Welcome to the

California Telehealth Resource Center 14th Annual Digital Health Summit

Bridging the Gap. Smarter Care for Sustainable Futures.

Building What Lasts: Rural Digital Health Sustainability in Practice

Lily Lau, PhD, CSRHA President-Elect, CEO Momentous Health
Martin Entwistle, MBA, MB, ChB, FRCSEd, Chief of Medical Affairs at Marshall Medical Center
Emilia Ochoa-Ruiz, MS, PMP, Manager and PI, CTRC

2:00 – 2:45pm (PT)

Disclaimer

This session is purely for informational purposes.

The California Telehealth Resource Center has no relevant financial interest, arrangement, or affiliation with any organizations related to commercial products or services discussed during the Summit.

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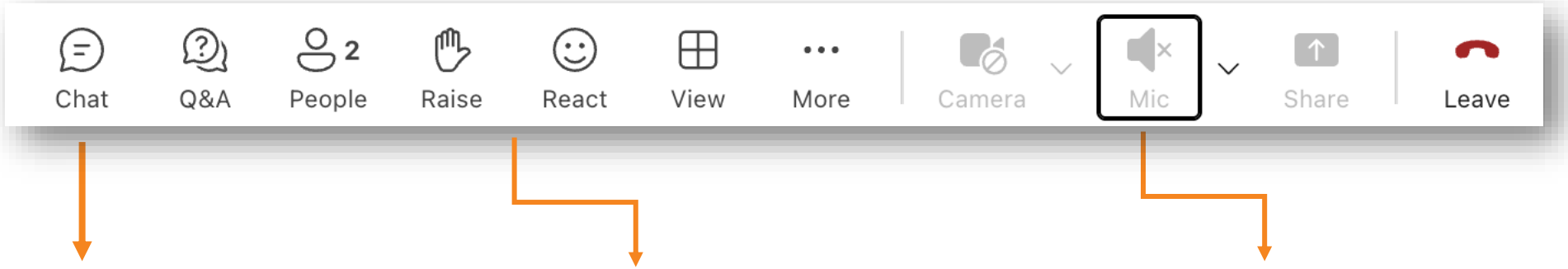
Summit Sessions

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.

Building What Lasts: Rural Digital Health Sustainability in Practice

Meet Your Presenters

Martin Entwistle, MBA, MB, ChB, FRCSEd

Chief of Medical Affairs, Marshall Medical Center

Lily Lau, PhD

CSRHA President, CEO Momentous Health

Emilia Ochoa-Ruiz, MS, PMP

Manager and Principal Investigator, CTRC

A Statewide View on Rural Digital Health Sustainability

Why rural California is forced to modernize — and what makes it actually last.

Lily Lau, PhD
President-Elect, Board of Directors, California State Rural Health Association
Chief Executive Officer, Momentous Health

You Can't Recruit Your Way Out

#1

California leads the nation in primary care shortage areas — and rural counties carry the worst of it.

HRSA, Dec. 2025

Specialists are scarcer still. Across rural California — from the far north to the Central Valley to the Inland Empire — many areas have no specialists at all, so patients lean on their primary care providers for conditions a cardiologist, urologist, or rheumatologist would normally manage. PCPs end up absorbing specialty load they aren't resourced for.

California Health Care Foundation, 2025; California Healthline, 2025

And it's worsening, not stabilizing. The pipeline takes years and keeps losing ground — one rural county health officer has declared the workforce situation a public health crisis. You cannot recruit your way out, which is what forces the turn to digital care.

“By the time we recruit a new doctor, another one is retiring.” — Mike Wiltermood, CEO, Enloe Medical Center (Chico)

The Distance You Can't Close

2–4 hours to the nearest provider

For many services, there's no local option at any distance.

It isn't only too few providers — it's distance.

Rural patients routinely drive hours for care that should be close to home. For many specialties, there's no local option at any distance.

One Humboldt County patient drove 520 miles round-trip to UCSF for a colonoscopy — and three hours each way for eye surgery, then waited three weeks before it was safe to drive home.

California Health Care Foundation, 2025

A Plumas County mother drove 100 miles in active labor, passing two hospitals whose maternity wards had closed.

CalMatters, 2025

Lose the Care, Lose the Revenue

50%

of California's rural hospitals now operate in the red — up from 40% in 2019.

California Hospital Association, 2025

1 in 4

of California's rural hospitals are at risk of closing — the end state of the revenue spiral.

CHQPR via Becker's Hospital Review, 2026

When patients leave, the revenue leaves with them — and rural hospitals can't sustain services on what's left. The result is visible across California: 17% of rural hospitals have ended obstetrics, 40% have dropped chemotherapy. Digital health is how you reverse the spiral — keep the care, and the revenue, local.

THE PROMISE

What Digital Health Promises

Create access that wasn't there

For many rural patients, some care isn't available locally at any distance. Digital health makes it reachable — and extends the team you already have.

Erase distance

Reach patients where they are, instead of asking them to drive hours for routine and specialty care.

Keep care & revenue local

Offer modern care at home so patients — and their revenue — stay in the community.

Digital health answers all three forces directly. That's the promise. The problem is it so often doesn't deliver.

THE PIVOT

Same technology.

Why does it stabilize one provider and burden another?

A lifeline — care and revenue stay local.

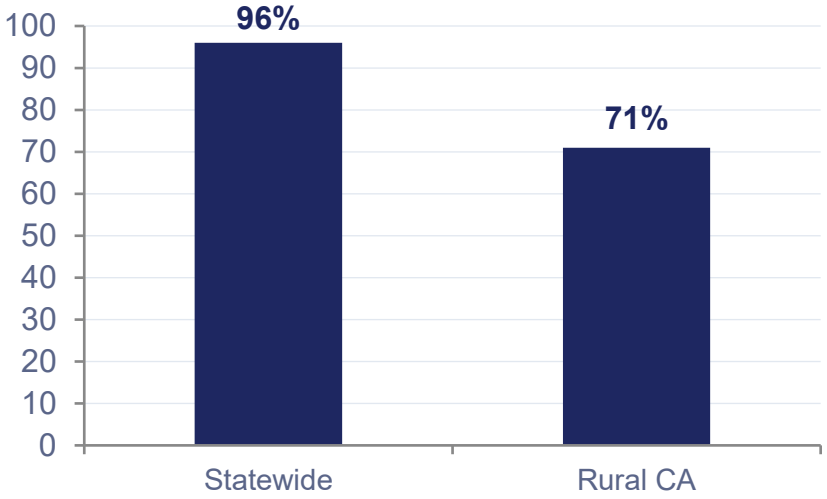
An expensive tool nobody uses — quietly disappears.

The difference isn't the technology — it's whether four things are true: a way to connect, someone to run it, someone to use it, and a way to pay.

WHY IT FAILS

No Way to Connect

Rural CA broadband at home vs. statewide



**Rural broadband at home has not improved since 2019, even as the state invested billions.*

PPIC, 2025

No signal

Only ~71% of rural households have broadband at home, versus ~96% statewide. You can't deliver virtual care over a connection that isn't there.

PPIC, 2025

Can't afford it

Where the wire exists, cost is the top barrier — $70–80/month puts a reliable connection out of reach for many rural households.

UC Riverside, 2026

And even with a perfect connection, three more things quietly kill the program.

WHY IT FAILS

No One Runs It · No One Uses It

No one runs it

No champion owns it, and there's no IT or trained staff to keep it running — credentialing, scheduling, and day-to-day operations fall to whoever has time.

When that person leaves, it collapses.

No one uses it

Not integrated into how care actually flows — so clinicians work around it and patients never use it.

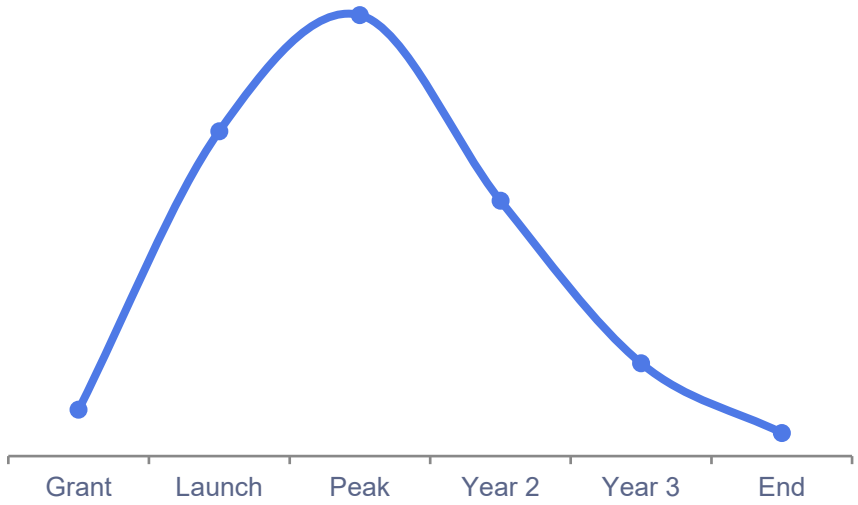
A tool nobody reaches for quietly fades.

Both are about people, not technology — and both are fixable by design.

WHY IT FAILS

No Way to Pay

The typical pilot lifecycle



Rural reimbursement is too thin to cover the cost, so programs lean on grants to survive — and die when the grant ends.

A pilot that can't outlive its grant was a demo, not a program.

THE LENS

The Shift: From Tools to Infrastructure for Survival

Four failures, four fixes: connect it, staff it, embed it, fund it.

A connection you provide

- Furnish the link directly (tablet or plan)
- Anchor sites: clinics, libraries, schools
- Mobile units and hotspots to the home

A real team to run it

- A named champion who owns it
- Local staff trained to deliver it
- IT support to keep it running

Wired into real workflows

- Built into how care already flows
- Part of the visit, not a separate task
- Easy enough that people choose it

A path to pay for itself

- Bill what reimburses well (e.g. mental health)
- Pool patients across clinics for volume
- Use grants to launch it — setup, not ongoing bills

AND A CONNECTED SYSTEM

None of these survives alone — they only hold together as one connected system. The tool is the easy part; the system around it is what lasts.

What lasts isn't the technology you buy.
It's the system you build around it.

Durability comes from the staffing, the connectivity, the workflows, and the financial model — not the platform.

Marshall Medical is one system building exactly that. ***Dr. Entwistle****, take us inside it.*

The Need: Rural Health Services

- **Provide care in the community to the extent possible**
  - Access to local specialist out-patient services
  - Share care even when referral out is required
  - Utilize local ancillary and support services
- **Shift from episodic care to continuous engagement with patients**
  - Expand tele-health and remote patient management services
  - Flexibility over site of service
  - Reimbursement models that provide financial sustainability
- **Sustainable staffing models**
  - Recruitment and retention of providers
  - Training and career pathways for staff

MARSHALL

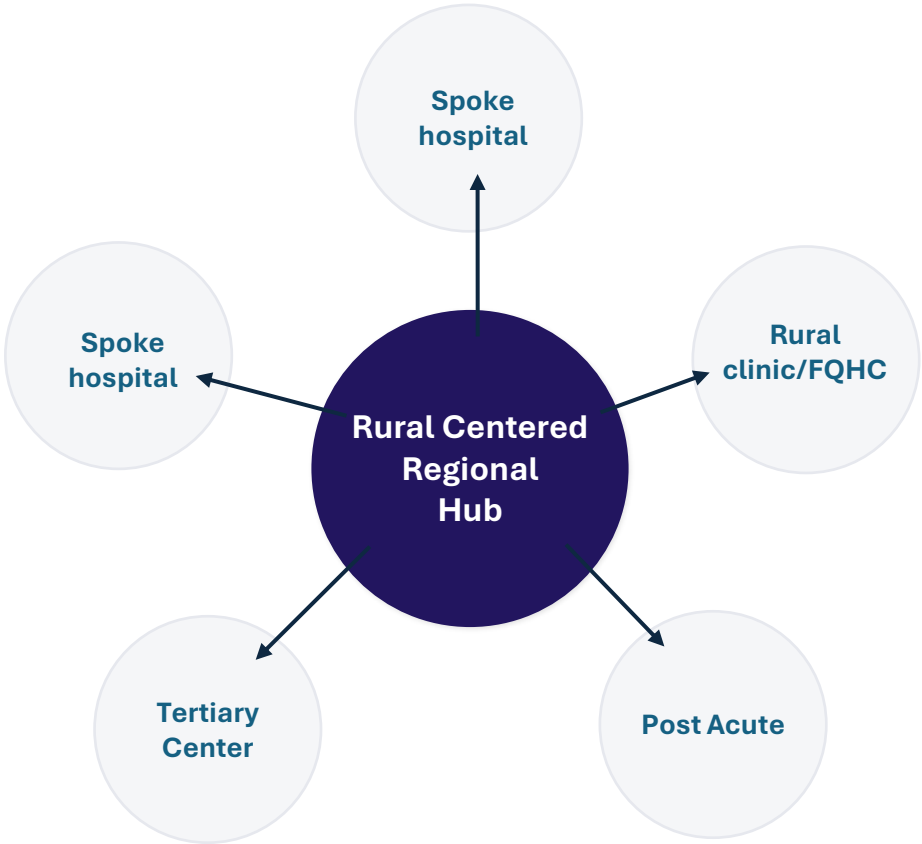
The Challenge: Rural Health Services

- **Limitation of skills and capacity**
  - Providers and staff – recruitment and retention
- **Limitations with technology**
  - Connectivity improved but some limitations remain
  - Techno-scepticism
  - Device deployment – who pays, who supports?
- **Tertiary care relationships are key, but…..**
  - Understanding and meeting rural healthcare needs
  - Patient capture
- **Limitations of funding and investment**
  - Reimbursement rates, new service development and infrastructure
- **Consequences**
  - Drives transfers and follow-up out of the community, plus lost ancillary services
  - Limits ability to coordinated care and deliver effective remote patient management

MARSHALL

The Solution: Rural Health Network ("Hub-and-Spoke" Model)

A coordinated regional network that expands specialty access while strengthening local capacity and retains patients in local communities



Core Capabilities

- Central referral + intake coordination
- Tele-specialty visits (scheduled + rapid access blocks)
- eConsults for PCPs and ED clinicians
- Remote monitoring to prevent avoidable ED/hospital use
- Standard escalation pathways to tertiary partners
- Shared quality, equity, and performance reporting

MARSHALL

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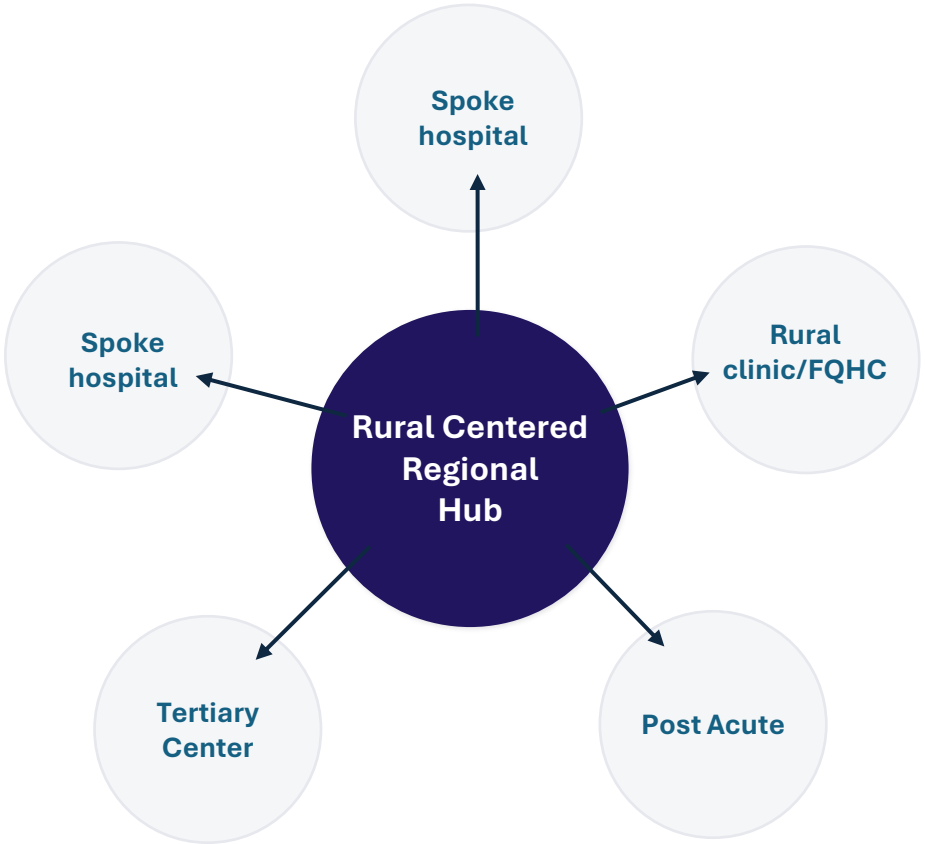


5 Year Vision

A scalable, technology-enabled rural care model that improves access, equity, outcomes, and financial sustainability:

- Standardized workflows
- Interoperable data systems
- Expanded specialty access
- Workforce development for training, recruitment and retention
- Advanced use of technology with AI-enabled data management
- Playbook for statewide replication

MARSHALL

Rural Network – Building Blocks

- **Marshall completed digital health assessment in 2025** (ReCast + CTRC)
  - Technical readiness (EHR, informatics, reporting)
  - Workflow, staffing, and revenue-cycle optimization readiness
- **Established partnerships**
  - Sierra Health Collaborative (Sierra Foothills providers 5 in California, 1 in Nevada)
  - Local FQHC, Tribal Health and County services
- **Established multi-disciplinary support teams**
  - Tele-health, RPM, AI and care coordination capabilities
- **Pilot programs**
  - FQHC partnership for behavioral health services
  - RHC digital health pilot to address social needs
- **Population level clinical care delivery**
  - Successful ACO participation helping achieve national-level outcomes

MARSHALL

Rural Network – Building Blocks

Four pillars create a durable network:

Governance

- Steering committee
- Clinical council
- Data-sharing norms
- Change control

Clinical Programs

- Specialty service lines
- Escalation pathways
- Coverage schedules
- Quality protocols

Operations

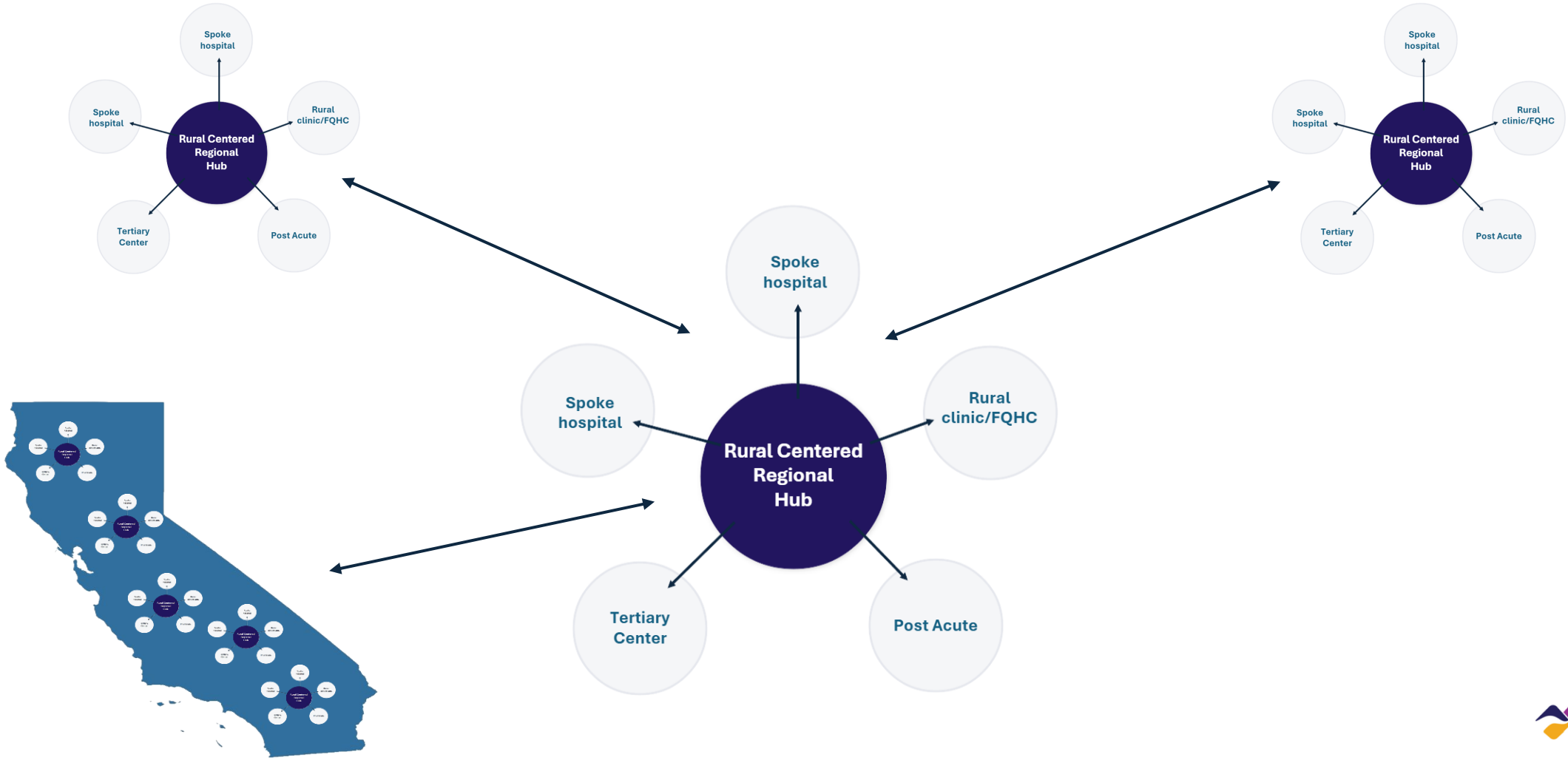
- Central intake
- Patient navigation
- Credentialing
- Training + support

Technology + data

- Telehealth platform
- eConsult workflows
- RPM devices + staffing
- Dashboards + reporting

MARSHALL

Scalability – A State-wide Rural Network



The Fit with CalRHT

- CalRHT (California RHTP, managed by HCAI), is designed to strengthen health care delivery in rural communities

- The program has five pillars designed to address access challenges, workforce shortages, and infrastructure gaps create unique barriers to care:
  - Sustainable access
  - Workforce development
  - Innovative care models,
  - Technology innovation
  - Connectivity

GET INVOLVED

Cal RHTP Partnership Pathway Assessment Webinar

A new statewide effort from the Rural Connection Coalition — CSRHA · CHA · CPCA

A free webinar featuring an assessment to help rural hospitals, health centers, clinics, Critical Access Hospitals, and Tribal entities find partners and build proposals for upcoming Cal RHTP funding.

WHEN

Wednesday, July 1, 2026
9:00 – 10:00 a.m. PT

REGISTER

https://calhospital.org/cal-rhtp-partnership-web/

California State Rural Health Association

California Hospital Association

California Primary Care Association

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
CTRC Summit

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

SESSION 3
June 24 | 4:00 pm
CTRC Summit

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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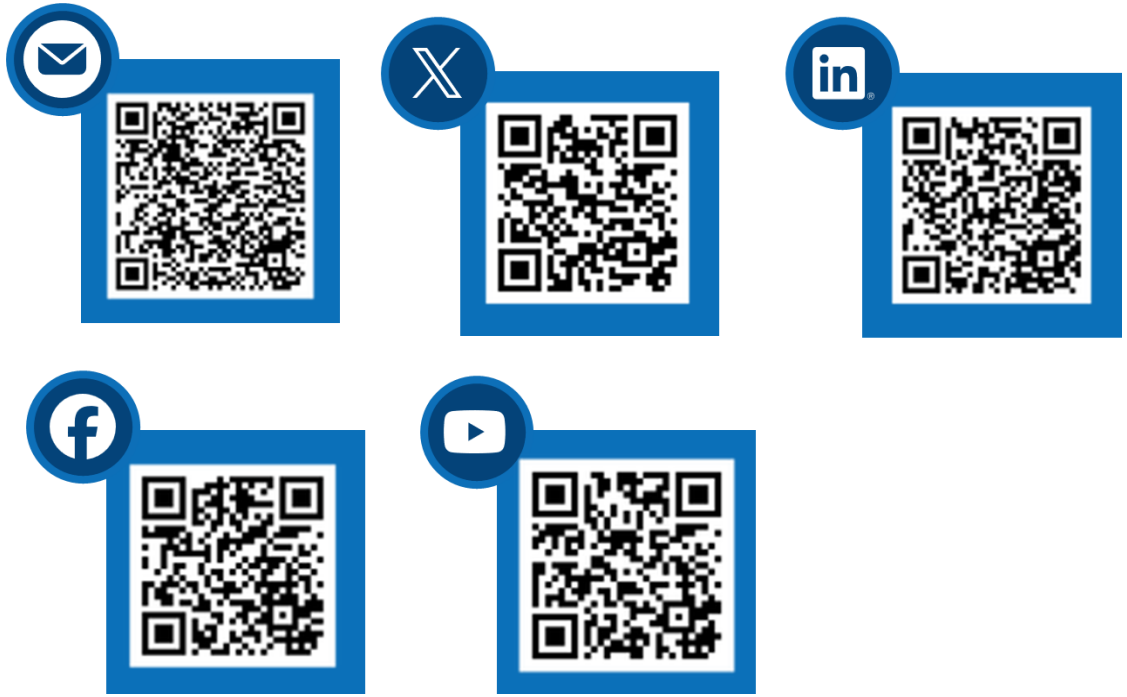
Stay **Connected**



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Thank **You**

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