Live Captioning by AI-Media SPEAKER: Recording in progress. ARIA JAVIDAN: Hello, my name is Arianna Java done, I am the product manager for the National Consortium of telehealth resource centres. Welcome to the latest session in the series. Today's session is on 'Bridging the Gap: Innovations in Telebehavioral Health Access'. It is hosted by the Southwest telehealth resource Centre. These ribs -- webinars are designed to provide timely information to support and guide the development of your telehealth programs. Just to provide a bit of a background around the construction located throughout the country full sub there are 12 regional telehealth resource centres and to national. One focus on telehealth policy and the other on telehealth technology. Each service focal points for advancing the effective use of telehealth and supporting use it to access to hell it -- telehealth and rural and underserved communities. A few housekeeping tubes before we get started. Your audio has been muted for today's webinar. Please use the Q&A function of the zoom platform to ask questions. Questions will be answered at the end of the presentation. Please only use the chat for communicating issues with technology or communication access issues. Please refrain using the chat feature to ask questions or make comments. Please note that closed captioning is available and that is located at the bottom of your screen. Today's webinar is also being recorded and you will be able to access today's and past webinars on the NCTRC YouTube channel and the and CTC RC website at (unknown name).org. With that, I will pass it over to today's moderator, Tara Sklar. TARA SKLAR: Thank you so much, Aria. Hi, my name is Tara Sklar, and I work with both the Southwest telehealth resource Centre and the (unknown name) program. Where I advise on telehealth law and policy will stop I am also the faculty director of the health law and policy program at the University of Arizona, (unknown name) College of Law where I teach a course of telehealth on policy. So, I required my students who are in the course right now to attend today's session. I am really glad to see many of them here. We are very fortunate to have three nationally recognized panelist today including Ms. Theresa Langley, Dr. Sara Gibson, and Dr. Jay Shore. But we will be discussing a wide range of tele-behaviour held across the country in areas of belong policy, prescribing of controlled substances, innovations happening in the field. Particularly, the Southwest. And then along with that, implications and the growth with AI. And at the core of a lot of these issues, how to better ensure equitable access to this essential healthcare service. Especially given the digital divide. So, the general flow for the day is -- as Aria mentioned, anytime you have a question, please use the Q&A. I will be monitoring it very closely and really do plan to incorporate your questions into today's webinar. If not, we will try to get to them after via email. Before I introduce our first panelist, I just want to also acknowledge the Southwest telehealth resource Centre. Which was created to advance the

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effective use of telehealth throughout this out the West including Arizona, Colorado, New Mexico, and Nevada. The Southwest telehealth resource Centre startups are just beginning at telehealth program to those of further along in the development across a range of areas including technology, policy, evaluation, and forming community partnerships. So with that, our first panelist, Ms. Theresa Langley, will really do a, I think, I mean I saw her slides. So, she will do a great job! Just laying out the regulatory landscape in this area and she is senior counsel at the national law firm, (unknown name), based in Houston, Texas. Her practice focuses on health law where she advises hospital systems, physician groups, mental health providers, on a variety of state and federal regulations including fraud abuse, Medicare, Medicaid enrolment and reimbursement, confidentiality of health information, and I am -- addictively relevant to today's webinar, the changing regulatory landscapes earning the provision of telehealth and telemedicine services. So with that, I will turn it over to Ms. Theresa Langley to present her site and then we will do a bit of a Q&A. THERESA LANGLEY: Thank you, Tara. I appreciate that introduction. let's get my slides going here. TARA SKLAR: Yes, thank you. THERESA LANGLEY: I will give you an overview of the legal background, specifically legislation and reimbursement roles that I have developed -- that have been developed since the 2019 pandemic. Before the pandemic, telehealth was relatively uncommon for many reasons. There was a lack of federal and state legislation. Addressing telehealth. There was limited reimbursement on the government and commercial level. And for Medicare, specifically, reimbursement was limited to only patients located in rural areas. And a specific type of medical facility, like a nursing home. So, the pandemic led to a huge explosion in the use of telehealth. Just to give you an example, there is a national study done and it showed that telemedicine encounters from the time. Up March to June 2019, so that was the first three months of the pandemic, telemedicine encounters increased 766% during that time period. That was in an increase from .3% of all healthcare interactions in telemedicine to 23.6%. Of all interactions being virtual or via telehealth. So, huge explosion! Expansion during this time was due to federal and state waivers that relaxed restrictions that were previously in place. And expanding reimbursement. So, flexibilities that were put in place during the pandemic expanded the locations where virtual care could be provided, the types of services that could be provided virtually, and the types of providers who were allowed to do that. The goal with this was to alleviate pressure on the healthcare system that was obviously overburdened and also allow patients access to care without, you know, requiring them to expose themselves. If it was not necessary. So, the federal public health emergency officially ended on May 11, 2023. But the flexibilities put in place during that time, a lot of them have been extended. And (indiscernible). So, here are some

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legislation that was passed during and beginning with the pandemic. I will get some background on how telehealth was expanded during this time. So, in January 2020, HHS Sec. (unknown name) declared a public health emergency. In March 2020, Pres. Trump declared a national state of emergency under the Stanford act. So, those two things in tandem allowed HHS and CMS the authority to issue a bunch of federal and state waivers. So, they did that. They allowed licensure practice across state lines, they expanded Medicare coverage, and they permitted discretion and endorsement. So, there are a series of bills that were passed that you can see here. And so, to touch on those, the coronavirus preparedness and response act of 2020 granted agents discretion to issue those waivers. -- HHS. And it made the Medicare restrictions that I was talking about. So, telehealth was no longer restricted to only rural sites and only very specific locations. Most recently, the consolidated appropriations act of 2023 extended a lot of the flexibilities put in place and it also removed the geographic restrictions and extended those through December 31, 2024. So, Medicare reimbursement is really important and did that is because a lot of state Medicaid and commercial will just follow kind of wherever Medicare leads. So, Medicare is setting the (indiscernible) for how a lot of things are handled. So, some temporary Medicare changes that were put in place through December 31, 2024, patients can continue to receive telehealth at any location, including at their home. They do not have to be in a rural area or in a day specific -- at a specific site. And there are no geographic restrictions. Telehealth services can be provided by all providers were eligible to build Medicare for professional services. And then finally, specifically for behavioural, the in-person visit requirement where you have to do that in person visit within six months after that initial telehealth visit and then annually after that is not required. Note that that requirement will go back into place after December 31, 2024. If these extensions are not continued forward. And then there are Medicare permanent changes that are really significant for the tele-behavioural space. So permanently, providers can provide behavioural telehealth services with no geographic restrictions on the patient's location. Again, the patient does not have to be in a rural area, in a specific facility for so they can be located at home or elsewhere. Behavioural telehealth services can be provided via audio only. So, that is kind of special. That is not something that is consistent for a lot of other services. Mental health counsellors and marriage family therapist have been added as eligible practitioners to go. And then SQ HC's and RHC's can serve as distant site providers for behavioural telehealth services. These are permanent changes that are in place, they will not aspire in December, 2024. So, you can see the Medicare it telehealth services from the Medicare physician, the schedule listed on the link here. There are a couple of new codes that were added for 2024 that may be relevant for the

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behavioural help providers. One of them is on a permanent basis, the social determinants of health risk assessment has been added. So, there is a code for that. And then on a temporary basis, health and well-being coaching services have been added. So, those two codes are there. State Medicaid reimbursement, again, often this will track Medicare requirements. States do have some flexibility in paying for telehealth services with Medicaid. So, you have to pay close attention to the state statutes. With the Medicaid program and the state manuals. You can see what states requirements are from their approved state plan amendments. Commercial, again, that will vary by private plan. And they could possibly have specific requirements for that pair on how to build, what modalities are required for telehealth, cost sharing requirements, prior authorization requirements, so it is important to look at the provider agreement and the provider manual to see what is available for telehealth. So, this is really important. For reimbursement. The mental health parity and addiction equity act, this is a federal law that prevents group health plans and health insurers from restricting mental health or substance use disorder benefits. More than it would be for medical or surgical services. So, there is an equity requirement if these plans are going to provide mental health or substance use disorder benefits, they need to be doing that on the same level as they are providing medical and surgical benefits. So, this does really apply to most plans because that would only applies to plans -- though it only provides to plans that provide those mental health and SDE benefits, plans are generally required to. Because this is an essential benefit under the Affordable Care Act. There are exceptions. So you can see here, listed self-insured, government and private employers that have 50 or fewer employees. Are exempt. And also, group health plans and issuers that have a cost increase, there is an exemption available for the next year. But it only lasts for that year and then the requirements go back into place. So, another really important area is prescription. And specifically, for controlled substances. So generally, the Ryan height act requires that there be an in person medical evaluation before provider issues a prescription for a controlled substance. That is the baseline rule. During the PHE, there is an exception that allows providers to prescribe controlled substances without first having the in person medical examination. If certain requirements are met. So, the video needs -- meeting needs to be during asynchronous audiovideo interaction and it needs to be for a legitimate purpose by a provider who is acting in their professional practice. This exception has been the extended through December 31, 2024. So, this is still in place. What we have yet to see, what, you know, further extension or flexibility will be developed here. Notably, the DEA is supposed to put in place a registration process. For telehealth providers to be able to sign up and issue prescriptions via telehealth. But that has been pending and they have yet to issue proposed

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rules on what that looks like. Another really important kind of legal compliance area is privacy and HIPAA, so the… Needs to comply with the state laws. The office of civil rights to have a. But during the public health emergency where they issued a discretion. So, providers were providing services during that time. They were able to use noncompliant platforms. So, providers were used to using scape -- Skype, FaceTime, chat with patients. That period has ended. Since 2023. So, now providers do need to be using HIPAA compliant platforms. There are listed here are some offenders who certify that they are HIPAA compliant and they will enter into BAA. This may require some updates to policies and educations to providers. A lot of providers started using telehealth during the pandemic. And they were used to those flexibilities that were in place. They may be used to jumping on the phone and using whatever app is available that they would normally use. And not be aware that, you know, there is a more formal requirements in place now. There also is issued guidance on audio only telehealth, and that is particularly relevant for the behavioural helps space because those behavioural helps services are some of the only ones that Medicare will reimburse. On an audio only level. So, just making sure that providers are interacting in a private setting using a low voice. Identifying the patient and document how they are using the safeguards in the EHR. OK, so that is the end of my slides. So, Tara, I can hit it -- hand it back to you for any questions. TARA SKLAR: Great, thank you very much, Theresa. I think you did such a nice job setting the stage with where we currently are at this point, on June 12. We do not know quite what will happen in December, 2024. So with that in mind, we are giving this changing landscape that many have described as also in uncertain landscape, particularly with reimbursement. What are some of the best practices that you recommend for those of us on the call that have provided tele-behavioural services are want to know how they would do so if there practice currently does not do that and they are wary of what to do given all of the changing laws and policies. THERESA LANGLEY: Definitely. So, I think there are some best practices we can talk about that really are consistent across provider types and across clinical settings. So, one of them is licensure. Generally, the provider must be licensed in the state where the patient is located. That will be across the board. There are some exceptions to this. So, there are certain state exceptions where, you know, maybe the patient is troubling. For a specific period of time. And where it would be permitted to care for them. But generally, this is the rule that needs to be followed. The provider needs to be licensed where the patient is located. There are some options for Park -- flexible pathways. For example, there is licensure compacts and there are multiple depending on what type of provider. So, there is the interstate medical licensure compacts for physicians. So, providers can apply and gain access to licensure in multiple different states through that venue. There are also

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some states that have kind of expedited telehealth registration process. That is faster than going through the normal licensure process where you do still have to apply and submit all of your materials. But they will expedited and rely on your licensure. In the other states. Also, it is important to note for telehealth providers, they are subject to the same standard of care and the same kind of documentation requirements as they would be if they were meeting with a patient in person. I think this is really important, especially in the area, kind of of compliance and enforcement. There are certainly telemedicine companies out there that are trying to contract with providers and encourage them to issue prescriptions, or order medical devices, you know, testing. When they have not really evaluated the patient or know the patient in a sufficient way to meet the standard of care and shown that necessity. So, it is really important to make sure that, you know, you are still meeting the same kind of standard of care expectations and documenting how that is happening. In the medical record. Informed consent is super important as well. So, when you get informed consent from telehealth services, you want to incorporate some language, making sure the patient is consenting to, like, the services being provided virtually. And the platform. This could incorporate some language like, you know, the patient recognizes there could be connectivity or technological issues and they may need to reconnect. Depending on the situation. Just making sure that they agree and understand that this is not just the care they are consenting to, but also that it is being provided virtually. And then, you know, telehealth providers are restricted by their spoken practice and or licensing board in each state. That will be the same as it would be an in person services. So, really, the telehealth requirements, they are not letting providers to -- do more than their scope of practice will stop they are not letting providers do less as far as standard care and necessity. Finally, telehealth providers should be aware and knowledgeable about professional liability rests in coverage. When you are practising on a national level, it is important to know the states really do vary on this. For example, Texas has a medical non-practice coverage caps, so liability is really (indiscernible). That will not be the case of your practice in other states. So, that is kind of the high points I would touch on. That we want to keep in mind for compliance purposes. TARA SKLAR: Thank you. You covered a lot of ground there. As you are speaking, we have actually gotten some questions from the audience. Including comments and excellent speakers. I wanted to pass that on. One of the questions is, and I think we see this a lot with psychiatry in particular, but for self-pay patients, they want to know, would there be any issues with the requirements and flexabilities that you have been describing for reimbursement for some pay patients who do not use insurance? Any thoughts on that? THERESA LANGLEY: Yes, definitely. I will say there is a lot more flex ability for self-pay

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patients because they are not subject to the requirements for government reimbursement requirements or commercial payor requirements. So really, for self-pay patients, what the provider needs to be observing is the law of the state. So, what does that state define telehealth as? What modalities are required based on state law? And then it is pretty open ended, for a lot of states, there may not be really specific restrictions on that. There is a lot more flexibility on what you can do. Again, there should be good documentation and support for how that service is meeting the standard of care and showing medical necessity just from a professional practice standpoint. But there is not kind of the same rules and restrictions around what you need approved to get that reimbursement. TARA SKLAR: That is great. I think for those of you on the call, I know you are from all across the country. Telehealth resource Centre are kind of like a Centre for connected health policy. CCHP, if you go to their website, you can click on your state and see specifically how telehealth is defined. Which might help you in getting some of the points Theresa was describing. It does vary by state. Our last question, actually revolves around the issue of the round paid act and what might happen at the end of December. They are asking, you know, for controlled substance, something that can be very, you know, commonly used for ADHD in particular. You know, what could happen at the end of December if the act returns, they will only be able to prescribe these medications if -- in person or what it be something we would do, in person, but then after that you can virtually prescribe? I know there is so much confusion and the DA has not quite waiting yet, so what is your thoughts in that area? THERESA LANGLEY: This is up in the air. Because we have been waiting for a while under pandemic exceptions. So, we really are trying to wait to see what the proposed rules are from the DAA on what they want this to look like next. And the industry, I think, has spoken. And is expecting them to provide some level of flexibility permanently moving forward. Something they are supposed to do under legislation is put in place this telehealth registration process. So, that is something we are looking out for. But you know, I think it is to be foreseen. But if we were to go back to, you know, non exception land, then the requirement for an in person meeting with the patient for you issue prescription, will be reinstated. TARA SKLAR: Thank you so much for a wonderful presentation in answering these questions. I hope you are able to stay on for the rest of our panel -- Panelists, and I think at the end, we might come back to looking ahead, how can we ensure to be compliant with Tele behavioural health services. So, they so much, Theresa. Oh, go ahead. I will now introduce our next panelist, Dr. Sara Gibson full so she will prevent -- present on a range of innovations she has been seeing from Tele behavioural health from the perspective of Blue Cross Arizona. Dr. Sara Gibson is a psychiatrist, medical director of telemedicine, Blue Cross (unknown name), which is in

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Flagstaff, Arizona. She sees the narrow -- narrow sense… For mental and physical health care systems. Clinical the, she has provided comprehensive psychiatric services to (unknown name) County. Telemedicine for nearly 30 years. Including 23,000 direct patient services over that time. We very much appreciate you joining us today, Dr. Gibson. To show your passion about providing high-quality, holistic, and timely medical care to underserved persons and places. Take you so much! DR. SARA GIBSON: Thank you. Yes. We have been around the block a little bit in behavioural and in rural behavioural, especially in Arizona. So, just briefly -- the briefest background. What we were looking at, almost 30 years ago. When some of us rural behavioural Health providers started trying to figure out some solutions and figure that out quickly. For example, here is the state of Arizona. And we were looking at almost 2/3 of Arizona's square footage area. But only a population of 11% of Arizona. So, they were large, large, large, distances. With very few people. So, we could be supporting full time. Psychiatrist at the time. And so, we dove into telemedicine. With a vengeance. And my thoughts when we talk about innovations in tele-behavioural healthcare, is that we have been doing that for 30 years almost. We have been highly innovative, we have been highly successful, I think of it as a tree where we were just branching out and figuring out thing -- Figuring things out and diving in and doing whatever we needed to do. We worked very hard and we innovated. And now, we are at a place. And of course, the pandemic hit and we really had to get creative again. Again, another layer of creativity and innovation. And now we are at a place where we need to settle. We need to stop branching out and start deepening our roots and really getting our foundation back, strengthened and underneath us. So, part of that is, as a lecture, the excellent lecture we just heard, was we need to really enhance and clarify our regulatory support. Of what we can and cannot do and what we should be doing. Another big, big issue, and this is across all of healthcare, but it comes to the fore in tele-behavioural, is mitigation of fraud and abuse. I personally believe that one of the major concerns of the DEA and some of the other issues is more about identity verification and that the correct patient is getting the correct prescriptions and the correct diagnosis. And that correct patient can be a big problem, so that is an area that I believe that we are really going to be looking at. And then my passion is, what can we do to improve our care quality? As care providers. So, we have this technology going. And what can we do to leverage technology? So, that it is supporting the practice of medicine or the practice of behavioural in its healing modality rather than being a distraction. We need to move the technology to the background, bring the clinicians to the forefront to be advising where we are going with setting up these systems. Part of that is using our technology to develop more of a community of practice. Where we get together, multiple groups, and I will

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show in our system, we are really looking at mentorship and how we can use telehealth administratively to really bring dividers together in community and doing mentorship. -- Providers. Technology can help us practice at the top of our license. So, that the terrible things that we have had to do in terms of documentation at night and trying to fill out to our DER's, and trying to figure out nonclinical things. Those are things where I hope that technology can be helping. Another amazing area that we are trying to really focus on right now, you can think of a home visit as a house (indiscernible), that was in one of the lectures recently that I thought was a great paradigm to think about. But trying to really work on utilizing telehealth as a diversion from urgent care in the emergency room. And then also, we are identifying patients who have not had primary care. For over a year or two or three, some that have never had a primary care visit. So, they are lacking in the basic health needs. And so, we are outreaching to patients who have not seen primary care and offering them in home, immediate, telehealth sessions to try to bridge some of those gaps. But really, my major point is talking about mental illness and substance use disorder. They are chronic diseases. These are long-term issues, if you think about things like hypertension and diabetes, you cannot just give a pill and fix it and you are done. And in the mental health arena, especially the medical behavioural health medical practitioners, we are asking people to take medications that are difficult to take, they might have side effects and they might not work right. So, we really need to be practising in -- in the relationship of trust. And we need to be utilizing what is telehealth, it's connection, right? So, to set up for success, yes, we need competence. We need to know what we are doing. We need to know the right pills, we need to know all of that competence. But we also need connection. In order to really think of these illnesses as a chronic disease model. Kindness is a term but you know not think about when you think about technology. Kindness is a whole concept that has been proven to increase health span. And health span is in contrast to lifespan. Lifespan is how long you live, help span is how long -- well you lived during that time. So, using this concept of connection, kindness, warmth, to increase our healing and our connection and our efficacy and our outcomes. So, well, this was an interesting study. If you are lacking social connection, your health outcomes are decreased to the point of is -- as if you were smoking 15 cigarettes a day. We are in the middle of a mental health epidemic. Over device and opioid epidemic. Fentanyl is devastating our communities! Often in your rural areas, but in all areas. So basically, if we are in a position of physical distancing, the addition of telehealth with that together, we can pull together social connection. And that, I will end with that. TARA SKLAR: That was wonderful, thank you so much, Dr. Gibson. Well, one issue that we have been talking about in preparation for this webinar, related to this topic, is the opioid epidemic and I

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would love to get your thoughts on, you know, what we can do about that in this tele-behavioural health space. DR. SARA GIBSON: Well, it is devastating. I am sure you have seen the recent statistics about fentanyl and how it is saturating our population. I was horrified to go to a lecture by our Arizona law, I think, the sheriff department. Of diversion. And they, first of all, I should have said some of these pictures. -- Sent. Pictures of a fentanyl, it looks like candy. It is multi-coloured, yummy, little candy pills. And that is what they are seizing and sequestering and what I do not know that horrified me, was that one pill, 73% I think of their procedures nationwide of fentanyl, 73% of those individuals -- individual pills curate a failed dose. What? And if our kids do not know that, they are dying. So, that is not OK. So, you know, our nation understands this, we are looking at this. And we change our date or waiver requirements so that more prescribers and medical providers could be providing (unknown term), and to do in-home inductions and they are not. So, what we are doing in Arizona, is we are trying to increase the support as I mentioned. We are reaching out to our providers both in primary care and of course mental health care. But everyone needs to be on board with this. And telehealth is vital to be able to provide the in-home inductions for safety, to really blanket the world with more and more tools that we need. I just heard from an emergency room doctor that, yeah, we will give people (unknown term), but they do not have anywhere to follow-up. And there is no providers. Well, the providers are out there, but they are not willing to stick their neck out, they are afraid. And we need to be supporting to them, but also offering this modality of in-home induction as a huge, lifesaving opportunity. TARA SKLAR: Thank you. Thank you for bringing that up. And those are frightening statistics of lethal doses. So, another question that we have been also kicking back and forth, is regarding the pandemic as we come out of it. It would be great to get your perspective. Of what you are seeing through Blue Cross, you have shown across Arizona. What have you found that you have learned from debt -- That experience? DR. SARA GIBSON: It is funny, Dr. Shore has been around the block with me too. We have been doing it forever, we thought we were really good at it, and then the pandemic happened, and suddenly we had to move into people's homes. I think you will be talking about that -- the digital divide in some of those issues. So, I will not go into that. But that is a big, big issue that when we went into the in-home provisions of telehealth, and medical care, was at -- absolute revolution that turned everything upside down. So, we did a lot of things. We provided tablets with data plans to patients. And I think - I really think the bottom line is that when you think about the elderly person in their trailer out on the edge of the res with no transportation and a bunch of medical problems, you need to find a way that you can go to them. Because they cannot come to you anymore. And if they do come to you, they are not

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going to make it. So, whatever we can do to help them out, if that means providing more technology, we can talk about that. But paying a person upfront to help them connect and, to help them figure out how to push the right buttons on their screen, those are things that are basic human kindness and warmth that can save lives and be (indiscernible). TARA SKLAR: That is great. Think you for bringing in those basic humanity roles that we have and the delivery of care. One of my students is living in a rural part of Arizona and she is taking the course in telehealth and she is like, we just have to offer this to everyone. Somehow because of that exact situation that you'd describe. That was fantastic for something you so much, Dr. Gibson. Hope you are able to say on while we move over to Dr. Jay Shore, our headliner for today's webinar. We will be talking more about the digital divide, particularly, the role of AI. Dr. Shore has many hats. So, I will just list a few of them. He is the founding Executive Director of the behaviour intervention Centre at the University of Colorado. And Scholz medical campus. He is also the vice chair for innovations at the Department of psychiatry and a Prof. and Department of psychiatry and family medicine in the School of Medicine and Centre for American Indian Alaska native health. At the Colorado School of Public Health. You can see from his resume, he is very involved with the veteran's office of rural health, veterans, and the chief medical officer from access Medicare -- Medical care services which provides telehealth medical care services to rural populations in Colorado and Alaska. Your career, focusing on technology and mental health. Ongoing filament, particularly for underserved populations. Native Americans, rural, and really thinking about how to bridge that digital divide going forward. So, just so excited to hear you speak, Dr. Shore! I will turn it over to you. DR. JAY SHORE: Great. Thank you for the nice introduction, can you hear and see me clearly? I assume, yes. We are good? TARA SKLAR: Yes, we are good. DR. JAY SHORE: And you are seeing my slides, correct? TARA SKLAR: Correct. DR. JAY SHORE: OK. I will briefly talk about the two specific topics of emerging themes and trends from the pandemic. As mentioned, I have multiple roles and just in the interest of disclosure, I am talking for myself today. I am not representing any of the organizations that I work with. So, that is my disclosure site. So, I wanted to just briefly, for a few minutes, talk about the digital divide. Particularly, in the context of Covid. And then shift gears, little different, so some similar themes about AI and its impact in mental health care. And specifically, telemedicine. So, the digital divide as a concept that has been there for a long time, and I think most people understand it is the idea of being able to access technologies, particularly in healthcare, to get your healthcare. There are many different ways people have conceptualized it. The way I have sort of simplified it for myself is, there are actually five. This is a bit of a -- the old slide. I see five key components that if your patient -- if you are a patient

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and you want to access healthcare, obviously, you need adequate broadband access. I think that is the most obvious thing that comes to mind when we think about the digital divide. Having that adequate broadband to access videoconferencing, patient charts. Digital imaging for your providers in rural areas. You obviously need the up-to-date technology, right? You need both the software and hardware to run whatever applications or programs to be able to access care. You need Tech literacy, not just broadly, but very specifically, right? We all have these different ways to connect with patients and in the healthcare system. So, you may be sorted if comfortable on a computer, but if your healthcare system has a complex way of scheduling through a patient portal with videoconferencing, you need that specific literacy to use the application. You are being asked to use. And then you need tech support. And it is very challenging in many, many systems. To need real tech support is real-time. When you are doing a clinical session, either a patient or provider, in many, many systems, work on the ticketing tip of tech support where, you know, you have problems. And we will get back to you within a day or two or even longer. And that really inhibits good technological care. And then the first, the fit issue, is a little broader. -- Fifth issue. It is having a mechanism to pay for this. So, that means having insurance or some kind of healthcare coverage that allows you to get healthcare. And then having a healthcare insurance that allows you to have digital access, and those are not necessarily always a line. I think Covid was like the letter Cohen song. One of his lines, he says, "there is a crack in everything and that is where the light gets in." And I think with COBIT, on one hand, we saw the power, especially during the quarantines of tele-mental health -- Covid. And creating care and access, the people would just not have been able to get without it. But then the crack was, that we saw significant populations completely cut off from healthcare because of one of these challenges with the digital divide. We saw eight increased morbidity and mortality in specific populations, including rural populations, American Indian, Alaska native populations that I work with. Driven by some of these access issues. So, I think sort of the good thing about Covid, it sort of did a spot check of a report card and where we are as a country. With these issues. And I think it is really critical that we stay very focused on these. And I think in each of these areas, there are large rooms for improvement. Particularly, if a pandemic hit again tomorrow like the one we experienced, I am very concerned that we would continue to see some of the significant disparities that were there, meaning the system-level problems that are not yet solved. So, that is one sort of, sort of, but emergency policy issue. I would've Covid. -- Out of Covid. Before I switched, I would say, on the positive side, when I was working, what I saw was a lot of challenges about the digital divide. But I saw a lot of creativity. Right? If we could just capture all of the different individual and organizational lessons of how people solved all

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of these areas, I think we would be well on our way to a solution toolkit. So, one of the stories I thought was very creative, I work with a rural organization that had the lockdown -- had to lock down a hospital during Covid. And at one point, really could have a patient's all coming into the facility because of restrictions. So, they were doing care out to the community into people's homes. But many of the patients did not have adequate bandwidth. So, they jacked up a van, putting satellite dish on it with satellite Internet. And they would actually drive this man outside -- this van outside a patient's house so the patient could then get on this mobile Wi-Fi that was adequate enough. And then that would allow them to videoconference back with their provider. So again, I have given hold talks. Maybe 20 different examples. So, just the flipside of the Covid that there was a lot of creativity and problem solving and lessons that we really want to capture. I think totally shifting gears a little bit, is AI. Right? And I think we have been hearing a lot, particularly in the last year, about sort of the promise and parallels of AI. And I will say some AI anxiety that Skynet is going to become life and possibly take over the world. I think both the risks and the promise of AI right now for those of us who have a whole familiarity and working with the film field, our a little over -- are a little overrated or over exaggerated. Currently today. Who knows what the future will develop. First of all, I think AI is a really long way of being a significant risk for catastrophe. Although, it is something we need to monitor. I also think right now that AI is in this phase where there is a lot of excitement of how to use it in healthcare. But a lot of uncertainty of how to really implement it and make it effective. I think that over the next five and possibly 10 years, because it takes a long time and our healthcare systems, organizationally, for these innovations to diffuse. There is a number of areas I think we will begin to see a I Machine Learning. For telehealth. These include things like smarter electronic health records, that help you with both the documentation and assistance. But maybe even suggesting, as you are seeing the patient, the digital avenues the treatments, helping with care coordination. Specifically, in telehealth, there have been many, for a long time, who have dreamed of having a videoconferencing overlay. That gave providers feedback through diagnoses and body language through signals. And the technology has never really been able to deliver that. I do think there is a promise in AI moving forward for that that we may see. And then obviously, I think AI can be very helpful and care coordination and treatment access… Although, these are all very theoretical. I think two of the biggest, real risks of AI, I will not go into this. That slide or maybe I will and with that. One risk is, this is the American cultural Association for framework for assessment for patients and the basic framework is that you have patients and providers interacting through Western medicine. And that culture is the medium that really determines those interactions. That include the impact of both patient and

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provider background. Over the last decade, we have really layered technology over that interaction. Both AI and videoconferencing. And the risk here, and I acutely call it the texture, the cross between culture and technology. I am not sure that is the best word. But basically, we really need to pay attention about how videoconferencing and other technologies may impact and lead to potential built-in biases as we treat patients. There is data and literature coming out of this. I think the most well-known in society is some of the problems with the facial recognition technology. And we have the same types of danger in health care as well. Of course, the final, I think, risk. And I will just leave up a few resources for my final comment. Some of the final risks of really AI is not the AI itself, it is how people will choose to leverage it, right? It is a tool, like many tools. We have certainly seen tools in healthcare that have been leverage for the wrong reason. If AI is giving leverage to maximize throughput or stockholder of value in the for-profit medical industry versus quality of care, I think that is our most immediate risk with AI. There is, I think, a lot of potential that will hopefully see come to pass. There are these risks. And I think there needs to be more thoughtful, proactive, national policy, legislation, as we move forward looking at these. So, with that, I am watching my time. I have 10 minutes. There is some contact information. I will stop sharing and that is the end of my comments. TARA SKLAR: That was great, thank you for that high level overview on those issues. Thanks to all of the panelists. All of you were very prompt with your presentations, I so appreciated! It is great that we are right on track. With that, I do encourage anyone listening to submit any questions you may have in the Q&A. I have just a few for Dr. Shore and then I will open it up to the wider panel. But you know, Dr. Shore, you specifically talk about the digital divide, you know, you mention broadband. And connectivity in general. But are there any specific solutions that you would like to raise at this point? DR. JAY SHORE: Well, and again, I think actually that there is some legislation in rural grant programs that have been looking at this for years and years. I think you really address this, that we need to, as a country, take on a systematic review of sort of our tech industry -- infrastructure. And really what the investment should be. Not just for rural, but other communities. There is urban communities that have disparities in this. So, I know there has been some talk about this. I know right now, the focus nationally is in our elections. But my optimistic hope is when we get through that, that these conversations will continue and increase. TARA SKLAR: Yes, absolutely. And I think -- think everyone else. I speak for myself, I was a surprise about the affordable connectivity program and then even though it has incredible bipartisan support. And could there be something that happened at the state level to provide some subsidies interim. Great, great points. You know, you really just explained the AI fears and risks very well (laughs). I found it very interesting! One of the

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panelists commented on how she is using AI in her practice and finding it helpful. Are there any other implications there that you would like to raise before we turn it to the broader panel? DR. JAY SHORE: I think there is a real promise, particularly in telehealth nowadays and AI. There is a real promise, particularly with documentation. That AI has the potential to take documentation away from us and support us in a good way. There are some companies that have been piloting and people may see with your resume, the transcribing features. We may get to a place shorter than -- where we think where you do a zoom call and all you really have to do as a provider is review the note. And one that will I think both increase through input, decrease provider burnout, and also allow more focus on the patient. Because all of us providers, even if we are working our hardest to be really present with the patient, you also have to manage the administrative burden, which has increased over the last couple of decades for providers. So, I think that is an exciting area to watch and I am optimistic and I know some individual providers already digging in and using it and I am beginning to see some systems. I think we are in early days, but I look forward to seeing what develops. TARA SKLAR: That is a great point and great intersection with long compliant as well on the issue of documentation. And where AI could really help make sure that providers are checking the boxes they need to check when they are writing up the notes. I do not know, Theresa, if you want to comment on that. Or anything you are seeing with your clients. THERESA LANGLEY: I am sorry, would you mind? So I make sure I am responding appropriately. Sure, we were just talking about, you know, one of the great uses of AI could be for documentation for providers. I just think that has such a promising intersection with law and compliance in the area. In terms of making sure that what is being documented is suiting, you know, whether it is for privacy or informed consent, whatever they are documenting, how the ream -- visit Wendy for reimbursement purposes, I am curious if you are seeing any of that in your practice. THERESA LANGLEY: Yes, thank you for (indiscernible). I totally agree. Obviously, AI, it put something together that needs to be checked. Right? Especially where we are at with it. You could not rely on it kind of putting together the notes and not having the provider review for accuracy. But absolutely. Any things that assist with documentation, making that process more thorough and faster, is going to be a huge benefit for providers and something I am sure, you know, they are interested in incorporating. Already with EHR, I think we have some kind of automated templates that are really helpful. They also need the provider to weigh in and, you know, customize for that specific patient and situation. So, I would see it as kind of a better, more amped up version of what we already have in the EHR systems. TARA SKLAR: Great, thank you. Before we let everyone leave, we have one last question for the group. I like this

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question because I think it explains general confusion in the area of delivering telehealth and also what it may lay ahead. It is from a student of mine and he asks, "how do providers typically verify patient information?" He wanted to know how you would do it synchronously and asynchronously. And whether that can be something that changes, right? That is interesting given Dr. Shore's comment about biases in facial recognition and how that could potentially impact identification, too. So, Dr. Gibson, I might start with you in terms of what you are seeing in your practice. With that direct patient care. And you know, how you would identify patients, how you might see that changing as the technology advances. DR. SARA GIBSON: So yes, here again we are but in the seat. You know? Just figure it out. So, for many years, well, most of the tele-behavioural health was provided to a patient in a clinic. So, that was not an issue. Because they had already gone through the whole identification process in that space. But now with the in-home provision of care, there are several ways you can do it. One way is if they have been to the clinic and they are associated with the clinic and the clinic has already provided that identity verification, but then it gives you the link you can use the clinics identity verification process. You can also ask the patient to just show you their drivers license or if they do not have video, and you might have to ask them to verify their date of birth. Or something like that that you can identify. But there is also some really cool things coming on the web of, down the pike of virtual identification. But without video, that is one of the reasons I think you have to be really careful. In the space of the DEA and prescribing controlled substances without video. I think it is really important that we be able to do that. But we have to make sure that we have those systems in place. TARA SKLAR: Excellent point. Thank you again to the panelists. Thank you again for joining us. This is recorded. I will turn it over to Aria for taking us away and I hope everyone enjoys the rest of your Wednesday! Area macc thank you, Tara. Just a reminder that her next webinar will be held on Thursday, July 18, and that will be on priority setting and digital health hosted by the specific (unknown name) Centre. Registration information is available on the NCTRC website. And then lastly, we do ask that you take a few short minutes to complete the survey that will pop up at the conclusion of this webinar for stuff your feedback is very valuable to us. Thank you again to the Southwest Telehealth Resource Centre for hosting today's webinar. And to all of our speakers for their presentations today. Have a great day, everyone! TARA SKLAR: Take care, thank you! Live Captioning by AI-Media

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