Nursing Roles and Interactions with Telehealth in Long-Term Care: An Interview with Nurses

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Executive Summary

Background

Telehealth use in long-term care (LTC) facilities expanded rapidly during the COVID-19 pandemic following Medicare policy changes in March 2020. Utilization has remained above pre-pandemic levels, but research has focused primarily on physicians, leaving gaps in the understanding of nurses' roles and experiences. Nurses, including nurse practitioners (NPs) and certified nursing assistants (CNAs), are central to telehealth implementation in LTC, yet little is known about their challenges, training needs, and perspectives.

Aims

The specific aims of this research were to:

1. Examine the role of nursing staff in the delivery of telehealth within LTC facilities.

2. Explore the challenges and facilitators nurses encounter in using telehealth for resident care.

3. Identify workforce and training implications to inform HRSA's Geriatrics Workforce Enhancement Program and related national initiatives.

Data and Methods

This qualitative study (IRB #24-42795) used a combination of online recruitment and professional networks. Fraudulent survey responses required multiple revisions to the screening process. Ultimately, five authentic participants (three NPs, two CNAs) were recruited from diverse LTC settings. Semi-structured telephone interviews (~1 hour each) addressed telehealth workforce adaptations, barriers, facilitators, training needs, and implications for LTC resident care. Thematic analysis guided interpretation.

Results

Seven themes emerged: (1) telehealth as a pandemic catalyst with lasting but reduced use; (2) technology as both an enabler and barrier; (3) workforce integration that improved efficiency for NPs but added burdens for CNAs; (4) mixed patient acceptance and unequal access, especially for residents with dementia; (5) variable support for care transitions depending on system integration; (6) training and support gaps, particularly for CNAs; and (7) sustainability marked by persistent inequities across roles and facilities.

Discussion

Telehealth improved continuity of care, reduced hospitalizations, and supported efficiency, particularly for NPs. However, CNAs experienced added responsibilities without formal training or integration into workflows. While telehealth engagement varied among patients, family involvement was critical for high engagement. Recommendations include extending telehealth training to all nursing roles, integrating telehealth into nursing education, and expanding standardized, interoperable systems. While limited by a small sample (n=5) and representation restricted to NPs and CNAs, this study provides needed insights into nursing perspectives on telehealth in LTC.

Introduction

Providers have long used telemedicine in rural long-term care (LTC) facilities to avoid hospitalizations, improve care coordination, and increase access to providers, especially on weekends or other times outside of regular business hours.[1,2] Medicare previously only reimbursed some telehealth visits in rural settings before COVID-19[3]; however, in March 2020, the US Center for Medicare and Medicaid Services (CMS) expanded the use of telehealth through new Medicare billable codes for patient care.[3,4] Additionally, CMS stopped requiring in-person visits for initial or follow-up visits in between telehealth visits.[3]

Physicians' use of telehealth for visits in LTC facilities increased significantly during the COVID-19 pandemic and has continued to be utilized post-pandemic. Telemedicine visits in LTC facilities rose from 0.15% to 15% for routine visits and 37% for outpatient visits in early 2020, then settled at around 2% and 10%, respectively, by mid-2021.[2] Physicians have raised concerns such as technical issues and increased workloads brought by telehealth.[5,6] They have also indicated benefits from using telehealth, such as reduced deferred care, improved efficiency, and enhanced communication with caregivers, suggesting that telehealth will likely remain a part of routine clinical services in LTC settings beyond the pandemic.[6]

Nurses play a crucial role in facilitating telehealth visits and caring for patients in LTC facilities, yet there is a notable lack of research specifically focused on their experiences and perspectives, especially in America. According to an Australian study looking at the experience of primary healthcare nurses, nurses perceived telehealth as a positive way to enhance patient care access; however, they expressed concerns about acquiring appropriate knowledge to use the technology effectively for themselves and their patients during COVID-19.[7,8] In remote areas, nurses have reported higher efficiency and care quality when utilizing telehealth for older patients compared to regular in-person care.[5] Despite these insights, there is a significant gap in the literature regarding nurses' specific roles, challenges, and adaptations in implementing telehealth in LTC settings during and after COVID-19. This lack of research highlights the need for further studies to understand and optimize nurses' involvement in telehealth initiatives within LTC facilities.

Aims and Methods

Aims

This study examines the role of nursing staff in the utilization of telehealth within LTC facilities through a literature review and interviews with nurses. While existing research has primarily focused on the physician's role in telehealth in LTC facilities, there is a significant gap in understanding the nursing perspective and experiences. This study aims to fill this gap by exploring the various roles nurses play in telehealth delivery, the challenges they encounter, and the potential benefits for both residents and staff. Interviews were conducted with NPs and CNAs in long-term care facilities.

How the Proposed Project is Linked to HRSA's Mission and Programs

Title VII funds are used to support the Geriatrics Workforce Enhancement Program, which includes education of nursing staff in LTC facilities. Understanding how telehealth has been integrated into long-term care, especially after CMS's March 2020 policy change, will provide valuable insight for HRSA. This information can guide program refinements, training updates, and new initiatives to support the long-term care workforce. The information from this study will also provide valuable

information to the Office of the National Coordination for Health Information Technology and Department of Labor.

This project will also expand on previous work that highlighted challenges related to electronic health records (EHRs) in LTC facilities, by further exploring the benefits and challenges nurses experience using technology in their care for patients.

Methods

We aimed to conduct 20–25 telephone interviews (approximately 1 hour each) with nursing staff (e.g., registered nurses, nurse practitioners) in long-term care (LTC) facilities. The sampling strategy was designed to capture variation across facility types, including independent nursing homes, multi-site chains, facilities integrated with other care settings, and both for-profit and not-for-profit organizations across different regions.

This project received IRB approval on 4/11/2025, as Exempt, Limited Review, Category 2. IRB #24-42795.

To recruit participants, we distributed a Qualtrics screening and eligibility survey through social media (a one-week Facebook ad), professional contacts, and organizational networks. Recruitment materials were sent to: Northern California Chapter of GAPNA, East Coast contacts (e.g., University of Pennsylvania), Southeast contacts (e.g., Emory University), the LeadingAge organization, and participants from a prior CNA study in our division. Recruitment ran from May–August 2025.

The first Qualtrics survey from May 1–7, 2025, yielded 494 responses, 421 of which were complete. However, metadata revealed widespread fraudulent responses (e.g., identical repeated IP addresses, Nigeria-based locations, sequential submissions completed within seconds). After review, nine responses appeared potentially legitimate and were sent follow-up a second Qualtrics survey using additional fraud detection features (e.g., bot detection, reCAPTCHA) via email. Out of the nine surveys, four surveys were completed, but no participants responded to subsequent email contact. A revised Qualtrics survey with fraud detection features and required responses was launched June 27–July 31, 2025, yielding 105 responses, of which 52 were complete and eligible. Based on metadata and eligibility, two participants were contacted, and one ultimately enrolled. A targeted Facebook ad for users in the United States ran from June 27–July 3, 2025, and linked to the second revised Qualtrics survey. Through prior study participants and professional networks, we recruited four additional eligible participants.

In total, we conducted five interviews. One additional case raised concerns about potential fraudulent participation and was excluded. Although the final sample size was smaller than anticipated due to recruitment and scheduling challenges, the interviews included participants from diverse LTC settings and roles. Interview questions focused on workforce adaptations to telehealth implementation, barriers and facilitators to telehealth effectiveness, training needs, and workforce implications for LTC resident care.

Results

Five interviews were conducted with participants in different nursing roles in LTC settings in the United States. Participant Demographic and Characteristics included: United States Region, Nursing Profession, LTC Facility in Rural Area, Years of Experience in Current Role, Employment Status (Full Time, Part Time, Per Diem), Position Type/Location, and Telehealth Systems Used in Role (Table 1).

Table 1. Participant Employment Demographics and Workplace Characteristics

Participant	United States Region	Nursing Profession	LTC Facility in Rural Area	Years of Experience in Current Role	Full Time, Part Time, Per Diem	Position Type/ Location	Telehealth Systems Used in Role
Participant 1	West	NP	No	2 years	Per Diem (10–25 hr./week)	Mobile Medical Group (telehealth and in-person care in LTC, SNFs, acute rehab, post-discharge follow-up, and homebound patient care)	Doximity and FaceTime (work phone); additional roles: MyHealthOnline (Epic) and FaceTime (work iPad)
Participant 2	West	CNA	No	1.5 years	Full Time	Nursing home providing resident care	Zoom (for resident appointments with psychiatrists or therapists)
Participant 3	Northeast	CNA	Yes	22 years	Full Time	Long-term care (Alzheimer's unit)	Zoom (for resident sessions with social workers, physician visits, or family meetings)
Participant 4	West	NP	No	14 years	Full Time	Home-based primary care for residents living in long-term care facilities	Zoom (for follow-up and urgent visits)
Participant 5	West	NP	No	15.5 years	Per Diem (previously Full Time for 14 years)	Academic hospital anticoagulation clinic, working with patients in assisted living facilities	MyChart (Epic) and telephone encounters

A majority of the participants (n=4) were based in the West region of the United States and one participant was based in the Northeast region (n=1). In our sample, we interviewed more nurse practitioners (n=3) than other nursing professions such as CNAs (n=2). The average years of experience in current roles varied between CNAs at 1.75 years and NPs at 17.17 years. Participants reported using a range of telehealth platforms across diverse care settings, including long-term care, skilled nursing facilities (SNFs), acute rehab, home-based primary care, and academic hospital clinics. Commonly used telehealth systems included Zoom, Doximity, FaceTime, and Epic (MyChart/MyHealthOnline). These systems are used to support resident care, follow-up visits, psychiatric and therapy appointments, and care coordination with families and providers.

Key Themes

Thematic analysis of the five interviews revealed seven significant themes reflecting nursing professionals' experiences with telehealth in LTC settings:

(1) telehealth as a pandemic catalyst and shifting legacy

(2) technology as a double-edged sword

(3) workforce integration and efficiency impacts

(4) patient experience: mixed acceptance and unequal access

(5) care transitions: integration for some, fragmentation for others

(6) training and support gaps across roles

1. Telehealth as a Pandemic Catalyst and Shifting Legacy

Across all interviews, participants shared that the COVID-19 pandemic was the main reason for telehealth adoption. Before 2020, some facilities had limited use and experience with video visits or telephone follow-ups, but the pandemic prompted widespread use almost overnight. One nurse practitioner described the abrupt transition in her anticoagulation clinic: "The telehealth is probably 90% telephone and 10% through our MyHealthOnline video access… since 2022, it's the only means now" (Participant 5, NP). Others highlighted how telehealth peaked during the pandemic but declined once in-person care resumed. "The bulk… like 75% [of visits were] virtual for almost a full year [in 2020]. Now I probably do only like 5% video visits" (Participant 4, NP). A frontline CNA during the panademic noted that telehealth was important for clinical visits, but also noted it was utilized in maintaining family contact during lockdowns but has since fallen out of routine use: "It was really important during COVID for them to talk with their family… it's not used as much now since families can come in again" (Participant 3, CNA). Overall, telehealth remains central to some clinical practices, serving as a primary source of visits for nurses in provider roles—especially those working in telehealth or telehealth clinics. For CNAs in LTC settings, however, it plays a more supporting role, providing an alternative option for patients who cannot attend in-person appointments.

2. Technology as a Double-Edged Sword

Participants consistently described technology as both enabling and constraining care with their patients. Telehealth enhanced continuity and flexibility, while also creating barriers related to digital literacy, infrastructure, and usability. Nursing professionals found telehealth systems to be useful for supporting patient education and continuity. For example, one nurse shared, "the MyChart [system has] a nice document if they're forgetful… and it's [also] an education tool" (Participant 5, NP). Telehealth also provided workflow benefits, particularly for nursing providers who previously spent time commuting between facilities. "It is nice to have a day… to not be driving and parking… that's also a provider satisfaction piece" (Participant 4, NP). However, issues with telehealth systems undermined efficiency. Connectivity issues, poor lighting, and hearing limitations were common. "Sometimes not hearing correctly… not the best lighting if they're trying to show me something on their skin" (Participant 4, NP). CNAs in nursing homes also noted gaps in awareness and engagement with telehealth availability. "New residents might not even realize it's an option" (Participant 3, CNA). Telehealth improves healthcare access for both nursing providers and patients, but challenges remain with ease of use and connectivity, particularly for older adults in various LTC facilities.

3. Workforce Integration and Efficiency Impacts

Telehealth adoption reshaped professional roles in long-term care settings, providing efficiency gains for some staff while creating additional burdens for others. Advanced practice providers (NPs) experienced significant structural changes and increased autonomy. For example, one NP described how anticoagulation management transitioned fully to an advanced practice provider model, delivered

remotely through telehealth, streamlining care and reducing unnecessary hospitalizations: "I can still check in on this person via video… and try and avoid unnecessary hospitalizations" (Participant 4, NP). CNAs also highlighted time savings from telehealth, such as avoiding transportation to appointments: "It saved having to take them in the van for an appointment" (Participant 3, CNA). Providers also encountered challenges when patients did not answer phones or required follow-up via mail: "We would just be leaving messages… if they don't answer, we send snail mail" (Participant 5, NP).

In contrast, CNAs often took on additional responsibilities without corresponding support. During COVID-19, CNAs reported spending a notable portion of their time assisting with telehealth visits: "During COVID, I probably spent 15% of my time helping with visits. Now it's maybe 5%" (Participant 2, CNA). While not a major part of their day overall, these added tasks accumulated, especially when they could have been assisting other residents: "Sometimes it freezes, and we just sit there waiting for it to reconnect" (Participant 3, CNA). CNAs also reported feeling excluded from formal training: "They did not pull us in for in-service training… I think they just kind of assume that everybody knew how to use Zoom" (Participant 3, CNA). As shared by participants, telehealth enhanced efficiency and autonomy for nursing providers but added tasks and stress for CNAs.

4. Patient Experience: Mixed Acceptance

According to the nursing professionals interviewed, patient engagement with telehealth varied widely. Many participants described mixed acceptance, particularly among older adults. One participant noted, "I have some patients who love it, and I have other ones who… turn it down. There's an initial kind of reluctance… but once they feel comfortable, they actually turn out liking it" (Participant 4, NP). However, telehealth was not considered a practical option for patients with dementia or cognitive impairment, as mentioned by Participant 3. Family involvement in patient care in LTC facilities emerged as a key determinant of telehealth's success: "We have some wonderful family that connect the dots with us, share information and updates… daughters that are on it" (Participant 5, NP).

5. Care Transitions: Integration for Some, Fragmentation for Others

Telehealth's role in care transitions varied depending on the systems available at participants' workplaces. In facilities using Epic, transitions were described as smoother: "[With] 'Care Everywhere'… you can download information from hospital systems that are different than your own" (Participant 5, NP). Another NP noted that when patients were transferred or hospitalized, "in Epic… it will pop up as an alert… some facilities call and tell us too" (Participant 4, NP). In contrast, facilities without integrated systems relied on manual workarounds: "Sequoia Hospital and Good Samaritan… are not connected to Epic 'Care Everywhere,' so I just call directly to the lab" (Participant 5, NP). CNA participants shared their exclusion from the handoff process, describing limited communication and vague paper records: "There is not a formal handoff at all between me and my nurse" (Participant 2, CNA). Overall, there were differences in the process of care transitions using telehealth, as there is no standardized system and communication practices vary across facilities.

6. Training and Support Gaps Across Roles

Training and IT support for telehealth were unevenly distributed across professional nursing roles. NPs reported structured onboarding and access to 24/7 IT support: "We just did like an online Zoom tutorial… Epic guidelines… UCSF has on-demand IT help" (Participant 4, NP). However, CNAs received little to no training: "We just kind of learned as we went along" (Participant 3, CNA), "no,

actually… they never announced anything [about training]" (Participant 2, CNA). The lack of structured training illustrates inequities in telehealth implementation, with nursing providers receiving training and support while CNAs had to troubleshoot independently or with their peers.

For nursing professionals in LTC settings, experiences with telehealth varied, both in enabling access, continuity, and provider satisfaction, and as a source of inequities in staffing, patient inclusion, and training. While telehealth became central to some clinical practices, its sustainability varied widely. Advanced practice nurses reported more advantages of telehealth, with more support, training, and family involvement when older patients used telehealth. At the same time, CNAs, cognitively impaired residents, and under-integrated facilities experienced ongoing barriers as well as limited support.

Discussion

The interviews with nursing professionals illustrate six themes related to the benefits and challenges of telehealth in LTC settings:

1. Telehealth as a pandemic catalyst and shifting legacy

2. Technology as a double-edged sword

3. Workforce integration and efficiency impacts

4. Patient experience: mixed acceptance and unequal access

5. Care transitions: integration for some, fragmentation for others

6. Training and support gaps across roles

Together, these findings highlight the role of telehealth in improving continuity and access while underscoring inequities in training, role integration, and patient engagement.

Benefits of Telehealth in LTC

Telehealth emerged as a critical tool during the COVID-19 pandemic, substituting for in-person visits and ensuring continuity of care in LTC. In some cases, such as anticoagulation management for patients in various LTC settings, it became the exclusive model of care delivery, reducing the need for resident transport for vital treatments. Participants described how platforms and features like Epic's "Care Everywhere," supported information sharing, while portals such as MyChart reinforced education and instructions for patients. Telehealth also reduced logistical burdens to allow nursing providers more time for patient care, documentation, and care coordination. From our interviews, CNAs described how video and phone visits avoided the need for transportation, while nurse practitioners emphasized its role in preventing unnecessary hospitalizations. These findings align with national perspectives that telehealth allows ongoing connection without patients leaving their homes or facilities, particularly benefiting those with mobility limitations or chronic illness.[9]

Challenges of Telehealth in LTC

Despite these benefits, nursing professionals shared several challenges with the use of telehealth. Connectivity issues, reliance on fax and phone when facilities were not integrated with Epic, and patient reluctance or inability to use technology disrupted workflow. CNAs emphasized that many residents were unaware of telehealth or unable to engage, especially those with dementia. Training and support were also not uniform. Nurse practitioners reported access to tutorials and IT help desks, while CNAs described little to no formal preparation, learning "as they went". This gap reflects

broader findings that telehealth use is limited by access to reliable internet and hardware such as smartphones or webcams.[9] Furthermore, concerns arise when patients cannot be reached for telehealth visits or urgent needs, as discussed by a nurse practitioner during our interview. In such cases, the option of a telephone visit was frequently reported by participants, mirroring national data indicating that roughly 30% of telehealth visits during the pandemic were audio-only, which also raised quality concerns.[10]

Workforce Implications

These findings highlight different experiences across nursing roles. Nurse practitioners described efficiencies and improved workflows, while CNAs experienced exclusion and added burdens. Although RNs and LVNs were not represented in our sample, national data suggest these roles are increasingly involved in telehealth. The 2024 National Nursing Workforce Survey found rising APRN credentials and multistate licenses, with many nurses noting these facilitated telehealth practice.[10,11] HRSA workforce projections suggest shortages of RNs and LPNs through 2036, but a surplus of NPs who may expand their telehealth roles.[10,12] These trends point to telehealth as both a workforce solution and a potential area of inequity of care quailty if training gaps are still present.

Research and Policy Recommendations

(1) Telehealth training for all nursing roles.
Structured, interprofessional telehealth training should be extended to CNAs, LVNs, RNs, and APRNs to reduce inequities and improve collaboration. Recent studies emphasize competency-based onboarding and continuing education as critical to facilitating effective telehealth use across nursing roles in long-term care.[13,14,15] Telemedicine Entrustable Professional Activities (EPAs) offer a standardized framework for consistent competency development in nursing telehealth practice.[16] Policy initiatives should require telehealth training for all nursing staff to support workforce readiness and quality care delivery.[14]

(2) Integration into clinical education.
Telehealth modules, simulations, and experiential learning should be embedded across nursing curricula at all levels, reflecting telehealth as an essential nursing competency.[17,14] Accrediting bodies and boards can standardize these competencies to ensure consistent training and promote workforce preparedness, especially given the growing use of telehealth by APRNs in long-term care and the telehealth standards already set by the American Academy of Ambulatory Care Nursing.[13,14] This integration should include hands-on training with clinical decision-making in virtual environments, health informatics and EHR systems, and communication and patient engagement skills specific to telehealth delivery.[17]

(3) Standardized telehealth platforms.
Interoperable, standardized platforms are essential to reducing fragmentation and improving communication across various settings, including long-term care.[18,19] Epic's "Care Everywhere" has been seen as a helpful tool by many, including nurses in our study. Evidence reveals that platform heterogeneity compromises care continuity and workflow efficiency.[20] Policy incentives and technical support should focus on broad integration of interoperable telehealth systems in long-term care to enable sustainable telehealth implementation in all populations from city to rural.[4,6,8]

Limitations

This qualitative study faced several limitations. Recruitment was conducted online and was heavily impacted by fraudulent survey responses. The initial Qualtrics screener produced hundreds of suspicious entries, flagged by repeated IP addresses, rapid completions, and non-U.S. locations. A second survey version with additional bot-detection features reduced fraudulent responses but still required extensive manual review. Ultimately, only five authentic participants were recruited via snowball sampling and network referrals. The final sample size was therefore lower than expected and did not meet the study goal of approximately 20 participants. This smaller sample may have limited the diversity of perspectives represented, particularly since only NPs and CNAs were included. These challenges mirror broader concerns that bots and fraudulent respondents are increasingly common in online research.[21] While requiring video-on during interviews improved authenticity, the extensive screening and recruitment barriers constrained the pool of eligible participants.

Conclusion

This study highlights the central but uneven role of nurses in the implementation of telehealth within LTC facilities. While nurse practitioners reported efficiency gains, increased autonomy, and structured support, CNAs described added responsibilities, limited training, and exclusion from formal workflows. Patient engagement with telehealth was variable, with technology access, cognitive status, and family involvement shaping outcomes. Differences in system integration further influenced care transitions and provider efficiency. These findings underscore telehealth's potential to improve continuity of care and reduce hospitalizations, while also revealing gaps in workforce preparation and equity across nursing roles. Addressing these challenges will require standardized telehealth training for all levels of nursing staff, greater integration of telehealth into nursing education, and broader adoption of interoperable health information systems in LTC. Although limited by a small sample size and recruitment challenges, this study provides needed insights into the nursing perspective and informs policy and workforce development to optimize telehealth use in LTC settings.

Endnotes

1) Driessen J, Castle NG, Handler SM. Perceived benefits, barriers, and drivers of telemedicine from the perspective of skilled nursing facility administrative staff stakeholders. *J Appl Gerontol*. 2018;37(1):110-120.

2) Ulyte A, Mehrotra A, Wilcock AD, SteelFisher GK, Grabowski DC, Barnett ML. Telemedicine visits in US skilled nursing facilities. *JAMA Netw Open*. 2023;6(8):e2329895.

3) Gillespie SM, Handler SM, Bardakh A. Innovation through regulation: COVID-19 and the evolving utility of telemedicine. *J Am Med Dir Assoc*. 2020;21(8):1007-1009.

4) Centers for Medicare & Medicaid Services. Long-term care nursing homes telehealth and telemedicine tool kit. March 27, 2020. https://www.cms.gov/files/document/covid-19-nursing-home-telehealth-toolkit.pdf. Accessed August 6, 2024.

5) Dai Z. Telehealth in long-term care facilities during the Covid-19 pandemic - lessons learned from patients, physicians, nurses and healthcare workers. *BMC Digit Health*. 2023;1(1):2.

6) Goldberg EM, Lin MP, Burke LG, Jiménez FN, Davoodi NM, Merchant RC. Perspectives on telehealth for older adults during the COVID-19 pandemic using the quadruple aim: interviews with 48 physicians. *BMC Geriatr*. 2022;22(1):188.

7) Mills CA, Tran Y, Yeager VA, Unroe KT, Holmes A, Blackburn J. Perceptions of nurses delivering nursing home virtual care support: a qualitative pilot study. *Gerontology & Geriatric Medicine*. 2023;9:23337214231163438. doi:10.1177/23337214231163438

8) James S, Ashley C, Williams A, Desborough J, McInnes S, Calma K, Mursa R, Stephen C, Halcomb EJ. Experiences of Australian primary healthcare nurses in using telehealth during COVID-19: a qualitative study. *BMJ Open*. 2021;11(8):e049095. doi:10.1136/bmjopen-2021-049095

9) National Academies of Sciences, Engineering, and Medicine; National Academy of Medicine; Committee on the Future of Nursing 2020–2030; Flaubert JL, Le Menestrel S, Williams DR, et al, eds. The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity. Washington, DC: National Academies Press; 2021. https://www.ncbi.nlm.nih.gov/books/NBK573910/. Accessed September 10, 2024.

10) Uscher-Pines L, Sousa J, Jones M, et al. Telehealth Use Among Safety-Net Organizations in California During the COVID-19 Pandemic. *JAMA*. 2021;325(11):1106-1107. doi:10.1001/jama.2021.0282

11) Health Resources and Services Administration. Nursing workforce projections factsheet. November 2022. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Nursing-Workforce-Projections-Factsheet.pdf. Accessed September 10, 2024.

12) Smiley RA, Kaminski-Ozturk N, Reid M, et al. The 2024 national nursing workforce survey. *Journal of Nursing Regulation*. 2025;16(Supplement). https://www.journalofnursingregulation.com/action/showPdf?pii=S2155-8256%2825%2900047-X. Accessed September 10, 2024.

13) National Association of Clinical Nurse Specialists. NACNS White Paper on Telehealth Competency for the Clinical Nurse Specialist: Gap Analysis and Recommendations. September 2021. Available at: https://nacns.org/advocacy-policy/position-statements/nacns-white-paper-on-telehealth-competency/. Accessed December 2024.

14) Rutledge CM, Gustin T. Preparing nurses for roles in telehealth: now is the time! *Online J Issues Nurs*. 2021;26(1). doi:10.3912/OJIN.Vol26No01Man01

15) Nabelsi V, Leclerc MC, Plouffe V. Nurses' and Nursing Assistants' Experiences With Teleconsultation in Small Rural Long-Term Care Facilities: Semistructured Interview Pilot Study. *JMIR Aging*. 2024;7:e65111. Published 2024 Nov 27. doi:10.2196/65111

16) Tan AJQ, McKenna L, Bramley A, et al. Telemedicine entrustable professional activities for nurses in long-term care: A modified Delphi study. *Nurse Educ Today*. 2024;140:106264. doi:10.1016/j.nedt.2024.106264

17) Nevada State University School of Nursing. Telehealth Training in RN to BSN Programs. NSU. Available at: https://nevadastate.edu/son/rn-bsn/telehealth-training-in-rn-to-bsn-programs-what-future-nurses-need-to-know/. Accessed December 2024.

18) Mahtta D, Daher M, Lee MT, et al. Promise and perils of telehealth in the current era. *Curr Cardiol Rep*. 2021;23(9):115. doi:10.1007/s11886-021-01544-w

19) Martin T, Veldeman S, Großmann H, Fuchs-Frohnhofen P, Czaplik M, Follmann A. Long-Term Adoption of Televisits in Nursing Homes During the COVID-19 Crisis and Following Up Into the Postpandemic Setting: Mixed Methods Study. *JMIR Aging*. 2024;7:e55471. Published 2024 Jun 6. doi:10.2196/55471

20) Chen Y, Lehmann CU, Malin B. Digital Information Ecosystems in Modern Care Coordination and Patient Care Pathways and the Challenges and Opportunities for AI Solutions. *J Med Internet Res*. 2024;26:e60258. Published 2024 Dec 2. doi:10.2196/60258

21) Simone M, Cascalheira CJ, Pierce BG. A quasi-experimental study examining the efficacy of multimodal bot screening tools and recommendations to preserve data integrity in online psychological research. *Am Psychol*. 2024;79(7):956-969. doi:10.1037/amp0001183