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Past Event: 2026 APRN Roundtable - Is Telehealth a Different Kind of Care? APRN Practice in a Virtual World Video Transcript

Event

2026 APRN Roundtable

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Presenter

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- [Kelli] Hi, everyone. I'm Kelli Garber. I'm director of the DNP Advanced Practice Program at the Ellmer School of Nursing at Old Dominion University, and I'm also a telehealth consultant for our Center for Telehealth Innovation, Education, and Research.

I'm excited to be with you today to talk about "Is Telehealth a Different Kind of Care? APRN Practice in a Virtual World." I've been doing telehealth now for about 12 years, long before COVID-19 entered our experience. So I have a lot of experience both with school-based telehealth and virtual urgent care.

I hope to impart to you some of the details that I've learned over the years, as well as the various best practices that have evolved over time. I have nothing to disclose, but I do want to make note that this presentation is for informational purposes only. It is not intended to suffice as legal advice.

It's really important that APRNs evaluate their unique practice setting, their location, as well as their state, to know how these factors and this information will impact the care that you provide in your unique setting. The objectives are listed here. We're going to describe telehealth applications for APRN roles throughout the Consensus Model.

We'll talk about some best practices for conducting clinical care across distance, and we'll examine key telehealth-related practice standards that impact APRN licensure integrity. I'd like to start with a simple question. Maybe it's not so simple.

Is telehealth a different kind of care? Feel free to enter your thoughts in the chat. Or is it really the same evidence-based care we provide in person, just across distance? I'll argue that it's the same care, and I hope to show you that as we go throughout the presentation. In the early days of telehealth, legal cases were limited to situations where telehealth was available but not used.

For example, telestroke. Perhaps a stroke patient comes into a rural setting, a rural emergency hospital, and they have telehealth equipment, but don't seek that academic institution through telehealth for guidance on the patient's care. Unfortunately, sometimes patients had poor outcomes as a result. Ever since COVID-19, when telehealth became an ongoing part of our healthcare system, we've started to see more focus on the benefits, risks, and limitations of telehealth.

This has become a very important topic for APRNs and one that really requires intentional understanding and education to ensure that APRNs are compliant with recommendations to ensure safe, quality, and ethical healthcare.

I always start my presentations with a few key terms. Telehealth is a broader term, more of an umbrella term, if you will, that includes anything and everything technology-based that impacts healthcare. Telemedicine, on the other hand, is clinical care conducted across distance. A third term you may hear is virtual care.

These three terms, anymore, are typically used interchangeably, though they originally had various definitions, as I've noted. So you'll hear me probably go back and forth between telehealth, telemedicine, and virtual care. And in this presentation, I'll generally be talking about clinical care across distance. The originating site is the patient location.

This is important to note as the originating site is considered the site of service. The distant site is the provider location. Now these can be various settings. The originating site could be a patient's home, a school, a jail, a skilled nursing facility, a clinic, an emergency room, and so on.

And the distant site also could be many different locations. The provider may be seeing patients from their home office, or it could be a setting in a clinic or an academic medical center, for example. There are various telehealth modalities. Asynchronous, or store and forward, refers to information that is gathered at one point in time, transmitted to a provider for review at a later point in time when a clinical decision is then made.

We often see asynchronous telehealth used for things like dermatology or radiology. Synchronous telehealth, or real-time communications, is often used either with or without video. Audio-only, really telephone, refers to a live synchronous communication that does not include video, whereas video-based or video-enabled telehealth includes both audio and visual.

Remote patient monitoring is where personal health and medical information is collected from a patient at one point in time at a certain location and transmitted electronically to a provider in a different location. This allows for more real-time observation of patient status and intervention.

Things like vital signs, or weight, or blood pressure, oxygen levels, heart rate, things like that are falling under the remote patient monitoring or RPM umbrella. M-health, or mobile health, refers to healthcare and public health practice that can be done from mobile devices, so your smartphone, your smartwatch, or a tablet, for example.

Across the U.S. and around the world, APRNs are leading in virtual care. The applications are truly endless. Regardless of the APRN's role, some form of telehealth is likely to be used to enhance patient care.

APRN telehealth roles can be applied in several of these, if not all of these, applications. In general, telehealth applications can be divided into these five buckets, if you will. Teleeducation. With teleeducation, the APRN may be the educator or the learner. They may be doing patient education or teaching other providers.

Telementoring is something that is built off of what originally developed at the University of New Mexico called Project ECHO. Project ECHO is an all-teach, all-learn program that includes didactic and case-based learning. It connects experts to local clinicians to allow them to be able to manage complex patients in their local community, reducing the need for patients to travel great distances to seek care.

APRNs may be the expert providing the guidance and didactic on the ECHO session, or they may be the local clinician who's connecting via ECHO to learn how to manage those complex patients. Teleresearch is a situation where telehealth can be used to expand research, such as the population being evaluated, or to conduct research.

The APRN may be the researcher or a participant in a research study. Teleconsultation refers to expert specialty consults. This is where the expert is connected to the patient for a consultation or connected to the local provider and patient for that consultation.

And the APRN may be the expert or the local provider seeking the consultation. You may have heard of e-consults. These are secure email exchanges between providers about a patient's health status. The APRN, again, may serve as that specialist or as the one seeking the consultation. And telepractice may be what you're most familiar with.

This is synchronous or asynchronous virtual care in which the APRN serves as the provider who is providing the care across distance to the patient. It may be acute care, primary care, behavioral, or mental health. Many different specialties use telehealth to conduct care. So the majority of this presentation will be focused on the telepractice role.

Now, APRN roles extend beyond just the telehealth visits. APRNs are often tapped to be the telehealth program developer, to actually develop and implement the program. They may be tasked with program evaluation and quality improvement initiatives. So as you can see, APRNs have a wide array of opportunity in the world of telehealth.

Each of the APRN roles and the Consensus Models and specialties can participate in telehealth related to their specific practice, but in different ways. I'm going to share a few examples for each of the roles. This is by no means exhaustive.

It's just a bit of example to get you thinking about how you might be able to use it in your practice setting. For example, our certified registered nurse anesthetist may use telehealth for pre-anesthesia evaluations, either audio-only, in which they delay some components of the evaluation until the patient presents at the institution, or with audio-video.

Now, video-enabled evaluations of this manner have been shown to be similar to in-person outcomes in terms of the number of patients who do show as expected for the surgery, but also it helps reduce cost and wait times. Nurse anesthetists can also use telehealth for post-operative follow-up visits.

Our nurse midwives can often use telehealth for prenatal and postnatal care, as well as perinatal care. With the advent of the various types of digital tools or peripheral devices, including ultrasound, they can

often provide care through a hybrid model and really extend that important care across distance to those in rural and underserved areas that may not have access to a nurse-midwife.

Clinical nurse specialists also use telehealth in many different ways, oftentimes direct clinical care, but they also may use it to provide education to the nursing team or to support nurses within their units and departments.

And, of course, our nurse practitioner population use telehealth to deliver primary, acute, and specialty care. Again, that can be consultations, direct patient care, e-consults, and even to provide care coordination. So this list, as you can see, is just a sampling of the ways APRNs are using telehealth every day.

The next section of this presentation will focus on synchronous telehealth applications and ensuring safe, equitable, quality clinical care across distance. Before the telehealth visit begins, there are several important considerations for APRNs to ensure safe and effective healthcare is delivered virtually.

Digital inclusivity, accessibility, and cultural competency are essential for APRN practice. Digital equity refers to the state where every person and community has the necessary information technology resources to participate in society fully.

Just think about how much technology impacts things we do every day, whether it's banking, or healthcare, education, communicating with one another. Technology is involved in every aspect of our lives. Now, inclusivity and equity differ in that equity provides the resources and structural changes that are necessary for fair and equal access.

But inclusivity actually refers to the resulting culture where people feel welcomed, valued, and able to participate. Both are needed for successful telehealth encounters. We must ensure that care provided via telehealth is available and accessible to all. APRNs need to evaluate their patient population before beginning a telehealth program to be able to identify areas that need to be improved to ensure that there is access for all.

The elderly and those in rural and underserved communities are often the most impacted by digital equity challenges. Several components impact digital equity and inclusivity. The digital divide, which you may have heard of, is the unequal access to technology and connectivity. This means, does the patient have access to a computer, or a laptop, or a phone to conduct a visit?

Do they have connectivity, Wi-Fi, or internet access, or even cellular service to have the telehealth visit? It's very important to understand what our population has access to in order to ensure a comprehensive program that's accessible to everyone.

Digital literacy is the individual's ability to find, evaluate, and communicate information using digital media platforms. It's important to note that there are many who struggle with digital literacy. I think particularly about the elderly population. My mother is 90 years old.

If you tell her to copy and paste this URL into the search bar to connect for a telehealth visit, she will probably panic. She will have no idea what that means. So we have to remember that what might be commonplace to us may be out of reach or very unfamiliar to our patients, and so we need to know what those challenges may be. Health literacy, of course, is the ability to find, understand, and use health information in order to make well-informed health decisions.

If you put health literacy and digital literacy together, you get what's called digital health literacy, or e-health literacy, as many people refer to it. And this is the ability to use digital tools and information to find, understand, and use health services successfully to have self-efficacy and improved outcomes for our healthcare. And of course, accessibility is important as well, particularly for those with limited English proficiency or disabilities.

Telehealth accessibility differs from access, and we'll talk about that. Telehealth accessibility differs from telehealth access in that it refers to the ability of patients to participate fully in remote services to receive equitable care. There are several federal laws that require telehealth to be accessible to those with limited English proficiency and those with disabilities.

I've listed those here for you. It's really important to note that failure to comply can result in unlawful discrimination. Nondiscrimination in healthcare means equal access to available services regardless of whether they're provided in person or virtually. Often, it's necessary to implement safeguards and modifications for those with disabilities.

Some of those things may include extra time before, during, or after visits to provide additional support. Many practices and offices are using what's called a digital navigator. Digital navigators connect with patients ahead of time to make sure that they do have access to the necessary technology, that their device actually has a camera or a microphone to conduct the visit.

They also help them understand what the steps are to connect at the time of the visit, and they provide opportunity for practice with them. This can be very helpful, particularly for those who may face disabilities or other challenges in understanding the technology. It's important to note that the platform should allow for a third party to join, and that might be an interpreter, for example, or maybe a family member or a care provider, depending on the needs of the patient.

Adaptations are also necessary. Things like screen readers for the blind or closed captioning for the hearing impaired can be very important, along with the availability of interpreters. My colleagues, Kobeissi and Manning, developed the ACCESS framework. It's an acronym to help APRNs and other healthcare providers who do telehealth remember the key components of accessibility, and this will help to make sure we don't forget any of these essential components.

In doing so, reduce the risk of discrimination based on disability. ACCESS is an acronym that includes Accommodations, Communication, Customization, Education, Support, and Security. The virtual visit requires intentional adaptation and unique skills that are different from in-person care.

APRNs must be intentional about learning and employing this unique skill set during telehealth encounters. Many of us have grown up using things like FaceTime or Skype, and so they've become very casual platforms. Often, I'll meet providers that say, "Oh, I FaceTime all the time. I know how to do telehealth."

Well, it's really not the same. We have to be intentional about how we conduct the visits in order to ensure safe, quality healthcare, as well as preserve the patient and provider experience. First and foremost, we need to ensure privacy and security. It's important to note that HIPAA does apply to telehealth. Not only is it necessary that we use a secure HIPAA-compliant platform to conduct our telehealth visits, but also you should have a BAA, a business associate agreement, with any business that is involved with the telehealth platform to ensure that the vendor handles the patient data in a secure way, as it should be, to protect the PHI.

Now, we also need to ensure privacy and security at both the patient and the provider location. At the patient location, if they're at home in particular, is anyone else present, and do we have permission for them to participate in the visit? For the provider location, is there a student or other professional located with the provider?

We need to make sure that we tell patients that, if there are, and get their permission, because they may not be able to see everyone that's in the room with us. Another issue that comes up sometimes, and I can tell you this really does happen, is that you'll connect for a visit and find that the patient is in a public place. Maybe they're in a grocery store or a restaurant. Maybe that's the only place they could access Wi-Fi to have the telehealth visit.

So we need to make sure to inform them of risks associated with using public Wi-Fi. If they still choose to continue the visit, maybe that's again the only access they have, we want to document carefully that we made them aware of the risks associated with that. Of course, equipment standards are important as well.

We need to make sure that not only do they have a camera, but that the camera can be positioned appropriately and that it's functional. We need to maximize the quality of those visual assessments when doing telehealthcare. And, of course, the quality of the connection. We need to ensure strong Wi-Fi or a wired connection, whenever possible, so that we can ensure that we don't miss anything that the patient is saying and that any visual assessments are accurate.

What about audio-only? Do you think that HIPAA covers audio-only? Well, of course, yes, it does. It's also important to note that the HIPAA security rule applies as well. Most audio connections, anymore, are done through the internet. They're not traditional landlines as we used to know them.

And so, therefore, the HIPAA privacy and the HIPAA security rule apply to the information that is shared. Now, it's essential that we set the stage for the visit. What does that mean exactly? Well, we need to take a check of our website manner and our telehealth etiquette. Website manner is the manner in which the provider engages with the patient virtually to make them feel comfortable.

It's your bedside manner just conducted across distance. Telehealth etiquette, on the other hand, is the code of acceptable behaviors to ensure successful telehealth encounters. And this includes privacy and security, but also the environment and your professionalism. These soft skills have been shown to improve patient satisfaction, enhance the patient-provider experience, and to build trust, which is essential to getting a patient to follow through on recommended care.

And then, of course, that makes a difference in terms of how successful our patient outcomes are. You want to first start with the professional environment. So, what does that mean? Well, you want to dress appropriately. Whatever you would wear in the clinic seeing the patient is what you should wear for a telehealth encounter, whether it's a lab coat or professional attire.

Be sure that your identification is at eye level. Sometimes platforms will put the provider's name along the bottom of the screen. Make sure that name matches yours. That can be very confusing and frustrating. For example, if you've just gotten married, the name should match what's on your professional licensure.

It's also important to sit at a desk or a table with the camera at eye level. You want the lighting behind the camera, not behind the provider. When it's behind the person, it can make you look like a shadowy

figure, and that can be a little scary, particularly for children. So, keep in mind avoiding any auditory distractions, you know, noises in the background, the television, the radio, the dog barking.

Avoid those, as well as any visual distractions. Your background should be neat and free of clutter or any inappropriate items. And I always advise against using a virtual background. You want to make sure to use the self-view to ensure that you are sort of in the passport view, if you will. This prevents you from being too close to the patient to where it feels like you're in their personal space, yet far enough away that they can see you and try to see as much of your body language as they can.

Be punctual. Now, we're all going to run behind, but you should have a mechanism in place to let patients know if you're running behind. When they're in a room, they can hear the chaos that's going on, and they know that they're still waiting for you. But in a telehealth visit, sometimes patients can feel as though they've been forgotten, and they wonder whether they should disconnect or keep waiting.

So, just being sure to make sure that there's a way that they're notified if the provider is running behind. Be sure to communicate clearly, speak slowly and clearly, and make sure that you use verbal cues as well as nonverbal cues to communicate empathy and warmth. This is really important since they don't have the same level of visualizing your body language as they would in an in-person encounter.

Now, even without a peripheral device, much of the physical exam can be completed through video-enabled telehealth. Think about how much you do when you walk into a room and evaluate that patient. All of that can be done through video before you ever even touch the patient with a stethoscope. So, be sure to remember that you can conduct a thorough evaluation through telehealth.

It's necessary to choose the appropriate modality for the chief complaint. Be sure that if it's required to see an element of exam to make the diagnosis that you do see that element of exam. The standard of care does not change.

Clinical guidelines do not change when you're doing telehealthcare. For example, if the guideline for evaluating ear pain to diagnose an otitis media is to see the tympanic membrane, then you need to see the tympanic membrane to make that diagnosis. If you're on audio-only and unable to switch to a video connection, then that means referring the patient to an in-person visit so that they can have a thorough exam.

When necessary, be creative. Use household items, you know, a flashlight, a thermometer, a scale. Remember that you can get a lot of what you need by being creative and working collaboratively with the patient. Now, the patient may also have to walk through some exam techniques with you. Be sure to avoid medical jargon.

Use clear language, and always refer to the patient's right or left when you're giving them guidance. And if you're lucky enough to have access to peripheral devices, be sure that you know how to use them and how to walk the person on the other end through those techniques. Many families now are purchasing devices that can be attached to cell phones so that you may be able to see that TM and an at-home visit.

It just depends on the population you're serving and what they have access to. Now again, when you're giving directions to patients, you might have to have them adjust the camera or the light so that you can get the best assessment. Just be sure to give clear step-by-step instructions. And don't forget about the environmental scan. When you're doing patient care through telehealth at home, one of the biggest benefits is you can see their environment.

You can acknowledge any dangers. Are there fall hazards, for example? Is there any sign of neglect or abuse? What is the home environment like? And that can really influence how you would manage their care. You can also have them just bring you the medications that they have at home that they're taking. And that way, you can see what exactly they're taking, rather than relying on what they may remember.

So that environmental scan is key. And, of course, continuity of care and quality assurance is so very important. We need to be sure that we're giving clear follow-up instructions as well as instructions on what to do if they worsen or if they need to have a referral to someone else for further evaluation.

How do they get that referral? What do they do next? And it's also important to evaluate the care that we're providing. We want to assess treatment response and medication management. We want to use quality metrics. The same ones for in-person care apply to telehealth. So we want to evaluate, are the providers prescribing appropriately, consistent with in-person care?

And, of course, ongoing patient safety monitoring is necessary. Ongoing evaluation of telehealth encounters to look for effectiveness, patient outcomes, and documenting any adverse events is significant. Technical considerations can really impact the quality of our visits. I've mentioned about audio-only and the limitations there without video.

Please remember, if you remember nothing else from my presentation, please remember that telehealth doesn't change the standard of care or the clinical guidelines. If you need to visualize something to make a diagnosis, you must visualize it. If you have access to peripheral devices, that is even better, but that is not often the case, particularly when you're delivering care to the home.

Now I'm going to talk specifically about APRN practice standards. There are many different standards that APRNs need to be aware of. First and foremost, practice standards are the guidelines and expectations of professional practice. They define the quality and the level of care that should be delivered to a safe, competent, ethical practice.

So in essence, the scope of practice is what healthcare professionals can do, whereas the practice standards define how the care is delivered to ensure quality. It's really important to understand that telehealth practice is governed at both the state and federal levels, including legislation and regulations, as well as guidance from licensing boards and professional organizations.

It's not just telehealth-related legislation. It includes legislation and regulation that's pertinent to healthcare that may be impacted by telehealth. So really important that APRNs know their practice act and know whether there are any advisory opinions or position statements pertinent to telehealth practice for APRNs in the state where the patient is located and where the APRN is located.

It's important that you know what your specific specialty organization recommends or how they view telehealth practice so that you can be sure to be practicing within those guidelines as well. Cross-state practice is somewhat of a hot topic.

I get questions about this all the time. Remember, I mentioned the originating site earlier. The originating site is considered the place of service, the location where the visit is actually happening, and that is where the patient is located. So that means that the APRN must be licensed in the state where the patient is located. Now, it's important to know that you also must follow all recommendations and requirements for APRN practice in that state.

What does that mean? Well, for example, if I am physically present in a state where I practice with full practice authority and I'm connecting to see a patient in another state that is a restricted state, then I have to follow all of the restrictions and guidelines in that state. The full practice authority doesn't transmit across state lines.

Now, the Nurse Licensure Compact, as you all know, I'm sure, does not apply to APRN practice. But I find so often that APRNs are confused by that. Many assume that the Nurse Licensure Compact does apply. So it's really important that we educate our APRNs and that they're clear on that.

The APRN compact is not yet in place because we haven't had seven states pass the legislation. Now, there are telehealth exceptions, such as waivers, or registrations, or specific telehealth licensures that can allow cross-state practice. But I caution APRNs to look at those carefully.

Many times, they're written specifically to apply to physicians. So really vet it carefully to be sure that it applies to your specific case if you expect to use one of those exceptions. As I mentioned, we need to maintain our scope of practice where we are physically present, as well as in the state where the patient is physically present.

Now, prescribing laws are important as well. There are both federal and state-level laws that impact prescribing across distance. You may have heard of the Ryan Haight Act. This Act, that was passed in 2008, actually required an in-person visit before a controlled substance could be prescribed across distance through telehealth.

This was waived during the COVID-19 pandemic and allows for controlled substance prescribing across telehealth without an in-person visit, as long as it's real-time audio-visual communications, it's being prescribed by a provider with the DEA in their usual course of practice, or if the patient is in a site where they are located with the person holding the DEA.

Now, they do have an exception for opioid use disorder, which can be prescribed through audio only, but otherwise, it has to be real-time audio-visual communications. Now, this exception has been extended as of today through 12/31/2026, which means you can prescribe if you meet those requirements for controlled substances, as long as you are meeting those specific guidelines.

Now, also, you have to make sure you're prescribing within your scope of practice, within your state laws, as well as checking appropriate prescription monitoring databases if required. The standard of care, as I've mentioned several times, does not change through telehealth. It's a fundamental legal concept that represents the duty owed by healthcare providers to patients.

It's the baseline level of competence, skill, and treatment that would be rendered by other providers in the same circumstance. And again, it doesn't change with telehealth. Really important to know that. There are several factors that determine the standard of care in any given situation. The patient's chief complaint and medical history, the provider's specialty and licensure, and the clinical circumstances and context will be evaluated.

It's truly important to be compliant with the standard of care because failure to meet the standard of care presents you with risk for liability and litigation, as well as professional investigations. There are six key elements to the standard of care that must be present in every telehealth encounter. Now, it doesn't differ terribly much from in-person care, but there are some additional things that with telehealth must be considered.

There has to be a valid patient-provider relationship, and this may vary by state. Depending on the state rules and guidelines around telehealth, it may be impermissible to establish a patient-provider relationship over telehealth, or it may be allowed as long as it's live video communication.

So, really important to check for your unique situation. Consent for telehealth. Most states require consent for telehealth. Some require a separate telehealth consent, and this should be informed consent. We need to make patients aware of any risks or potential limitations to the visit happening over telehealth and document that.

We also need to make sure that we have informed them of our credentials and who we are, and document that as well. We have to conduct an appropriate examination for the chief complaint and the type of visit for the patient we're seeing, using the correct modality. It is never okay to use a lesser modality because of a technical failure.

I'll go over documentation in just a moment. There are some additional things beyond the usual clinical documentation that need to be noted. We've talked about prescribing. And, of course, document and provide clear follow-up instructions. Make sure the patient knows how to contact the provider and when to be concerned and seek additional care.

Really important to have an emergency protocol in place. With regard to documentation, in addition to your usual clinical documentation, you want to provide documentation of consent for telehealth, anyone that participated in the visit, and whether there was permission granted for that, the patient and provider locations, the modality used, the date, time, and duration of the visit, standard of care elements should all be addressed, as well as your usual clinical documentation and follow-up instructions, as well as the appropriate billing compliance.

Now, recently, and this reference is in your reference list, recently, my colleagues and I published an article in the "Journal of Nursing Regulation" that includes the telehealth standard of care evaluation matrix. This is a helpful tool for APRNs and Board of Nursing members who are charged with evaluating care that's been provided through telehealth.

Sort of, you can walk through the Q&A, if you will, to determine if that standard of care was met for each category. So, I encourage you to take a look at that when you have a minute. And, of course, program evaluation and continual quality improvement is essential. There are a lot of different frameworks out there. Most of them include some component or most of these components of quality, access, key performance indicators, you know, in terms of numbers of visits, numbers of unique patients, the impact on the stakeholders related to cost, cost savings, and that sort of thing.

The patient and provider experience and/or satisfaction, technology effectiveness, you know, how many visits had to be converted because of technology failures, for example. And, of course, the clinical quality. This should be measured consistent with clinical guidelines for in-person care, as well as prescribing guidelines.

Are we prescribing consistent with in-person care? I'd like to end with a case study just to illuminate the importance of these components. This is a fictitious case, and it's not intended to represent an actual patient or legal case. An adult male presented to APRN via audio-only communication for evaluation of a rash. The patient reported a medical history consistent with shingles in the same location.

The patient provided their own medical history and their own description of the rash. The APRN did not convert the visit to a video visit or recommend that the patient be seen in person. But based on the history and the description, she went on to provide a prescription for antiviral medication.

Within about 48 hours, the patient worsened dramatically and was seen in the local emergency room. Was later diagnosed with necrotizing fasciitis and passed away. Now, let me ask you, is audio-only sufficient to diagnose a rash? Is the APRN at risk?

Is she at fault? What should be done in the event of a technical failure that prevents a switch to video? Should she have referred them to in-person care right away? Did this visit meet the standard of care? Should there be a lawsuit related to the patient's poor outcome? I leave you with those questions, but I hope I've shown you throughout this presentation the importance of having attention to the standard of care.

I provided you with some resources in the handout. Center for Connected Health Policy is a great way to locate laws and regulations, both at the state and federal level. We have 12 regional, national consortium of telehealth resource centers that are there to use for free to help you with telehealth programs, as well as HRSA. And the Center for Telehealth Innovation, Education, and Research has a series of HRSA-developed videos that are free to use that help with teaching exam techniques over telehealth.

And so I look forward to taking your questions. Thank you so much for your attention.

- [Emily] Hi, Kelli. How are you?

- I'm well. How are you?

- Good. Thank you for joining us today. Thank you for your time. That was a wonderful presentation on all things telehealth. We have...

- Thank you.

- ...some audience questions that came in through the chat. In the beginning of your discussion, you talked about three different terms that are used for telehealth, including telemedicine, telehealth, and then virtual visits. Someone in the chat has talked about, should we be referring to this as telenursing rather than are we providing telemedicine?

Is that the practice of medicine? Has it ever been considered as a term to refer to it as telenursing?

- That's a great question. Yes, telenursing is a common term. A lot of times, it's used to refer more to various types of nursing care delivered through telehealth, like in hospital settings. For example, sometimes nurses are doing admission and discharge planning remotely.

And so a lot of times, that term is used more globally for nursing care in telehealth. But I think that's a very good question. And APRN practice certainly would fall under telenursing as well.

- Yes, thank you. So another question from our audience members is, as you know, APRN graduate programs require a certain amount of direct clinical care hours. Would you consider providing telehealth or having this experience within that direct patient clinical hours, or do you consider that sort of a separate piece of their clinical time?

- Generally speaking, it is considered direct clinical care, provided they are, again, providing care across distance to patients. Some programs, and it depends on your state, your program, your accreditation, there's a lot of factors that go into this. But if the preceptor is able to observe and be involved, and the student is able to actually provide care across distance, then it absolutely is direct care hours.

It's not considered simulation, obviously, since we're using a live patient encounter.

- That makes sense. Do you have any recommendations or have schools have recommendations about how many of those direct patient care hours could be considered use for telehealth, or visits, or virtual visits?

- I'm not aware of any restriction around that number of visits. As a faculty member myself, I think it's important that all programs include telehealth visits as part of their practicum experience. However, to my knowledge, there are no expected standards or limitations around that.

- In order to make sure a certain standard of care is met, is there a list of appropriate conditions that would be considered for telehealth versus some conditions, like you mentioned in the last scenario, like a rash, would certain conditions not be considered for telehealth or a virtual visit?

- Again, a great question. I really like to emphasize that what's important is whether you can meet the standard of care for that chief complaint and that patient's presentation through telehealthcare. So some programs, offices, clinics, etc., may have a list of conditions for the schedulers, for example, to help guide them as to what can be scheduled as a telehealth visit or what can't.

But ultimately, it's on the responsibility of the provider to determine if that case can be completed fully over telehealth and that they meet the current evidence-based guidelines for that care.

- So in order for somebody to practice, and let's say they were doing a virtual visit that was a cardiology visit, and they're complaining of shortness of breath or reporting shortness of breath, and you obviously cannot listen to lung sounds and such, would it be okay to document that an assessment was not done?

Is that something that is a standard of care, or is that something that should be avoided?

- Well, in that example, of course, I'd refer that patient immediately to in-person care to make sure that they have an appropriate evaluation. But I do get this question a lot when I present, where people will tell me, "Oh, I just documented no exam done because it was a telehealth visit." And I always like to point out the vast majority of your assessment and exam can't be done through telehealth.

You only use a stethoscope for a small part of it. So, for example, if you're doing a patient visit to the home and you don't have a peripheral device, a digital stethoscope to listen, you can look at their respiratory rate, you can look at their color, you can look at, you know, their nails for clubbing. There's lots of other signs and symptoms that can guide you as to whether this is a visit that's appropriate to continue through telehealth or whether they need to be seen in person for further evaluation.

So it's never appropriate to just say no exam done because if you're...particularly if you're connected via video, you're able to do a lot of that exam. Now, if you're connected via audio only, obviously, you're not going to be able to visualize and do an exam.

So you do need to document the modality that you're using. And if there were certain components of the exam that were deferred or not able to be completed, and why, but always remember, if you can't

complete that element of exam and it's necessary for the particular case you're seeing, then they should be referred to in-person care for further evaluation.

- Thank you. That makes perfect sense. So you mentioned that there are several APRNs and even nurses that practice across state lines. So you could be sitting in Illinois like I am today, and I could be providing care for a patient in Florida, let's say. Would it be pertinent or appropriate for that APRN, or nurse, or whoever the provider is to introduce themselves and then say, "I am licensed in your state as well as my state?"

Would that be something that you should include in your introductions?

- Yes. I think that's very important to confirm that you're licensed in the state where the patient is located. And by the same token, if you're not licensed in the patient state to halt the visit, explain why, and then let the patient know that you can't complete the visit.

I've had occasions... Over the years, I've done not only school-based telehealth, but also virtual urgent care, which is direct-to-patient care, direct-to-the-home, for example. And in the platforms that I've used, there's a box that patients would check to say they are within the state of South Carolina, where I was practicing. And inevitably, I would connect to them, and they would not be physically within the state of South Carolina, but they check the box because that's where their primary address is.

So I would have to explain, "I'm not licensed in the state where you're located. Unfortunately, I can't continue the visit. I recommend you be seen in person locally or through a provider within that state." So it can be confusing for patients sometimes. They don't always think about the fact that it's literally where they are physically present rather than where their primary address is.

And so we have to be careful to clarify that.

- Especially if people are traveling, right? So you could be traveling and on vacation or visiting somebody, and something happens, and you want to connect with your provider. It would be important, as you were saying, to say, "Okay, I am from South Carolina, but now I'm in Florida." And that APRN needs to know, if I don't have a license there, I should not be providing care.

Correct?

- Exactly. Unless there's one of those telehealth waivers that applies to APRN practice. And as I said, it's really important that APRNs look ahead of time to know if their patients are particularly in...you know, maybe they live near a state line. And so they have a lot of patients from a different state. Make sure that you're aware in advance if there is a waiver, or, of course, whether you're licensed in that state.

And really vet those waivers and exceptions because they don't all apply to APRN practice.

- What is the guidance for those who are going to college in a different state? And so their home address is in Illinois, for example, and then they are attending college in, let's say, Louisiana, and they want a telehealth visit, either with their primary care or a mental health visit, or something to that effect.

What are the regulations around that?

- They're exactly the same. The originating site where the patient is physically present is the site of service. So if the APRN is not licensed in that state, or there's not an appropriate exception in place that applies to their practice, then again, they shouldn't be providing care across state lines.

- What would be a good place for an APRN or an RN to know and go and find those regulations for each state? As you had mentioned, the practice, depending on what state you're in, could be different.

- Sure. The Center for Connected Health Policy is one of those national telehealth resource centers that I mentioned. And they track all 50 states' legislation and regulation related to telehealth, as well as federal initiatives. You can even send an email with a question if you're not clear by looking at all of the incredible content on their site.

And I did include that on that resource list that's in the slides, if you've downloaded them. But it's the Center for Connected Health Policy. And I strongly encourage everyone doing telehealth to check out that site. It's a wonderful resource.

- So along those lines, if you are in a state that has full practice authority and you're providing care to a patient who is in a state that is more restricted and requires a collaborative agreement, does that APRN need to have a collaborative agreement with a physician in that particular state where the care is being provided?

- Yes, absolutely. They have to follow all of the guidelines and requirements within the state where the patient is located. So the full practice authority, if they're physically present in a state where they normally practice and they have full practice authority, that doesn't extend with the provider across state lines.

And some states, as you all probably know, not only require a collaborative agreement, but there may be specific guidelines around the physician who can be part of that collaborative agreement, whether they have to be physically located within the geographic boundaries of that state, versus just being licensed in that state where the patient is located.

So really important that we not only make sure we have a collaborative agreement, but that we're meeting all of the details related to the restrictions and guidelines within that state. We need to know what the advisory opinions and position statements are for that Board of Nursing, what's in their Nurse Practice Act. I've been doing telehealth since 2014.

So long before COVID was a thing, if you will, when it really pushed telehealth forward. And it's important to note that while we've come a very long way in terms of telehealth guidance and regulation, some states have more details than others. And so really very important that we understand, not only for telehealth, but also our in-person practice.

I encourage everyone to be very familiar with their practice act and their Board guidelines.

- That's great. Thank you so much, Kelli. We appreciate your time. This has been very rich information. And I encourage audience members to continue to put your questions in the chat. The resources are available on the website through the APRN Roundtable within the slides. And we'll move on to our next speaker, who will give us some updates on legislative initiatives that are going on with Nicole Livanos.