April 2022

What we Heard:
Results of a Policy Lab on the Appropriate Use of Virtual Care in a Primary Care Setting

Healthcare Excellence Canada

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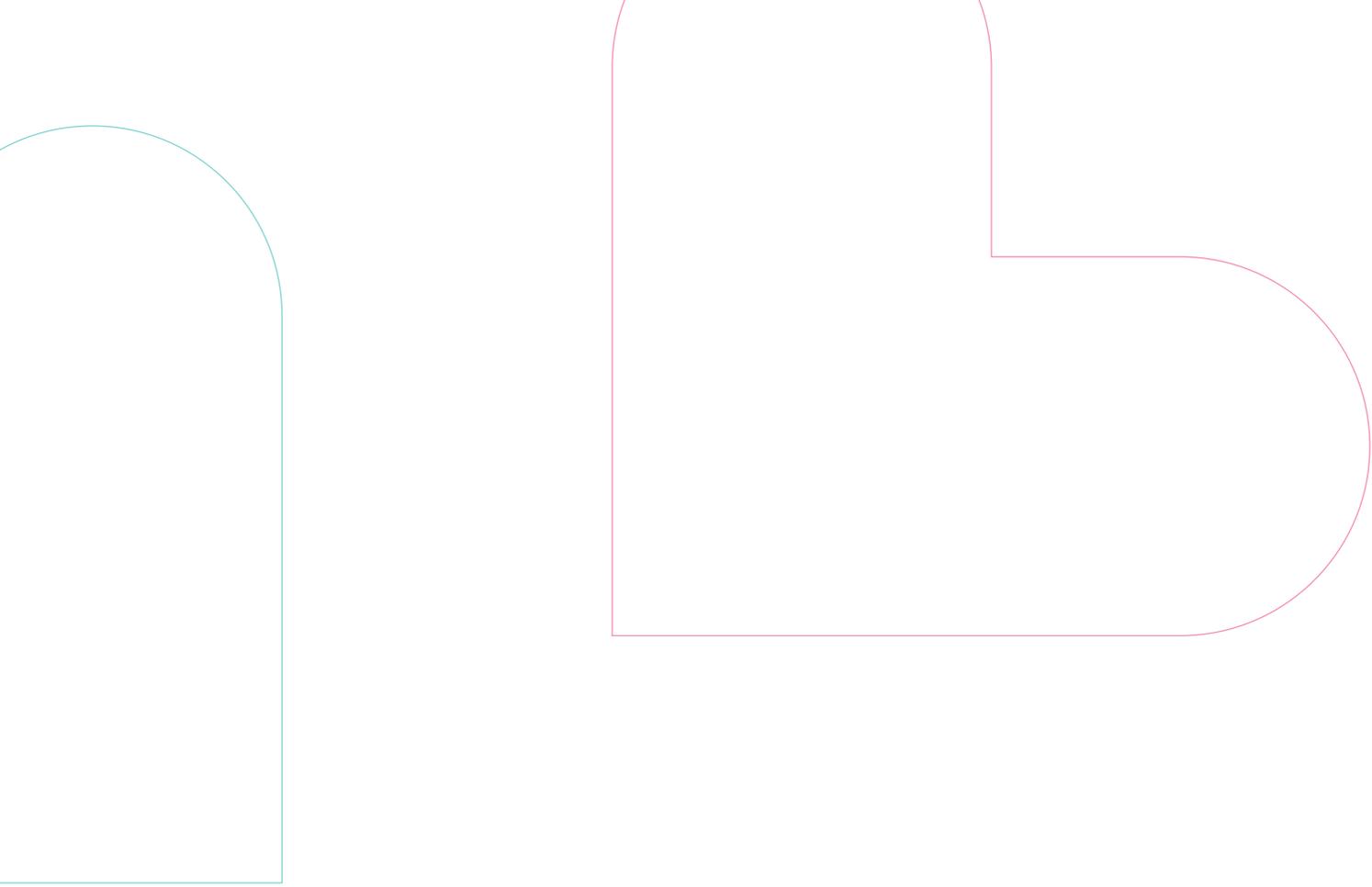
About Healthcare Excellence Canada

Healthcare Excellence Canada (HEC) is an organization with a relentless focus on improving healthcare, with — and for — everyone in Canada. Launched in March 2021 from the amalgamation of the Canadian Patient Safety Institute and the Canadian Foundation for Healthcare Improvement, Healthcare Excellence Canada has greater capacity to support partners to turn proven innovations into widespread and lasting improvement in patient safety and all the dimensions of healthcare excellence. We believe in the power of people and evidence and know that by connecting them, we can achieve the best healthcare in the world. HEC is an independent, not-for-profit charity funded primarily by Health Canada.

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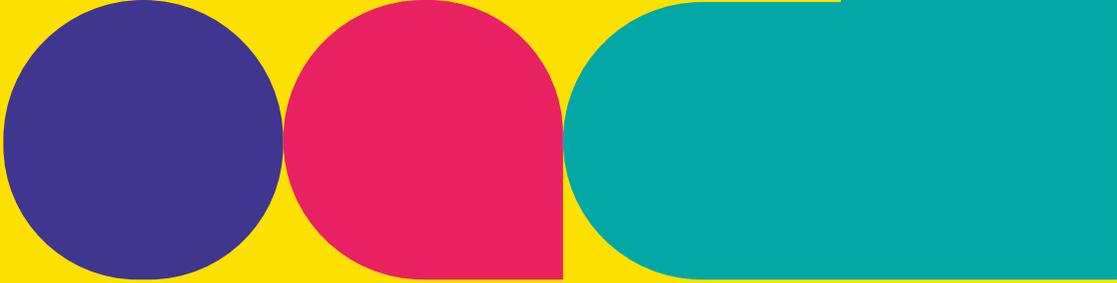
Contents

Executive Summary

The Covid-19 pandemic served as a catalyst for the expansion of virtual care[1] in Canada. By 2021, more than 90 percent of physicians were providing virtual care in some format.[2] Now that virtual care has become a more widely-used and accepted modality of care in Canada, there is a need to ensure that policies and systems are aligned to enable ongoing equitable and safe use of virtual care to complement traditional face-to-face models in primary care. According to work undertaken by various virtual care taskforces, challenges remain with issues such as licensure, interoperability, equity and appropriateness, among others.[3] Provinces/territories, provider associations and regulators continue to work to address these challenges and improve patient and provider experiences.

Healthcare Excellence Canada (HEC) convened a policy lab, that brought together representatives from across the country including patients (defined as individuals with personal experience of a health issue and informal caregivers, including family and friends[4]); primary care providers; policy- and decision-makers to answer the following questions:

- What are the key principles and components (for example equity, continuity of care, etc.) that enable appropriate virtual primary care?

- How can healthcare providers and patients be supported to share decision-making to determine the most appropriate modality for treatment/care (virtual or otherwise)?

A policy lab is a collaborative, facilitated process meant to shorten the path between an idea and learning so that you can have greater confidence in a more refined product. It's a co-design process which recognizes the value and insights coming from the lived experiences of those who will experience the policy (patients/families/caregivers); those that will implement it (healthcare providers); and those who are responsible for developing it (policy/decision-makers).

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[1] For the purposes of the Policy Lab, we adopted this definition for virtual care:

"Virtual healthcare has been defined as "any interaction between patients and/or one or more members of their health circle of care, occurring remotely, using any forms of communication or information technologies with the aim of facilitating or maximizing the quality and effectiveness of patient care".

Virtual care encompasses all the methods that healthcare providers use to interact with patients when separated by space (in different locations) and/or time (synchronicity). These interactions are called virtual visits.

A virtual visit is an electronic exchange via teleconferencing, videoconferencing, secure messaging, or audio digital tools, where one or more healthcare providers deliver healthcare services to a patient

Retrieved from: Heart & Stroke Foundation of Canada. Virtual care decision framework. 2021.
[2] Canada Health Infoway and the Canadian Medical Association. Retrieved from 2021 National Survey of Canadian Physicians. August 11, 2021 and Canada Health Infoway Insights.
[3] Health Canada. Summary Report of the Federal-Provincial-Territorial (FPT) Virtual Care Summit. 2021; Canadian Medical Association, College of Family Physicians of Canada, Royal College of Physicians and Surgeons of Canada. Virtual Care in Canada: Progress and Potential. 2022.
[4] CIHR. Strategy for Patient-Oriented Research: Patient Engagement Framework. 2019.

The guidance in this report is designed to support health leaders in developing policies and regulations to further the delivery of appropriate and safe virtual care. It's not intended to solve all the challenges facing virtual care delivery, but instead provides guidance co-developed by those who access, deliver and regulate virtual care. It's hoped that it will offer tools and resources to enable greater uptake and sustainability of appropriate virtual care as part of a high-quality primary care system in Canada.

Throughout the course of the policy lab participants identified six high level principles that were necessary to ensure the delivery of appropriate virtual care. Many reinforce core principles of safe, high-quality primary care that are as important in a virtual environment as for in-person care.

Ensure equitable access

How healthcare services — whether virtual or in-person — are designed and delivered can either improve or worsen equitable access. There is a need for virtual care strategies to understand and plan for the different needs of patients, as well as the realities of digital literacy and technological availability, (for example devices or data/internet for video-based care in certain communities). Additionally, questions of cultural competency and cultural safety must be identified and addressed to ensure that virtual interactions are culturally safe and appropriate, not causing further harm to those who may already have had negative interactions with the healthcare system.

Broaden the definition of appropriateness

Participants noted three areas that should be considered when determining appropriateness for virtual care: clinical considerations (for example is this a condition that can be treated/assessed virtually?); provider considerations (for example is the primary care practice set-up for virtual visits, and/or are there legal requirements for in-person visits for example the prescribing of narcotics?); and considerations of the individual patient circumstances and/or preferences (for example are there language/understanding barriers to certain modalities, geographical barriers?)

Ensure shared decision-making for care modality decisions

In order to ensure that the care that is being delivered virtually is clinically appropriate and meets the needs and preferences of patients, strategies are required to ensure that decisions are shared and not based on unilateral decisions by healthcare providers, or their staff. Additionally, barriers including inequities must be addressed so that shared decision-making is not only available to privileged patients.

Continuity of care and integration are fundamental for appropriate care

Effective primary care requires a strategy to ensure that continuity of care, including options to convert virtual visits to in-person visits if required. Additionally, virtual care must be integrated into the existing primary care system, including through shared information systems (for example electronic health records [EHR]). Maintaining the patient/provider relationship strengthens care, regardless of the modality by which it is delivered.

Develop models and strategies for team-based virtual care

In Canada, the vision of an ideal primary care model is one that involves team-based care.5 In the virtual space, that team-based dynamic is still being worked out but could potentially lead to increases in team-based care as those practices who don't have interprofessional resources/supports could potentially link to other healthcare providers, including specialists, in a virtual way. Challenges will need to be overcome to ensure that the insights from all team members can contribute to the health and well-being of patients.

Leverage discussions of quality and safety in virtual care to identify ways to measure quality in all modalities of primary care

Much work has been done by provinces/territories, professional associations, regulators and others to develop guidelines and tools for providers to allow them to use their clinical judgment to work with patients to provide appropriate care in the rapidly evolving world of virtual care. However, there is still a gap in the necessary frameworks and metrics which allow this care to be measured and evaluated to ensure that quality and safety is being preserved. This need represents an opportunity to look beyond just virtual primary care, to develop metrics and systems to measure safety and quality in all primary care delivery regardless of the modality.

Based on the consensus of the policy lab participants, the guidance in this report is designed to offer strategies which reduce potential divergences. Divergences are those areas where there could be potential conflict in the needs of different user groups (see Appendix A for a full list of user needs) or where there was a potential conflict between the needs of a group or groups and the existing paradigms in the current healthcare system (for example payment models, decision-making processes). This is not to say that conflict will or will not arise, or that the needs of groups are in complete opposition, but instead they represent areas where guidance can help ensure that potential differences are mediated in ways that encourage appropriateness of care.

Divergence	Guidance

Balancing patient choice and provider autonomy to improve patient-centric care	Policy lab participants indicated that an optimal balance between patient choice and provider autonomy can be achieved when:
	
	• Patient preference is the default and is respected. Where decisions about modality of care may be more complex, a shared decision-making approach is taken to ensure mutual understanding of options and implications, patient preferences, and clinical needs that exist.
	
	• Providers work with patients to co-design clinic flow and develop appropriate processes for the intake and triage of patients to different modalities of care.
	
	• There is seamless integration into existing service models to allow the opportunity to move from virtual care to an in-person visit as needed in a timely and coordinated way, or to accommodate virtual participation from essential care partners or other experts if they're unable to attend in-person.
	
	• There is one point of access or "digital front door" for patients to allow them to obtain information about the type of care available and the modality that is appropriate.
	
	• Targeted literacy campaigns and education are developed and made available for providers (and teams/administrative staff) and patients around appropriateness of care and flexibility for shared decision-making.
	
	• Tools and approaches regarding the various modalities of care are tailored and made available to balance the needs of both patients and providers and their staff. These could include:
	
	  Centralized lists of primary care options available to patients by location and type of care provided.
	
	  Tools to support shared decision-making between patients and providers and their staff (for example scripts).
	
	  Digital literacy and technology training tools to support patients and providers with technical confidence and where to access support.

Divergence	Guidance

Balancing the need of patients to have reasonable access to care with the need to ensure continuity of care, regardless of care provider and/or care modality	Policy lab participants indicated that a balance between reasonable access to care and continuity of care is achieved when:
	
	• The onus is on all providers to ensure that virtual care is appropriate for the clinical situation and that there is continuity with a patient's primary provider (as applicable).
	
	• All providers offering virtual services can/will also provide/make arrangements for in-person care if it's requested by the patient and safe to do so (with exceptions for those that offer fly in services to remote areas).
	
	• Informational continuity is built into virtual care. Regardless of the care provider, notes/outcomes are sent back to a patient's primary care provider (as applicable).
	
	   Patients have access to and ownership of their information and can choose which medical records they would like to share with providers.
	
	   Informational continuity is supported and incentivised (for example compensation for visits is tied to sharing information back with primary care provider in a privacy-sensitive way, as applicable).
	
	• Interoperability and data sharing permit providers to access medical records for patients regardless of where or how they access treatment/care.
	
	• Patients being referred to the ER have warm handovers from the provider making the recommendation to ensure continuity and reduce unnecessary referral of patients to ER (for example call, email or letter/referral written).

Balancing the need to foster flexibility and innovation in care delivery with the government/ decision-maker need to establish and maintain quality and safety standards	Policy lab participants indicated that quality and value can be achieved without sacrificing flexibility and innovation when: • Standards and minimum criteria for virtual care are established by governments, professional associations, and other regulators and are consistently applied, without being too prescriptive (for example the need to allow for clinical judgment and individual patient circumstances and preferences). See Appendix B for guides that have already been developed • Modernize primary care quality and safety measurement, regulation, and processes to reflect all care modalities, whether in-person or virtual. • Virtual care is not considered in isolation but rather integrated into larger strategies for digital health and integrated into the existing health system to ensure continuity of care.

Examples of solutions to put this guidance into action can be found in Tables 1 to 3 of this report. More detail about the principles, guidance and solutions can be found in the full report which follows.

Overview

The COVID-19 pandemic accelerated the use of virtual technologies to enable the provision of care, which would have otherwise been greatly reduced due to the risk of community transmission. Data from February 2020 suggested that just 48 percent of physicians had provided at least one virtual care service. By September 2020, this number had increased to 83 percent[6]. During this time, the proportion of Canadians being treated virtually jumped from six percent to 56 percent[1]. In a more recent 2021 survey, over 94 percent of physicians currently provide primary patient care via telephone (93 percent), video visits (51 percent) and secure email or messaging (36 percent)[7].

While the rapid uptake of virtual care enabled primary care delivery during COVID-19, tools, processes and enabling policies were often implemented as temporary and stopgap solutions. Policy and system challenges remain in ensuring uptake that is equitable and patient-centred and that ensures quality as well as sustainability.

For the purposes of the policy lab, we used the following definition of virtual care:

"Virtual healthcare has been defined as any interaction between patients and/or one or more members of their health circle of care, occurring remotely, using any forms of communication or information technologies with the aim of facilitating or maximizing the quality and effectiveness of patient care".

- Virtual care encompasses all the methods that healthcare providers use to interact with patients when separated by space (in different locations) and/or time (synchronicity). These interactions are called virtual visits.

- A virtual visit is an electronic exchange via teleconferencing, videoconferencing, secure messaging, or audio digital tools, where one or more healthcare provider(s) deliver healthcare services to a patient.

Heart & Stroke Foundation of Canada. Virtual care decision framework. 2021.

According to the work of both the Federal-Provincial-Territorial (FPT) Virtual Care/Digital Table, and the Virtual Care Taskforce, chaired by the Canadian Medical Association, the Canadian College of Family Physicians, and the Royal College of Physicians and Surgeons of Canada, the following system and policy issues will need to be addressed to ensure greater uptake and sustainability:[8]

- interoperability and governance
- licensure and quality of care
- payment models
- medical education
- patient- and community-centred approaches
- appropriateness
- equity

To support the continued adoption of safe and appropriate virtual care, Healthcare Excellence Canada, and Canada Health Infoway have partnered to deliver the Clinician Change Management Project to support providers in adopting virtual care. Through stakeholder feedback and evidence reviews, it became clear that there is a need to catalyze policy change surrounding the question of what constitutes an appropriate virtual visit, and what parameters/criteria guide this decision.

There is a need to consider more than just clinical appropriateness, but also what constitutes appropriate virtual care in the context of a person-centred primary care system (for example continuity of care, access, patient choice, language, cultural safety, etc.). Additionally, there is a need for guidance regarding principles for shared decision-making that would allow healthcare team members (for example receptionists, intake nurses, clinicians) and patients to work jointly to determine the appropriate modality of care.

The guidance in this report was co-designed through a policy lab approach that HEC convened in parallel to the Clinician Change Management Project. Participants worked across four virtual sessions to answer the following questions:

- What are the key principles/components (equity, continuity etc.) that enable appropriate virtual primary care?
- How can providers and patients be supported to share decision-making to determine the most appropriate modality for treatment/care (virtual or otherwise)?

This report is intended to build on the work that has already been done on enabling appropriate virtual care (see Appendix B for some of the resources that have been developed). It aims to provide guiding principles for implementation as well as guidance for those who are involved in delivering, receiving, or funding/regulating virtual care in the primary care setting. While it's hoped that this report will contribute to the delivery of appropriate virtual care, it must be emphasized that it in no way addresses all the policy challenges (for example payment models, interoperability, licensure requirements, etc.) that are facing the digital health environment in Canada. Other groups, with different levers of influence, will need to review policies and practices to ensure that appropriate virtual care is fully integrated into the Canadian healthcare system.

[8]Health Canada. Summary Report of the Federal-Provincial-Territorial (FPT) Virtual Care Summit. 2021; Canadian Medical Association, College of Family Physicians of Canada, Royal College of Physicians and Surgeons of Canada. Virtual Care in Canada: Progress and Potential. 2022

Policy Lab Approach

A policy lab is a collaborative, facilitated process meant to shorten the path between problem identification and solution generation. This process puts the people using and applying policies in the centre of the design. It involves using creative approaches to explore the issues more widely (also called divergent thinking) and then focus on potential solutions (convergent thinking).[9] The result is better, more reliable solutions.

The virtual care policy lab series brought together 19 participants from across Canada to develop guidance that supports the appropriate use of virtual care in the primary care setting. It was a co-design process that recognized the value and insights coming from the perspectives of the four stakeholder groups:

- policymakers/decision-makers
- primary care providers and their staff
- patients (defined as individuals with personal experience of a health issue and informal caregivers, including family and friends[10])
- other healthcare experts (for example healthcare regulators, professional associations, academics etc.)

In advance of the lab, a series of key informant interviews and focus groups (with providers, support staff, and patient partners), a national survey and social media scans were completed by a third-party contractor to help understand the policy environment as well as user needs. During the lab, a range of design-thinking facilitation tools and techniques were used over four virtual sessions that took place between September 29 and November 9, 2021, to develop guidance for healthcare leaders, including:

- **Understanding the system:** Using a mind mapping exercise, participants outlined the principles and components that would be required to enable appropriate virtual care. Participants then reviewed the principles/components from the perspectives of our different user groups to understand the current challenges and areas for potential action.

- **Exploring divergences in user needs**: Using pre-populated lists that were developed based on background research and scanning, participants reviewed and confirmed what they saw as the top needs for each user group to support appropriate virtual care. The group then examined these needs to understand potential divergences (for example where the needs of one group could be different from or in conflict with the needs of another group).

- **Development of guidance options**: Multiple guidance options were developed using an "idea on a page" template for each area that was prioritized for solution generation.

- **Prototype development**: Using the ideas that were generated in session three, participants drilled down and developed prototype ideas in the identified areas. These prototypes have not been validated or tested but are available upon request for those interested in seeing the draft tools that were generated.[11]

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[9]Design Council UK. What is the framework for innovation: Design Council's evolved Double Diamond
[10]CIHR. Strategy for Patient-Oriented Research: Patient Engagement Framework. 2019.
[11]Please contact info@hec-esc.ca for the prototype tools

Guiding Principles

In the first session of the policy lab, participants were asked to outline what they believed constituted appropriateness in the context of virtual care, along with the key components and principles that would be necessary for appropriateness to be achieved. Participants highlighted the following as principles that were foundational for ensuring that the design and delivery of virtual care was appropriate and met the needs of patients, healthcare providers and policymakers. Many of these principles reflect what is necessary for safe, high-quality primary care whether for in-person care or in a virtual environment.

Ensure equitable access

Depending on how care is designed and delivered, different primary care modalities can either improve or compromise equitable access. Some patients who typically had barriers such as needing to leave work or finding and paying for childcare have been able to access care in a way that was not possible before the pandemic. Likewise, some who have felt stigma accessing in-person care have benefited from virtual options. However, increased access with virtual care has not been universal. Challenges with bandwidth, especially in remote and rural communities, and access to technology have made it difficult for some patients to get care when video visits were the only option. Additionally, some patients have personal needs or circumstances that make a virtual visit inappropriate and have faced barriers to access in circumstances where primary care providers were only scheduling virtual visits. There is a need for those providing virtual care to understand and plan for the different needs and realities of patients including digital literacy, having an appropriate/safe place to conduct the visit, and technological availability, to name a few. Additionally, more can be done to ensure that virtual care interactions do not cause harm, for example by improving cultural competency and cultural safety. To ensure that virtual care doesn't further exacerbate inequities, it must be integrated into a primary care system that treats virtual as only one modality of care rather than either the only option available or one that is not available at all.

Broaden the definition of appropriateness

Providing care that is clinically appropriate is a fundamental requirement of any care delivered, virtual or otherwise. However, there is a need to expand the definition of appropriateness beyond just medical decision-making. Participants noted three areas that should be considered when determining whether a virtual visit is appropriate:

- clinical considerations (for example is this a condition that can be treated/assessed virtually)

- provider considerations (for example is the primary care practice set-up for virtual visits, and/or are there legal requirements for in-person visits such as the prescribing of narcotics)

- considerations of the individual patient's circumstances and preferences (for example are they comfortable with the technology, are there language/understanding barriers to or opportunities with certain modalities etc.).

Participants highlighted the need for guidance to be developed and/or updated that was principle-based and flexible rather than prescriptive, which encapsulated the broadened definition of clinical appropriateness, and which allowed for decisions to be made between patients and primary care providers.

Shared decision-making for care decisions

Virtual care offers the opportunity to make primary care more patient-centred by granting patients more agency about the time and circumstances of their care and may allow patients and providers to have easier follow-up and/or receive education (for example through secure text) and generally be more prepared before and after visits. Additionally, it may broaden the scope of attendees that can participate in a visit (for example a patient having a family member attend from another city). However, no care modality will work for all patients in all circumstances. In order to ensure that the care that is being delivered virtually is clinically appropriate and meets the needs and preferences of patients, strategies to ensure that decisions are shared and not based on unilateral decisions by providers, or their staff are required. There is a need to ensure that systemic barriers such as power differentials and other inequities are addressed to ensure that shared decision-making is not only an avenue for privileged patients. Patients must truly be partners in their care including how it's provided, virtual or in-person.

Ensure integration and continuity of care

Virtual care offers patients the opportunity to access care in a way that might be much more convenient than traditional face-to-face delivery and could reduce barriers for those without a regular primary care provider. However, the potential downside of this increased accessibility could be a lack of continuity of care if patients receive care from a provider with whom they have no existing clinical relationship. What is needed is a strategy to ensure that continuity of care is maintained for virtual visits, including options to convert virtual visits to in-person visits if required. This will require informational continuity between patients and providers and between different providers (for example primary care and specialists), such as recording information from virtual visits in shared EHRs, as well as strategies to ensure the consistency of the patient/provider relationship.

Develop models and strategies for team-based virtual care

In Canada, the vision of a patient's medical home outlines an ideal primary care model involving team-based care. While this type of practice is not available to all people who live in Canada, the ideal sees insights from physicians, nurses, and allied health professionals contributing to the health and well-being of patients. In the virtual space that team-based dynamic is still being worked out but could potentially lead to increases in team-based care as those practices who don't have allied staff could potentially link to other providers in a virtual way. Additionally, it could allow primary care providers to broaden the team even further by including specialists in virtual visits. However, challenges related to technology (separate systems for separate providers), billing (who can be paid for virtual visits) and privacy (sharing of health information) are all still barriers to effective virtual team-based care.

Leverage discussions of quality and safety in virtual care to identify ways to measure quality in all modalities of primary care

When the pandemic started in March 2020 there was a move to virtual visits as the risk of in-person care was seen to be too great. At the time, the focus was on access to care, rather than how virtual care could best be employed. Since that time, much work has been done by professional associations, regulators, and others to look at the questions of quality and safety in virtual delivery and develop guidelines and tools for providers to allow them to use their clinical judgment provide safe high-quality care in the rapidly evolving world of virtual care. See Appendix B for examples of tools that have been developed to date.

However, there is still a gap in quality frameworks and metrics designed to measure this care and ensure that patients receive high-quality and safe care. This need represents an opportunity to look beyond just virtual primary care, to develop metrics and systems to measure quality in all primary care delivery regardless of the modality.

Policy Guidance

The guidance in this report is based on the identification of divergences by the participants in the policy lab. Divergences are those areas where a potential conflict was perceived in the needs of different user groups (see Appendix A for full list of user needs) or where there was a potential conflict between the needs of a group or groups and the existing paradigms in the current healthcare system (for example payment models, decision-making processes). This is not to say that conflict will necessarily arise, or that the needs of groups are in complete opposition, but instead they represent areas where guidance and tools can help ensure that potential differences are mediated. The group prioritized action on three divergences throughout the course of the lab. Provided is a summary of the guidance for each of these divergences, as well as potential tools.
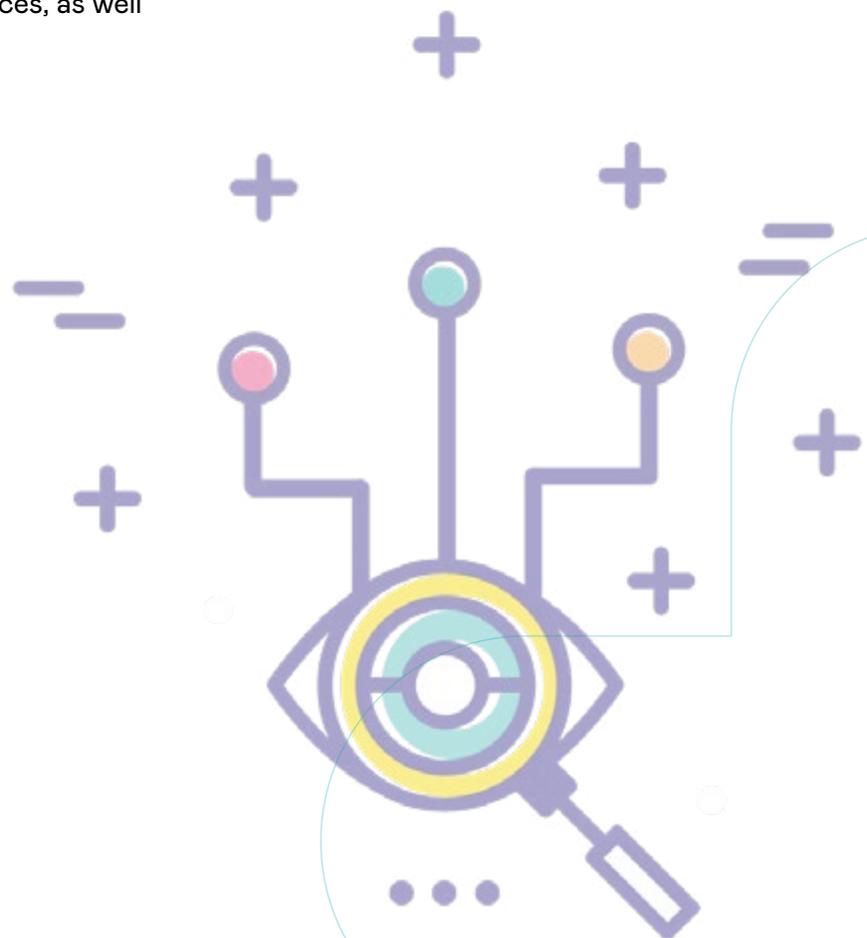
Balancing patient choice and provider autonomy to improve patient-centric care

The current primary care system (like many parts of the healthcare system) tends to be designed around the needs of providers rather than patients. Virtual care offers an opportunity to address how primary care is managed to create a more patient-centred care experience. As virtual care allows for both synchronous and asynchronous communication it could mean that both parties can be more involved and have more time to prepare between or in advance of visits. Additionally, it could help increase continuity of care by ensuring greater access to a patient's primary care provider. Finally, done well, virtual care could facilitate a reduction in existing power differentials between providers and patients by allowing patients to be more active in their care.

In order to realize the promise of virtual care, however, there is a need to ensure that both patients and providers are equal partners in care decisions, that flow and processes are designed with patients needs/ preferences in mind, and patients and providers/staff have the requisite education, health literacy and digital literacy to both make decisions about modality and effectively participate in care.

→ **Guidance: Policy lab participants indicated that an optimal balance between patient choice and provider autonomy can be achieved when:**

- Patient preference is the default and is respected. Where decisions about modality of care may be more complex, a shared decision-making approach is taken to ensure mutual understanding of options and implications, patient preferences and clinical needs that exist.

- Providers work with patients to co-design clinic flow and develop appropriate processes for the intake and triage of patients to different modalities of care.

- There is seamless integration into existing service models to allow the opportunity to move from virtual care to an in-person visit as needed in a timely and coordinated way, or to accommodate virtual participation from essential care partners or other experts if they're unable to attend in person.

- There is one point of access or a "digital front door" for patients to allow them to obtain information about the type of care available and the modality that is appropriate. This should also be available through telephone or other modalities to ensure equity in access for those that don't have internet access.

- Targeted health and digital literacy campaigns and education are developed and made available for providers (and teams/ administrative staff) and patients around appropriateness of care and flexibility for shared decision-making with patient and provider (or staff).

- Tools and approaches regarding the various modalities of care are tailored and made available to balance the needs of both patients and providers and their staff. These could include:

  centralized lists of primary care options available to patients by location and type/ modality of care provided

  tools to support shared decision-making between patients and providers and their staff (for example scripts)

  digital literacy and technology training tools to support patients and providers with technical confidence and where to access support

Table 1: Potential Solutions to Optimize the Balance Between Patient Choice and Provider Autonomy

Potential solution	Examples of how to take action
Shared decision-making regarding care modality	Principles: • Relational decision-making embedded as a core practice for health care providers • Co-design with patients/families/caregivers from diverse backgrounds and perspectives Key components: • Create a good understanding and high-level guidance on principles of shared decision-making • Provide guidance on what modalities are appropriate for certain types of care (to maintain quality and safety) • Create a good understanding of general patient flows and needs and where there will be differences • Support a nuanced understanding of context and setting dependence re appropriateness, for example remote vs urban (travel, weather, tech, etc.) • Provides support for change management and culture change to move from provider/staff decisions to patient/family partnership in decision-making
Service delivery co-design	Principles: • Patient/family/caregiver partnership in all aspects of the co-design process • Consider the needs and challenges of underserved populations during co-design both in terms of technology and communications Key components: • Happens at the regional/community and service level • Consider the entire patient journey/flow (including considerations of access points to booking etc.) and design in such a way that allows patients to switch modality of care throughout, where appropriate • Create processes that act as guidelines around what an ideal patient-centred care model would look like

Potential solution	Examples of how to take action
Digital front door	Principles: • Access point must be patient-centric and easy to use • Consider 'digital first' options but with telephone or other options such as text for those that do not have internet access • Focus on training/triage for administrative staff/first point of contact for practices Key Components: • Create online, accessible information, guidelines and information for patients • Prioritize seamless follow up • Provide support to primary care providers to achieve efficiencies in virtual care (better triage systems and approaches to prioritization and follow up) • Focus on change management and utilize diverse provider, patient voices
Provider training in person-centred care	Principles: • Appropriate virtual care will balance the needs of providers and patients • All members of the provider team will need to be trained Key components: • Provider and team require both interprofessional and administrative training to improve patient experience and facilitate discussions regarding the appropriate care modality • Look to other industries for customer service best practices • Training content includes compassion in care, use of digital technologies, patient-oriented co-design • Jobs and requirements be redesigned to account for different modalities of care being offered • Add training requirements to clinic policies • Include patients in the development of this training

Potential solution	Examples of how to take action
Global digital literacy – patients	Principles: • Should be co-designed with patients representing diverse backgrounds and perspectives • Design to meet the needs of population (for example access to technology/Wi-Fi, language, culture etc.) • Must be mindful of equity considerations and built in such a way to allow patients of all ages, abilities etc. to access Key components: • Understand the digital literacy needs of different groups, and the impact that policies and structures might have on access and understanding • Use relatable language and experiences when discussing digital literacy needs • Offer training and resources in multiple forms and languages etc. to reflect Canada's diverse population Source: https://www.infoway-inforoute.ca/DigitalHealthLearning
Provider education and digital literacy	Principles: • Education must cover all aspects of provider education from undergraduate to continuing education Key components: • Build on existing sets of competencies that have been developed[12] • Look to international best practices for curriculum and practices • Professional school digital literacy curriculum (for example MD residency program) • Understanding processes and workflows • Education and training of providers established, with clear objectives (for example core evidence-based competencies) • Better evidence and measurement around best practices, to inform training and target-setting • Stratifying appropriateness guidance for care modalities according to settings and condition

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[12]Bhyat et.al, Chapter 17 - Implementing Informatics Competencies in Undergraduate Medical Education: A National-Level "Train the Trainer" Initiative. 2017; Association of Faculties of Pharmacy of Canada. Informatics for Pharmacy Students: Preparing Pharmacy Students to Practice in a Technology-enabled Environment. 2014; CASN, Canada Health Infoway Nursing Informatics: Entry-to-practice competencies for registered nurses. 2014.

Balancing the need of patients to have reasonable access to care with the need to ensure continuity of care, regardless of care provider and/or care modality

Virtual care has provided greater convenience for many patients who, for example, no longer have to take time off work or find and pay for transportation and/or childcare to be seen by their primary care provider. Virtual care has the potential to increase access for patients who are unattached and don't have a regular care provider. Some provinces have tied virtual walk-ins to efforts to find unattached patients primary providers which could have large benefits for the overall system and continuity of care.

However, virtual care is not solely provided by an individual's own primary care provider. While this can be beneficial for unattached patients and can provide greater access to care outside of regular business hours, there is a risk that continuity of care and therefore patient safety is undermined if processes are not developed to ensure that

information is shared between these providers and the regular providers with whom patients have an existing clinical relationship.

Given that recent virtual care growth has happened quickly with a driving force of necessity rather than a comprehensive over-arching strategy, it's not surprising that integration with other parts of the health system and interoperability of data, there are still challenges. While progress been made there are still critical gaps in the system leading to duplication of care and negative outcomes such as missed test results. Gaps that are not unique to virtual delivery but exist in the primary care system more broadly. **Virtual care must become just one modality of care that is delivered in the context of a well-integrated primary care system.**

→ **Guidance: Policy lab participants indicated that a balance between reasonable access to care and continuity of care is achieved when:**

- The onus is on all providers to ensure that care is appropriate and that there is continuity with a patient's primary provider (as applicable).

- All providers offering virtual services can/will also provide/make arrangements for in-person care if it's requested by the patient and safe to do so (with exceptions for those that offer fly-in services to remote areas).

- Relational continuity is established through the development of a patient-provider relationship, (for example through in-person visits that take place at least some of the time).

- Interoperability and data sharing permit providers to access medical records for patients regardless of where or how they access treatment/care.

- Patients being referred to the ER have warm handovers from the provider making the recommendation to ensure continuity and reduce unnecessary referral of patients to ER, for example call, email/e-referral, or letter/referral written.

- Informational continuity is built into virtual care. Regardless of the care provider notes/outcomes are sent back to a patient's primary care provider (as applicable):

    Informational continuity is supported and incentivised (for example compensation for visits is tied to sharing info back with primary care provider, as applicable)

    Patients have ownership over their information and can choose which medical records they would like to share with providers

Table 2: Potential solutions to optimize the balance between reasonable access to care and continuity of care

Potential Solution	Examples of how to take action
Informational continuity	Principles: • Onus on provider to ensure that information is shared with patient's primary care provider in a privacy-sensitive way, and that test results etc. are followed up Key components: • Ensure that there is system (for example connected care provisions) to have information from virtual clinics and other healthcare sites shared back with the primary care provider; if patients consent to having this information shared • Make existing systems available on every EHR and mandate that walk-ins provide the information into this • For those that are unattached, and those who choose it, have an electronic access portal for patients to have their own information to be able to share with their providers to ensure continuity
Registry for unattached patients	Principles: • Virtual care has been beneficial to some unattached patients; however, a regular primary care provider would have better continuity of care and overall benefits for patients Key components: • Designed for patients that don't have regular access to primary care provider • Links access to virtual walk-ins to a provincial/territorial registry so that action can be taken by ministries/health authorities etc. to link patients, if they're interested, to a regular primary care provider • Priority access to virtual walk-ins would be given to registry patients to ensure that they have access to care • For information about an example registry, please see the resource section of this report.

Balancing the need to foster flexibility and innovation in care delivery with the government/decision-maker needs to establish and maintain quality and safety standards

The pandemic spurred rapid innovation, including accelerated adoption of virtual care. Most provinces/territories introduced emergency legislation to allow the delivery of, and payment for, virtual care in the early days of the pandemic with a view to ensuring on-going access to care. While this fast-paced policy-making and implementation undoubtedly enabled care for those that would otherwise have gone without, it did not allow for fully integrated frameworks or approaches. Looking ahead, a challenge will be to retain the flexibility and responsiveness that has served us well while ensuring longer-term strategies consider quality, safety, access, and value broadly.

Currently there are only limited means to measure and hold primary care providers accountable for outcomes, and professional colleges that do ensure quality and fitness for practice do not have the capacity to monitor the practices of all providers on a continual basis but instead provide oversight through random reviews and/or when complaints have been made. Rather than focusing on quality and outcomes for just virtual visits, there should be room to talk about primary care more broadly — as care is care — and virtual is just a modality rather than a separate system. The emphasis for providers, patients, and policy-makers should be on designing a primary care system that consistently measures quality and outcomes regardless of the modality of care.

→ **Guidance: Policy lab participants indicated that quality and value can be achieved without sacrificing flexibility and innovation when:**

- Standards and minimum criteria for virtual care are established by governments, regulatory colleges and other regulators, and are consistently applied, without being too prescriptive (for example need to allow for clinical judgment and individual patient circumstances and preferences). See Appendix B for guides that have already been developed.

- Modernize primary care quality and safety measurement, regulation, and processes to reflect all care modalities, whether in-person or virtual.

- Virtual care is not considered in isolation but rather integrated into larger strategies for digital health and integrated into the existing health system to ensure continuity of care.

Table 3: Potential solutions to increase quality and value without sacrificing flexibility and innovation

Potential Solution	Examples of how to take action
Quality improvement modules/ assessments for primary care practices	Principles: • Focus on quality improvement strategies and priorities for all modalities of care, including virtual delivery • Be based on core criteria with flexibility for clinical judgment and practice characteristics Key components: • Create a good understanding and high-level guidance on the core criteria for quality and safety as established by medical associations, regulators and government • Provide an understanding of the value of improvement science for health and healthcare • Provide education regarding quality improvement processes and tools, how they can be utilized in primary care, and strategies for change, including implementation guidance • Provide assessments that apply across a wide variety of primary care practice settings, and which help identify opportunities for improvement

Conclusion

The COVID-19 pandemic continues to test the healthcare system and its effects will be long-lasting. Lessons learned over the past two years can be utilized to catalyze change and make improvements to policies and practices which benefit all people who live in Canada. HEC has committed to work with partners to address pandemic recovery and health system resilience by including it as core focus area in the 2021-26 strategic plan. Through the scope of this work, nine priority areas were identified, one of which is continued work to support and enable appropriate virtual care.

The increase in virtual care has occurred rapidly over the past few years and in response to an emergency situation. The initial goal was simply to preserve access to care. As a result of the need for rapid access, many of the policies/interventions were not as well integrated into larger provincial/territorial primary care or digital health strategies as they would have been given more time for planning. There is an opportunity to do so now as we move forward and seek to re-shape primary care, regardless of modality. There is a need now for governments, healthcare providers, and patients to examine the ultimate goals of virtual care and develop strategies to ensure that it's integrated into existing primary care systems and that the care that is being delivered is appropriate and meets the needs of both patients and providers.

The guidance in this report is designed to support health leaders in developing strategies for the delivery of appropriate virtual care, which is high-quality, safe and well integrated into existing health care systems. The guidance in this report will also inform HEC's development of new programming for 2022-2023, that will further identify and support the spread of evidence-based practices and catalyze policy change in virtual care so that more people can benefit

from safe and high-quality primary care. Planning for this work is currently underway with the conclusion of the Virtual Care Together Design Collaborative, a partnership between Healthcare Excellence Canada and Canada Health Infoway. A Toolkit of information, resources, and case studies of virtual care is also forthcoming.

This guidance was co-designed by system users, providers of care, and those who regulate and create policies. It represents the insights and experience of those who participated in the lab series. While it's hoped that this report will help with uptake and sustainability of appropriate virtual care, it's recognized that the guidance in this report addresses only some of the challenges facing virtual care delivery, and that many of the policy challenges are system-wide with implications for all modalities of care delivery.

Given the nature of the lab, participants focused on appropriateness of care, rather than other issues in virtual care delivery. Strategies to engage, educate and communicate with policy and decision-makers at the local, provincial/territorial, and national level will be required to address barriers related to strategies for digital eco-systems, including the use of health data for population health planning; interoperability of data systems; curriculum for healthcare providers, and payment models that support team-based care, to name a few. Health leaders can work with partners to share their learnings about the benefits of virtual primary care and the need for supportive policy change. COVID-19 was and remains a challenge for the Canadian health system. However, by building on lessons learned and partnering for meaningful change, much can be done to ensure a more resilient and sustainable healthcare system in the future.

Appendix A: User Needs

Guiding Principles	Patients/families/ caregivers	Policy/decision- makers	Primary care providers and teams
Ensure equitable access	• Inclusion of care partners/caregivers • Meeting patients at the level of engagement that they choose	• Equity and ensuring safe, high-quality care for all people	• Tools/education/ resources • for patients to support appropriate virtual care interactions • for providers and their teams to support decision-making and use of virtual care
Broaden the definition of clinical appropriateness	• Clinically appropriate • What's the purpose; this guides options • Appropriate means there's a predetermined root to that decision	• Policy guidelines for care that is provided out of jurisdiction (for example Ontario doctor providing virtual visit to Quebec patient) • System based needs – having adequate preparation, is there a way to monitor quality	• Balancing needs/ priorities of clinicians and patients
Shared decision- making for care decisions	• Flexibility in choosing modality of care – patient's comfort and preference really considered	• Standards and best practices	• Clinical autonomy/ shared decision-making to decide appropriate modality of care via shared decision- making processes with patients and caregivers • Enabling technology for provider as well as patients including a digital 'front door' that: • links up or triages patients with the appropriate care modality • facilitates shared decision-making • integrates with existing tools (for example EMRs)

Guiding Principles	Patients/families/ caregivers	Policy/decision- makers	Primary care providers and teams

Ensure integration and continuity of care	• Continuity and connectedness in circle of care (including specialists and caregivers)
	
	  Consults with specialists, allied health professionals – all in one
	
	  Patients setting agenda
	
	  Patients being supported so they feel prepared
	
	• More patient-centric data access and control
		• Regulatory alignment of continuity and accountability of care
		
		  Team-based continuity
		
		  Accountability must align standards across professions/ regulating bodies
		
		  Balancing needs/ priorities of clinicians and patients
			• Existing clinical relationship between patients and provider(s)

Develop models and strategies for teams-based virtual care	• Education around use of technology • Secure and private delivery	• Literacy and education: need clinical guidance, but that control is left with providers and will vary with relationships between providers and patients.	• Enabling workflows/ processes for patients and clinical teams

Guiding Principles	Patients/families/ caregivers	Policy/decision-makers	Primary care providers and teams
Ensure quality and safety	• Cultural safety- think of patient context as a whole	• Outcome measures, comparable to in-person • Move from custodial framework of information management to a person-centric/ stewardship model • Vendor standards and accountability • National/minimum standards and compatibility – Continuity of Care • Alignment across colleges – patients move, and virtual care allows for more movement	• Payment structures that enable modality of care to be based on appropriateness rather than billing/fees provided • Having spaces to provide virtual care that ensure patient privacy as they would for a face-to-face visit

Appendix B: Resources

The resources listed in this appendix were those suggested by policy lab participants as well as tools/resources found through a scan of provincial associations and regulatory authorities. This is not an exhaustive list but meant to provide some additional information for those who might be interested in the work of other organizations.

Provider Resources:

Royal College of Physicians and Surgeons of Canada. Telemedicine and virtual care guidelines (and other clinical resources for COVID-19)

Canadian Medical Association. Virtual Care Playbook

Ontario College of Family Physicians. Considerations for Physicians: Balancing In-Person and Virtual Care

College of Nurses of Ontario. Practice Guideline – Telepractice

Doctors of BC, Doctors Technology Office. Virtual Care Toolkit

Collège des Médecins du Québec. Télémédecine

Alberta Medical Association. Virtual Care Toolkit

Doctors Nova Scotia. Getting Started with Virtual Care

Provincial Health Services Authority. Virtual health COVID-19 accessible solution toolkit

College of Family Physicians of Canada. Preparing our Future Family Physicians: An educational prescription for strengthening health care in changing times.

College of Physicians and Surgeons of Saskatchewan. COVID-19: Virtual Care.

Réseau-1 Québec. Optimiser la téléconsultation en GMF-U: comment s'y prendre ? » par Dr Mylène Arsenault, Dr Marie-Thérèse Lussier et Aude Motulsky

Patient Resources:

Canada Health Infoway. Virtual Appointment Checklist

Canada Health Infoway. How to Prepare for a Virtual Appointment

Canadian Medical Association. How to navigate a virtual visit: patient guide

Gouvernement du Québec. La télésanté, c'est quoi? (What is telehealth?)

Nova Scotia Health Authority. Virtual Visit Tips for Patients

Nova Scotia Health. VirtualCareNS (Family Practice Registry)

OTN eVisit Guide

NWT Health and Social Services Authority. NWT Virtual Care