PTAC
PASRR Technical Assistance Center

TELEHEALTH: OPPORTUNITIES FOR PREADMISSION SCREENING AND RESIDENT REVIEW

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Introduction

Many providers have identified telehealth as a solution to meet the current needs of patients and address health care access and delivery barriers. The American Telemedicine Association (ATA) and the Centers for Medicare & Medicaid Services (CMS) cite numerous benefits to using telehealth and describe it as a cost-effective alternative to more traditional face-to-face ways of delivering care.[1,2] Many of the barriers that people face when seeking in-person health care—including time, transportation, and affordability issues and access to the appropriate health care provider—can be mitigated by using telehealth.[3]

In addition to providing an alternative method of health care service delivery, telehealth may be a viable way to improve the efficiency of Medicaid programs such as Preadmission Screening and Resident Review (PASRR). The PASRR program requires that all applicants and residents of Medicaid-certified nursing facilities be screened for specific disabilities to ensure that they receive the most appropriate care. PASRR requires states to employ or contract with behavioral health care professionals to conduct assessments across a state, which may include assessments for individuals in remote locations, and assessments must be done within a relatively short time frame. In addition, the growing shortage of skilled behavioral health care professionals needed to conduct assessments may magnify barriers to PASRR compliance.[4]

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[1] American Telemedicine Association. Telemedicine Benefits. 2018. http://www.americantelemed.org/main/about/about-telemedicine/telemedicine-benefits

[2] Centers for Medicare & Medicaid Services. Telemedicine. 2018. https://www.medicaid.gov/medicaid/benefits/telemed/index.html

[3] American Telemedicine Association, 2018. Op cit.

[4] Institute of Medicine. The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands? Washington, DC: The National Academies Press; 2012.

Thus, the state entities that oversee PASRR may face similar resource and access issues that other health care providers have begun to avoid or minimize by using telehealth (e.g., long travel times for assessors).

This white paper provides an overview of telehealth and the PASRR program and discusses the potential applications of telehealth to address barriers in PASRR. Although telehealth offers the opportunity to improve program efficiency and effectiveness, PASRR authorities must balance state-specific barriers, available resources, operational considerations, regulatory requirements, clinical quality, and budgetary limitations.

Overview of Telehealth

Telehealth is defined generally as the use of interactive telecommunication technology to provide health care services to patients from a distance. Whereas the term *telemedicine* typically refers to the remote delivery of clinical services, *telehealth* encompasses clinical and nonclinical health care services. Telehealth seeks to resolve or minimize health care delivery challenges across populations and disciplines, including the following:

- Access to the appropriate clinician, such as specialists who may be limited in number
- Burdensome travel for patients in rural areas who must drive long distances to receive care or for individuals with limited resources and/or who have disabilities
- Rising health care costs for patients to access, and for providers to deliver, the right care from the right person at the right time

Central to the operational design of telehealth is an *originating site*, the location of the patient, and a *distant site*, the location of the health care provider. Examples of originating sites include, but are not limited to, offices of physicians or practitioners, hospitals, nursing facilities, and community mental health centers. The Center for Connected Health Policy (CCHP) describes four main telehealth modalities used to facilitate health information sharing between originating and distant sites[5]:

[5] Center for Connected Health Policy. What is Telehealth? 2018. http://www.cchpca.org/remote-patient-monitoring

- Live video (synchronous telehealth): real-time, two-way communication using audiovisual telecommunication technology. For example, in this modality, the originating and distant sites may be outfitted with cameras that are capable of transmitting live video (e.g. through an internet connection and web conferencing software). The individual and practitioner are able to see one another on a monitor (e.g. computer or television screen), talk to and hear one another through a phone or computer microphone and speakers, and the healthcare service is conducted through this interaction.
- Store-and-forward approach (asynchronous telehealth): secure transmission of prerecorded data such as video, images, or audio that are later reviewed by a health care professional. For example, an x-ray may be conducted in a rural clinic and the digital image may be securely transmitted electronically to a specialist in another city or state for analysis and diagnosis.
- Remote patient monitoring: collection and transmission of digital health and personal data to a health care professional for review (e.g., the use of medical devices in a person's home or at a nursing facility to monitor and transmit vital signs, blood sugar levels, and heart rate to a healthcare provider)
- Mobile health: the use of mobile devices, such as tablets and smartphones, to collect and communicate health information, including preventive health coaching programs

Telehealth and telemedicine are becoming more prevalent. The ATA reports that about half of all U.S. hospitals use telemedicine.[6] Telehealth has been applied to numerous health care disciplines, including oral health, behavioral health, cardiovascular health, and maternity care.[7,8] An example of the large-scale application of telehealth is the Veterans Affairs (VA) Telehealth Services program, which uses multiple modalities to provide mental health,

[6] American Telemedicine Association. About Telemedicine. 2018. http://www.americantelemed.org/about/telehealth-faqs-

[7] Ibid.

[8] Medicaid and Children's Health Insurance Program Payment and Access Commission. (2018). Report to the Congress on Medicaid and CHIP. Washington, DC: Medicaid and Children's Health Insurance Program Payment and Access Commission; March 2018. https://www.macpac.gov/publication/march-2018-report-to-congress-on-medicaid-and-chip/

rehabilitation, and specialty care to veterans.[9] Research shows advantages to telehealth's application to behavioral health, including its potential to increase access to evidence-based behavioral health care and to address patient concerns about stigma and confidentiality when accessing traditional modes of behavioral health care.[10,11]

Few federal policies govern telehealth; as such, CMS has given states a great deal of flexibility to design Medicaid coverage policies. As of fall 2017, 48 states and the District of Columbia provided Medicaid reimbursement for some form of telehealth, with live video being the most commonly covered service.[12] Conversely, Medicare coverage is much more constrained. Key Medicare coverage parameters include restrictions on originating site location (i.e., must be in a rural area), originating site facility type, the type of modality used[13], distant site providers permitted to provide care, and services covered.[14] Recently, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care Act of 2017 expanded Medicare coverage for telehealth. With these policy changes, ongoing technology innovations, and a growing body of published research supporting its use, telehealth is primed for even wider adoption across health care delivery systems.

Overview of the PASRR Program

In 1987, Congress passed the Nursing Home Reform Act in response to growing concerns and reports about the care and rights of individuals in long-term care. The central intent of the act

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[9] U.S. Department of Veterans Affairs. VA Telehealth Services. 2018. https://www.telehealth.va.gov/index.asp

[10] Medicaid and Children's Health Insurance Program Payment and Access Commission, 2018. Op cit.

[11] Substance Abuse and Mental Health Services Administration. Rural Behavioral Health: Telehealth Challenges and Opportunities. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2016. https://store.samhsa. gov/shin/content/SMA16-4989/SMA16-4989.pdf

[12] Center for Connected Health Policy. State Telehealth Laws and Reimbursement Policies: A Comprehensive Scan of the 50 States and District of Columbia. Sacramento, CA: Center for Connected Health Policy; 2017. http://www.cchpca.org/sites/default/files/resources/Telehealth%20Laws%20and%20Policies%20Report%20FINAL%20Fall%202017%20PASSWORD.pdf

[13] Currently, Medicare only covers interactive audio and video telecommunications systems that permit real-time communication between the practitioner and the individual receiving care at the originating site. An exception is Alaska and Hawaii, in which asynchronous store and forward technology is permitted only in Federal telemedicine demonstration programs. Medicare Learning Network, Telehealth Services. Washington, DC: U.S. Department of Health and Human Services; 2018. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

[14] Medicaid and Children's Health Insurance Program Payment and Access Commission, 2018. Op cit.

was to ensure that nursing facility residents receive the care and services needed to maintain the "highest practicable" mental, physical, and psychosocial wellbeing.[15] Additionally, the law included provisions to prevent individuals with specific disabilities from being inappropriately institutionalized in nursing facilities. The PASRR provisions[16] aim to ensure that individuals with serious mental illness (SMI), an intellectual disability (ID), or conditions that require services and supports similar to those that a person with ID requires (referred to as related conditions [RC]) receive the necessary services and supports to meet their needs in the most appropriate setting. However, some states face difficulties complying with certain PASRR provisions, particularly requirements related to assessor qualifications and timeliness of assessments. These and other PASRR requirements are summarized below.

PASRR Assessments

The PASRR requirements stipulate that all individuals seeking admission to a Medicaid-certified nursing facility be screened for the presence of a PASRR disability—SMI, ID, and RC. The goals of the screening and assessment process are as follows:

- Identify individuals with SMI, ID, and RC
- Determine whether a community setting or nursing facility is the most appropriate placement for the individual
- Describe the disability-specific services and supports the individual will need in the community or the nursing facility

There are two key steps in the PASRR process. The first step is a brief screening to identify whether a person has or is suspected of having a PASRR disability. This is called a *Level I* screen. If a person is suspected of having a PASRR disability, a more extensive, individualized evaluation called a *Level II* assessment is conducted. Level II assessments are conducted before admission for individuals seeking nursing facility care; they are conducted after admission for nursing facility residents who experience a significant change in status such that their treatment needs

[15] 42 CFR 483.24.

[16] 42 CFR 483 Subpart C, Social Security Act §1919(e)(7)

have changed or a new disability is discovered, both of which warrant a new assessment.[17] Level II assessments typically are conducted in person between an assessment professional and the individual in a hospital, a nursing facility, or a community setting.

Oversight of the PASRR program is uniquely structured to require the collaboration of three separate state entities: the state Medicaid agency (SMA), the state mental health authority (SMHA), and the state intellectual disability authority (SIDA). The SMA has ultimate oversight of the program. The SMHA may issue Level II determinations but cannot perform Level II evaluations, and the SIDA may perform Level II evaluations and determinations but may choose to delegate either[18]. Finally, nursing facilities or entities that have direct or indirect affiliation with nursing facilities cannot conduct PASRR assessments[19].

Assessor Qualifications

PASRR regulations give states the flexibility to identify appropriately credentialed professionals to conduct PASRR assessments. For individuals who are evaluated for SMI, states may identify mental health professionals to conduct assessments.[20] However, the regulations clearly set the expectation that the professionals have the clinical ability to conduct the following assessments as part of the evaluation: comprehensive drug history, psychosocial evaluation, comprehensive psychiatric evaluation, and a functional assessment. For individuals who are evaluated for ID or RC, PASRR regulations allow states to identify "appropriate personnel" to conduct assessments.[21] Again, the regulations include items that an evaluator must be able to assess, including medical history, medication history, and sensorimotor, speech/language, social, and independent living development.

States typically align their credential and licensure requirements for PASRR assessors with federal definitions for qualified mental health professionals and qualified intellectual disability professionals, although some states may have stricter requirements. The regulations also

[17] Status change reporting requirements for PASRR are further detailed in Chapter 2 of the Minimum Data Set 3.0 RAI Manual.

[18] 42 CFR 483.106(e)

[19] 42 CFR 483.106(e)(1)(iii)

[20] 42 CFR 483.134(c).

[21] 42 CFR 483.136(c)(2).

require access to medical history, the results of a physical conducted by a physician, and intellectual functioning testing when necessary. Intellectual functioning testing must be conducted and interpreted by clinicians licensed to do so in that state (e.g., licensed professional counselor, psychologist, psychological examiner). State PASRR authorities also must ensure that conflicts of interest do not exist for the evaluators. The regulations prohibit evaluators from having a direct or indirect affiliation or relationship with a nursing facility,[22] and states may choose to identify additional conflicts of interest to further restrict who may serve as an assessor.

Timeliness Requirements

The PASRR regulations include timeliness requirements for preadmission assessments. Level II preadmission assessments must be completed within an annual average of 7 to 9 working days of referral by the entity that performs the Level I identification screen.[23] However, states are increasingly under pressure by PASRR stakeholders—including the individuals assessed, hospitals and nursing facilities, and disability rights advocates—to complete assessments faster than the regulations require. Thus, state PASRR authorities must have an agile assessor network that can complete evaluations quickly while maintaining good quality.

PASRR Reimbursement

Federal regulations give states the authority to claim Federal Financial Participation (FFP) for administrative activities associated with the PASRR program included in their state plan as required by at §433.15(a)(9) of the CFR. This reimbursement allowance can greatly offset costs associated with PASRR assessments. State Medicaid agencies may claim the following activities at a 75 percent match:

- Time, including salary and fringe, of SMA, SMHA, and SIDA staff who administer PASRR
- Time of the individual assessors (state employees and assessors who are contracted by the state) who conduct the Level I screen or Level II PASRR evaluation
- Time to develop a Request for Proposal (RFP) for a vendor
- Time developing policy or program materials

[22] 42 CFR 483.106(e).

[23] 42 CFR 483.112(c).

- Any information technology for PASRR administration, whether developed by the state or a vendor (e.g., a web-based portal for tracking Level I screens and Level II evaluations could be claimed at the 75 percent match rate)
- Office overhead, supplies and equipment, and printing forms, copying, and mailing notifications
- Management, including management of appeal activity
- Development and delivery of training and professional education
- Mileage and other travel
- Professional consultations and translation services
- Stakeholder and interagency meetings
- Quality assurance activities
- Any other costs necessary to carry out the PASRR program

The key to receiving the FFP reimbursement is setting up the mechanisms to claim the match. More information about claiming the 75 percent FFP can be found at the PASRR Technical Assistance Center's website (www.pasrrassist.org).

Applications of Telehealth to PASRR

The application of telehealth to the PASRR program is a relatively new endeavor that could mitigate barriers that state PASRR entities face to maintain compliance with regulatory requirements. The component of the PASRR process that could most likely benefit from telehealth solutions is the individualized, more extensive Level II assessment. Currently, several states allow the use of teleconferencing for language interpretation for PASRR assessments; however, this service is not clinical in nature. Telehealth—in the form of two-way, live video conferencing to conduct the Level II assessment—may help mitigate barriers related to assessments in rural areas, shortages of the health professionals needed to conduct assessments, and timeliness of assessments.

Rural Assessment Locations

PASRR assessments typically take place at the location of the individual who is considering nursing facility placement. Preadmission assessments are completed in hospitals and in community settings such as a person's home or doctor's office. Postadmission

assessments are conducted in nursing facilities, although they may be conducted in hospitals before a nursing facility resident returns after receiving acute treatment. States that are largely rural may struggle to obtain and afford an assessor network that can quickly and easily access rural evaluation sites. Telehealth could allow state PASRR authorities to connect assessors with individuals in rural areas to avoid costly and time-consuming travel. California already has identified specific counties in which telehealth may be used for PASRR assessments with prior approval.

Shortage of Mental Health Professionals

There is a growing shortage of mental health professionals across the United States,[24] which may exacerbate the issues that states face with maintaining a network of qualified assessors. As of December 2017, there were 5,042 mental health care health professional shortage areas in the United States.[25] This landscape creates a limited pool of qualified PASRR assessors. States with limited assessor networks and high nursing facility admission rates face the challenging task of keeping up with assessment demand. Allowing assessors to conduct Level II assessments remotely using telehealth could help states meet assessment demand in areas with shortages of qualified mental health professionals.

Assessment Speed and Efficiency

State PASRR entities must ensure that assessments are conducted by appropriate health care professionals within a short period of time. In addition, health care providers such as hospitals that typically are caring for the individual at the time of the preadmission assessment advocate for quick and efficient assessments. Considering the potential financial impact providers and individuals may incur for discharge delays caused by slow PASRR assessments, timely assessments are key to PASRR stakeholder satisfaction as well as critical to compliance with

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[24] Substance Abuse and Mental Health Services Administration. Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2013. https://store.samhsa.gov/product/Report-to-Congress-on-the-Nation-s-Substance-Abuse-and-Mental-Health-Workforce-Issues/PEP13-RTC-BHWORK

[25] Health Resources and Services Administration, Bureau of Health Workforce. Designated Health Professional Shortage Areas Statistics. First Quarter of Fiscal Year 2018: Designated HPSA Quarterly Summary. Washington, DC: Health Resources and Services Administration; 2018. https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Qtr_Smry_HTML&rc:Toolbar=false

federal requirements. Telehealth provides an opportunity for more timely assessments by eliminating the time assessors spend traveling to a site to conduct a PASRR evaluation in person.

Considerations and Limitations

When considering telehealth to address issues with PASRR assessments, states must weigh the advantages and costs. Although telehealth solutions and resources are becoming more readily accessible, managing a telehealth solution has complexities that must be considered.

Program Structure

One factor that state PASRR authorities must consider when determining whether to use telehealth for Level II assessments is how the program is structured in their state. State Level II assessment program design and operations vary greatly. For example, a key variation is the entity that conducts the Level II assessments. Some states delegate all Level II assessment activities to an independent party. Other states choose to delegate only those assessments for individuals with SMI (as required by 42 CFR 483.106[e]) and retain the responsibility for conducting assessments for individuals with ID or RC with the SIDA. States that contract with PASRR assessment vendors could allow or require the use of telehealth for certain situations and create policies and procedures that govern its use.

Technology Resources

When considering telehealth as an option for administering evaluations, states must identify the source of telehealth technology and determine whether there is access to adequate internet services (e.g., bandwidth and connectivity) at both the originating and distant sites. One option is to create agreements with health care systems within the state that already have access to telehealth technology. States could identify health care systems and providers in rural locations that already use telehealth for other health care services and determine whether it could be leveraged for PASRR activities. With this model, states would need to identify appropriate reimbursement and fee methodologies and any applicable state-specific authorizations, comparing the resulting cost against the costs associated with qualified assessment personnel traveling to the rural location. Another option is to outfit a lower-cost network of staff with telehealth resources and send them to the originating site to facilitate the

telehealth encounter with more qualified personnel. Regardless of the model, state PASRR entities have a unique opportunity to offset the costs of implementing telehealth procedures and technology with the 75 percent FFP for certain PASRR activities.

Privacy and Security

All entities that use or provide telehealth services are subject to the same privacy and security laws that govern traditional health care services. Entities that use telehealth must incorporate the necessary policies and safeguards to ensure compliance with, for example, the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic Clinical Health Act of 2009. In addition to compliance with federal privacy policies, many states have additional technology security requirements for state-run programs.

States that employ professionals or contract with vendors to conduct PASRR assessments will need to ensure that the appropriate technology and resources are in place to comply with privacy laws and rules. If a state and a health care facility agree that the state may use the facility's telehealth devices and network for PASRR assessments, both entities should ensure that the resources comply with applicable privacy and security requirements. Key security considerations for PASRR entities include the privacy of the assessment location (originating and distant site), encryption of devices, network security, application and/or software security (e.g., web conferencing services), and data storage requirements. Telehealth also may require the support of technical personnel. States should evaluate the entities involved in facilitating telehealth and create business associate agreements where necessary to obligate compliance with privacy laws.[26,27]

Policies for Appropriate Use

Although there are studies that cite positive results in both patient satisfaction and health outcomes, telehealth still largely is considered a tool in health care delivery and not a complete replacement of face-to-face encounters. CMS and state PASRR entities may want to consider

[26] Telehealth Resource Centers. Privacy, Confidentiality and Security. 2018. https://www.telehealthresourcecenter.org/toolbox-module/privacy-confidentiality-and-security

[27] Center for Connected Health Policy. HIPAA and Telehealth. Sacramento, CA: Center for Connected Health Policy; 2018. http://www.cchpca.org/sites/default/files/resources/HIPAA%20and%20Telehealth.pdf

parameters for the appropriate use of telehealth that align with best practices in care while addressing the practicalities of delivering a service across a state. For example, PASRR regulations require an individualized, in-depth, and person-centered Level II assessment. To accomplish this goal, observation of an individual and interviews with the individual, current caregivers, and family members yield the best information and provide robust data to help the assessor make recommendations for a person's level of care and necessary services and supports. Two factors for states to consider when creating policies for the use of telehealth in PASRR are (1) the barrier the telehealth solution is intended to resolve and (2) the clinical appropriateness of telehealth at the time of the assessment.

As described earlier, telehealth may be a prime solution to address resource limitations to completing face-to-face assessments for individuals in rural or hard-to-reach areas. For PASRR purposes, states may wish to emulate Medicare or state-specific Medicaid regulations in which the geographic or health care workforce barriers of the originating site affect reimbursement. For example, states may consider requiring that originating sites be a non-metropolitan statistical area or a rural health professional shortage area.

States also may wish to implement a prior authorization process to ensure appropriate use of telehealth for PASRR assessments. States may encounter unique situations that do not meet set criteria (e.g., individual must be located in a rural area) but for which they may want the flexibility to grant the use of telehealth to best serve an individual. An approval process would allow states to vet and monitor the use of telehealth. It also would allow states to adjust policies for the use of telehealth in PASRR assessments as they learn more about the needs of their state and as state and national telehealth policies evolve.

Another key factor when considering the appropriate use of telehealth is the clinical status of the individual at the time of the assessment. Because the population that PASRR seeks to support includes individuals with mental health and intellectual/developmental disabilities, it is essential to consider the severity of an individual's condition, the individual's capacity for interaction, and consent to use technology for the assessment. Most individuals who receive PASRR assessments are likely psychiatrically stable at the time of the assessment. However, some individuals may be experiencing acute symptoms at the time of the assessment. States

should ensure evaluators have the expertise and ability to navigate telehealth in various contexts, including ranges in behavioral health acuity, cognitive impairment, and intellectual functioning.

PASRR assessments are conducted in many different settings and for individuals in various stages of their disability. Hospital and nursing facilities likely make up most assessment sites because of the typical health events leading to nursing facility admission and because Level II resident review/status change assessments are completed after nursing facility admission. The American Psychiatric Association (APA) supports the use of telehealth for multiple treatment purposes and in a variety of settings, including outpatient settings, hospitals, and nursing facilities.[28] Some research shows that regardless of location and treatment intervention, telehealth generally is an effective tool for behavioral health services, including psychiatric assessments, and services for those who may be experiencing psychosis.[29,30,31] These findings support the application of telehealth to PASRR assessments. Nonetheless, PASRR evaluators should judge, for each specific assessment situation, the clinical appropriateness of conducting the assessment with telehealth.

States also should consider policies and procedures to obtain informed consent for the use of telehealth. Although there are no federal policies that require informed consent, some state Medicaid reimbursement policies require documentation of informed consent, and the ATA incorporates it into its practice guidelines.[32,33,34] Advance notice and agreement to the use of telehealth by the individual or his or her guardian also may address concerns from those who

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[28] American Psychiatric Association. What is Telepsychiatry? 2018. https://www.psychiatry.org/patients-families/what-is-telepsychiatry

[29] American Telemedicine Association. Practice Guidelines for Video-based Online Mental Health Services. 2009. https://higherlogicdownload.s3.amazonaws.com/AMERICANTELEMED/618da447-dee1-4ee1-b941-c5bf3db5669a/UploadedImages/Video-Based%20Online%20TMH%20Guidelines.final.new%20format.pdf

[30] Medicaid and Children's Health Insurance Program Payment and Access Commission, 2018. Op cit.

[31] Substance Abuse and Mental Health Services Administration. Rural Behavioral Health: Telehealth Challenges and Opportunities. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2016. https://store.samhsa. gov/shin/content/SMA16-4989/SMA16-4989.pdf

[32] American Telemedicine Association. Practice Guidelines for Video-based Online Mental Health Services, 2009. Op cit.

[33] Center for Connected Health Policy, 2017. Op cit.

[34] Telehealth Resource Centers. Informed Consent Laws. 2018. https://www.telehealthresourcecenter.org/toolbox-module/privacy-confidentiality-and-security

may be unfamiliar with the use of technology for health care and could result in higher rates of participation, stakeholder satisfaction, and assessment efficacy.

Licensure Requirements

Some states have enacted legislation that requires providers using telehealth technology across state lines to have a valid professional license in the state where the individual is located. Similarly, some states may have administrative code or other policies that require specific licensure for PASRR evaluators. Licensure and other credential requirements must be considered when designing a PASRR telehealth solution.

Quality

Central to a successful PASRR telehealth solution is ensuring the quality of the assessment. In addition to the typical quality indicators that states consider when assessing their PASRR programs, states also will want to identify quality benchmarks and requirements for assessments conducted via telehealth. States may elect to have policies that address the quality of the internet connection of the originating and distant site as a prerequisite for conducting the assessment using telehealth. Policies also might cover alternative approaches to take when connection issues disrupt the integrity of the assessment. States may establish quality benchmarks and checks for distant provider assessment facilitation, which may include stakeholder feedback and satisfaction surveys.

Ensuring that those who use or facilitate PASRR telehealth are appropriately trained also will support overall quality. Key training topics include complying with privacy and security requirements, mastering telehealth technology, and conducting clinical assessments using technology. Those using the technology must have the skills to easily engage with it, instruct others who may interact with it during the assessment, and troubleshoot any unexpected difficulties. Clinicians at the distant site may need training and experience conducting remote assessments to create an assessment experience that results in stakeholder satisfaction.

Conclusion

Health care providers have used telehealth to create innovative programs to address many health needs. Applying telehealth to PASRR is a possible solution when a face-to-face Level II assessment is not feasible or practical for the individual or state

authorities. Identifying whether telehealth is an advantageous and cost-effective solution requires states to assess their specific barriers and resources and to understand and consider clinical, operational, technical, and administrative requirements.

In addition to obtaining telehealth program implementation guidance from available resources such as TRC, ATA, and CCHP, states are invited to work with the PASRR Technical Assistance Center and CMS to design telehealth solutions that are compliant with the requirements and intent of PASRR regulations.