Assignment 2: Research the Issue DUE October 4

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Conduct a literature and resource review regarding your policy of interest. The research report will have two main components: the written narrative expounding on the questions asked, and a one-paper fact sheet with no more than two sides [see Libby's Step 2 & 3]. (70 pts.)

Explain the nature of the policy issue as it presently stands [Define the issue if it is not commonly understood and any relevant categories. Present the social problem rates with which the existing and proposed policy is concerned and breakdowns in rates or disparities, negative consequences of the problem/issue. Discuss here things are currently in the policy area such as has a bill been drafted, introduced, and where it is in the legislative or decision-making process, and what if any action has been taken. For existing policies, you write things such as if it has been implemented and how, funding, etc.] (10 pts.)	**Social Issue** Currently, HB 8002 (SB 8003) is a bill that addresses the extension of Telehealth services. The underlying social issue associated with this policy is the inadequate access to health care services, specifically for those living in rural areas or those with limited transportation. A statewide study suggests that Tennessee's population is relatively sick and has inadequate access to health care resources (Dubois, 2014). A significant consequence of no Telehealth services is the financial loss hospitals continue to procure. Hospital expenditures nationwide, for the year 2019, were 253 billion dollars (CMS, 2020). In 2017 in the U.S, the annual cost savings per hospital facility using Telehealth services was $ 20,841.00 (NTCA, 2017). Using Telehealth services helps save hospitals money, and not using them could cost hospital owners, taxpayers, and stakeholders thousands. **Prevalence/Rates** In dealing with the state numbers, even though Tennessee has some of the best medical professionals, it still is among rated 40th in the nation of overall health care for a state (DuBois, 2014). The rank is partially due to the inadequate accessibility, specifically for rural areas in Tennessee. In fact, in 2015, about 1 in 4 Tennessee hospitals were at an increased risk of closure, resulting in 8 rural hospitals in T.N. (Pelligrin et al., 2018). Around 1.5 million residents live in rural areas, and a majority of those residents are elderly, have significant health issues, and come from a lower-income family (Pelligrin et al., 2018). Along with a higher prevalence of sickness and old age, people living in rural areas are also in jeopardy of a hospital closure in that area. Telehealth will reach people in more rural areas and struggle with healthcare accessibility. Telehealth services provide medical and mental health care through the use of technology and provide services remotely. The American Hospital Association discovered that between the years of 2010 and 2017, telehealth services have grown from being provided by 35% of hospitals to 76% in seven years (American Hospital Association, 2019). Since the increase in Telehealth services being provided by hospitals, the percentage of adults who had a regularly scheduled place to go for medical care increased, and in the year 2017, 86.4% of adults not living in metropolitan areas had a regular health care provider (Elfein, 2020). These increased numbers in Telehealth services have helped to provide access to rural and urban populations. The American Hospital Association reported that 80% of virtual hospital visits resolve the medical issue without a trip to the emergency room (American Hospital Association, 2019). The research results show that Telehealth services can provide adequate medical help. Continuing to grow in the Telehealth field is vital because many rural and urban communities suffer from severe health issues, that if an early intervention was available many medical issues could be prevented. In 2017, 13.8% of people living outside a metropolitan area were not covered by health insurance (Elflein, 2020). Lack of healthcare coverage is a problem because a lack of health care translates over into a lack of services for that population. Even though cancer rates are higher in metropolitan areas, cancer rates are higher in rural areas (Elflein, 2020). There is a vast disparity in how many people in rural areas die because of cancer, resulting from the services individuals receive when they have cancer. Furthermore, from 2012 to 2015, over 20% of adults in rural areas stated their health was fair or even

low (Elflein, 2020). Telehealth services can help bridge the gap in those numbers through early detection of health issues like cancer and other medical problems.

Inadequate Accessibility

A reason for inadequate access to health care is transportation. In a national study from the years, 1997-2017 transportation barriers were analyzed related to health care services (Wolfe, 2020). This study examined the proportion of people who did not receive medical services with those who reported a lack of transportation. Results revealed that transportation as a barrier to services grew from 4.8 million to 5.8 million over the time of 1997 to 2017 (Wolfe, 2020).

Telehealth services have helped over the years, but there is still progressed to be made. One of the most significant factors influencing this policy's development is the inadequate accessibility of healthcare services for underserved populations. Rural America has been hit hard when it comes to the accessibility of healthcare services. Teladoc Health (2020) states that Telehealth received $16 million in 2016 to expand access to rural areas. There have been different technical, financial, health systems, and even behavioral barriers that have affected the development of furthering Telehealth and this policy (Bagchi, 2019). Most of these barriers come from these rural areas where the underserved population exists.

Inadequate accessibility to services even extends into the mental health field. A study found that rural populations receive 73% less mental health visits than urban residents (Patel, Huskamp, Busch, & Mehrotra, 2020). A potential reason for this could be the distance of the clients from the mental health worker. It is too far to drive to see the client provide those services, so that need goes unmet. This 43% of those living in rural communities stated they had unmet mental health care needs (Patel, Huskamp, Busch, & Mehrotra, 2020). Some telehealth services include a mental health aspect. In HB 8003, a section allows for private and public medical services to cover the cost of drug, alcohol, and various other mental health services (Tennessee General Assembly, 2020).

Tennessee Policy Implementation

According to the U.S department of health and human services, the number of people receiving public and private insurance has increased. There have been limits on which services insurance agencies would cover, explicitly dealing with Telehealth (2019). When the state of Tennessee drafted this bill, it was created to require insurance agencies to cover the cost of telehealth services comparable to face-to-face treatment. The current bill went into effect on August 27, 2020, and approved by the Senate on August 12, 2020 (Tennessee General Assembly, 2020). S.B. 8003-HB 8002 is a 15-page amendment to the law T.N. Code 63-1-155, which was passed by both the house and the senate for the state of Tennessee (The Tennessee Star, 2020). Now, insurance agencies are required to cover the cost of those receiving telehealth services. An increase in state spending from $692,500 for the year 2020-2021, to $1,385,000 for years 2021-2022 (Tennessee General Assembly, 2020). This increase in funds will be used to enact HB 8002 and ensure coverage is provided under this policy. This group is in full support of this bill with one recommendation. This group recommends that the deadline for these services of April 2022 is repealed, and this bill be enacted as a permanent health care change. There is no proposed amendment to this change, so a new bill would need to be

drafted to appeal this amendment. The new bill would need to remove any time constraint and ensure that telehealth services become a permanent service provided by insurance agencies.

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Discuss the contextual factors that have influenced the development of both the actual policy and opinion on the policy/issue. (As applicable, incl ude historical movements, key figures, theoretical forces, political forces, etc.) (20 pts.)	**History of Access to Healthcare** According to Ballotpedia in the United States, health care has been an essential topic of conversation in the political realm for years (Ballotpedia, n.d). Access to health care became a political issue when BlueCross began offering private insurance to individual citizens (Truman Library Institute, n.d.). Implementation of BlueCross's private health insurance coverage revealed a gap for individuals who would not be covered by this private insurance. On January 11, 1944, Franklin D. Roosevelt signed the Economic Bill of Rights (U.S. History, 1995). Often sourced as the Second Bill of Rights, this revised law ensured adequate healthcare for the United States citizens as a whole (U.S. History, 1995). Before this, the Social Security Act has been established, and healthcare was omitted from this bill (PBS, 2020). President Truman continued efforts to support his predecessor, via a five-point national healthcare plan rejected by the American Medical Association (Truman Library Institute, n.d.). The plan focused on the lack of training amongst healthcare professionals in all communities, growth in public health services, more funding towards the research, funding towards the education of the medical profession, decreased cost in individual medical care, and lost wages for the duration of a significant medical sickness (Truman Library Institute, n.d.). Another major piece of health care policy that sparked public and political interest in accessible health care was when President Lyndon Johnson signed title XVIII and XIX in 1965 (Ballotpedia, n.d). Title XVIII and XIX were the foundation of Medicare, which provided medical coverage for citizens over 65 years old (Ballotpedia, n.d). Title XVIII and XIX sought to rectify some of those populations of people that would otherwise be left out of medical service if it had not been for this legislature. In 1977 as an extension to this law, President Carter drafted that Medicaid should be expanded, but this bill was not passed in through (Richard, n.d). The expansion of Medicaid started an ongoing war between the republican and democratic parties when it came to health care reform. No health care change was made until 2009 when the Affordable Care Act (ACA), initially drafted by President Carter, went into effect in the President Obama administration (Richard, n.d). The ACA was one of the last significant documented changes that address health care except for new Telehealth policies. **Telehealth History** There have been many challenges in health care services that have made technology a need and use in medicine. The history of the use of technology in the practice of medicine has evolved over the years. There has been a long history of embracing new technologies to have better health outcomes (Arigo et al., 2019). Dr. Thomas Nesbitt of the University of California at Davis identified in his work that hospital-based telemedicine was utilized in the late 1950s and early 1960s (Nesbitt, 2012). This implementation included a closed-circuit television link established between the Nebraska Psychiatric Institute and Norfolk State Hospital for mental health consults (Nesbitt, 2012). However, home and community-based care are rooted in an observation program with the National Aeronautics and Space Administration (NASA) that recorded the body's physiology at a distance. This observation was termed the Mercury Space Program, which sparked health care from a distance

(Nesbitt, 2012). Office-based telemedicine is another type of telemedicine that Nesbitt mentioned in research that Alaska utilized as a model (Nesbitt, 2012). In this research, he states that community health aides could execute ear exams and hearing tests, and the results would be provided to specialists in bigger cities such as Anchorage (Nesbitt, 2012). His research would determine if a patient needed to travel for further treatment (Nesbitt, 2012).

Telehealth in Tennessee

Tennessee Code 63-1-155 was enacted in 2015 as a prevailing law that provided Telehealth services to T.N. citizens (T.N. Code & 63-1-155). This law laid out the stipulations for Telehealth services to be provided and guidelines for insurance agencies to provide coverage for services (T.N. Code & 63-1-155). In 2016, Tennessee HB 699, an amendment stipulated in T.N. Code 63-1-155 (2015), put a parity law that ensured that remote healthcare services would require commercial insurance providers to compensate for Telehealth providers as they would face-to-face healthcare services (Nashville Medical News, 2016). HB 699 was signed in law by Governor Bill Haslam, and Tennessee became the twenty-first state to enact a statewide law to address inadequate access to healthcare. However, in April of 2015, this particular bill was amended to include that commercial insurance providers are required to pay for out of network telehealth services as they would for out of network face-to-face providers (Nashville Medical News, 2016). The drafted law would establish a more secure process of telemedicine practice within the State of Tennessee. Previous regulations required that face-to-face visits be mandated before Telehealth appointments and one face-to-face visit every year after (Nashville Medical News, 2016). Tennessee HB 699 was a stipulation for commercial insurance providers only. However, Medicare insurance rules superseded Tennessee laws. TennCare is required to participate in Telehealth funding under the state parity law, but various HMOs under the Tennessee Medicaid umbrella have their requirements and policies concerning Telehealth (EVist, 2020).

Present Day Telehealth Information

Fast forward to the present day, in 2020, and research revealed that once the COVID crisis hit, physicians used telehealth services about 48% more versus the 18% that was seen back in 2018 (Bagchi, 2019). The need for solutions for the lack of access is a significant factor that comes into play. In response to COVID-19, The Federal Communications Commission provided $200 million of funding through the COVID-19 Telehealth Program. This funding was meant to help healthcare providers purchase items necessary for Telehealth (Bagchi, 2019). Telehealth was able to deliver healthcare to people that needed to travel long distances for regular healthcare. As a result, amendment H.B. 8002-SB 8003 was proposed by House representative William Lamberth and Senate representative Jack Johnson (Tennessee General Assembly, 2020).

Supporters/Opposition

Those in support of Telehealth believe telemedicine is a way to develop next-generation Telehealth tools and technology (Ackerman et al., 2010). The development of Telehealth tools is crucial to enhancing healthcare delivery, specifically for individuals in underserved communities (Ackerman et al., 2010). A few of the key drivers for these advancements in Telehealth include healthcare

service providers, patients, stakeholders, researchers, policymakers, and patient communities (Ackerman et al., 2010). The American Telemedicine Association, International Council of Nurses (ICN) Telenursing Network, The Office of Advancement Telehealth (OAT), and the Consortium of Telehealth Resource Centers are all in support of advancing telehealth services (Chiron Health, n.d).

Even with Telehealth's increasing popularity, around 85% of all physicians' practices are not utilizing Telehealth services (Joshi, 2020). Those opposed to Telehealth struggle with the regulations regarding care (Joshi, 2020). Some beliefs trying to regulate the continuity of care, best practice, and other vital elements in the healthcare arena would be difficult (Joshi, 2020). Even though all medical caretaking place via technology still has to comply with all HIPAA regulations, it is more difficult to regulate those rules. Another reason individual physicians are opposed to Telehealth services is how a physician's license is obtained (Joshi, 2020). If Telehealth is conducted with an out of state patient, the physician would need a practicing license for that particular state (Joshi, 2020). The requirement would be an additional license that physicians may not want to secure, especially if they do not regularly practice in that state. Lastly, physicians may struggle with the technology required to provide Telehealth services, which is why they are not in full support of Telehealth (Joshi, 2020). Having the right technology is essential, and it could potentially take time and money to train each medial worker on how to administer care. With that being said, Telehealth benefits outweigh those concerns, especially for rural areas.

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Discuss in detail the impact that existing policy has on critical populations, both aggregate and specific populations. (May include related pervasiveness, influence, prevalence, differential impacts, etc.; How varying implementations of the policy may have impacted populations differentially) (10 pts.)	**Impact of Telehealth Services** The use of Telehealth has indeed increased from years 2013-2016, due to its new technological advances. However, what remains an issue is access to Telehealth. Those who have low-income Medicaid and live in rural areas are within those underserved populations who still struggle with this access to Telehealth and healthcare (Park, 2018). The White Paper Commentary identifies Telehealth as the rapidity of the global healthcare delivery development in response to the COVID-19 Pandemic (2020). One study recognizes that Telehealth appears to be most effective when the patient population and Telehealth utilization is more specific (Totten et al., 2016). Totten and associates' (2016) study indicated that Telehealth interventions have resulted in positive outcomes, primarily when used in patient monitoring. This study identified that Telehealth is more effective when the targeted utilization such as remote home monitoring of chronic conditions, communicating with and counseling patients with chronic conditions, and behavioral health services (Totten et al., 2016). The result and impact of Telehealth increase the quality of life, reduces hospital admissions, and other improvements. This particular study was produced based on data from at least fifty-eight published reviews and 950 studies between 2007 to 2015. Research supported by evidence published between 1996 and 2018 immediately focuses on an intentional collaboration between clinicians and providers that recognizes various time zones or distances (Totten et al., 2016). An additional study determined that localized medical departments, specifically ICUs, could be managed by specialists remotely (Hansen et al., 2019). These specialized sites, which provided services to a targeted population, reported reduced health delivery complications and increased overall morale (White Paper Commentary, 2020). **Policy Impact on Aggregate and Specific Populations** Tennessee has thirty underserved counties, with a significant population to one primary care provider ratio (Allen et al., 2016). For example, Davidson County is ranked number two in the population (694,144) and has a ratio of patients to primary care providers of 1,611:1 (Allen et al., 2016). Another source ranks Davidson county as 27th, with the least access to primary care services (U.S. Census Bureau, 2020). Shelby County (937,166) has a patient with a primary care provider ratio of 1,548:1 (Allen et al., 2016). These counties are the most populated and urban counties in the state of Tennessee. In comparison, the least underserved rural counties of Jackson County (11,786) with a patient to primary care provider of 2,104:1 with a ranking of number 11 and Meigs County (12,422) with a patient to primary care provider ratio of 1,649:1 rank 26th as least underserved (U.S. Census Bureau, 2020). Telehealth service alleviates high volume workloads for healthcare providers. According to the Healthcare Information and Management Systems Society (HIMSS), studies have shown that telehealth services have improved and expanded access to treatment (HIMSS Tennessee Chapter, 2020). Inadequate healthcare accessibility promotes disease presentation that has progressed farther along, for example, persons with diabetes who show up to medical treatment with severe organ damage (Association of American Medical Colleges, 2018). The policy that is being advocated for in this document ensures that communities with limited resources and accessibility have equal opportunity to receive healthcare services. Rural America makes up 15% to 20% of the United

States (Association of American Medical Colleges, 2018). Rural communities are susceptible to inequities that cause worse health care than urban and suburban residents (Association of American Medical Colleges, 2018). One incident of these inequities is indicated when a patient presented with an abscess that required draining the infected area (Association of American Medical Colleges, 2018). The patient was discovered to have insurance, yet in his community, he could not find an appropriate provider in-network within proximity one to two hours from his home (Association of American Medical Colleges, 2018).

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Discuss any future direction related to the policy. (Information in this section could include research gaps, lingering issues/questions such as other things other than what you are advocating that needs to be addressed concerning this policy such as social justice issues, better funding, implementation, evaluation, or more detailed evaluation such as longer follow-ups or more mixed-method or qualitative, more representative samples, more benefits. You can also include any upcoming events pertinent to the policy/issue, etc.) (10 pts.)	**Other Proposed Amendments** To discuss the future direction related to S.B. 8003-HB 8002, this writer will first talk about other proposed Amendments correlative of the bill. Three Amendments were passed concerning S.B. 8003-HB 8002. HA 8003 and SA 8002 proposed to amend and substitute language used in a particular bill portion. HA 8014 proposed to add a new subsection to section five of the bill. SA 8002 proposed to amend and substitute language used in a particular portion of the bill. Amendment One (HA 8003) and (SA 8002) amends S.B. 8003-HB 8002 by defining the word health care provider as any licensed provider, any state-contracted crisis service provider, and any licensed alcohol and drug counselor (2020). Next, Amendment Two (HA 8014) states that any telehealth service provider is required to report data that will aid in the delivery of telehealth services to the department of commerce and insurance (2020). This same amendment also requires the data mentioned in the previous sentence to be reported to the senate and speaker of the house on or before February 1 of each year, and data reported should not violate HIPAA guidelines (State of Tennessee, 2020). **Research Gaps/Evaluation Issues** There are specific evidence gaps in telehealth research that exist. Evidence gaps include effectively reaching populations with limited access to technology or might need culturally tailored interventions (Patient-Centered Outcomes Research Institute, 2020). Urban African Americans and Latinos with low incomes found telehealth services convenient and appreciated no waiting times, but they expressed concerns about confidentiality, privacy, and safety using telehealth services (George et al., 2012). Telehealth technologies may help address unmet health needs in the United States, particularly for rural populations and transportation and childcare barriers. However, there are still barriers to implementation and widespread use, such as the cost of setting up Telehealth and insurance coverage (Weigel et al., 2019). There are concerns that due to telehealth services becoming such an accelerated adoption due to the Pandemic that the use of algorithmic tools will have uncertain implications of the equitable distribution of health resources and that it will widen racial and class-based disparities related to health (Clair et al., 2020). Post-pandemic, telehealth services could provide more access and convenience for many patients; however, health disparities could worsen if not implemented carefully and strategically (Clair et al., 2020). **Inadequately Addressed (Issues) Social Justice/Disparities** Disparities in health care access for minorities have been extensively documented, and the need to leverage Telehealth to expand capacity in a health system marked by significant and persistent physician shortages and geographic disparities have been made worse during the global Pandemic (Balderas-Medina Anaya et al., 2020). According to Balderas-Medina Anaya, telehealth services have been proven to improve access and reduce costs and will likely prove to be transformative past COVID-19 and will also help accelerate the pace of the nation's response to future pandemics. The author further discusses the implementation of telehealth services having the potential to reduce barriers for patients and providers and can recognize the value of physician time and work offering parity in payment for parity in

services (Balderas-Medina Anaya et al., 2020). Currently, in the state of Tennessee, S.B. 8003-HB 8002 has enabled telehealth services to be paid at the same costs of an in-person visit. Prioritization for overcoming accessibility to broadband/internet in rural areas should be considered to efficiently implement telehealth services, especially in rural settings (Hirko et al., 2020).

Funding/Implementation

In March 2020, the U.S. Department of Health & Human Services awarded $15 million to support telehealth providers during the COVID-19 Pandemic (U.S. Department of Health and Human Services, 2020). The Tennessee Department of Health was awarded $3,204,046 from the Coronavirus Aid, Relief, and Economic Security (CARES) Act, 2020, to expand Telehealth service provisions (Health Resources & Services Administration, 2020). As of now, the insurance provider to patient coverage dates vary. CMS, Medicare, and other Federal Payors and Humana insurance agencies telehealth coverage ends on October 23, 2020. United Healthcare Medicare Advantage ends its coverage on October 22, and United Healthcare commercial insurance agencies end theirs on September 30, Aetna, BCBS TN are providing ongoing coverage. BCBS from other states has not announced a date. The Department of TennCare is the only insurance provider who has implemented S.B. 8003-HB 8002, which has extended its coverage date to April 1, 2022 (Vanderbilt University Medical Center, 2020). This policy is currently in its beginning stages of implementation, and further research should be conducted to gather data.

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Fact Sheet is attached (20 pts- follow the guidelines in the textbook. Additionally, you can find the requirements on the Fact Sheet Checklist on E-Class	**X** Yes ☐ No (This fact sheet should be designed for public consumption by both key stakeholders invested in the policy and the general public. The fact sheet should not be overly research-focused or technical. Organize the content in a reader-friendly manner and may, if you choose, make use of graphs, charts, figures, and other visual aids, but these should not be overpowering. Ensure the font size and color of text are legible and easy to read based on background. *****Please see attachment*****