OMA Ontario Medical Association

Ontario Medical Association Submission

CPSO Telemedicine Policy – Preliminary Consultation

November 2020

The Ontario Medical Association (OMA) welcomes the opportunity to provide comments in response to the CPSO's preliminary consultation on its Telemedicine Policy. We commend the CPSO for recognizing the need to update this policy given the dramatic shift to virtual care arising from the pandemic. Our comments below highlight some of the current key issues within the rapidly evolving landscape of virtual care in Ontario. We hope our comments are beneficial in guiding framing and direction of the Telemedicine Policy as future revisions are contemplated. We would appreciate the opportunity to engage in further discussions as the feedback is reviewed and the policy consultation process progresses.

Virtual care is probably better described as care delivered virtually. Virtual care has rapidly evolved in recent years with advancements in technology. Convenience has increased from no longer requiring physicians and patients to travel to separate telemedicine studios for video visits hosted by the Ontario Telemedicine Network (OTN), to now allowing physicians and patients to use software on their own devices from a location of their choice. Modalities have expanded from traditional video visits to include calls via regular telephone or audioconferencing, messaging via regular email and text-messaging or secure messaging, and remote monitoring. Virtual visits no longer must be in real-time but can either be synchronous or asynchronous. Platforms have grown from OTN to a variety of virtual care solutions – some integrated with EMRs, some standalone solutions, and even those technologies not traditionally used in healthcare. Together, these changes reflect the shift from what was commonly referred to solely as 'telemedicine' to a more-encompassing 'virtual care'.

Virtual care enhances access to care, particularly for those patients who are unable to seek in-person care, including those in rural/remote/northern/Indigenous communities, those with limited mobility, or those unable to take time for an in-person visit (e.g. due to travel costs, childcare/caregiver costs, or lost income due to taking time off work). Rather than forgoing seeking care – which may result in further health complications down the line – virtual care allows these patients to seek the care they need in a manner more accessible to them. The use of virtual care may also yield other potential benefits, including decreasing emergency/walk-in utilization, and reducing wait times and hallway medicine. However, it may also lead to a proliferation of virtual walk-in clinics leading to fragmented care.

The OMA has been integral in advancing virtual care in the province through its work with the Ministry of Health on the bilateral Virtual Care Working Group originally struck in 2019. In November 2019, OTNinvite was rolled out across the province allowing eligible doctors and patients to have video visits using their own personal devices from a location of their choice. Given that travel to a telemedicine studio was no longer required for physicians, the telemedicine premium was removed starting April 1, 2020, with certain transitional time-limited exceptions including for rural patients.

The onset of the COVID-19 pandemic has highlighted the fundamental importance of virtual care in the delivery of care, by allowing for the continued provision of care to patients during a time where physical distancing is required. The introduction of the temporary K billing codes for video and phone has enabled access to and uptake of virtual care by physicians and patients. A national poll conducted by the Canadian Medical Association (CMA) in May 2020 found almost half of all Canadians have now had a virtual appointment with a physician, with a 91% satisfaction rate.[1] Canadians would like virtual care options not only continued after the COVID-19 crisis subsides, but improved and expanded in the future. The CPSO's support for the use of virtual care during the pandemic has also been fundamental in

[1] Canadian Medical Association. Virtual care is real care: National poll shows Canadians are overwhelmingly satisfied with virtual health care [Internet] 2020 June 8 [cited 2020 July 30] Available from: https://www.cma.ca/news/virtual-care-real-care-national-poll-shows-canadians-are-overwhelmingly-satisfied-virtual

encouraging and enabling physicians to continue to see their patients safely when in-person care is not required.

While the pandemic persists, virtual care will continue to be a key modality of care delivery. However, we must also contemplate the future of virtual care within our health care system, given the desire of both physicians and patients to make it a permanent fixture. The role of the CPSO in regulating the use of virtual care for physicians will fundamentally shape what this looks like. Overall, any future policy must continue to support the use of virtual care as a key modality of care delivery in our health system in a manner that is enabling for physicians and safe for patients. It should reflect that virtual care tools can provide a means of entry into the health care system, especially for those who lack access to care. It should also recognize that virtual care is simply care delivered virtually, and thus should continue to be held to the same standard of care as that delivered in-person.

Below are some of the key issues in the current landscape of virtual care. This overview is intended to highlight the shifting space of virtual care, and some of the considerations that may impact future revisions to the policy. This is not an exhaustive list of all potential issues and the OMA welcomes the opportunity to continue the dialogue with the CPSO as issues evolve and arise.

Appropriateness of virtual care

Through the increased uptake of virtual care during the pandemic, there have been many calls for additional guidance to be developed for physicians on when virtual care is appropriate and inappropriate. While physicians need to be supported and guided in their decision-making, ultimately clinical and professional discretion is paramount. Appropriateness is a clinical decision and thus must be left to the physician's clinical discretion. Physicians must be able to use their professional judgement to determine if and what type of virtual care is appropriate on a case-by-case basis. As such, the policy should not be revised to include prescriptive requirements for determining appropriateness. Rather, enabling physician discretion within a guiding framework will be essential. As further detailed below, guidance and decision-making frameworks on whether and what type of virtual care is appropriate in a given clinical situation would be best developed by physicians, such as specialty-specific groups and organizations, who have clinical expertise and experience in the use of virtual care.

In general, there are three aspects for physicians to consider when determining if a virtual visit is appropriate:

1. Is a virtual visit possible?
2. Is a virtual visit appropriate?
3. If a virtual visit is possible and appropriate, then which modality is appropriate?

Physicians will have to use their professional judgement in making these determinations. Some factors that will be germane to their decision-making are suggested below – this is not intended to be a prescriptive or exhaustive list.

Is a virtual visit possible?

Going forward, clinical care will be fundamentally different comprising a mix of both in-person and virtual care. In-person care will continue to be an important manner of care delivery, given it is not possible to deliver all care virtually; for example, where physical touch is required such as for immunizations or surgery. The ultimate decision should reside with the physician depending on the

clinical condition, the context, and the patient. That said, technology will continue to advance over time making more aspects of care possible to deliver virtually. As such, the policy will need to remain flexible and agile to account for advancements in virtual care and what is virtually possible.

Whether both the physician and patient have access to the necessary technology is an additional factor that will determine whether a virtual visit is possible. If one party does not, a virtual encounter cannot take place. Access to technology includes not only having the physical device, but also high-speed internet, broadband and/or cellular connection. Patients in rural/remote/northern/Indigenous communities and vulnerable populations continue to lack access to technology based on geographic and/or socio-demographic factors. As such, while virtual care can increase access to care generally for these patient populations, they are also the ones which generally lack access to virtual care.

In some situations, a virtual visit may be possible, but not appropriate.

Is a virtual visit appropriate?

When considering whether a virtual visit is appropriate, there are several factors a physician would have to consider, including the physician's and patient's comfort and ability to use technology (i.e. 'digital health literacy' level), and whether the physician and patient are respectively in a private and safe physical setting for the virtual visit.

It is recognized these types of factors place different expectations on physicians compared to in-person care – but these should not place additional or undue burden on physicians. For example, using professional judgement to determine if the patient is in a private and secure physical setting for the virtual encounter is not a determination physicians have to make for in-person visits. In these situations, taking 'reasonable steps' to make this determination (e.g. asking the patient "are you somewhere you can speak privately" and relying on the patient to respond accurately) should continue to be the level of expectation and not place additional obligations or burden on physicians.

There may also be some situations where a virtual visit is both possible and appropriate, but it is beneficial to have an in-person visit based on the patient's best interests.

Ultimately, the mix of in-person and virtual care will vary by physician, depending on their patient population, the type of care they provide, and the general nature of their practice. For some, it may be a 50:50 split, for others 40:60 or 80:20. A set ratio should not be prescribed as appropriate; what is important is that virtual care is possible and appropriate in each clinical situation it is delivered.

Further, with increased access to virtual care there will be increased utilization of virtual care. However, increased utilization does not equate to inappropriate care. In most circumstances, virtual care is intended as a 1:1 replacement of in-person care. Virtual care also increases access to care generally (i.e. circumstances where patients should have seen a physician, but due to demands or barriers in access did not). As such, any increases in virtual care may be representative of increased access to appropriate care for those who normally would not have sought care.

If a virtual visit is possible and appropriate, then which modality is appropriate?

Given the vast array of modalities available, physicians will need to determine which modality is appropriate. The right modality should be used for the right patient in the right clinical situation. In some cases, video may be more appropriate than telephone; in others, secure messaging may suffice.

The appropriate modality may also depend on a physician's workflow and the general nature of the care they provide. Choosing technology that aligns with their technological preferences and capabilities, and is seamlessly integrated with their workflow, can help to reduce burnout caused by technology for physicians. At the system level, this will require equipping physicians with educational and change management supports to ensure they are aware of and can connect to the available digital solutions which fit best the needs of their practice. Examples of such supports include:

- Virtual care use case scenarios outlining what conditions are required for a safe and appropriate virtual visit. Specialty-specific groups and organizations comprised of physicians would be best positioned to provide any guidance and decision-making frameworks for physicians on whether virtual care is appropriate for the type of care provided and if so, which modalities may be most suitable for certain clinical situations/use cases based on their clinical expertise and experiences.
- IT services could be an externalized resource for physicians to have access to when they encounter technical issues during a virtual visit, to ensure they can continue to provide high-quality care without the added burden of having to troubleshoot problems that are out of their scope of knowledge.
- Patient-centered training material physicians or their staff can send prior to a virtual visit, to ensure the patient is ready and knows what expect to ensure the encounter goes smoothly for both parties.
- Easily accessible and concise physician training modules on issues such as privacy and security, including ensuring awareness of data privacy laws and policies of the location where they are providing care, as they might differ from Ontario especially if they are using services more susceptible to privacy and data breaches, e.g. email, and video conferencing.
- Clarity on delivering out-of-province virtual care, including licensure requirements and barriers from regulatory colleges.

Patient education will also be fundamental to ensure they understand how to use and participate in virtual care, to encourage appropriate care-seeking, and raise awareness about the benefits of virtual care including access to care for remote or marginalized communities, public health and safety during the pandemic, and providing a pathway to attach people to a family physician (see *Virtual Walk-in Clinics* below). This would serve to better integrate virtual care into mainstream clinical practice where appropriate, possibly resulting in greater efficiencies on the system.

Virtual Care Platforms

The number of virtual care platforms has grown significantly beyond just the availability of OTN to a variety of solutions – some integrated with EMRs, some standalone solutions, and even those technologies not traditionally used in healthcare such as Skype, Facetime and Zoom.

The temporary K codes have allowed physicians to bill for the use of any platform to deliver virtual care during the pandemic via phone or video, including these non-traditional technologies. While these technologies are more readily accessible, there are concerns about whether such platforms adequately provide privacy and security compared to platforms designed specifically for healthcare. While patients must consent to the use of such technologies, going forward, there is a need to ensure privacy and security of virtual care tools beyond just obtaining patient consent to the potential risk. As such, a standards-based approach is being taken by government which involves verifying non-OTN platforms that meet minimum requirements, including privacy and security standards. It is likely the government will propose that only verified platforms are billable under the Ontario Virtual Care Program. While specifics are largely unknown at this time, the potential impact of introducing a standards-based framework for virtual care on physician obligations will need to be considered. For example, what are the obligations for physicians to ensure the platform they use meets privacy and security requirements if they are relying on vendor attestations for verification?

Further, the level of integration of virtual care tools with point of care systems (i.e. EMR or HIS) will continue to be a key consideration for providers in selecting technology. For example, stand-alone solutions will require manual transfer of information to point of care systems for documentation purposes, compared to seamless integrated solutions.

Ultimately, choice of a virtual care platform should be left to the physician's discretion. Even within a standards-based framework, an equivalent choice in platforms will continue to be important to ensure both patients and physicians are able to choose a virtual care platform(s) that aligns with their technological preferences, capabilities, and is seamlessly integrated with their lifestyle and workflow, respectively. This will ensure physicians can choose a platform that allows them to safely deliver virtual care to their patients. Choice in modalities – including telephone – is also important to ensure all patients can access virtual care, particularly those populations who are often unable to access video visits, which require more advanced technology (e.g. high-speed internet and bandwidth, camera, mic), such as the elderly, new immigrant populations, low income groups, and rural/remote/northern/Indigenous communities. Without allowing choice of virtual care, certain patients will be disadvantaged.

It is also important to note it is the role of the CPSO to regulate the physician, and not the technology.

Virtual Care as an Insured vs. Uninsured Publicly Funded Service

Virtual care under the government's Ontario Virtual Care Program (comprised thus far of only OTN and OTN-approved solutions) has historically been an uninsured but publicly funded service. This means that while physicians bill using a service fee code from the Schedule of Benefits (SOB) and a program 'B' code for OTN, funding comes from outside OHIP through the Ontario Virtual Care Program. However, the temporary K codes introduced virtual care under a Ministerial order as an insured service in March 2020. As such, the issue of whether virtual care is an insured or uninsured publicly funded service will need to be resolved.

The main implication is that uninsured services allow providers to charge additional fees (i.e. a "user fee") directly to patients while user fees cannot be charged on top of insured services. However, the issue is significantly complex and intersects with many other issues including whether virtual care should be in or out-of-basket, whether or not it impacts the access bonus, whether it curbs or proliferates virtual walk-in clinics, whether it increases or impedes access to care, whether it promotes or fragments

continuity of care, whether it encourages or reduces appropriate care, and whether user fees are permissible under CPSO policy on Uninsured Services and if so, what limitations apply.

Whether virtual care is permanently an insured or uninsured publicly funded service will impact how care is delivered virtually within our health system.

Virtual Walk-In Clinics

Virtual walk-in clinics have been a fixture of the virtual care landscape for many years and have utilized much of the market long before virtual care become a part of mainstream healthcare. There are two types of virtual walk-in clinics: for-profit clinics with lucrative business models that charge patients directly and/or partner with commercial businesses to increase revenue, and not-for-profit clinics run by fee-for-service physicians, such as the Ontario Virtual Care Clinic (OVCC).

Virtual walk-in clinics, such as the OVCC, can provide timely care to attached patients who are unable to access their regular provider and unattached patients who do not have an established primary care relationship by connecting and attaching them to a primary care provider in their community. Access to OVCC was expanded to be generally available to the public through the seethedoctor.ca and has been well received by physicians and patients generally.

Stand-alone for-profit virtual walk-in clinics that focus on providing convenient and episodic care without any opportunity to receive in-person care, can greatly fragment continuity of care for attached patients, further perpetuate the lack of attachment for unattached patients, and silo patient information in the system.

As the issue of virtual walk-in clinics is contemplated in the virtual care and primary care landscapes, consideration should be given to developing virtual walk-in clinic models, such as OVCC, that provide continuity of care for attached patients (e.g. by connecting information back to the existing care provider) and establishing attachment for unattached patients, as opposed to only providing episodic care.

The OMA appreciates the opportunity to provide the CPSO with preliminary feedback concerning its Telemedicine Policy. We would welcome the opportunity to engage in further discussions as the feedback is reviewed and the policy consultation process progresses.
Thank you.