

Welcome to the
California Telehealth Resource Center
14th Annual Digital Health Summit
Bridging the Gap. Smarter Care for Sustainable Futures.

*From Clinic to Community, Scaling Chronic
Disease Management Beyond the Visit*



Dr. Yimdriuska (Gigi) Magan, MD, MPH
Board-Certified Family Physician, FQHC, Northern California
Co-founder, Alma First
Time of Session 10:00 – 10:45 (PT)

Disclaimer



This session is purely for informational purposes.

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Summit Sessions

8:30 am

Opening Remarks | Setting the Vision:
Digital Health, AI, and the Future of a
Sustainable Health Ecosystem

9:00 am

Opening Keynote | Setting the
Foundation: Statewide Digital Health
Priorities under California's Rural
Health Transformation Program

10:00 am

**From Clinic to Community: Scaling
Chronic Disease Management Beyond
the Visit**

11:00 am

From Innovation to Sustainability:
Payment and Policy Pathways That
Make Digital Care Scalable

1:00 pm

Trust Is Built, Not Bought: Making AI
Safe and Defensible in Clinical Care

2:00 pm

Building What Lasts: Rural Digital
Health Sustainability in Practice

3:00 pm

Clinical AI That Delivers: Evidence,
Workflow Fit, and What Actually
Changes Care

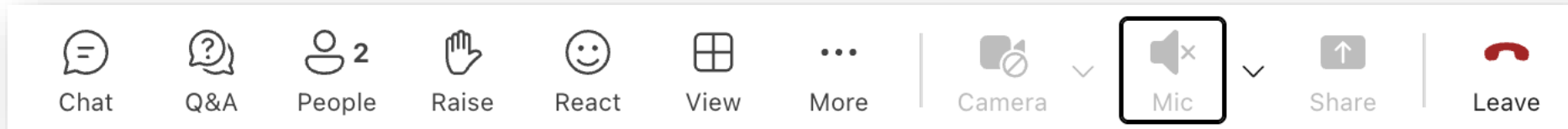
4:00 pm

Closing Keynote | From Promise to
Practice: Preparing Care Teams for
Generative AI in the Next Year

[Register Here](#)

All times are in Pacific Time Zone (PT).

Microsoft Teams Tips



Open the Chat

Please open the chat and use it liberally; we want to hear from you!

Raise your Hand or React

Attendees will have an opportunity to ask questions. Raise your hand or send reactions!

Muted on Entry

You are muted on entry.

Session Recording

Today's session is being recorded! Keep an eye out for attendee announcements when recordings are available.

Thank You, CTRC Funders



Established in 2006, the California Telehealth Resource Center (CTRC) exists to share **unbiased, no-cost digital health resources and consultative support services** with providers and patients located across all 58 California counties and beyond. As part of a collaboration of 12 regional and 2 national Telehealth Resource Centers, CTRC is **committed to implementing digital health programs for rural and underserved communities.**

The work of the CTRC would not be possible without funding and support from the Health Resources and Services Administration's **Office for the Advancement of Telehealth** and the **CA State Office of Rural Health**, part of the Department of Health Care Access and Information.

From Clinic to Community, Scaling Chronic
Disease Management Beyond the Visit

Meet Your Presenters



Yimdriuska Magan, MD, MPH

Co-founder Alma First

From Clinic to Community

Scaling Chronic Disease Management Beyond the Visit

A journal-club style CME walk through the current peer-reviewed evidence, the 2026 payment landscape, and what to do Monday morning. Evidence current through June 2026.

Dr. Yimdriuska (Gigi) Magan, MD, MPH

Board-Certified Family Physician · FQHC, Northern California

Co-founder, Alma First

Where we are going, and what you will leave able to do

01

The Burden

Why visit-centric care is buckling.

02

The Evidence

A rapid journal-club tour of the data.

03

The Practice

Workflows, 2026 billing, the ACCESS model, pearls.

04

Equity & Horizon

Who gets left behind, and what is coming.

By the end of this accredited CME activity, you will be able to:

- 1 Describe the evidence base for telehealth and RPM in safety-net chronic-disease care.
- 2 Identify team-based workflows that reduce clinical inertia and burnout.
- 3 Apply the 2025 AHA/ACC and 2026 ADA guidelines to home monitoring.
- 4 Navigate the 2026 CCM, APCM, and RPM billing updates.
- 5 Name evidence-based design strategies that mitigate digital-health disparities.

Care is built around the visit. Health happens everywhere else.

Under 3 hrs

A patient with hypertension, diabetes, COPD, or heart failure is face-to-face with us under 3 hours a year.

8,760 hrs

The rest of the year they manage complex disease alone, amid work, family, and daily life.

The math is impossible. Porter (J Gen Intern Med 2023) modeled that one PCP would need **26.7 hours a day** to deliver full guideline care to a 2,500-patient panel; team-based care more than halves it but does not close the gap.

Over 40% of clinicians report burnout, driven largely by after-hours documentation.

The shortage is here, and the safety net already runs on virtual care

1 in 4

Californians live in a primary-care Health Professional Shortage Area.

10,500

projected primary-care provider shortfall in California by 2030.

20%

of California FQHC visits now occur via telehealth, the highest state rate.

Five conditions define the primary-care battleground:

Hypertension · Diabetes · Cardiovascular disease & COPD · Chronic kidney disease · Obesity

All five are highly measurable, monitorable, and protocol-driven. That is exactly what makes them the best candidates for remote monitoring and telehealth.

The guidelines have moved to meet the digital model

2025 AHA/ACC HYPERTENSION GUIDELINE

First major update since 2017. Elevates home BP monitoring (HBPM) to a central role for diagnosis and control. Treat to under 130/80 for most adults. Adopts the PREVENT risk equation in place of the Pooled Cohort Equations. Explicitly cautions against cuffless or smartwatch BP devices until validated.

2026 ADA STANDARDS OF CARE

Recommend continuous glucose monitoring (CGM) at diabetes onset and anytime thereafter for anyone on insulin or on a non-insulin therapy that can cause hypoglycemia, across the lifespan and in pregnancy. Shifts the conversation from a quarterly HbA1c to a daily, real-time picture (time-in-range).

Home monitoring is no longer an add-on. It is guideline-concordant, standard-of-care medicine for both conditions.

The American Heart Association PREVENT™ Online Calculator

About the PREVENT Equations

 [Online Calculator](#)

CVD

ASCVD

Heart Failure

Sex*

☒ Male ☐ Female

Age (years)*

30-79

SBP (mmHg)*

90-200

Total Cholesterol (mg/dL)*

130-320

HDL Cholesterol (mg/dL)*

20-100

eGFR (mL/min/1.73m²)*

15-140

BMI (kg/m²)*

18.5-39.9

Diabetes

Any history of diabetes.

☒ No ☐ Yes

Current Smoking

Any cigarette use within the last 30 days

☒ No ☐ Yes

Lipid-lowering medication

Current use of statin medication to lower cholesterol

☒ No ☐ Yes

Anti-hypertensive medication

Current use of any medication for hypertension

☒ No ☐ Yes

The following three predictors are optional for further personalization of risk assessment. When they are clinically indicated or available,

If available or indicated, select "Yes" and enter the value.

UACR (mg/g)

UACR is clinically indicated for individuals with chronic kidney disease, diabetes, or hypertension

☒ No ☐ Yes

HbA1c

HbA1c is clinically indicated for individuals with diabetes, prediabetes, overweight, or obesity, or those with history of gestational diabetes

☒ No ☐ Yes

Zip Code

valid 5-digit zip code is needed to estimate social deprivation index [SDI]

☒ No ☐ Yes

Calculate

Reset

Does telehealth control blood pressure and glucose as well as usual care?

Kelly FA et al. The effect of telehealth on clinical outcomes in hypertension and diabetes. J Telemed Telecare 2024;31(10):1382-1400.

DESIGN

Meta-analysis of randomized controlled trials of telemonitoring-based care.

POPULATION

75 RCTs, 106,261 patients with hypertension and/or type 2 diabetes.

INTERVENTION

Telemonitoring-based care versus usual care, with disease-specific outcomes.

Limitations: High statistical heterogeneity (pools many platforms); intermediate outcomes, not events.

KEY FINDING

-4.9 mmHg

Mean systolic BP reduction versus usual care.

Also: HbA1c fell 0.42% versus usual care; effect rivals adding a second oral agent.

Bottom line: Virtual care is not a lesser substitute; it matches usual care on the numbers we track.

Does RPM paired with human coaching actually drive Stage 2 hypertension down?

Dennis L, Koyfman I. Effect of remote patient monitoring on stage 2 hypertension. Am J Manag Care 2025;31(9):e244-e248.

DESIGN

Quasi-experimental retrospective cohort over 12 months.

POPULATION

Community-dwelling Medicare patients, each assigned a nurse care coach.

INTERVENTION

RPM plus monthly nurse contact and ≥ 20 min care management per month.

KEY FINDING

75% drop

Share meeting Stage 2 criteria fell from 100% to 25%; mean BP 152/85 to 132/74.

Also: A real-world swing in a high-risk Medicare group over 12 months.

Bottom line: The technology brings the signal; human coaching drives the clinical outcome.

Disclosure & limits: Observational, single practice, no randomization. An author is affiliated with the RPM vendor used; selection/engagement effects likely inflate the effect.

Hypertension: the target, the pathway, and the highest-yield combination

TARGET & RISK TOOL (2025 AHA/ACC)

Treat to under 130/80 for most adults, as close to 120/80 as is safe. Use the PREVENT equation (adds kidney function and social drivers; drops race) in place of the Pooled Cohort Equations.

STAGE 1 (130-139 / 80-89)

Lifestyle first. Add medication if uncontrolled after 3-6 months, or now if CVD, diabetes, CKD, or PREVENT 10-yr risk $\geq 7.5\%$.

STAGE 2 (140/90 or higher)

Start two agents at once, ideally a single-pill combination (ACE/ARB plus a CCB or thiazide) to speed control and adherence.

NURSE-LED CARE WITH PRESCRIPTIVE AUTHORITY

Vay-Demouy 2025 (meta-analysis, 5 RCTs): systolic BP fell about 16.5 mmHg versus usual physician-led care. Effect is large but heterogeneity was high, so read it as direction plus mechanism, not a precise expected drop.

BUILT-IN EQUITY WARNING (FQHC PILOT)

In a pilot that was 65% Black and 33% Hispanic, missed transmission days rose with higher social deprivation scores.

Clinical pearl: HBPM is a diagnostic tool. ~20% have white-coat HTN. Protocol: AM & PM, seated, 5-min rest, 2 readings, 5-7 days before any change.

Diabetes: CGM moves management from a quarterly number to a daily picture

WHAT THE EVIDENCE SHOWS

A 2025 JMIR Diabetes systematic review found CGM in primary care expands time-in-range and lowers HbA1c, but requires dedicated staff for data interpretation and patient education.

WHO & WHAT IT DELIVERS

2026 ADA: insulin users and anyone at hypoglycemia risk, across children, adults, and pregnancy. Reliably adds roughly 1-2 hours of time-in-range per day. The biological benefit holds across income and education.

THE FRICTION IS COST & ACCESS

Uninsured: roughly \$160-\$500/month; with insurance often under \$40/month. Prior authorizations can paralyze workflows. Access, not biology, is the barrier.

SAFETY-NET ROADBLOCKS (JAMA NETWORK OPEN)

Qualitative studies flag insurance gaps, cost, and lack of clinician training. Build proactive formulary navigation and manufacturer-assistance enrollment directly into the workflow. A 2-week blinded professional CGM can reveal patterns without device ownership.

Clinical pearl: Spend 5 minutes on the ambulatory glucose profile with the patient, time-in-range and overnight lows, more actionable than HbA1c alone.

RPM disrupts the hospitalization cycle, even with low-tech tools

HEART FAILURE: the strongest signal

A 2026 systematic review and meta-analysis reported reduced all-cause mortality at moderate GRADE certainty (this specific mortality finding is from a preprint, so present it cautiously); hospitalization and quality-of-life benefits rest on peer-reviewed meta-analyses.

Actionable pearl: Pre-specify the trigger in your HF templates: call the nurse line if weight rises >3 lb in 24 hours or >5 lb in a week. Catches volume overload days before a crisis.

COPD: low-cost works

A 2025 RCT (Koksal, Int J Nurs Pract) of a 12-week telecounseling plus home-monitoring program cut readmissions by more than half, from a mean of 3.26 to 1.51, using printed tracking sheets, phone calls, and breathing exercises.

Scalable in FQHCs: This did not require expensive software. Brief, structured 10-15 minute nurse calls are entirely feasible in resource-limited settings.

Digital health does not mean high-tech. The intervention that works is structured human follow-up, delivered remotely.

Can ambient AI documentation reduce clinician burnout, and is it safe?

Olson KD et al. Use of ambient AI scribes to reduce administrative burden and clinician burnout. JAMA Netw Open 2025;8(10):e2534976.

DESIGN

Pre/post observational study over 30 days, multivariable adjusted.

POPULATION

263 ambulatory clinicians across 6 U.S. health systems.

INTERVENTION

Ambient AI scribe vs. each clinician's own baseline.

KEY FINDING

52% to 39%

Burnout fell from 51.9% to 38.8% in 30 days; adjusted odds about 74% lower (OR 0.26).

Limits: Self-report, no control group, 30-day window, volunteer adopters, no patient outcomes.

Bottom line: A strong burnout signal. Pilot it, keep human review, and audit accuracy across your patients' languages.

The accuracy guardrail (Ng 2025): A review of 29 studies found word error rates from 0.087 in clean dictation to over 50% with accented or multi-speaker speech. Some tools added editing burden.

Evidence at a glance: match your confidence to the data

TOOL	STRENGTH	WHAT IT RESTS ON
Telehealth for HTN & T2D	Strong	Kelly 2024: 75 RCTs; -4.9 mmHg SBP, -0.42% HbA1c.
Heart-failure RPM	Strong	Reduced hospitalization (peer-reviewed); mortality signal (preprint).
Nurse-led titration	Moderate	Vay-Demouy 2025: ~16.5 mmHg, high heterogeneity.
RPM at scale / underserved	Moderate	Koyfman 2025 (vendor-affiliated); Acharya 2024: -7.3 mmHg US trials, smaller in non-White cohorts.
CGM in primary care	Moderate	Improves time-in-range; needs staff and access support.
COPD telehealth	Moderate	Koksal 2025: readmissions 3.26 to 1.51.
Ambient AI scribes	Emerging	Olson 2025 burnout signal; Ng 2025: error up to >50%.

Synthesis of studies cited above. Sun et al., Lancet Digit Health 2024: 42% of pooled effects non-significant; little research in low-income settings, a caution on over-generalizing.

The financial case: prevention costs less than failure

~\$15K

average cost of a single 30-day hospital readmission (AHRQ HCUP).

\$1,200-1,500

annual Medicare RPM reimbursement per patient (device + care-management codes).

+\$2,500

higher annual medical cost per patient with uncontrolled hypertension.

The C-suite math

Avoid one 30-day readmission per patient per year and the RPM program pays for itself roughly 10 times over. Multiple cohorts report substantial reductions in 30-day readmissions and ED use for high-risk patients. Direction is consistent; effect sizes vary by program design.

Bring this slide to your CFO.

The codes that pay for care beyond the visit

CODE	PROGRAM	DESCRIPTION	2026 RATE
99490	CCM	Non-complex, clinical staff, first 20 min/month	\$66
G0556	APCM L1	1 or no chronic conditions, flat monthly	\$15/mo
G0557	APCM L2	2+ chronic conditions, serious risk	\$50/mo
G0558	APCM L3	2+ chronic conditions + QMB status	\$110/mo
99453	RPM	Device setup + patient education (once)	\$19
99454	RPM	Device supply + 16+ days of data / 30 days	\$56
99445	RPM (new)	Device supply + 2 to 15 days of data	\$47
99457	RPM	First 20 min care management / month	\$52
99470	RPM (new)	10-20 min treatment management	\$26

Rules that matter: APCM (highlighted) is the big 2026 win, a flat monthly rate, no minute-counting. You cannot bill APCM and CCM the same month, but APCM and RPM together is fine. CPT 99445 ends the old 16-day minimum. Medi-Cal covers RPM for established patients 21+.

From fee-for-service to outcome-aligned care: the CMS ACCESS Model

ACCESS = Advancing Chronic Care with Effective, Scalable Solutions. A voluntary 10-year CMS Innovation Center model, announced December 2025, beginning July 1, 2026. It pays recurring outcome-aligned payments, not fee-for-service per visit.

Outcome-aligned payments

Full payment contingent on hitting measurable targets (e.g., a set systolic BP reduction), not on visit counts.

Flexibility to scale

Waives the visit requirement, so RPM, asynchronous care, and digital tools can be the primary management path.

Four clinical tracks

Early cardio-kidney-metabolic; cardio-kidney-metabolic; musculoskeletal pain; and behavioral health.

Why it matters: This is the payment model the digital infrastructure you build today is designed to win under.

The one design choice that decides success or failure

Three additive layers

- 1 Monitor & connect**
RPM, video/audio visits, async touchpoints, eConsults.
- 2 Manage as a team**
Registry-driven, protocolized care takes the physician off the critical path.
- 3 Reach into community**
CHWs and trusted local partners extend care past the clinic door.

Programs that FAIL: those that route raw biometric alerts, billing tracking, and outreach into the PCP's inbox. They collapse under alert fatigue.

Programs that WORK: the provider-centered model. A dedicated care team owns consent, device setup, billing, outreach, and documentation. The physician only reviews a pre-processed message and adjusts the plan. MacIsaac 2026 (40 providers): 93% provider satisfaction.

Role clarity, not technology, sustains the program. MAs/CHWs onboard devices; RN coaches own alerts and titration; physicians act only on escalations.

Implementing RPM in primary care: a four-phase framework

PHASE 1	PHASE 2	PHASE 3	PHASE 4
Identify & stratify Use the EHR to flag the top 10-20% highest-risk: uncontrolled HTN, poorly controlled T2D, CHF, CKD.	Enroll & onboard FDA-cleared cellular devices (skip the Wi-Fi barrier). A loaner program boosts uptake. Onboard in the patient's language.	Workflow & team RN care coaches own alerts and coaching (~1 RN per 300-350 patients). Physicians review only escalations.	Bill & sustain The 16-day rule is gone: CPT 99445 covers 2-15 days. Consider APCM bundles or the ACCESS model. Track avoided readmissions.

Start small: pilot 10-20 patients, measure BP control at 90 days, and use that hard data to build the business case for scale.

What you can do Monday, and what your clinic can build

FOR THE BUSY CLINICIAN • no new tech

- 1 Standardize a written HBPM protocol sheet; review the log every visit. A \$30 validated cuff is all it takes.
- 2 Use nurses to full scope under standing titration orders, backed by the 2025 guideline.
- 3 Default canceled chronic-disease visits to same-day telehealth.
- 4 Do a 5-minute CGM walk-through: time-in-range and overnight lows.
- 5 Document HF weight-gain call-triggers in every care plan.

FOR FQHCS & RESOURCE-LIMITED SETTINGS

- 1 Design nurse-led standing-order sets for titration.
- 2 Launch a loaner-device program (NYU Langone: loaners raise RPM uptake).
- 3 Deploy cellular-enabled devices to bypass the broadband gap.
- 4 Embed CHWs as digital navigators, the most evidence-supported equity move.
- 5 Move LTBI monitoring to asynchronous Video Directly Observed Therapy.

A strong state foundation, and a federal reprieve through 2027

CALIFORNIA: strongest framework in the nation

AB 744 (2019): commercial payment parity. AB 32 (2023): made Medi-Cal flexibilities permanent, including audio-only, critical for non-English-speaking, elderly, and rural patients. Medi-Cal covers video, audio-only, store-and-forward, and RPM (established patients 21+ since 2021). \$233.6M is flowing to California under the federal Rural Health Transformation Program. This is why 20% of CA FQHC visits are now virtual.

FEDERAL: a reprieve, not a fix

The Consolidated Appropriations Act, 2026 extended Medicare telehealth flexibilities through December 31, 2027, preserving the home as an originating site, FQHCs as distant-site providers, and audio-only coverage. But it is an extension tied to funding bills, not permanence. Rural and older patients face the cliff first. Brief leadership now, document outcomes, and support the CONNECT for Health Act and Telehealth Modernization Act.

“If scaling widens the gap, it is not scaling. It is sorting.”

WHO IS LEFT BEHIND

Up to 40% of low-income U.S. households lack broadband. Older adults with low digital literacy, non-English speakers, and patients with disabilities are most at risk.

WHAT THE DATA SAYS

An npj Digital Medicine 2025 review of 119 RPM programs found equity reporting inconsistent and incomplete: we assume programs are equitable without measuring it. Khoong 2025 (JAMIA, CA safety net): non-English speakers worried about inconveniencing staff.

SIX DEFAULTS THAT OPERATIONALIZE EQUITY

- ✓ Offer devices at no cost (billable under RPM setup).
- ✓ Onboard in the patient's preferred language.
- ✓ Assign a navigator or CHW for low digital literacy.
- ✓ Offer audio-only check-ins as a real alternative, not a lesser one.
- ✓ Track enrollment demographics to catch disparate uptake.
- ✓ Audit AI tools by subgroup for bias before deployment.

What it looks like: a team-based RPM model

Maria, 58 (composite): uncontrolled HTN 158/96 · T2D HbA1c 9.2% · works two jobs · limited English · misses appointments.

THE OLD MODEL

Called for follow-up

↓ Misses appointment

↓ Conditions worsen silently

↓ **Preventable hospitalization**

THE NEW MODEL: TEAM-BASED RPM

1 IDENTIFY

Flagged via EHR as high-risk.

3 MONITOR

Readings transmit automatically; RN coach reviews daily.

5 TREAT

Physician adjusts meds via same-day telehealth.

2 ONBOARD

Bilingual navigator provides cellular cuff + glucometer.

4 INTERVENE

BP spikes to 172/104; coach calls within 2 hours.

6 RESULT

BP controlled within 6 weeks, no time off work.

Illustrative composite, not a real patient and no identifiers. Outcomes reflect programs of this design (AJMC 2025; Smith 2024 HTN cohort).

Five technologies primary care should prepare for now

1

Ambient AI scribes

Validated burnout reduction (Olson 2025). Deployable today, start your pilot now.

2

AI-integrated & closed-loop CGM

Moving beyond type 1; FDA-cleared CGMs now available over the counter.

3

Predictive risk stratification

EHR-based AI flags deterioration 30-90 days before crisis.

4

Wearable continuous BP

Cuffless 24/7 monitoring, not yet guideline-endorsed until accuracy is proven.

5

Hospital-at-Home

CMS-supported; RPM + telehealth replace inpatient stays for select diagnoses.

Equity guardrail: every AI tool requires validation across diverse populations and bias auditing before deployment.

What you can do this week, by role

CLINICIANS

- 1 Identify your top 50 highest-risk HTN and T2D patients via the EHR.
- 2 Standardize a written HBPM protocol and review logs every visit.
- 3 Request an RPM pilot; trial an ambient AI scribe for one week.

NURSES

- 1 Advocate for the RN care-coach role and standing-order titration.
- 2 Request a documentation-burden assessment.
- 3 Champion ambient AI adoption to reclaim patient time.

C-SUITE

- 1 Pull your 30-day readmission cost (HCUP or your own data).
- 2 Model RPM ROI; review APCM and the ACCESS model.
- 3 Approve a 6-month RPM pilot with 90-day BP control as the endpoint.

For everyone: use CTRC's free 2026 Digital Health for Chronic Disease Guide, the Sustainability Calculator, and no-cost TA. caltrc.org · (866) 498-6634.

The visit is the beginning, not the boundary.

The clinic is where care is planned. The community is where health is made.

- 1 Chronic disease is continuous, and the 2025/2026 guidelines agree: home monitoring is now central.
- 2 The evidence is real across hypertension, diabetes, COPD, heart failure, and LTBI, and the underserved benefit.
- 3 The model is team-based and provider-centered, and 2026 payment (APCM, RPM, ACCESS) finally pays for it.
- 4 Equity is a design choice. Start narrow this week: one condition, one population, one channel, one team, one 90-day metric.

Evidence base

TELEHEALTH, RPM & AI

Kelly FA et al. J Telemed Telecare 2024;31(10):1382.
Acharya S, Pokharel Y et al. Hypertension 2024;81(3):648.
Dennis L, Koyfman I. Am J Manag Care 2025;31(9):e244.
Olson KD et al. JAMA Netw Open 2025;8(10):e2534976.
Ng JJW et al. BMC Med Inform Decis Mak 2025;25:236.
Sun S et al. Lancet Digit Health 2024;6(11):e857.
Koksal N, Durgun H. Int J Nurs Pract 2025;31(3):e70021.
MacIsaac MF et al. Am J Med 2026.

GUIDELINES, POLICY & EQUITY

2025 AHA/ACC Hypertension Guideline. Circulation 2025.
ADA Standards of Care in Diabetes 2026. Diabetes Care 49(S1).
Vay-Demouy J et al. BMC Nurs 2025;24(1):763.
Porter J et al. J Gen Intern Med 2023;38(1):147.
CMS CY2026 Physician Fee Schedule; ACCESS Model (cms.gov).
Consolidated Appropriations Act 2026; AB 744; AB 32.
Abejirinde IOO et al. npj Digit Med 2025;8:320.
Khoong EC et al. JAMIA 2025;32(8):1276.

Latent TB: nurse-led telehealth outperforms the legacy model

SHORT-COURSE REGIMENS (Feb 2025 NSTC/NTCA GUIDE)

3HP: weekly rifapentine + isoniazid for 12 weeks. 4R: daily rifampin for 4 months. Both are strongly preferred over the legacy 9-month isoniazid regimen because they markedly improve completion rates.

WHY TELEHEALTH FITS

Short regimens pair perfectly with Video Directly Observed Therapy (VDOT), reimbursable under modern telehealth codes. Nurses can check adherence and screen for hepatotoxicity without a weekly clinic trip.

The equity case

VDOT removes the requirement that a low-wage worker take a bus to the clinic every week for observed dosing.

Asynchronous check-ins let the care team monitor adherence and side effects between visits, exactly the workflow short-course LTBI treatment needs.

What we still do not know, and why that matters

Hard endpoints in safety-net populations

We lack long-term RCT data on MI, stroke, and mortality from RPM run exclusively in FQHC or Medicaid populations.

Sustained engagement

High short-term engagement is followed by dropout; no validated strategy for maintaining RPM use over 1-2 years.

EHR integration & alert fatigue

Integrating continuous data without overwhelming clinicians is unsolved; ambiguous clinical responsibility persists.

Equity measurement

We need validated tools to prospectively measure equity progress, not assume it.

Behavioral health & adherence

Integrated behavioral-health RPM is understudied; reminder-only adherence tools underperform tailored ones.

Abejirinde IOO et al., npj Digit Med 2025; Claggett J et al., J Med Internet Res 2024;26:e51234; Moon Z & Walsh J, Front Pharmacol 2025.



Questions?

Ongoing Support



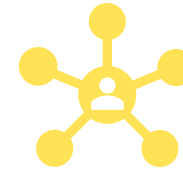
TECHNOLOGY ADVANCES

The technology continues to advance and the evidence base grows.



CONNECT WITH US

Shoot us an email, join us for a webinar, give us a call, visit the website, or even better, sign up for our newsletter to ensure you are informed on updates, events and opportunities.



OUR RESOURCES

DIY kind of person? We have numerous resources and a reliable network to get your answer. We're federally funded so our information and resources are at your disposal.



THE CTRC

CTRC is committed to advancing equitable and sustainable access to our communities via the adoption of digital health services.

INTRODUCING THE 2026 AI COHORT

VIRTUAL SERIES WITH AVAILABLE OFFICE HOURS | NO-COST REGISTRATION



SESSION 1

June 24 | 1:00 pm
CTRC Summit

Trust Is Built, Not Bought: Making AI Safe and Defensible in Clinical Care

SESSION 2

June 24 | 3:00 pm
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Clinical AI That Delivers: Evidence, Workflow Fit, and What Actually Changes Care

SESSION 3

June 24 | 4:00 pm
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From Promise to Practice: Preparing Care Teams for Generative AI in the Next Year

SESSION 4

July 29 | 2:00pm

AI Scribes in Action: Real-World Lessons from a Practicing Physician
Yimdriuska Magan, MD, MPH

SESSION 5

Coming Soon

Harnessing AI to Advance Maternal Health Outcomes
Melissa Wong, MD, MHDS

SESSION 6

Coming Soon

From Policy to Practice: Designing an Effective AI Governance Strategy
Maria Liu, Healthcare VP

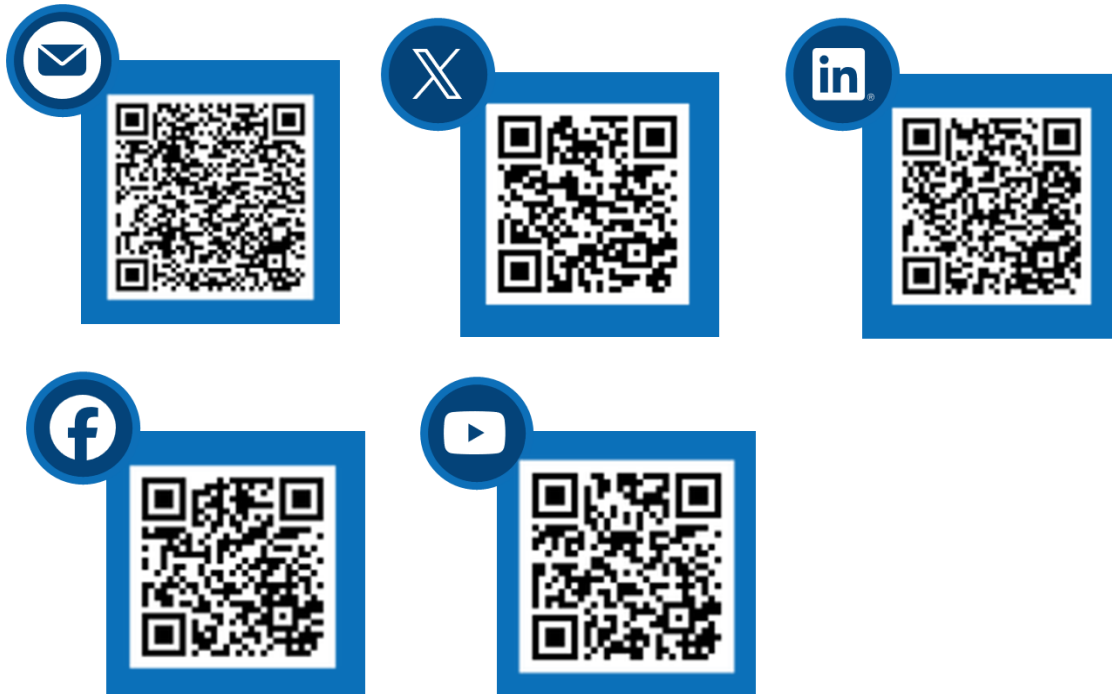
Scan the QR Code or visit HealthcareAIbootcamp.org



We value your input!
Please take a quick minute to complete our exit poll.

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