Quality Framework for Telehealth in the SNF Setting
October 1, 2022

CMS is ending waivers that have allowed unlimited telehealth visits in nursing facilities to be performed by physicians and non-physicians as of May 7, 2022, thereby reinstating the requirement for in-person visits per 42 CFR §483.30. The ending of these waivers does not coincide with an ending of all telehealth waivers in all settings. The reasoning behind this is outlined in QSO 22-15-nh & NTLTC & LSC, out of a concern "about how residents' health and safety has [sic] been impacted by the regulations that have been waived, and the length of time for which they have been waived."

The California Association of Long Term Care Medicine (CALTCM) is the medical voice of long-term care in California. We advocate for quality patient care and achieve our mission through education and policy. We are in full support of measures to reinforce quality of care, and we believe there is an opportunity to leverage telehealth to do so in both urban and rural settings.

Telehealth, is a broad term that refers to providing medical care remotely rather than in-person. In the broadest sense, telehealth includes connecting by phone or video, sending and receiving information, maintaining files electronically, and remote medical monitoring (U.S. Department of Health and Human Services, 2022). It can also include training providers to use telehealth technology, the process of setting up necessary equipment, and other activities involved with delivering telemedicine to patients.

The terms ***telehealth*** and ***telemedicine*** are often used interchangeably, yet, there are differences. Telemedicine is "the practice of medicine using technology to deliver care at a distance" (Mao et al., 2022). Although the focus of this document primarily involves direct patient care, given the inclusion of training as well as the need to discuss the benefits and challenges of using equipment, we use the term **"telehealth"** throughout this document.

While in-person visits may allow a provider increased diagnostic information, and facilitate communication with the patient, family and staff, telehealth visits increase opportunities to observe residents, and interact with staff and families with greater frequency. Telehealth also allows access to specialty visits that are presently not readily available to most nursing home and assisted living residents. Many specialty visits occur in the physicians' offices and thus require residents to leave the facility usually accompanied by facility staff, thereby adding transportation, coordination and staffing challenges. Leaving the facility may reduce participation in activities and may be disconcerting for cognitively impaired residents. Telehealth

facilitates optimal care management and minimizes the potential for cancellation of services to frail older adults in SNF, ALF, and smaller residential care (e.g. board-and-care) settings. Nuanced guidance is needed to ensure that patient care is delivered within the competency range allowed by current telehealth technology. We propose the following guidance:

1. While in-person visits provide for a more comprehensive sensory evaluation, telehealth visits may result in better care when an assessment is needed within a timeframe that is not possible to meet with an on-site presence.
2. Telehealth visits should meet the existing requirements of medical necessity and meet the requirements of what is standard medical practice that is expected during those visits, including the visual and auditory examination of bodily functions.
3. Primary care providers or SNF attendings who perform in-person visits in the facility should be allowed to perform telehealth visits for both regulated and nonregulated visits. (perhaps a %, e.g., no more than 50% of a provider's regulated visits to a facility can be done by telehealth during a calendar month).
4. Specialty consults performed in close collaboration with the primary care provider or SNF attendings should be allowed as telehealth visits without a requirement for in-person visits.
5. Telehealth visits allow providers (physicians and advanced practice providers) to assess when discharge to the hospital may be necessary at off hours, or to mitigate risk factors when new medical issues arise post in-person visit. Such telehealth visits have been shown to reduce re-hospitalization and ED visits.
6. Non-emergent Telehealth visits must be consented to in advance.
7. Residents' surrogate decision makers should be invited to participate and residents with capacity should be asked if they would like the responsible party or other friends or family to participate.
8. Telehealth visits meeting these criteria should be reimbursed on par with in-person visits as the evaluation and management burden is equal, if not more, than when done in-person.
9. In order to promote equity of care, all SNFs that do not currently have telehealth capability should be provided reasonable support to ensure telehealth access for their patients and residents.
10. Medicare facility fees, used appropriately in conjunction with a telehealth visit, should recognize the demands on staff, including technical assistance and clinical input necessary for visit efficiency and value.