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59TH MEDICAL WING

59TH MEDICAL WING INSTRUCTION
46-102

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Nursing

NURSING TELEHEALTH

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This instruction implements Air Force Policy Directive 46-1, *Nursing Services.* This instruction outlines the responsibilities and establishes the standard of care to include uniform procedures for telehealth nursing practice by nurses at the 59th Medical Wing (59 MDW); not applicable to the 959th Medical Group. It directs telehealth nursing scope of practice and operations, decision support tools, protocol usage, and documentation of patient encounters in Military Health System (MHS) Genesis and staff selection. This instruction applies to all military and/or civilian nurses who perform telehealth nursing duties and functions. This publication requires the collection and or maintenance of information protected by the Privacy Act of 1974 authorized by 10 U.S.C. 55, *Medical and Dental Care*, and E.O. 9397 (SSN). The applicable SORN F044 AF SG D, and Automated Medical/Dental Record System is available at: **http://dpclo.defense.gov/privacy/SORNs/SORNs.htm**. Refer recommended changes and questions about this publication to the Office of Primary Responsibility using the AF Form 847, *Recommendation for Change of Publication*. The authority to waive requirements is the publication approval authority. Ensure all records generated as a result of processes prescribed in this publication adhere to Air Force Instruction 33-322, *Records Management and Information Governance Program*, and are disposed in accordance with the Air Force Records Disposition Schedule, which is located in the Air Force Records Information Management System.

SUMMARY OF CHANGES

This publication has been revised. This rewrite of 59 MDWI 46-102 includes updated references and telehealth operations.

1. Program Overview. Telehealth refers to the delivery, management, and coordination of health services that integrate electronic information and telecommunication technologies to increase access, improve outcomes, and contain or reduce costs of health care. It involves an encounter with a patient/caller in which a specially trained and experienced registered nurse, utilizing clinical judgment and the nursing process, is guided by medically approved protocols and decision support tools to assess and manage care and to determine the urgency of the patient's problem and to direct the patient to the appropriate level of care. This plan of care is ideally developed in collaboration with the caller and includes patient education/advice as appropriate and necessary.

2. Standards of Care. The Telephone Nursing Practice Administration and Practice Standards published by American Academy for Ambulatory Care Nursing (AAACN) have been adopted by the 59 MDW as the standards for telehealth nursing. A copy of the standards are available in the 59 MDW Medical Library.

3. Telehealth Operations.

3.1. Patient Care Delivery Model. Telehealth is a useful tool for demand management within the primary care management process. It facilitates appropriate access to care by helping patients determine the urgency of their problem and directing them to the appropriate location for optimum delivery of care. Patient empowerment resulting in an informed and responsible healthcare consumer is a desired outcome of telehealth programs. The goals of telehealth include: improved patient access to care, increased efficiency in healthcare delivery/management and appropriate utilization of available resources and return of beneficiaries to the 59 MDW for care.

3.1.1. Use of secure messaging (i.e., MHS GENESIS patient portal) does not constitute a telehealth nursing encounter. While secure messaging is a valuable communication tool between the patient and their care team, if clinical decision making is required, an encounter should be initiated in MHS GENESIS IAW processes identified in this instruction.

3.2. Staffing Selection Criteria. Telehealth services may be staffed by active duty, contract, and civilian registered nurses. Telehealth nurses require a minimum of three (3) years experience in various clinical settings. The 59 MDW Chief Nurse (59 MDW/SGN) will coordinate waiver requirements on a case-by-case basis through Defense Health Agency (DHA). Clinical experience in medical-surgical nursing and pediatrics nursing is highly desirable. The telehealth service will be under the direction of the clinic's nurse manager, element leader, or flight commander as applicable for larger clinics. The ultimate accountability for the program rests with the 59 MDW/SGN. Favorable characteristics for telehealth nurses include: critical thinking skills, ability to prioritize quickly, ability to handle stress, maturity, excellent customer relations skills and ability to immediately establish rapport/trust on the phone.

3.3. Telehealth nursing is decentralized into individual clinics.

3.4. Nurse Responsibilities. The telehealth nurse provides advice regarding access to care and, when appropriate, home care instructions. Every effort will be made to honor the wishes and preferences of the patient within the parameters dictated by patient safety. The nurse will act on behalf of the patient in cases where the patient is the victim of violence/abuse or when emergency medical services are required for life-saving care. Although guided by protocols

and decision support tools, nursing judgment will prevail at all times, superseding care indicated by the protocol as the patient's situation dictates. Consultation with provider will be required when a protocol or nursing judgment does not adequately address the patient's concerns or needs. The nurse will clearly document in the patient's medical record any deviation from any protocol, to include documenting the provider they spoke with and the decisions that were made.

3.4.1. The nurse will consider more than the chief complaint to determine the magnitude of the encounter, to include: age, chronic illnesses, comorbidities, time of day, availability of patient and medical resources, distance from care, duty status, cultural factors, the reliability of the patient/caller as historian, their ability to understand and comply with the recommended disposition.

3.5. Accountability for Patient Care. While the provider is ultimately responsible for the patient's healthcare management, the nurse maintains accountability for his/her decision making and will not implement an order that he/she feels to be contraindicated for that patient. If there is a discrepancy between the judgment of the nurse and the order of the provider, the nurse will document the rationale for his/her decision and will defer via telephone consultation to the provider for final treatment plan.

3.6. Protocols/Decision Support Tools.

3.6.1. The following protocols will be used at the 59 MDW: The Schmitt-Thompson Clinical Content's electronic telephone triage protocol will be used in all primary care clinics for telephone triage (e.g. Family Health, Pediatrics, Internal Medicine, Aerospace Medicine and Women's Health) The Barton Schmitt and Schmitt-Thompson Clinical Content for pediatrics reference will be used for all patients under the age of 18; as part of the electronic telephone triage Pediatric protocols. Any other published commercial protocols must be approved by the individual work centers' medical directors and by the 59 MDW/SGN. As the approved references may contain a wide spectrum of protocols within the decision tool set any approved reference protocols are acceptable for use within the 59 MDW though individual clinical areas should use a consistent tool set.

3.6.2. All patients' telephone calls identified as requiring disposition will be in accordance with approved protocols. If no appropriate protocol is identified, the nurse will collaborate with a provider for appropriate disposition and care. Provider recommendation and disposition will be clearly documented in MHS GENESIS.

3.6.2.1. Non-urgent walk-ins. In some instances, non-urgent "walk-in" patients may be triaged using telehealth clinical protocols, or similar DHA Approved Clinical Support Staff Protocols (Dysuria, Injections, Pregnancy Test, Sore Throat, Test Results, Wart Treatment, Adult Sore Throat, Pediatric Sore Throat, Adult Cold, Pediatric Cold). Decision-making processes and assessment for these patients will be IAW the appropriate and approved clinical protocol. Appropriate documentation, provider consultation, referral, and dispositions will be as described in this Instruction.

3.7. Documentation. All telephone encounters involving symptom-based medical/nursing decision-making will be documented via MHS GENESIS. Each clinic or specialty area may develop templates for MHS GENESIS documentation. If MHS GENESIS is not working, documentation will occur on Standard Form (SF) Form 600, *Medical Record Chronological*

Record of Medical Care and will be uploaded into the patient's MHS GENESIS record as soon as it is available.

3.7.1. Document at a minimum the following data for each encounter: date, patient's full name, patient's date of birth, patients DOD number, caller's identity if different than patient's, patient phone number, patient age, onset of symptom, patient complaint, age-specific immunization status for pediatric and elderly patients, current medications to include over the counter/herbals, allergies, use of home treatment(s) attempted, subjective and objective data collection supporting assessment category, pain level assessment, protocol choice, protocol override: upgrade or downgrade as appropriate, plan of care, intervention, disposition, patient understanding, call-back instructions as appropriate (patient was provided with after-hours resource information on when/how to access the Nurse Advise Line and nurse and provider signatures.

3.7.2. All symptom-based calls requiring decision making as well as the encounters described above will be signed by the nurse providing care/advice and will be reviewed and co-signed by a privileged provider within 24 hours, preferably by the end of each duty day whenever possible. Symptom-based calls will be received as a high priority in between encounter from the Central Appointments Scheduling Office. A copy of the encounter must be forwarded to the patient's provider via *in-between encounter* to facilitate continuity of care.

3.8. Scheduling/Operations.

3.8.1. Calls for routine appointments, or deemed non-urgent by the telehealth registered nurse may be scheduled by clinic appointment clerks or the nurse. Other non-symptom based contacts (i.e, test results, Rx renewal, etc.) may be addressed via telehealth or secure messaging format.

3.8.2. Unlicensed assistive personnel, appointment clerks or licensed practical nurses will not manage a telephone request for health information. Callers requesting health information and/or advice regarding access to care will be immediately assessed by the telehealth registered nurse and assigned an appropriate disposition based on approved protocols. Callers requesting information will be assessed to clarify their need and given the appropriate information/home care advice.

3.8.3. Medical and administrative technicians may manage requests for medication refills and assist with leaving messages for the provider per individual clinic instructions.

4. Education and Training.

4.1. Newly selected telehealth nurses and/or intra-facility transfers to the unit must be adequately prepared to provide safe and effective telephone nursing care and service. Nurses with previous telehealth experience will complete initial telehealth and unit specific training.

4.2. "AFMS Telehealth Nursing Initial Training" will be assigned by Education and Training Officers and/or Unit Education and Training representatives in Elsevier. All nurses with or without previous telehealth experience will complete initial and unit-specific training if not completed previously. If the nurse has previously completed initial training, then annual training will be completed as well as unit specific training.

4.3. Telehealth Nursing orientation will follow the flexible 6-week orientation plan as outlined in AFMOA Telehealth Nursing Standardization. The orientation schedule is meant to be a guide and includes but is not limited to: live simulation scenarios/mock calls, tandem triage/dual headsets for real-world training, orientation to AFMH teams/other clinical areas (Health Care Integrator/Disease Manager/Clinical Case Manager/Group Practice Manager), telephone triage training with Carol Rutenberg Telephone Triage Consulting, Inc training program videos, available in Elsevier.

4.4. The telehealth initial competency assessment and orientation checklist must identify and address learning needs based on core competencies, orient the member to facility-specific practices and community resources and provide initial competency training using the Sweeny-Clark Performance Rubric. Training will be conducted in a one-on-one preceptorship format. The length of orientation will be based on the nurse's previous experiences or qualifications, the preceptor's assessment and how well the nurse independently comprehends and completes required competencies. Preceptors may be active duty, civil service, or contract registered nurses.

4.5. Documentation. Training will be documented on AFMS Telehealth Initial Clinical Competency Assessment and Orientation and placed in the nurse's Competency Assessment Folder; Part 1 Section C3: Clinical Competencies.

4.6. Training/Competencies.

4.6.1. On-going training will consist of no less than an annual in-service directed towards the approved protocols and current trends in telephone nursing practices.

4.6.2. Annual refresher training will be completed by all personnel performing or could perform telehealth duties in the course of their normal duties (Family Health, Pediatrics, Disease Management, Internal Medicine). Individuals who have completed training prior to 1 July of the preceding year will compete annual training between January and March of each year. The training occurs between the nurse and supervisor. The senior nurse of each section will ensure this training is accomplished and documented in member's Competency Assessment Folder.

4.6.3. "AFMS Telehealth Nursing Annual Training" will be assigned by Unit Education and Training Representatives via Relias.

4.6.4. Carol Rutenberg Telephone Triage Consulting, Inc training program videos, available in Relias will be completed during initial orientation and every 5-years thereafter.

4.6.5. Competencies will be completed/measured via per reviews. Documentation of competencies will be in training records.

5. Clinical Management.

5.1. Disposition categories will be assigned to all encounters as follows:

5.1.1. Emergent. Problems deemed to pose an imminent threat to life, limb or vision will be referred immediately to the nearest emergency department (ED). The 911 emergency medical system may also be employed by the nurse, patient, family, or other caregiver if movement by privately owned vehicle is not recommended per protocol or nursing judgment.

5.1.2. Urgent. Problems that pose a potential threat to life, limb, vision or if delay of care would result in an increased severity of illness will be seen within 24 hours by ED, clinic visit, or acute care deferral.

5.1.3. Non-Urgent. Problems that pose no reasonable threat to life, limb, vision or will not cause an increase in severity of illness will receive a routine appointment or home care instructions with appropriate follow-up.

5.2. Medication Reconciliation will be completed and documented for every encounter that involves medication refills or recommendation of over-the-counter medications.

5.3. Evaluation. Prior to the termination of each call, a plan must be developed for evaluation of the interventions. In all cases (with the exception of those instructed to activate the Emergency Medical System), patients must be given information regarding how to appropriately access care if indicated, how to care for themselves at home, and how and when to call back and under what circumstances. Reliable patients who have a low acuity problem may be instructed to call back if their situation gets worse, changes, or does not improve.

5.3.1. Patient Understanding. Upon the conclusion of each call, the patient's understanding of the plan will be verified and documented in the medical record. Calls should not be terminated until the nurse is certain that the caller understands and verbalizes the instructions.

5.3.2. Patient Intent to Comply. The patient's intent to comply will be ascertained and documented. In the event that a patient does not intend to comply with the recommendations of the nurse, the situation should be handled as described in **paragraph 6.1**.

6. Risk Management and Performance Improvement.

6.1. Non-compliance with Recommended Disposition. In the event that the patient does not intend to comply with the recommendation of the nurse, the nurse is expected to take reasonable measures to assure that the patient understands the consequences of their actions and is able to act in their own best interest. If the patient has a life-threatening condition and does not comply with instructions to call an ambulance or otherwise proceed directly to care, the nurse must reassess the patient for the following:

6.1.1. Understanding of the seriousness of the situation and ability to act in their own best interest. All reasonable measures, including clear and complete information about the possible consequences of inaction (up to and including death, if indicated), should be taken to assure that the patient understands the potential consequences of noncompliance.

6.1.1.1. If the patient is believed to understand the potential consequences and is assessed to be competent to make this decision, the nurse will respect the patient's wishes, document the situation comprehensively, include the timeline of events and close the call with an open invitation to call back at any time. The situation will be brought to the attention of the provider or the medical director for further guidance and documented in MHS GENESIS. The *in-between encounter* will be closed out by the provider.

6.1.2. If the patient is a minor, incompetent, or otherwise legally unable to make informed health care decisions, and the caller refuses non-emergency care deemed appropriate by

the nurse, the situation will be brought to the attention of the provider or the medical director for further guidance. The encounter will be documented in MHS GENESIS and closed by the provider.

6.2. Demanding/Angry/Abusive Callers. Patients/callers who are demanding or angry will be handled in a manner to defuse the situation. Care will be taken to avoid escalating the patient's anger. Efforts will be made to determine the reason for the patient's dissatisfaction and reasonable steps will be taken to remedy the situation. If the nurse is unable to defuse the caller's anger or handle the concern to the patient's complete satisfaction, the call will generally be referred to the nurse manager/element leader. The goal with such callers is to defuse their anger, determine the reason for their dissatisfaction, address their concern and provide for their safety and appropriate level of care. At no time should interpersonal factors be allowed to interfere with the delivery of safe and appropriate care.

6.3. Suspected Drug Seekers. In the event of calls from a known or suspected drug seeker, the message will be taken and passed on to the provider via *in-between encounter*. Generally speaking, all patients who call with complaints of pain should be appropriately assessed and taken seriously.

6.4. Threats of Violence. Threats of violence (to self and/or others) are to be taken seriously and reported to the proper authorities. The nurse will keep the caller on the line while activating emergency services on another line, or by instructing a co-worker to call 911.

6.5. Domestic Violence. In cases of suspected domestic violence, the nurse will act in the best interest of the alleged abused individual. Cases of suspected abuse and/or neglect must be reported to the appropriate authorities, including emergency services and Family Advocacy, IAW DAFI 40-301 *Family Advocacy Program* and 59 MDWI 44-133, *Plan for the Provision of Patient Care*.

6.6. Suicidal or Paranoid Behavior. In cases of suicidal, delusional, or paranoid behavior, the nurse will notify Mental Health to coordinate immediate interventions. The nurse will attempt to keep all suicidal patients on the phone until appropriate help arrives and will be directed to the nearest emergency department to seek immediate care.

6.6.1. For reports of suicidal intent, paranoia or other mental health disorders, contact Mental Health for referral. If Mental Health is unable to support immediate intervention, the patient will be referred to the ED (i.e., San Antonio Military Medical Center). If concerns arise as to the ability of the patient to seek emergent services, they will be instructed to call 911, go directly to the nearest ED for assistance or the nurse may choose to notify emergency services while keeping the patient on the line.

6.7. Frequent Callers. In the event of frequent callers, the following principles will guide their care.

6.7.1. The patient's chief complaint will be carefully reassessed with each call and an *in-between encounter* in MHS GENESIS will be placed.

6.7.2. The frequent caller who is thought to be abusing the system will be brought to the attention of the provider, who will make a determination of whether to speak to the patient personally or turn the situation over to another appropriate resource.

6.7.3. If the calls persist, attempts should be made to identify the source of the problem and address it appropriately (such as via a team conference, through referral to a healthcare integrator/case manager, or via other interventions).

6.8. Other Common Situations Regarding Telehealth.

6.8.1. In the event that the appropriate disposition is not clear, the nurse will err on the side of caution, directing the patient to seek care at the appropriate level and medical facility.

6.8.2. For cases in which the nurse or the patient/caller does not feel comfortable with the disposition suggested by the protocol, the nurse should upgrade the disposition, instructing the patient to seek a higher level of care immediately and document in an *in-between encounter* in MHS GENESIS.

6.8.3. If a patient or family member reports that this is the second call in a 24-hour period regarding the same problem, the patient should be given an appointment or directed to seek care.

6.9. Clinical Quality. Quality of care delivered by the telehealth program will be routinely tracked, analyzed, and reported to the 59 MDW Executive Committee of the Medical Staff via Nurse Executive Function feedback. When deficiencies are identified, a plan for improvement will be developed and implemented.

6.9.1. Peer Review. All telehealth encounters that are symptom-based calls requiring decision making will be co-signed by a privileged provider. Each nurse participating in telehealth practice will have such encounters reviewed on a recurring basis (i.e, quarterly) by their respective clinic peer. Respective clinic flight commanders or nurse managers will be responsible for ensuring the peer review process is in place. Peer review will be reported on a quarterly basis to the group SGN. Negative trends will be identified, addressed and corrective measures taken to ensure nurses are practicing IAW current AAACN standards for telehealth nursing. Peer reviews should rotate quarterly, where RNs peer review a different RN each time whenever possible. Further guidance on peer review can be found on the AF Kx. The group SGN will be advised of any negative trends, as well the corrective action/s taken to address any discrepancy. The group SGN will be advised of any negative trends, as well the corrective action/s taken to address any discrepancy.

6.9.2. Confidentiality. All calls will be handled in a confidential manner. Information of a potentially sensitive nature will not be released to anyone over the phone without the patient’s permission per Health Insurance Portability and Accountability Act standards.

6.10. Outcome Metrics.

6.10.1. Patient Satisfaction. Patient satisfaction will be monitored and addressed through the 59 MDW customer feedback program. Dissatisfied customers should be given the opportunity to address their concern with the original telehealth nurse. If they are unable to remedy the situation, the patient/customer will be referred to the Patient Advocate and then follow the chain of command appropriately if indicated.

6.10.2. Call Volume. The number of incoming calls may be tracked as needed for purposes of demand management and template revision in coordination with the respective clinic Group Practice Manager and clinical leadership (i.e., nurse manager, medical director, etc.).

JEANNINE M. RYDER
Brigadier General, USAF, NC
Director, Wilford Hall Ambulatory Surgical Center

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

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DAFI 40-301, *Family Advocacy Program*, 13 November 2020

AFI 46-101, *Nursing Services and Operations*, 30 January 2015

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59 MDWI 44-133, *Plan for the Provision of Patient Care*, 5 February 2021

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https://kx.health.mil/kj/kx5/AFMOANursingProvisionofCare/Pages/Nursing-Telehealth.aspx

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Telehealth RN Orientation Schedule

Adopted Forms

AF Form 847, *Recommendation for Change of Publication*

SF Form 600, *Medical Record-Chronological Record of Medical Care*

Abbreviations and Acronyms

AAACN—American Academy for Ambulatory Care Nursing

AFMRA—Air Force Medical Readiness Agency

ED—Emergency Department

IAW—In Accordance With

MDW—Medical Wing

MHS—Military Health System

SF—Standard Form