That's what we look at ourselves
16 as. So I say the simple things -- interconnectivity,
17 simple thing to be able to simply dictate. Most of
18 the EMRs you can't dictate on them. So you're
19 actually have to type information into this product.

20 And you're right. A lot of the big
21 companies, there wasn't a lot of movement. They don't
22 want interconnectivity, because what they want is:
23 when you want to switch to the other one, they want to
24 have a barrier for you to get all of your repository
25 data from where you are to the next EMR. So they make

1 it cost-prohibitive.

2 So there are a lot of things that can be
3 done I think with smaller entrepreneurs can be a
4 really dynamic force in this; and force the kind of
5 innovation in this area that's really, really needed.

6 The last thing I was going to say is that,
7 you know, one of the things that - with respect to
8 technology we're looking for best practices, evidence
9 based, data driven, all of that. I remember, I was
10 sitting in a meeting once, and I got a text; and it
11 was my vet who was texting me to alert me to the
12 appointment of my cat's echocardiogram.

13 Now first of all, I had to call my wife to
14 figure out why my cat needed to get that.

15 (Laughter.)

16 DR. SMITHERMAN: That was my first question.
17 You know, I go like, "well, what in the world," and I
18 don't even like the cat. But I'm going to say --

19 (Laughter.)

20 DR. SMITHERMAN: But what I said was this is
21 fascinating to me. I'm getting a text -- this is
22 several years ago. I'm getting a text reminding me of
23 an appointment.

24 So what we did was, you know, we had text
25 for babies. Then we had text for diabetes here.

1 Well, we started giving phones to urban inner city
2 patients who did not have the kind of technology. We
3 started texting them about their appointments. We
4 started texting about health information on diabetes.
5 We started texting them lab results, what their
6 hemoglobin A1C improvement was. What do we see? We
7 see improved patient appointments. We saw improved
8 compliance with medication.

9 So we know what works. So the question we
10 have; I think as a country we go, okay, these things
11 are not that expensive. They're not that even
12 technologically advanced. It's simply giving a phone,
13 a disposable phone most of the time. Texting
14 information, appointments, etc.

15 It works. We improve health. We improve
16 access to care. We improve compliance. And then what
17 happens? No more grant, the program goes away. We
18 never see or hear anything about it and then there's
19 no more funding.

20 So the issue is there are the solutions out
21 there. We have the solutions. The question is: as a
22 country, how are we logging, taking this information
23 and broadening it and expanding it to the rest of the
24 country and implementing these real solutions that we
25 know work. They improve health. They improve

1 compliance, all of these kinds of things. Why aren't
2 we implementing them? That's the question.

3 COMMISSIONER CLYBURN: And to your question
4 on the FCC side, we have an Office of Communications
5 and Business Opportunity that is looking to expand
6 some of our initiatives and efforts on the health
7 care. Traditionally, you might have guessed it. It's
8 been on wireless devices in a pure communications
9 sense, just a kind of the cell phone and the other
10 media and the like.

11 We talked just a couple weeks ago about
12 creating a sort of, you know, health care series of
13 workshops, or conversations, or peer-to-peer, or, you
14 know, even having the companies having sort of a
15 matchmaker type. Because part of the issue is, not
16 getting your message across and not getting your
17 product introduced before, you know, someone who could
18 mean like something.

19 So let's talk about that because I think it
20 might be multiple ways. No promises, but just, you
21 know, the opportunity or pathway towards that, and
22 you've got a couple of the questions.

23 DR. AXELROD: Hello? Yeah, my name is
24 Stephen Axelrod. I'm a physician, graduate of Wayne
25 State University School of Medicine. I live in

1 Colorado now. But I'm in medication adherence, and
2 I'm very interested. I'm very appreciative for you
3 being here, for Wayne State putting this on, and for
4 the FCC to participate.

5 But this is a very, kind of aggravating
6 conversation. I'm one of those entrepreneurs that's
7 out there. There's thousands of us that have great
8 workable inexpensive solutions. My area is medication
9 adherence, where we waste as a country \$300 billion a
10 year, and people are dying every day -- but the same
11 issue as what we're all talking about.

12 Everybody, you can't even -- entrepreneurs
13 can't even bother to go through the grant process,
14 because the process itself is designed to go to
15 academic organizations. The vested interest that you
16 mentioned about who gets the money and who pays for
17 these things, I mean, it's -- there's really now no
18 motivation, from anybody that really could make the
19 change, to make the change. Because if I take a head
20 out of a bed, the people that run the hospitals have
21 an issue with that.

22 MR. SIMMONS: Exactly.

23 DR. AXELROD: And so all these incubators
24 that are out there -- and I'm participating in a
25 couple in Denver -- there's tremendous creativity,

1 tremendous technology because of the technology
2 changes that are coming. But you can't prove it to
3 CMS. It's the chicken and the egg. You can't get a
4 reimbursement for it. Everybody always asks you the
5 first question is, "who's going to pay for it?"

6 I have come to the conclusion after 30 years
7 that you can't sell anything based on savings -- only
8 on revenue. So I guess what I'm looking for is, how
9 are we ever going to get out of a conversation where
10 we have a room of people that are interested in doing
11 this but nothing ever gets done?

12 MR. SIMMONS: Let Adam get on here.

13 DR. PERZYNSKI: I really like this question.

14 DR. AXELROD: Your program's a good example.
15 Who pays for that Stat 12 week program.

16 DR. PERZYNSKI: Sure. So I think this is a
17 great -- it's a great discussion. I think, you know,
18 it sort of started with Patrick's question about how
19 to recover value, and a lot of the panelists have
20 talked about it. We -- the matter of shared savings
21 is a really important one. Is this thing -- oh, I
22 think I -- oh, I went orange.

23 MR. SIMMONS: Technology.

24 DR. WISDOM: It's a Buckeye thing.

25 (Laughter.)

1 DR. PERZYNSKI: It just shuts it down. Hey,
2 my mom went to Michigan, and I think she's watching.

3 (Laughter.)

4 DR. PERZYNSKI: So this issue of shared
5 savings is critically important. At this point, you
6 know, under Affordable Care Act policies, there are
7 some sort of optional programs. Some optional entry
8 into an accountable care organization, optional
9 rearrangements of state Medicaid programs to build
10 shared savings programs.

11 And the provider organizations in general
12 are, see, are risk averse to entering into a lot of
13 those types of programs. Because if your payments are
14 accapitated for a certain type of length of stay of
15 illness, right, whether somebody has a stroke or a CHF
16 or COPD, has an exacerbation; you're only going to get
17 this amount of money. And you're on the dime for the
18 extra care that the person receives. Then you're not
19 really willing to enter into those new arrangements.

20 But there are some places that have been a
21 little bit bold across the country and are saying,
22 "look, we think things are going this way, and we're
23 ready and we're going to try it." And they're willing
24 to take on those risks.

25 Our hospital, Metro Health in Cleveland, is

1 one of those places. We are entering into these sorts
2 of contracts with payers. There are other places that
3 are doing this. And so instantaneously there's this
4 total reorientation toward innovation of the sort that
5 you're talking about, especially things like
6 medication adherence. I really want to talk with you
7 more about this maybe offline.

8 So what happens is, is so let's say all of a
9 sudden we have 7,000 patients, and we're only getting
10 this money for them. But we are getting all of that
11 money.

12 So now if we can save some of that money by
13 making sure they take their medicine and they don't
14 end up back in the hospital -- because they have an
15 asthma action plan, they're on a steroid inhaler
16 instead of a rescue inhaler, they -- we are doing
17 better. We're going to their home, and we're managing
18 their congestive heart failure to keep them out of the
19 hospital once we send them home. We're making sure
20 that people don't have strokes again after they've
21 just had one and we sent them home.

22 So when -- because they're now taking their
23 anti-hypertensive medication that they weren't taking
24 before, those savings actually are for the patients
25 under which we've entered into some of these

1 arrangements at our hospital, we actually get to keep
2 that money.

3 So, and I think you find among provider
4 organizations an excitement for partnering with
5 entrepreneurs and innovators to make -- if we can do
6 anything that's going to help us to save -- help us to
7 not cross that cost threshold that's in the contract,
8 then we're interested in talking to someone about
9 doing it.

10 So I think, in general, nationwide, the pot
11 is not sweet enough for people to take on the risk.
12 And so maybe some experiments in shared savings that
13 would -- you know, we really need to double down the
14 bonus for the organizations that are saving money. So
15 that they are more likely to enter into those
16 arrangements, which are often right now optional.

17 MR. SIMMONS: So I've got one question
18 before we close. We've got just a couple of minutes
19 here. I've love to get this in; because I don't know
20 about you, but I've got several people in my family
21 who are devoted conspiracy theorists. And so all this
22 talk about downloading health records and putting
23 things up in a cloud and all that stuff gets them a
24 little hinky.

25 So what do you see as practitioners on the

1 privacy question in terms of patients not interacting,
2 and then maybe, Dr. Perzynski, from someone who's
3 managing data, how do we assure them that their data
4 is secure and their privacy is being taken care of.

5 DR. PERZYNSKI: I think this is a great
6 question. I hate the idea of somebody else going into
7 my MyChart account and seeing what's in there, even
8 though it's nothing that I'm ashamed of. I don't want
9 anybody else in there. That's my information. It's
10 between me and my doctor and maybe my wife and the
11 rest of my family and nobody else. So protecting that
12 information is, I think, critically important.

13 I think there's another layer here besides
14 just the data protection, and it's a layer that
15 concerns me; which is that we tend to have at least in
16 our health system we do see this that -- and this
17 crosses all across health disparity research over the
18 past 20 years. Which is that there's a trust barrier
19 between persons out in the community and the health
20 care system in general. And so that -- any effort to
21 improve trust between patients in the community and
22 the health care systems and providers that serve them,
23 is an important effort here.

24 So in addition to, you know, fire walling
25 data, and doing everything that we can to protect it,

1 and having the sorts of steep penalties that already
2 exist in law for places that have breaches; I think
3 there is an even more critical need to have -- to sort
4 of tear down the barriers between these, you know,
5 glass and steel, beautiful buildings and health care
6 systems where a lot of us get our care; and the
7 communities around them. Which seems like a really
8 steep barrier for some folks, and that barrier
9 includes trust.

10 So I think, you know, a dialogue about that
11 trust with community members is probably the pathway
12 to success, something like, you know, Silas mentioned
13 having school kids at the Hackathon. We also need to
14 have folks in the community in our dialogue about the
15 solutions that we build, maybe things like having
16 community-based independent developers is a way toward
17 that.

18 DR. GIBBONS: Yeah, I add to that. I think
19 all of those things are true. But I also have
20 found --

21 So, when I go out and do these focus groups
22 with seniors all over the country and start asking
23 them that specific question, it's actually very -- I
24 was personally surprised by the small -- very few put
25 this up as a real big issue that would stop them from

1 using. You know what they say? "Yeah, it's an issue.

2 But if I don't use, I'm only going to be left further
3 behind." That's what they tell me.

4 So it's real, yes. But it's not enough --
5 there are some. There are some. So I'm not saying
6 it's nobody. But more of them are in the category
7 that, "I don't have a choice. The world is going in
8 this direction. I'm already behind. And if I
9 continue to put up this wall, I'll be further behind."

10 That's not to say we shouldn't do these
11 things. We should. But this is why I think it's so
12 important to get communities of color involved -- not
13 just go after what we as experts think they want, at
14 all parts of the cycle.

15 MR. SIMMONS: Okay, rapid fire, and we've
16 got a question.

17 COMMISSIONER CLYBURN: A couple questions,
18 right.

19 MR. SIMMONS: Right here.

20 COMMISSIONER CLYBURN: Why don't we handle
21 it this way? Would you ask your question, and we'll
22 ask the last three questions. And then if the
23 panelists, who are very smart, can take note; then
24 we'll answer them all in succession if you don't mind
25 doing that.

1 MS. MASON: Yeah, actually my name is Lisa
2 Mason. I'm from the Greater Detroit Area Health
3 Council, and I actually wanted to make a suggestion,
4 make a comment -- both. And I think I'm just
5 elaborating on what's already been said.

6 But Dr. Perzynski's absolutely right. Until
7 we fundamentally change the financial equation, we
8 can't make progress. And Dr. Axelrod is right. We
9 have to pay for value, and we have to change right now
10 the way we're paying. Until we're saying, "you're at
11 risk for the health," then all those savings don't
12 mean anything either.

13 So I just wanted to emphasize that. But the
14 other comment I had was about the voice of the
15 consumer -- not just entrepreneurs but the people
16 we're trying to serve. GDAHC is a multi-stakeholder
17 table, and we've learned that unless you have the
18 voices present when you're having a conversation, you
19 miss out.

20 And we think -- as Dr. Smitherman said, we
21 think we know what they think. But you need to have
22 their voice right here in these kinds of
23 conversations. The people we're targeting to serve
24 need to be at the table. And, so I just urge you when
25 you do these kinds of things, get someone that we're

1 trying to serve to help talk about the solutions.

2 COMMISSIONER CLYBURN: Absolutely. Next
3 question, Roger, or run over.

4 DR. WATSON: I probably don't. My name is
5 Mike Watson. I practice and teach at the Michigan
6 State Communication and Policy. And the point that
7 Dr. Smitherman and Dr. Wisdom in particular raised.
8 Isn't the fundamental issue here the same as we face
9 with respect to this disparity that we faced a hundred
10 years ago with electricity? Highways? And phone?

11 And as a nation, didn't we say -- rise up
12 and say enough is enough, we're not going to let the
13 industries who have their hands in the till stop us
14 from providing this fundamental -- the information
15 super highway, to everybody because if we don't
16 include everybody, don't we have a fundamental
17 problem.

18 So we've got precedent. We just have to
19 step up and make it happen, by demanding it, yes.

20 COMMISSIONER CLYBURN: Okay, remember that.
21 We'll hold that thought. And the last question?

22 MR. EVELYN: Hello, and thank you for
23 putting this together again. My name is Javier
24 Evelyn, and I am actually a mobile application
25 developer and new entrepreneur as well.

1 Just building upon what everyone has pretty
2 much spoken on, I've worked in health care as well in
3 the past within a mobile applications development
4 atmosphere. And one of the big things that I worked
5 on was projects geared around medication adherence as
6 well, but also just anything that was geared around
7 just reducing the readmission cost for hospitals for
8 the most part.

9 What is -- there's a lot of red tape around
10 that. There's a lot of steps and barriers that I
11 guess Tony mentioned, about having to go up a couple
12 floors to get approval. I know there's a lot of
13 politic behind it. But why do you think even though
14 you know you're going to save a ton of money by doing
15 X, Y, Z technology does not take that much effort from
16 a developer's standpoint to do.

17 But what slows it down -- I guess that's one
18 of your thoughts on that.

19 COMMISSIONER CLYBURN: Okay. So, Jamal, if
20 you don't mind, we can -- all of you have heard the
21 questions. If you don't mind addressing and
22 integrating them in your close, that might be the most
23 efficient way for us to do it. So to my left, Dr.
24 Smitherman.

25 DR. SMITHERMAN: Yes, yes and yes.

1 (Laughter.)

2 COMMISSIONER CLYBURN: There you go.

3 DR. SMITHERMAN: I agree 100 percent.

4 COMMISSIONER CLYBURN:

5 MR. SIMMONS: He's not done.

6 (Laughter.)

7 DR. WISDOM: I was going to say ditto.

8 (Laughter.)

9 DR. SMITHERMAN: I would add water with
10 that, with the electricity and highways and phones. I
11 mean we are -- I spend a lot of my time in my practice
12 with primary-care-based patients -- I'm an internist
13 -- calling electric companies, water companies and
14 heat companies in the middle of the winter, trying to
15 keep people's basic utilities on. People who have
16 nebulizer machines that are asthmatic or have
17 asthmatic kids that without that electricity their kid
18 goes into the hospital.

19 So, we deal with this all the time. These
20 are not hard solutions for a country as innovative, as
21 creative, with the history we have, to solve. So you
22 know, all I can say is; I couldn't agree with you
23 more. We need to have in a Congress that to me is
24 just locked down right now. I mean we basically need
25 an enema up there in some kind of serious way.

1 COMMISSIONER CLYBURN: Do go there, Doctor.

2 DR. SMITHERMAN: No, I'm clinical.

3 (Laughter.)

4 DR. SMITHERMAN: Everything's translated in
5 clinical terms here.

6 So I can say I don't -- we -- there are real
7 people suffering that need real solutions, and all we
8 need is to have people come together and make common
9 sense, pragmatic, consensus-based policy, and that's
10 really what we're searching for. So I don't really
11 have anything more.

12 COMMISSIONER CLYBURN: No, you've said it
13 all. Thank you.

14 (Laughter.)

15 DR. WISDOM: So as the token Wolverine here,
16 I think now it's clear to me why I was invited to be
17 on this panel. Someone had to represent. So, I ditto
18 what Dr. Smitherman shared.

19 But I think in large part much of this boils
20 down to leadership -- leadership at the grasstops
21 level and leadership and the grassroots level. And
22 I'm so excited that the FCC has, and others have come
23 to the table around addressing broadband issues
24 because it's a key social determinant of health. I
25 just was fascinated to say wow, people are really

1 getting it, and that's great. But the ability to have
2 that like highways and electricity, you know, and
3 utilities, I mean it should be a no brainer that
4 people have access.

5 And if we're going to be a 21st Century
6 nation that is going to be competitive across the
7 world, we just need to figure this out -- but also
8 leadership at the grassroots. And that's where I
9 think the community health worker model is so key and
10 the front line worker is so key.

11 I mean to have, you know, a highly skilled
12 doctor making calls to heating companies, is not that
13 provider working at the top of the license. And I
14 think that that's the challenge that we -- God bless
15 him, and God bless the patients that have, you know, a
16 tremendous resource. Their providers on the -- but I
17 think we can find more efficient ways.

18 And I think there's a model where we can pay
19 people that are really, really good at this. They
20 know the neighborhoods. They know the water's shut
21 off. They know the symbols on the ground when water's
22 going to be shut off. They know when they see lines
23 moving from, you know, one house to another, you know,
24 that's illegal use of utilities.

25 I mean that's not -- there's a lot that

1 community health workers -- and I've learned it
2 through my community health workers and being in the
3 neighborhoods. But I didn't know when you had those
4 long lines between houses that it was actually
5 indicative of people stealing, you know, energy.

6 MR. SIMMONS: Energy, yeah.

7 DR. WISDOM: Energy, exactly. So community
8 health workers are so savvy, and they're expert at
9 community and they're expert at addressing the social
10 determinants very efficiently. So I think leadership,
11 leadership, leadership at the grassroots as well as
12 the grasstops.

13 COMMISSIONER CLYBURN: Dr. Gibbons?

14 DR. GIBBONS: I would agree. I think in
15 addition to that, you know, some things are going to
16 happen outside the health care system. It ain't going
17 to push the health care system, and I'll give you one
18 example why.

19 You know, years ago when I was a resident in
20 medical school, the whole notion of sort of eastern
21 medicine, you know, weeds and seeds and that kind of
22 stuff was coming in this country. And I can remember
23 all my attendings, everybody was training, they were
24 like stay away from that stuff, it's going to kill
25 you, stay away from it on the internet. You know,

1 it's going to kill you. Stay away.

2 And then it became an \$85 billion industry
3 in this country, and that was several years ago. Now
4 every medical center that's worth its salt has a CAM
5 -- complementary alternative medicine research center
6 and is doing acupuncture.

7 I think it's the same thing in large part is
8 going to happen in the health IT side. It's really on
9 the consumer side, but also on the provider side --
10 that it's going to get so large and patients, as Dr.
11 Smitherman is saying, are going forward anyway, you
12 know, that one day we'll start doing those things that
13 patients and consumers are demanding.

14 And so some of this gain I think would
15 benefit those of us from the health care system to
16 start playing outside the system, too, which is why
17 I'm at the FCC.

18 COMMISSIONER CLYBURN: Mr. Buchanan.

19 MR. BUCHANAN: So, yeah, I agree with, up
20 and down the food chain, here. Some health takes
21 place outside of health care. Some, yeah, at most, I
22 think, right?

23 DR. GIBBONS: Well, yeah, we agree. We
24 agree.

25 MR. BUCHANAN: If you go to church

1 regularly, right, and you're fairly healthy, you could
2 spend 20 minutes a year with your physician, but you
3 could spend 70 hours a year in church, right? So
4 having those people at the table is, you know,
5 absolutely critical.

6 And having their voice and developing, you
7 know, Javier, you know, interventions that sit at the
8 community level. You know, I think that everybody,
9 you know, HHS Health 2.0, right? Health 2.0 and
10 others have had these challenges, and they've
11 challenged folks to spin up these interventions. I'm
12 kind of back to that again.

13 They spin up these interventions. And then
14 at the end of the day, HHS says, oh, whoever won,
15 they'll give them a thousand dollars or five thousand,
16 whatever it is. But you know, we can't give anyone a
17 sole source contract. So, you've spun this thing up
18 kind of in hopes that you're going to work with the
19 government on some level, and they're going to adopt
20 on some level. But then they say, "you won, but we
21 can't buy what won," right?

22 So I think as we figure out how to sit at
23 the community level and to develop things, you know,
24 for the community, with the community, you know, I
25 think the market's going to beat a pathway to your

1 door.

2 COMMISSIONER CLYBURN: Dr. Perzynski?

3 DR. PERZYNSKI: So I think you guys all
4 really covered the questions. I'm just going to add
5 something very briefly -- a very brief personal
6 anecdote.

7 I remember very clearly the first time that
8 I used the internet. I was sitting in a computer lab
9 at the University of Toledo in about 1993. It's the
10 first time I sat in a terminal, and I saw this ship's
11 wheel which was Netscape and I clicked it; right? And
12 I go in there and I realized like, "oh, man,
13 everything is here." Like, literally everything is
14 here, and I see this little sign for the link to the
15 library, right.

16 The library is only three buildings away,
17 but it's going like the library, and I opened it up
18 and everything in the library is there right in front
19 of me, right.

20 And so there's this principle in social
21 informatics that the internet is more than just a
22 tool. It's more than just a device. It has this
23 social connectivity, and it has this other thing where
24 it sort of collapses distance. And so things come
25 very, very close to you immediately in a way that

1 never happened before.

2 And I think that to the extent that that
3 ability is not available to some persons in our
4 society, that is a crisis for us, right. That's a
5 mission critical problem. And so I'm sorry I didn't
6 answer the questions more. But I just wanted to get
7 that out.

8 COMMISSIONER CLYBURN: Jamal, this has been
9 an incredible day. It's very seldom that you will
10 hear two people at opposite ends meeting physically at
11 a table say that we're not done even though this part
12 of our discussion is over.

13 One of the things that all three of you may
14 be thinking about, is that we should not be surprised
15 about the conversations and the challenges we face
16 today.

17 When you talk about our country's evolution
18 when it comes to provisioning what we now consider
19 essential services, that did not come without cost,
20 investment, friction and ultimately, you know,
21 positive decision-making because it was ultimately
22 realized that connectivity and all of those portfolios
23 are to the benefit -- the national benefit of us all.

24 So we this very -- comparatively young
25 republic are going through yet another growing pain

1 when it comes to technology and to deliver of health
2 care. So we should not be surprised. We should,
3 however, learn from our history. These silos, you
4 know, when I wrote down -- when I thought about what
5 you said, the silos that currently exist, they happen
6 organically.

7 But what we have the power to do with
8 technology, with good regulation because of this
9 conversation, we are better equipped to deliver with
10 that. What we have the power to do is allow the
11 benefits and efficiencies that are fueled by
12 technology to enable us to make better decisions.

13 So I am uplifted. Even with the challenges
14 and the stats that we know are true that we have the
15 capacity because we have more connectivity and
16 interactions with all of us. Many of us did not know
17 each other before we talked in this room, to do so.
18 So what would be a shame if this ends our interaction,
19 and I trust because of technology that that will not
20 happen. Jamal?

21 MR. SIMMONS: True. I think everybody here
22 has said everything there is to say. I just want to
23 thank you all again for letting me be a part of this
24 discussion.

25 Also I want to thank the Commissioner for

1 inviting me and for convening this discussion. And I
2 think the more you follow her, the more you pay
3 attention to what she's up to in Washington, the more
4 impressed you'll be at her commitment to making these
5 big complex problems that we read about in the Wall
6 Street Journal and all those newspapers really
7 effective for individual citizens. So I'm committed
8 to being supportive of that, and I hope you all will
9 commit to that also. Thank you.

10 COMMISSIONER CLYBURN: Thank you very much.

11 (Applause.)

12 DR. SKYRZNIARZ: Well, this concludes our
13 program this morning. You are free to go to lunch now
14 for the next hour and 15 minutes. We're going to
15 start the afternoon session at one o'clock over at
16 TechTown which is immediately adjacent behind the iBio
17 Building in this next block. And we'll see you over
18 there at one o'clock. And there is lunch over there
19 at TechTown for people that would like some lunch.
20 Thank you.

21 (Whereupon, at 11:48 a.m., the forum in the
22 above-entitled matter concluded.)

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REPORTER'S CERTIFICATE

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I hereby certify that the proceedings and evidence are contained fully and accurately on the tapes and notes reported by me at the hearing in the above case before the Federal Communications Commission.

Date: October 28, 2015

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