Chapter 7
Artificial Intelligence (AI), Disability, and Telemedicine/Telehealth:
Building an Academic Program

Sharon L. Burton
https://orcid.org/0000-0003-1653-9783
Grand Canyon University, USA

ABSTRACT

Research reveals the significance of artificial intelligence's applicability for disability through telemedicine/telehealth education for advancing health care in rural, remote, and underserved locations. Improperly researched requirements, failure to include artificial intelligence (AI), and skewed monetary knowledge are derailing components for academic programs in the United States. Artificial intelligence is a key component to pinpoint inadequacies and drive them out of telemedicine/telehealth educational clinical processes and, as an outcome, help diminish costs and enhance outcomes for learners and administrators. This chapter revealed information for developing best practices, which will lead to the development of a series of academic courses for a community-based telehealth program at a medium-sized telehealth organization based out of Virginia. This research offers to practitioners, learners, and academicians academic program development suggestions for meeting a process improvement initiative.

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INTRODUCTION

Treating patients through telemedicine and telehealth in this global market is increasing and is expected to reach 34.27 billion individuals by the end of 2020 (Gruessner, 2015); growing at a compound annual growth rate (CAGR) of more than 25% (InTouch Health, 2019) since the beginning of 2015. By 2025, the overall telemedicine/telehealth market is projected to exceed USD 130.5 billion. Continuing ubiquitous technological progressions are reorganizing the manner practitioners and Human Resource/Human Resource Development (HR/HRD) professionals handle health care activities and apply novel technologies. These same progressing ubiquitous technological progressions are propelling changes in HR/HRD. Corporate health risk solutions consultants are working to (a) handle increased numbers of employees, (b) provide benefits to employees who live in rural, remote, and underserved communities in relation to care, (c) educate on changes in the affordable care act, as well as (d.) how to deliver health care (Moody, 2016). Health risk solutions consultants have grasped that organizations and employers value telemedicine and telehealth because of the services being opportune and minimally invasive (Moody, 2016). United States Government at federal, state, and local levels have acknowledged telemedicine and telehealth as significant to reducing the disturbing impact of the COVID-19 coronavirus (O'Brien, 2020).

Telehealth gained a boost when the Department of Veterans Affairs (VA) amended its medical regulations by homogenizing the delivery of health care by VA health care providers (Federal Register: The Daily Journal of the United States Government 2018). Telehealth technology is fueled by changes for the more than 48 million individuals who previously did not have medical insurance (Telemedicine Executive Launches, 2014). The bureaucratic conditions for health care in America have long been the circumstances of five key points. Aging populations defined as Baby Boomers born between 1945 – 1964 and Matures X born before 1944 (Burton, 2007) are increasingly concerned about the costly and unsustainability of public pensions, social security, health care, and long-term care programs since the end of the 20th century (Gusmano & Okma, 2018). Snowballing health care burdens continue to be the topic for political debates, and HR/HRD practitioners (McCarthy-Alfano, Glickman, Wikelius, & Weiner, 2019). The establishment of required medical insurance rules for the Affordable Care Act continues to update due to administration turnover and Congressional bills passed (Collins & Lambrew, 2019; Health.gov, 2020). The projected shortage of physicians (Telemedicine executive launches, 2014) by the year 2032 forecasts a need for primary care doctors between 21,100 and 55, 200 (Heiser, 2019), and specialty care doctors between 24,800 and 65,800 (Heiser, 2019). The last circumstance is the void in telemedicine/telehealth