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Public policy seeks to solve societal problems by ensuring an appropriate government response; health policy seeks to favorably influence health outcomes, often by addressing problems in health care.1 Advanced practice nurses serve patients and facilitate person-centered care by advocating for policies aimed at improving health outcomes. Some of these policies focus on health service delivery. Other policies address factors that underlie service delivery on the health systems’ side and access and use on the patients’ side. One way of understanding the relationships between patient outcomes and the societal-level factors that underlie them is through the social determinants of health.3

Healthy People 2030 broadly defines social determinants of health as “the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”2 Two premises of the social determinants framework are that (1) societal conditions underlie the individual decisions and behaviors that result in patient- and population-level health outcomes and that (2) population-level interventions, such as policy, are the most effective mechanism to make the changes necessary to drive health equity. Social determinants of health frameworks group these underlying factors into 5 domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.2

Because these domains may fall outside of what has been historically included under the umbrella of health policy, it is valuable to examine them through a tangible example. Within the neighborhood and built environment domain, for example, access to care has commonly been understood as being undergirded by transportation access because it can facilitate appointment compliance. Health care’s rapid scale-up of telehealth under the current coronavirus disease 2019 (COVID-19) pandemic highlighted limitations in our conventional understanding of policy related to the neighborhood and built environment domain.

The COVID-19 pandemic revealed an urgent health policy concern within the social determinants of health’s neighborhood and built environment domain: equitable access to telehealth services. COVID-19 necessitated social distancing mandates, the conservation of limited personal protective equipment, and the prioritization of health care resources for suspected cases in the United States beginning in March 2020. The US health care system was forced into delivering care in an alternative format, prompting systems to expand or, in some cases, adopt telehealth services. While the shift was necessary as part of an effort to flatten the curve and reduce new cases of COVID-19, the movement to telehealth unintentionally disrupted care to patients and communities that lacked access to high-speed internet or patients who experience what is popularly known as the digital divide.3

Increasing population-level broadband access is a Healthy People 2030 objective, which reports that as of 2017 only 55.9% of US adults had broadband internet.2 In 2019, the Pew Foundation found that nearly one-quarter of rural Americans reported problems accessing high-speed internet and that low-income people were both more likely to use a mobile device for connectivity and more likely to encounter a disruption in mobile service secondary to fees for data usage.4

Importantly, many of those who experience the digital divide also experience health disparities, thus indicating the potential of a duplicative effect of the digital divide on existing health inequities.
Broadband access has been increasingly named as an explicit social determinant of health during the COVID-19 pandemic. This article demonstrates advance practice nurses’ stake in advocating for equitable access to telehealth, which encompasses infrastructure to allow access, safe space to use telehealth, and payment equity to reduce burden as a way to pursue equitable patient-centered care under pandemic conditions. The case demonstrates how pandemic-driven liberalization of telehealth service delivery policy is inadequate, when taken on its own, to drive equitable access to telehealth and speaks to the necessity for advanced practice nurses to engage in broad policy initiatives to address social determinants of health care.

Telehealth Policy Before COVID-19

Telehealth was first conceptualized in the 1950s. Since then, outcomes research has demonstrated that it is a safe and effective care delivery model and that it is an important mechanism to increase access to preventive and specialty care among underserved populations. This is particularly true in rural areas where access is negatively affected by transportation barriers and shortages in the health care provider workforce.\textsuperscript{6,7} Results from systematic reviews and meta-analyses indicate that telehealth outcomes are equal to face-to-face care outcomes in a variety of patient populations.\textsuperscript{5,9}

The acceptability of telehealth among patients has grown in recent years. The American Hospital Association conducted a national survey which reported that nearly 75% of patients would use telehealth services, particularly if this ensured timely access to care, and that patients felt comfortable using electronic communication in addition to face-to-face visits.\textsuperscript{10} Provider comfort with telehealth varies, with a recent systematic review demonstrating that telehealth in primary care was generally more acceptable to patients than providers, with providers working in a rural setting or a practice owned by an integrated health system being the most comfortable using telehealth.\textsuperscript{11,12}

Despite evidence supporting telehealth as a viable solution to safely improve access to care and increasing acceptance of telehealth by patients, wide adoption was slow before COVID-19 due to barriers on both the health system side and the patient side. Barriers on the health system side include poor payment parity, questions regarding interstate licensing, and privacy concerns/ constraints related to the Health Insurance Portability and Accountability Act.\textsuperscript{10}

US health systems lacked financial incentives to integrate telehealth services, partly due to lack of universal coverage.\textsuperscript{13} Medicare began providing payment for telehealth services in 1999 using a split model where 75% of the fee was allocated to the distant site provider and 25% to the originating site provider.\textsuperscript{14} Despite this payment reform, uptake of telehealth services by health systems was low. In 2001, the Benefits and Improvements Protection Act authorized paying distant providers at the same rate as face-to-face encounters and eliminated the splitting of payment by instead instituting a $24 facility fee to be paid to the originating site. Yet this Act, meant to incentivize telehealth service delivery on the provider side, created a disincentive on the patient side by charging consumers more for a telehealth visit than for a traditional face-to-face visit.\textsuperscript{14} Consequently, incremental payment reforms did not result in large scale telehealth use, even as telehealth-improved service categories expanded.

Telehealth use gradually increased among fee-for-service Medicare enrollees between 2006 and 2016.\textsuperscript{15} Yet, less than 10% of US consumers overall used telehealth services by the end of that period.\textsuperscript{16} Notably, three-quarters of consumers remained unaware of the availability of telehealth services or reported that their provider or payer, or both, did not offer them, a finding consistent even when accounting for demographic diversity that might have predicted different understandings and appeals of telehealth such as residing in a rural setting vs a suburban or urban setting.\textsuperscript{10} While health policy removed several health system-side barriers to telehealth provision before the COVID-19 pandemic, barriers on the patient-use side remained inadequately addressed.

Telehealth Policy Liberalization Under COVID 19

The COVID-19 pandemic forced the US health care system to quickly shift to using telehealth services system wide. As part of the Coronavirus Preparedness and Response Supplemental Appropriation Act, the Secretary of the US Department of Health and Human Services enacted the Social Security Act Section 1135 (Waiver 1135), which expanded access to telehealth services by allowing Medicare to reimburse for telehealth services in broader circumstances. Specifically, Waiver 1135 mandated that telehealth visits be paid at the same rate as traditional face-to-face visits, pay for professional services delivered to patients in all settings, including the patient’s home, allowed for audio-only visits and reduced cost-sharing for telehealth visits in federal health care programs.\textsuperscript{17} Private insurers followed CMS’s lead because Waiver 1135 provided a mechanism to continue to provide health care while adhering to social distancing guidelines.

The monumental shift in health care delivery was necessitated by the pandemic and its impact on access to care as an enabling resource warrants investigation. Particularly since the changes allowed by Waiver 1135 are temporary, their impact can inform decision making moving forward regarding reimbursement for telehealth services after COVID-19. Yet, as the history of telehealth before the pandemic demonstrates, health policy that prioritizes service delivery reform to the minimization or exclusion of patient usage factors is inadequate to strengthen telehealth and its favorable impact on health outcomes overall and as a method to drive health and health care equity.

Enabling resources must be present for individuals to use health care and include variables such as insurance coverage, transportation, and availability of services.\textsuperscript{18} To have use of any health service, individuals and systems both require the enabling resource of payment. In the US context, this means health insurance coverage that adequately covers services for patients, adequately reimburses health systems, and, within an equity ideal, ensures coverage for all or most patients. The adoption of telehealth services by both health care organizations and consumers of health care before and after COVID-19 exemplifies the importance of insurance coverage as an enabling factor.

Achieving Equitable Access Under COVID 19

Access to health care is complicated by poor social determinants that result in worsening health concerns or poor health outcomes. During the response to COVID-19, ambulatory care clinics decreased their appointment volumes and at times, closed altogether. Telehealth offered patients the option of accessing their usual care provider for routine services as opposed to accessing the emergency department or forgoing care altogether. Offering telehealth as an alternative addressed ambulatory closures while simultaneously creating barriers related to social determinants. An essential social determinant domain in the uptake of telehealth services is the neighborhood and built environment domain. In the context of health policy, agendas should be based on these needs as well-designed policy is aimed at addressing societal needs. Nurse advocates should consider policy agendas that address the domains of social determinants.
The rationale for advanced nursing practice to advocate for strengthening broadband access is likely clear once described using examples from telehealth; for example, patients who are unable to complete appointments due to internet bandwidth limitations or the bandwidth overloading that occurs when multiple members of a household need to be online simultaneously, such as occurs when children need to complete school lessons under quarantine while adults complete work and also attend to important health care appointments.

Perhaps a less obvious platform in the same domain is housing instability. An enabling factor for the use of telehealth by consumers is a safe, private space. For example, answering sensitive questions regarding sexual practices or screening for abuse requires a high level of privacy and a safe environment. The enactment of Waiver 1135 allowed for this space to be a patient’s home, which promoted convenience but did not necessarily promote equity as many patients’ housing situations were negatively affected by the pandemic.

The pandemic contributed to a national housing crisis, particularly among renters; more than half of renters lost income as a result of the pandemic compared with 39% of homeowner. The Aspen Institute estimated that by Fall 2020, nearly 23 million renters would be evicted, which aligns with results from the National Coalition for a Civil Right to Counsel’s July 2020 survey that reported nearly half of renters were unable to make rent. The threat of eviction during COVID-19 has been disproportionately experienced by Black and Latinx households. The Coronavirus Aid, Relief, and Economic Security (CARES) Act provided protection for homeowners with mortgages and renters in public housing. It did not, however, provide the same relief for the vast majority of tenants, who rent from private entities. In response to the housing crisis, the Trump Administration ordered a moratorium on evictions for the unemployed until December 2020. Housing advocates support this action, yet there is concern that the order stops short of providing landlords with a mechanism to recoup lost revenue.

Stable housing has always been a need in health care, as demonstrated by the association between evictions and emergency department use. With the rapid expansion of telehealth as the mainstay of care under COVID-19 and the pending housing stability crisis, nurse advocates should consider it imperative to advocate for equitable and compassionate housing policy as part of larger health policy agendas, to provide the stability necessary to ensure optimal and equitable telehealth use.

### Ensuring Telehealth Uptake Before and After COVID-19

Beyond inadequate reimbursement, the integration of telehealth by health care systems before and after COVID-19 was influenced by patient and staff perceptions of telehealth services. Ensuring supportive perceptions is challenging if they do not already exist. A recent example of policy-driven mechanisms to change perceptions was the US response to the opioid epidemic. Stigma around opioid dependence was identified as a perceptual barrier to developing and implementing health policy to address the health concern and subsequently improve health outcomes. Legislative initiatives aimed at reducing stigma supplemented conventional health policy approaches like improving surveillance infrastructure. They included improving reimbursement for integrated pain management services and expanding harm reduction. Similarly, patients and providers may experience perceptual barriers to telehealth use, for example, believing it is a subpar method of health service delivery or feeling inadequately familiar with how to use technology to obtain health services. Legislative initiatives around perceptions of telehealth are warranted as we continue to promote telehealth use.

Advocates may not always consider legislation aimed at improving training as a health policy initiative. Legislation aimed at addressing the opioid epidemic serves as an example of the potential positive impact. In 2018, the 115 Congress passed H.R. 6 Support for Patients and Communities Act; among many things, this act designated increased funding to support clinician continuing education for opioid prescribing and treatment of addiction. Many states subsequently mandated specific continuing education requirements at part of licensure in the state. Similarly, as health care organizations were forced to create new processes to quickly shore-up or establish telehealth service delivery lines under COVID-19, telehealth advocates have identified the need to provide patients, providers, and health care administrators with education on telehealth, including how to adopt new technology to enhance services and understanding coding requirements.

### Call to Action

The COVID-19 pandemic forced rapid adoption and expansion of telehealth services to meet a need. Before the pandemic, payment reform was desperately needed to make telehealth a viable solution to improve access to care. Waiver 1135 served as an enabling resource by improving payment parity in the time of the pandemic. Nurse advocates should consider whether telehealth payment liberalization should be continued after the pandemic and what revisions may be necessary. Informing payment legislative decisions is a standard health policy agenda item for professional nursing, and telehealth payment reform should not be an exception. However, the liberalization of telehealth as part of the response to COVID-19 requires that nurses think beyond payment reform to promote equitable access to telehealth.

Barriers to telehealth still exist, including poor broadband access, a housing crisis, and lack of training. The Federal Communication Commission Task Force, Connect 2 Health’s mission is to “address regulatory barriers that hinder the adoption of broadband-enabled health care solutions.” Indeed, the insufficient breadth of the Healthy People 2030 objective to “increase the proportion of adults with broadband access to the Internet” from 55.9% in 2017 to 60.8% in 2030 is made clear by the COVID-19 pandemic’s drive of health care to hotspots.

Advanced practice nurses would be ideal partners in this endeavor. In addition to federal programs, nurse advocates could participate in any one of the private/public partnerships that exist to overcome digital disparities; examples include the Digital Health Connectivity Project and the Phones for Families Project led by the Nurse-Family Partnership community health program. In both of these projects, health care experts partner with private industry to provide free technology to patients, including mobile devices and hot spots to allow them access to telehealth services. Professional organizations are now including telehealth initiatives in their policy agendas; for example, the American Hospital Association includes broadband in its Federal Telehealth Advocacy initiative. Professional nursing organizations should consider including access to broadband as well as safe housing as part of their legislative agendas.

The domain of neighborhood and built environment lends its self to policy fostering the development of broadband infrastructure. On March 3, 2020, the very day that the US surpassed 100 confirmed cases of COVID-19, the US House of Representatives unanimously passed S. 1822, joining the Senate in requiring the Federal Communications Commission to collect and share accurate data about broadband distribution. This legislation is an important
step to hold broadband providers to account on the issue of equitable access but failed to address essential supports for widening distribution, including funding for broadband expansion. In this regard, 31 states and Puerto Rico were much more successful during 2019 legislative sessions, enacting measures to stoke infrastructure expansion, municipal-run broadband networks, and stronger oversight. Although 43 states, Guam, and Puerto Rico carried legislation that addresses broadband issues, including topics such as funding, governance authority, and infrastructure, in 2020, just over half of these states actually enacted legislation or adopted resolutions.30 Nurse advocates should monitor both federal and state legislative sessions for bills that address access to broadband to promote health equity during the new normal and when bills are introduced, advocate for them.

Before the pandemic, many clinicians might not have included broadband legislation, training legislation, or housing legislation in their understanding of health policy. This case demonstrates the need for advanced practice nurses to conceptualize health policy as broader than health care policy, particularly when equity is the goal. The Centers for Disease Control and Prevention recognizes the importance of health considerations across policymaking, along with other public health policy leaders such as the World Health Organization, and refers to this concept as “Health in All Policies” (HiAP).31,32 The HiAP initiative emphasizes the significance of promoting health by making it a visible aim on policy agendas outside of typical public health activities. The COVID-19 pandemic illustrates the imperative need for nurses to be equal partners in HiAP initiatives.

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Shelly Smith, DNP, ANP-BC is an Associate Professor and Director of Nursing Practice Program Director at Virginia Commonwealth University School of Nursing, Richmond, Virginia, and can be contacted at ssmith@vcu.edu. Sarah Raskin, PhD, MPH is an Assistant Professor at Virginia Commonwealth University, L. Douglas Wilder School of Government and Public Affairs, Richmond, Virginia.

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