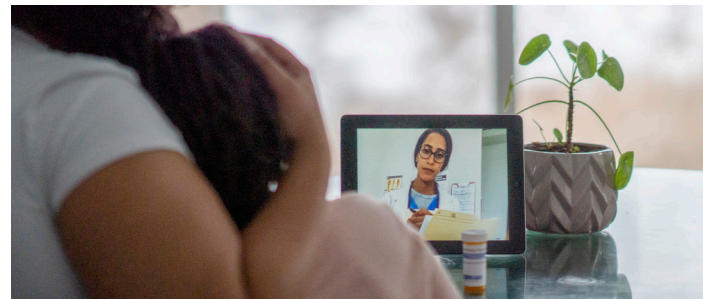# VIRTUAL CARE IN CANADA:
PROGRESS AND POTENTIAL

REPORT OF THE VIRTUAL CARE
TASK FORCE

FEBRUARY 2022

EXECUTIVE SUMMARY

The outbreak of the COVID-19 pandemic in the early spring of 2020 and the necessity of imposing physical distancing to prevent infection has done more to advance the use of virtual care in Canada and globally than could ever have been predicted when the Virtual Care Task Force (VCTF) **released its first report in February 2020**.

Suddenly, both physicians and patients had to adopt the use of virtual platforms ranging from the telephone to video for all but the most serious of health concerns that required in-person care. This radical transformation of the care environment was coupled with significant investment by the federal government in virtual care and the creation of a federal/provincial/territorial table to advance the virtual care agenda.

As a result of these changes, together with the launch of a number of initiatives by medical and health organizations as well as the development of resources for practitioners, many of the recommendations made in the initial VCTF report have been advanced. However, it is the view of the VCTF that there is still much work required to put in place the necessary legislative, regulatory and compensation frameworks to make sure excellence in virtual care becomes an integrated part of the health care system.

Also, not all developments have been positive as there has been **a reluctance by some physicians to return to in-person care**. With what appeared to be a waning of the pandemic before the Omicron variant emerged, the "virtual first" approach recommended to protect against COVID-19 infection was being challenged in favour of considerations about delivering care in the most appropriate manner — which in many instances means in-person care.

In reviewing their earlier report, VCTF members remain in support of the principles behind the recommendations made in that report, as well as the recommendations themselves.

Two issues that have transcended the discussions of all reconstituted VCTF working groups have been **EQUITY** and **THE APPROPRIATENESS OF VIRTUAL CARE.** A further issue raised in the initial report — the growth of virtual care services by private companies and payment for these services outside the publicly funded system — has become a growing concern.

On the basis of its review of developments in virtual care since the release of its first report, the VCTF is re-emphasizing two of its initial recommendations as well as making four new recommendations.

Restated recommendations:

1. Establish a framework for pan-Canadian quality-based virtual care governance.
2. Ensure that standards set by medical regulators support the provision of competent and safe virtual care.

New recommendations:

1. Ensure that appropriate virtual care services are funded as part of the publicly funded health care system.
2. Make equity a fundamental principle underpinning the delivery of virtual care in Canada.
3. Promote guidance for providers and patients on the appropriate use of virtual care.
4. Urge governments and provincial/territorial medical associations to work to incorporate the following aspects of virtual care in their negotiated agreements:

- provide a permanent basis for virtual care fee codes within fee schedules;
- provide for remunerating physicians at the same rate whether care is provided virtually or in person;
- provide support for an appropriate balance of both in-person and virtual care that does not include arbitrary caps on the volume of virtual care services;

- provide for payment for virtual care services that can be delegated appropriately and within scope to other staff within the medical practice;
- provide for payment for virtual care services provided asynchronously via secure email/text messaging; and
- provide for payment for managing portals that patients can access and into which they can input personal health information.

The VCTF also feels that incorporating virtual care optimally into the Canadian health sector requires more work on the part of the federal/provincial/territorial governments and national organizations. As the development of a pan-Canadian framework for governing virtual care remains a priority, the VCTF commends the inclusive multi-stakeholder approach advocated by the Alberta Virtual Care Working Group to other jurisdictions as a model for developing equitable frameworks for the delivery of virtual care. Given the multitude of initiatives currently underway in Canada with respect to virtual care, the VCTF believes the Canadian Medical Association, the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada should continue to support its meetings and its working groups as needed to provide a unified physician voice.

INTRODUCTION

On Feb. 11, 2020, the Canadian Medical Association (CMA), the College of Family Physicians of Canada (CFPC) and the Royal College of Physicians and Surgeons of Canada released the Virtual Care Task Force (VCTF) report as a roadmap for expanding the use of virtual care in Canada. Since the release of the report, the COVID-19 pandemic has led to a major acceleration in the use of virtual care both in Canada and globally.

During the summer and fall of 2021, the CMA, CFPC and Royal College felt it would be timely for the VCTF to release an updated report tracking developments in the use of virtual care in Canada since the release of the initial report. The VCTF also reconstituted its four working groups to evaluate progress made on their initial recommendations and make new and updated recommendations if felt appropriate.

These working groups are as follows:

- interoperability and governance
- licensure and quality of care
- payment models
- medical education

The mandate of the reconstituted VCTF remained the same: to develop principles and recommendations for promoting a pan-Canadian approach to the delivery of publicly insured medical services by Canadian physicians through virtual means.

The definition of virtual care used by the VCTF also remained unchanged as "any interaction between patients and/or members of their 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."
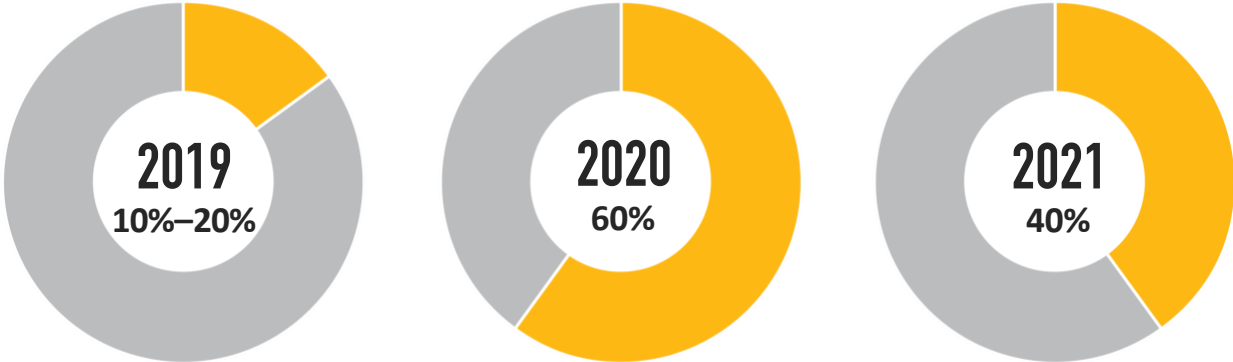
OVERVIEW

The release of the first VCTF report on Feb. 11, 2020, coincided with the World Health Organization giving the name of COVID-19 to the disease caused by the new coronavirus, which was first reported in Canada on Jan. 25. Since then, COVID-19 has killed millions, transformed society and health care systems and led to the widespread adoption of virtual care in a way the VCTF could not have foreseen.

The introduction of public health strategies stressing physical distancing to reduce the risk of viral transmission has meant that the vast majority of routine visits between physicians and patients during the pandemic have been conducted using virtual methods — predominantly the telephone, but also video and text messaging. Supporting this, in the spring of 2021 all Canadian jurisdictions rapidly moved to institute a variety of fee codes to support virtual care.

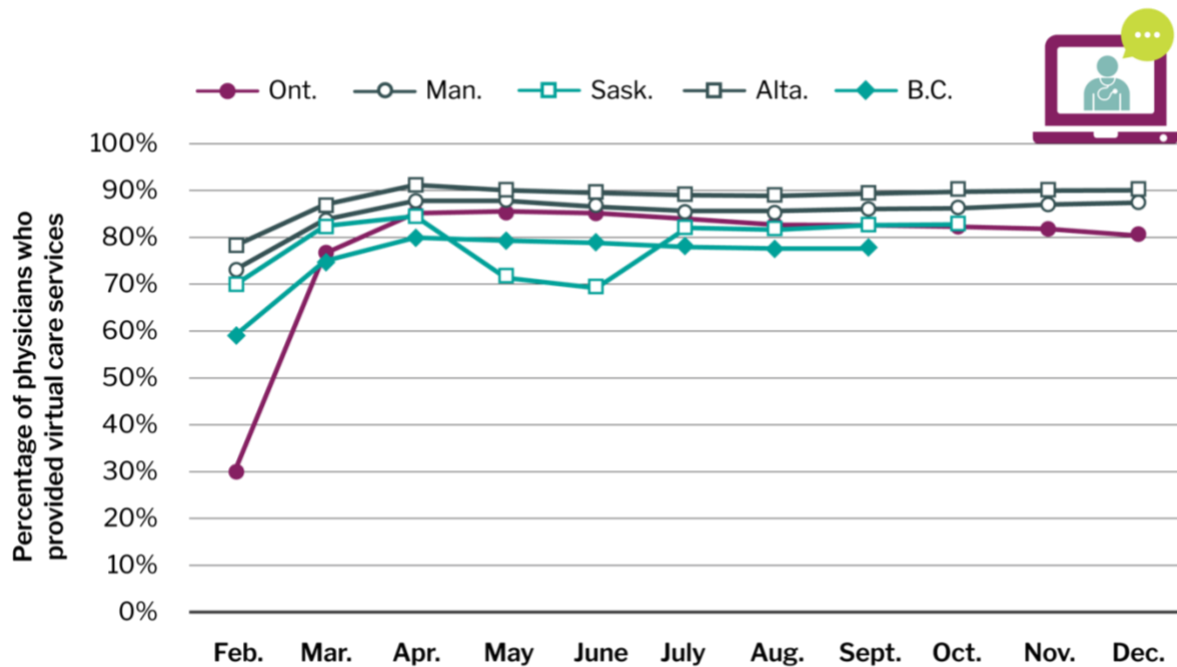> *"In some ways the COVID pandemic was the match that lit the fire around this revolution in virtual care,"*

said Dr. Sacha Bhatia, FM Hill Chair in Health Systems Solutions and the chief medical innovation officer at Women's College Hospital, during one of the Massey Dialogues held in May 2020.

Virtual care use in Canada

According to Canada Health Infoway data published in June 2021, rates of virtual care use in Canada rose from 10%–20% in 2019 to 60% of all health care visits across provider categories in April 2020, falling back to 40% of all visits in 2021. Results of a KPMG survey conducted in June 2021 showed 31% of Canadians who had a family doctor had not seen them either virtually or in person since the pandemic began.

The [Canadian Institute for Health Information (CIHI) released data](#) indicating that, in February 2020, for the provinces where data were available, 48% of physicians had provided at least one virtual care service. By September, this number had increased to 83% (see chart). According to CIHI, "an even bigger change occurred in Canadians accessing virtual care services: for those same provinces, the proportion of people receiving at least one virtual care service jumped from 6% to 56%, although the proportion varied among the provinces."

Reproduced with permission from the Canadian Institute for Health Information (CIHI). Increase in virtual care services provided by physicians. Published Aug. 19, 2021. Accessed Jan. 19, 2022. https://www.cihi.ca/en/health-workforce-in-canada-highlights-of-the-impact-of-covid-19/increase-in-virtual-care-services

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In this report from August 2021, CIHI also noted that "Moving forward, better data and information related to equity of virtual care access, services and outcomes will lay the foundation for improved reporting on virtual care delivery."

[A study published in *CMAJ*](#) showed that in Ontario, virtual visits accounted for **71.1%** of all primary care visits during the first four months of the pandemic in 2020 compared with **1.2%** of all primary care visits during the same period in 2019. Between January and April 2021, [virtual visits accounted for 38% of all the most recent patient-reported visits](#) (52% of the most recent visits with family physicians).
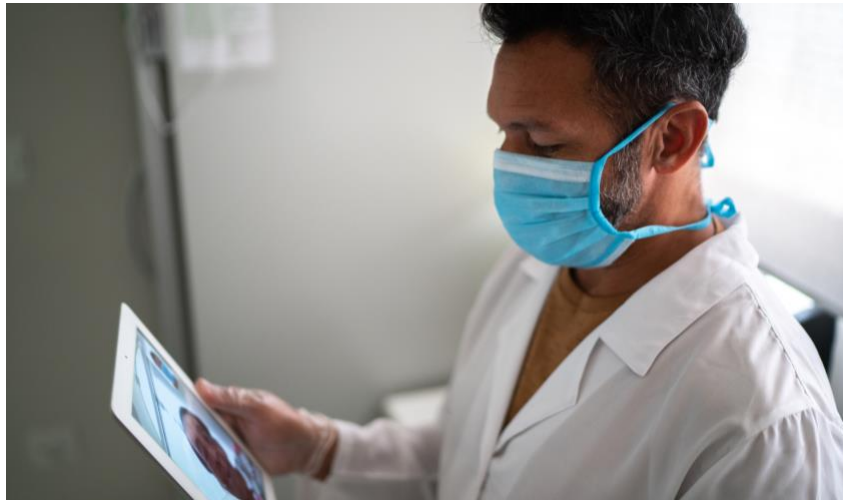
71.1% VS 1.2%

of all primary care visits in
Ontario Mar. 11 – July 28, 2020

of all primary care visits in
Ontario Mar. 12 – July 29, 2019

Satisfaction with virtual care during the first part of the pandemic was high among patients and just marginally below that reported for in-person care. A nationwide survey of 1,800 people conducted by the CMA in May 2020 showed **91% of those polled were satisfied or very satisfied with the care they had received virtually**. In addition, 42% of those who had had the opportunity to use virtual care since the pandemic began said they would prefer a virtual method as the first point of contact with their physician.

Results of a survey of more than 3,000 Canadians with stroke, heart disease or vascular impairment conducted in the spring of 2021 showed **80% of respondents had had a virtual appointment during the pandemic**. A similar percentage said they found these virtual appointments to be convenient and 60% rated virtual care to be as good as in-person appointments.
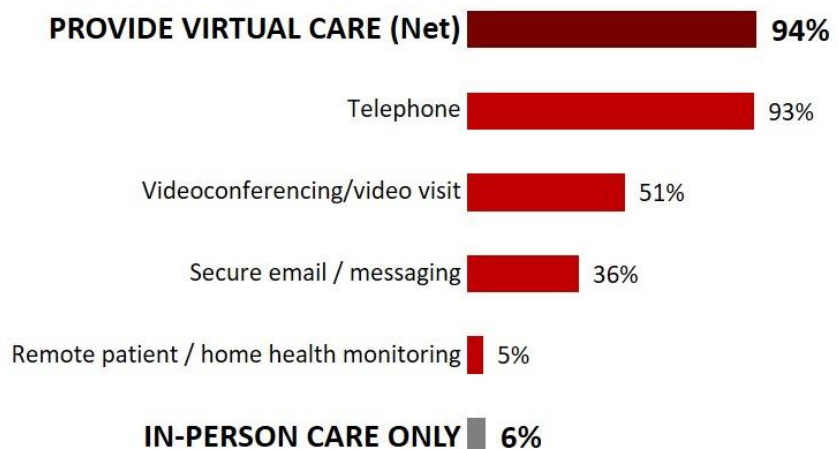
The KPMG survey found 56% of respondents felt their family doctor was using virtual care or telehealth services effectively whereas a CFPC poll conducted at the same time found patients rated virtual care conducted by phone as being less satisfactory than in-person care.

Results from a survey of just over 2,000 physicians conducted for Canada Health Infoway and the CMA in April and May 2021 and released in August 2021 showed that almost all Canadian physicians who responded to the survey said they will **continue to use virtual care after the pandemic**, and 64% said they will maintain or increase their current level of use.

Ninety-four per cent of physicians said they currently use virtual care, with a variety of modalities (see chart).

More than 70% of respondents said they believe virtual care improves patient access and enables quality care and efficient care for patients.

CURRENTLY PROVIDING PATIENT CARE VIRTUALLY
(% OF PHYSICIANS)

PROVIDE VIRTUAL CARE (Net)	**94%**
Telephone	93%
Videoconferencing/video visit	51%
Secure email / messaging	36%
Remote patient / home health monitoring	5%
IN-PERSON CARE ONLY	**6%**

Source: 2021 National Survey of Canadian Physicians, Canada Health Infoway and the Canadian Medical Association. Used with the Permission of Canada Health Infoway and the Canadian Medical Association.

In the fall of 2021, governments started to signal they wanted physicians to return to offering more in-person care. In British Columbia a letter dated Sept. 3 from top provincial government health officials and the College of Physicians and Surgeons of British Columbia urged physicians to restart in-person visits when appropriate.

On Oct. 13, 2021, the chief medical officer of health for Ontario, an Ontario assistant deputy minister of health and the registrar and CEO of the College of Physicians and Surgeons of Ontario sent a similar letter. **It said in part that:**

> *"There are limits to what can be done virtually and the standard of care is often difficult to meet in a virtual care environment…There are many patients for whom the standard of care cannot be met in a solely virtual care environment."*

To date Alberta has been the only jurisdiction to indicate changes to the fee schedule supporting virtual visits would be made permanent.

On May 3, 2020, the federal government announced an investment of **$240.5 million** to accelerate the use of virtual tools and digital approaches. Of this, $200 million was allocated to help provinces and territories accelerate their efforts to meet health care needs through virtual tools and approaches, with the remaining sum earmarked for virtual care initiatives in mental health.
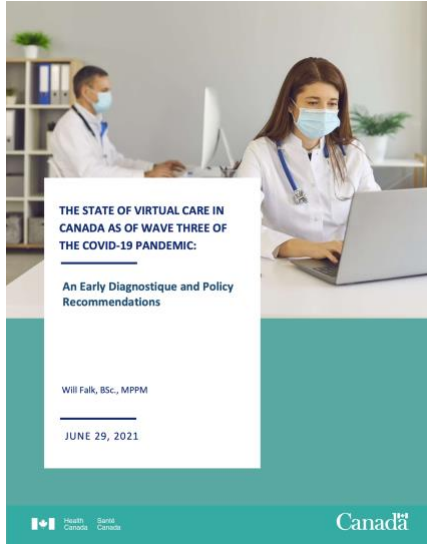
A federal/provincial/territorial virtual care/digital government coordinating body was struck in March 2020, and later in the year it endorsed a preliminary policy framework identifying barriers and opportunities for the long-term adoption of virtual services within Canada's publicly funded health systems.

These were categorized as follows:

- patient- and community-centred approaches
- equity in access to care
- provider remuneration/incentive structures
- appropriateness, safety and quality of care
- provider change management
- licensure

THE STATE OF VIRTUAL CARE IN CANADA AS OF WAVE THREE OF THE COVID-19 PANDEMIC:

An Early Diagnostique and Policy Recommendations

Will Falk, BSc., MPPM

JUNE 29, 2021

Health Canada   Santé Canada   Canadá

Despite the merit of the Falk report, the VCTF believes the report does not address the necessity for pan-Canadian governance and policy alignment to achieve true patient-centric virtual care.

Will Falk, a policy expert in digital health, was commissioned to validate this framework and develop recommendations for advancing virtual care in Canada. His report formed the basis for a summit meeting on digital care hosted by the federal government on June 22–23, 2021.

Falk's report, *The State of Virtual Care in Canada as of Wave Three of the COVID-9 Pandemic: An Early Diagnostique and Policy Recommendations*, was officially released on June 29.

Falk summarized the recommendations in his report as follows:

1. Care is care. Virtual care is no longer an adjunct therapy.
2. Key health information components — diagnostic test results, prescriptions, consults and referrals— should always be created in a usable digital format.
3. Payment policies should not favour one modality of care over another, except when warranted for clinical reasons.
4. Governments must switch their mindset from paying for particular technologies to paying for desired outcomes and services (allowing providers and patients to make technology choices within a standards framework).
5. Licensure needs to be modernized. A national licensure framework agreement should be the goal.
6. A new approach to clinical change management and medical education is needed to ensure that we keep the best of what we have learned and gather new data to further improve practice standards.
7. Equity of access must be a priority.
8. User experience needs to be a priority for system development and adoption.

In October, Health Canada released a summary of the summit meeting that concluded "while the focus of Summit was to support the appropriate enablement of virtual care within the publicly funded healthcare system, it is clear that many of the current policy gaps are also reflective of changes needed to address broader health system-wide challenges which could support Canada's overarching approach to delivering health services." The report indicated that the Federal/Provincial/Territorial Virtual Care/Digital Table would use proposals from the summit to form a plan of action over the next 12–18 months.

In March 2021, creation of the Canadian Network for Digital Health Evaluation was announced to strengthen Canadian capacity to evaluate digital health interventions. Supported with Health Canada funding, the network is led by the Centre for Digital Health Evaluation (CDHE) at Women's College Hospital, in collaboration with CADTH, Canada Health Infoway and CIHI — as well as the Centre for Wise Practices in Indigenous Health.

Starting in the spring of 2020, the CMA and various other medical organizations produced a number of **resources and tools for Canadian physicians and patients** to better support virtual care during the pandemic. Some organizations, such as the Canadian Medical Protective Association (CMPA), rolled out an extensive series of webinars for physicians on how to appropriately use virtual care.

The CMA National Health Policy Conference, held in October 2020 with participants from most provincial/ territorial medical associations, dedicated a significant amount of time to reviewing the situation at the time with regard to remuneration for virtual care.

In the summer of 2021, the CMA held a series of three summit meetings where physicians, patients and other stakeholders in the health care system discussed what was needed to rebuild the system and make it more equitable in the wake of the COVID-19 pandemic. Virtual care was a major topic in many of the roundtable discussions held during those meetings. Participants noted that while virtual visits had made care more accessible for some during the pandemic it had widened the digital divide for others who did not have the knowledge or technology to take advantage of virtual care — which had often been the only option.

On Aug. 30, 2021, the CFPC released a position statement, "Strengthening Health Care – Access Done Right," which stressed the need for "access to high-quality comprehensive continuous primary care close to home." The statement noted that family physicians report that virtual care improves access but "at the cost of quality."

The statement added that "virtual care should be one way to access a patient's dedicated family practice that follows and supports their health and health care over time." The document implicitly questioned the growth of private companies providing intermittent virtual services detached from the relationship between patients and their family physicians.

The VCTF and governments are not the only groups to have undertaken a review and advanced discussions of virtual and digital care issues in Canada in during the pandemic.
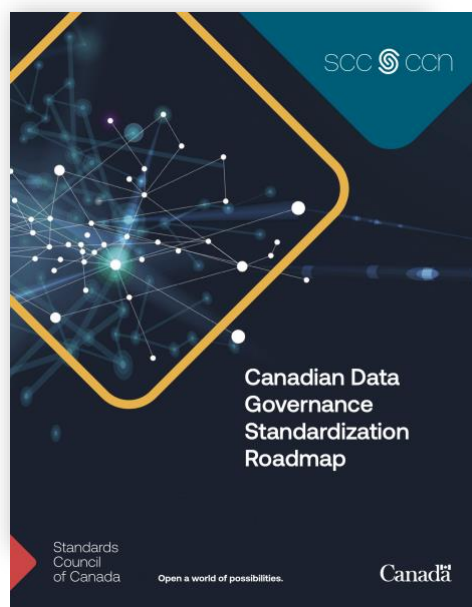
On July 30, 2020, the Competition Bureau launched a market study of Canada's health care sector to "better understand existing or potential impediments to innovation and choice, and possible opportunities for change, in digital health care." The bureau's final report is expected to be published in the spring of 2022.

In 2020 Health Canada provided funding to Canadian Health Infoway to provide leadership and strengthen greater collaboration in support of pan-Canadian interoperability. **Consultations with stakeholders resulted in two interoperability priorities through 2022:**

- sharing of patient summaries across different solutions using the International Patient Summary (IPS) as the standard, to support transitions of care and cross-jurisdictional patient flows; and

- secure messaging across solutions to enable safer and more efficient collaboration across the circle of care. While some solutions offer secure messaging capabilities, they operate in silos, with no ability to communicate with one another.

Canada Health Infoway stated it was ramping up efforts to accelerate collaboration among stakeholders to develop specifications that can be implemented to address the two challenges outlined above.

On June 28, 2021, the Standards Council of Canada released the Canadian Data Governance Standardization Roadmap, which describes the current and desired Canadian standardization landscape and makes 35 recommendations to address gaps and explore new areas where standards and conformity assessment are needed. One of the use cases developed to help facilitate discussions on this work involved community health data and examined data weaknesses in our health care system.

Healthcare Excellence Canada announced a partnership with Canada Health Infoway to advance virtual care change management. As part of this initiative, the Virtual Care Together design collaborative, which launched in October 2021, will support community-based primary care practices and organizations from across Canada to prepare, implement and evaluate virtual care tools and practices. The design collaborative will run to the end of March 2022.

Since the start of the pandemic there has been a surge in the use of private virtual care services in Canada providing services that are either paid for by the individual or offered by an employer as a supplementary benefit and not covered by provincial or territorial health plans.

An evaluation of virtual care in Canada by CADTH published in June 2021 listed 12 private companies offering a variety of virtual care services in Canada; most were being paid on an individual basis, although some services were covered by private insurance or public health plans. Articles in daily newspapers during the pandemic have documented this increase in the private delivery of virtual care and have often contained criticism by those who feel this trend threatens universal access to virtual health services and the continuity of care.

INTEROPERABILITY AND GOVERNANCE WORKING GROUP

As noted in the introduction to this report, a number of initiatives have been taken at the national level that could advance many of the recommendations made by VCTF and this working group in its initial report.

- Health Canada convened a federal/provincial/territorial group with some expert advisors to consider virtual care initiatives.
- The CMA has developed a draft statement on personal health information governance in collaboration with patient representatives from the CMA Patient Voice.
- The Ontario Ministry of Health has been developing a new policy approach to health information.
- A pan-Canadian health data strategy working group has been established by the Public Health Agency of Canada to look at a new strategy for health data.
- Digital Health Canada has released a virtual care lexicon.
- Canada Health Infoway has been collaboratively developing interoperability standards, focusing on standards around messaging, and international patient summaries that can be transferred between systems.
- A consortium of all principal health stakeholders in Alberta has been working to develop system-wide standards for virtual care design.

The VCTF report recommendation to draft a charter of patient health information rights has been advanced by work being done by the CMA to develop a statement on personal health information governance in collaboration with patient representatives from the CMA Patient Voice. The working group noted this draft statement is predicated on the key principle that such governance must be patient-centric with "full, free, and equitable patient access to and enhanced patient control over their personal health information."

The second recommendation on interoperability and governance contained in the VCTF report to develop a pan-Canadian framework for health information architecture is being advanced through the work of the pan-Canadian Health Data Strategy Expert Advisory Group.

The working group endorses the efforts of the Alberta Virtual Care Working Group, which has proposed a broad stakeholder co-design approach to virtual care policy and governance, and its core recommendation for establishment of a coordinating body with substantive patient involvement. It was felt that this model of principle-based co-design could be adopted by other jurisdictions. This team-based approach to governance also fulfills another of the recommendations in the initial VCTF report for the development of a framework for interprofessional teamwork to support pan-Canadian virtual care.

Despite this progress, the working group acknowledges that significant work remains to be done in the arena of virtual care governance and interoperability, specifically:

- convergence of all the work and initiatives being undertaken around virtual care governance, notably the ongoing challenges of taking a unified, national approach within the Canadian political system (the CMA, among other national health organizations, was identified as being well positioned to provide leadership in this area); and

- the adoption of true patient co-design in developing a virtual care governance model as a standard of being.

LICENSURE AND QUALITY OF CARE WORKING GROUP

Throughout the pandemic, licensing requirements for physicians providing virtual care have continued to be determined at the provincial and territorial level by regulatory authorities. A review of the status of these requirements prepared by Louise Sweatman and Christine Laviolette and published in July 2021 noted that "from a provider's perspective, access to a patient across Canadian borders does not come with the same ease" because of these differing requirements. The article goes on to state, "although there have been discussions regarding a pan-Canadian license, there is no pan-Canadian approach to licensure for any health provider group allowing practice across the country under one license."

In a review published in August 2020, CADTH detailed how the Federation of Medical Regulatory Authorities of Canada (FMRAC) was working on three projects related to the review of physician licensing in Canada. Having investigated the possibility of a single licence to support virtual care across all jurisdictions in Canada, FMRAC indicated in the fall of 2021 that this work had been suspended. Work on a licence for portability to enable physicians to work for a short time in another jurisdiction based solely on licensure in their home jurisdiction was also suspended. However, FMRAC did develop a framework to fast-track licensure for physicians holding full registration in another province or territory through the traditional route (medical doctor, Licentiate of the Medical Council of Canada, certification with either the CFPC or the Royal College) and who had a clean certificate of professional conduct.

A FMRAC working group is expected to report in the first part of 2022 on a FMRAC framework on virtual care that will update a 2019 document to address any issues that are new or require further emphasis or clarity in a post-pandemic environment. As with all such initiatives, FMRAC notes it is at the discretion of medical regulatory authorities to adopt or adapt the framework and recommendations as they deem appropriate and/or feasible.
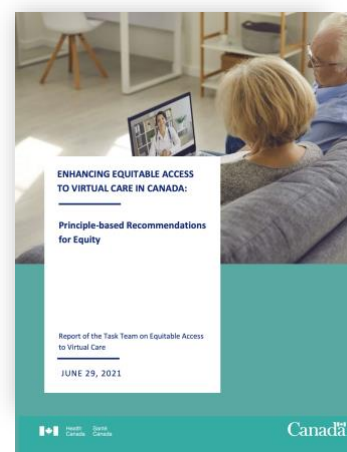
While development of a pan-Canadian medical licence remains of high interest to many, little concrete action has been taken in advancing this initiative since the release of the initial VCTF report. In fact, when it comes to virtual care, some regulatory authorities have strengthened their requirements that physicians must be licensed in their jurisdiction to offer care to patients in that jurisdiction. For example, the new College of Physicians and Surgeons of Ontario (CPSO) draft statement on virtual care states that "physicians providing virtual care to Ontario patients located in Ontario must hold a valid and active certificate of registration with the CPSO, unless the provision of virtual care from an unregistered physician is in the patient's best interest."

The working group feels Canadians who move across jurisdictions for work or personal reasons or who might reside in more than one province or territory should continue to have access to their regular physician, if necessary, through virtual means. Further, the working group is concerned that more restrictive regulations for providing virtual care may affect Canadians who live in underserviced jurisdictions without a full complement of tertiary care services and have to travel to an adjoining jurisdiction for this specialized care.

On the issue of quality of care, the first VCTF report noted that "although virtual care has the potential to increase access to medical and health care, it also has the potential to exacerbate inequalities in access to care, both in terms of geography and socioeconomic status." Equity is well accepted as one of the main principles underlying a quality health care system.

This issue has been of growing concern as the COVID-19 pandemic has widened existing inequities in care across the spectrum of care delivery including virtual care. As a result of these concerns, the Federal/Provincial/Territorial Virtual Care/Digital Table commissioned an Equity Task Team chaired by Dr. Ewan Affleck to develop high-level design principles for the consideration of equity in virtual care.

The final report of that working group, Enhancing Equitable Access to Virtual Care in Canada, stated that "Canada lacks a defined pan-Canadian approach to, or vision for, equity in virtual care services" and that this "contributes to and potentially exacerbates underlying inequities in the provision of high-quality digital care."

ENHANCING EQUITABLE ACCESS TO VIRTUAL CARE IN CANADA:

Principle-based Recommendations for Equity

Report of the Task Team on Equitable Access to Virtual Care

JUNE 29, 2021

The report went on to say that:

> A lack of health data related to equity makes it difficult to understand the scope of the problem in Canada, as well as to determine the differential impact for underserved populations. In particular, a dearth of disaggregated data is of significant concern in designing virtual care services in an equitable manner.

> …it is critical to examine both social and digital determinants of health in examining barriers to equity in access to virtual care. In the literature, there is a general tendency to focus on the social determinants in studying inequity in health, which in the context of digital health leads to the exclusion of important, uniquely digital factors that can promote inequity in virtual care. … In addition, we recognize that the widespread deployment of virtual care should not exacerbate pre-existing inequities in the broader health system.

The report made several recommendations based on the need for a pan-Canadian vision for digital health equity that would make sure all Canadians benefit from patient- and caregiver-centred virtual care design, with this care being delivered by providers who are competent to deliver equitable digital care.

During the pandemic, the need to address equity in delivering virtual care has been acknowledged by a number of individuals and organizations, such as the Heart and Stroke Foundation. Its position statement is representative of the views being expressed; it notes that "a concerted effort is required to focus on populations that might face barriers accessing virtual healthcare including seniors, low-income earners, northern/remote communities, newcomers, Indigenous peoples, people with disabilities, people experiencing homelessness and those with low literacy levels."

With an unprecedented number of physicians who had little or no experience with virtual care suddenly being urged to conduct visits by telephone or video, numerous initiatives were undertaken to ensure that the appropriate standards of care were maintained.

Regulatory authorities in several jurisdictions undertook the process of reviewing and updating their guidelines for the delivery of virtual care and the Canadian Medical Protective Association amalgamated a series of articles, podcasts and learning activities to advise their members.

> The updated Practice Standard released by the College of Physicians and Surgeons of British Columbia in June 2021 (revised Nov. 2, 2021) gives an overview of the type of approach adopted by regulatory colleges with respect to virtual care. **As stated in that document, the college's position was that:**
>
> *Virtual care is a core component of medical care. Registrants who provide virtual care are held to the same ethical and professional standards, and legal obligations related to in-person care. The use of virtual care can address access issues and increase both effectiveness and efficiency in delivering medical services. Virtual care can be highly beneficial to patients (e.g., for those living in remote communities or who have mobility issues); however, it can also exacerbate disparities for those who lack access to technology, have limited digital literacy and/or face other challenges with participating in virtual communication. Registrants are reminded to use an equity-oriented approach and seek to understand and address any barriers their patients may face in participating in virtual care.*

A new standard of practice for virtual medicine implemented by the College of Physicians and Surgeons of Manitoba in November 2021 requires a blended model of care balancing in-person and virtual care delivery.

The CMA and some provincial medical associations were also quick to advise their members on best practices with respect to virtual care. The Virtual Care Playbook produced by the CMA, the CFPC and the Royal College is typical of these tools, with its aim to cover key considerations for providing safe, effective and efficient care, including how to fit virtual care into your practice workflow, technology requirements and scope of practice. Some organizations such as the CMA also provided advice to the public on how to use virtual care most effectively.

The impact of delivering a large proportion of care via virtual channels on the quality of that care still remains very much an unknown. As Dr. Bhatia noted during the Massey Dialogues in May 2020:

> There was a rush for us to do this to protect our patients and providers ... but now if we're going to make it sustainable we need to do the research to begin to understand what the impact of that has been. Canada has an opportunity here to be a real leader internationally in understanding the impact of virtual care and changing the care model.

Many standards of practice for virtual care have not yet been fully developed, Dr. Bhatia acknowledged.

The current lack of data on outcomes related to virtual care makes it impractical to develop clinical practice guidelines on the best use of virtual service in clinical care. However, the working group does feel that development of national standards for delivering virtual care that respect patient and physician choice — as has been proposed by the Ontario Medical Association — could be beneficial.

As the pandemic has progressed, concern has grown about the appropriateness of care delivered virtually. There have been a growing number of complaints to regulatory authorities from patients unable to access in-person care and from emergency physicians and other specialists concerned that patients referred to them have not been seen in person or given an appropriate workup by a primary care physician. As noted in the introduction, in some jurisdictions the regulatory authorities and governments are coming together to tell physicians that the era of virtual care "first" is over and that in-person care can and should be safely provided.

The new standard of practice in Manitoba published by the college explicitly states that examples of virtual care that do not meet the standard include:

- physicians not offering in-person appointments, including during a pandemic, unless advised by a health authority to not see patients in person;
- virtual medicine–based businesses that do not offer timely in-person appointments by the same physician; and
- physicians unnecessarily restricting in-person visits with patients or having very limited in-person appointments.

The appropriateness of virtual care, like other forms of health service, is inevitably nuanced and will be subject to relational and experiential evaluation between the patient and provider. Appropriate use of virtual care needs to be a core element of digital health training (see section on medical education) and not represented as fixed standards but rather reflected in high-level or global guidelines.

The working group believes a hybrid model of care is preferred in which both virtual and in-person care are offered by a practice or practitioner depending on the nature of the medical condition, the needs of the patient and the physician's best judgment. The working group also wants to emphasize that virtual care should be provided in the context of an ongoing relationship with a family physician or specialist and their care team.

PAYMENT MODELS WORKING GROUP

Within weeks of the pandemic being declared, all jurisdictions in Canada had revised their fee codes to facilitate the virtual delivery of care. These changes are summarized below.

Newfoundland and Labrador

A Pandemic Virtual Care Assessment fee code ($42), which was initially introduced for family physicians and consultants with a daily cap of 40, was later restricted to just family physicians. Specialists (both facility based and in private offices) can now bill the traditional consultation and reassessment codes from the telemedicine section of the Medical Payment Schedule. All changes were stated to have been made on a temporary basis; they have been extended once and will probably continue until permanent codes are negotiated. Both the patient and the physician have to be located in Newfoundland and Labrador to be eligible to bill the interim codes.

Prince Edward Island

During the pandemic, virtual care was eligible for billing for a number of specified services when approved Health PEI technologies (telephone and secured videoconferencing) were used. Specialists were able to bill for consultations for patients who had been initially referred by physicians and certain other health care providers and for subsequent visits related to the same diagnosis.

Nova Scotia

Broad virtual care codes were made available retroactive to Mar. 13, 2020, and they allow any in-person code to be billed as a virtual code. Zoom licences were made available to physicians at the government's cost. Walk-in clinics are not able to bill the virtual codes.

New Brunswick

In March 2020, the Government of New Brunswick and the New Brunswick Medical Society (NBMS) agreed to create a single code for virtual care valued at $45. This was subsequently discontinued in favour of a move to allow all nonprocedural care to be billed using the existing fee schedule at the in-person rates. Virtual care generally consists of visits, consultations, outpatient department visits and follow-up care, psychotherapy and psychiatric care, among others, that do not require a physical examination. The current arrangement will continue until March 2022, at which time the New Brunswick Department of Health and the NBMS will review the data on the experience to date.

Quebec

For Quebec family physicians the same rates and the same nomenclature apply for virtual care as for face-to-face visits. No cap and no limitation have been put in place, except the fact that the physician must be in Quebec to render the services. For specialists, existing fee codes can be billed when services are delivered remotely by telephone or video conference, up to a maximum of $300/hour. However, physicians compensated according to the mixed mode of remuneration cannot charge more than $195/hour of telemedicine. Including the daily allowance, this corresponds to $300/hour. Both physician and patient need to be present in the province for virtual care, with the exception of bordering physicians seeing known patients.

Ontario

A detailed schedule of fees and fee modifiers was put in place to allow physicians in Ontario to bill for virtual visits with different codes dependent on whether physicians were using the existing Ontario Telemedicine Network system or not. Use of these fee codes has been extended until September 2022. Most recently, Ontario physicians have been asked to specify whether they are using the telephone or video for virtual visits billed.

Manitoba

In March–April 2020 Manitoba established temporary tariffs for virtual visits, virtual consultations, virtual psychotherapy and psychiatric care and virtual personal care home visits. The rate for a virtual visit is equivalent to the rate for a bloc's regional or subsequent in-person visit. In the fall of 2020, additional virtual visit codes were negotiated for virtual comprehensive visits paid at a rate equivalent to that for an in-person complete examination and, for family physicians, age-based virtual visit tariffs for elderly patients. Virtual visit services may be provided by telephone or videoconference. Services are insured only when the patient and provider are both located in Manitoba. An accommodation was made to enable Manitoba physicians to continue to care and bill for their patients residing in northwest Ontario, Nunavut and Saskatchewan. Provincial officials have confirmed these tariffs will be in place for the duration of the pandemic.

Saskatchewan

Virtual care fee codes are part of the new negotiated agreement package as a two-year pilot with commitment from government to continue funding the fee codes after the pilot is complete. Temporary codes were put in place until a new agreement came into effect in January 2021. Video and telephone services are treated equally. Video and telephone fees and descriptors mirror the applicable in-person fee codes but are priced at 90% of the in-person rate (for the period of the pilot). A "limited" virtual care fee code was created for "virtual-only clinics." The limited virtual care fee code is defined as a single encounter with a patient who is unattached to the clinic and where neither the physician nor patient have the expectation of an ongoing care relationship, and it is priced at 70% of the in-person rate for family physician visits. Virtual care visits are payable to a maximum of 3,000 services per physician per year.

Alberta

The provincial government in Alberta implemented virtual fee codes for short patient contacts by telephone, video or email, specialist follow-up assessments, specialist virtual consultations and virtual psychotherapy. These fee code changes were made permanent in June 2020.

British Columbia

There was a temporary expansion of the definition of telehealth services to include services provided by telephone, not just video technology. Claiming of face-to-face fees for consultations, office visits and nonprocedural interventions where there is currently no telehealth fee was permitted. Temporary COVID-related fees were introduced to ensure support for effective patient management and care planning during the crisis. The daily volume limits for family physicians were suspended and subsequently reinstated on Oct. 1, 2020.

Yukon Territory

Virtual care codes for telephone and video conference were negotiated at the start of the pandemic, paid at the same level as in-person visits. Since the end of the state of emergency, new virtual care codes have been included in the memorandum of understanding between the Yukon Medical Association and the government; virtual visits are remunerated at essentially 90% of in-person visit rates.

Northwest Territories and Nunavut

Information not available

As the pandemic progressed, changes in fee codes to facilitate virtual care were extended in jurisdictions that had initially set expiration dates for the changes. However, as of late November 2021, only Alberta had announced that these changes would be made permanent. The working group considers many of the changes made to line items in fee codes that support virtual care to be positive and supportive of recommendations made in the initial VCTF report; however, they also identified issues of concern that have emerged during the pandemic:

- restrictions or plans for restrictions to cap physician payments for virtual care;
- the need for payments for delegated virtual care;
- the need for appropriate payment to manage patient portals;
- payment for asynchronous care (e.g., emails; this is currently only available in BC and Alberta); and
- the need to make virtual care an insured service.

To address these concerns, the working group makes the following recommendation:

Governments and provincial/territorial medical associations should work to incorporate the following aspects of virtual care in their negotiated agreements:

- provide a permanent basis for virtual care fee codes within fee schedules;
- provide for remunerating physicians at the same rate whether care is provided virtually or in person;
- provide support for an appropriate balance of both in-person and virtual care that does not include arbitrary caps on the volume of virtual care services;
- provide for payment for virtual care services that can be delegated appropriately and within scope to other staff within the medical practice;
- provide for payment for virtual care services provided asynchronously via secure email or text messaging; and
- provide for payment for managing portals that patients can access and into which they can input personal health information.

The working group also feels there is a need for continued policy development by all the stakeholders, as well as investments in infrastructure, to support access, quality and efficiency in the use of virtual care.

MEDICAL EDUCATION WORKING GROUP

Restrictions imposed for public health reasons have affected all levels of medical education since the beginning of the COVID-19 pandemic. In most instances this has involved an acceleration in the use of virtual teaching methods in both undergraduate and postgraduate education, as lectures previously delivered in person switched to delivery via Zoom and other online platforms.

An article published in *CMAJ* in August 2020 outlined the range of impacts COVID-19 has had on postgraduate medical education training with an emphasis on the shift to distance learning. The authors of that article contend the following:

- Technology and novel means of learning, including online resources, simulation, video conferencing and virtual reality, must be embraced to facilitate ongoing medical education.
- National written examinations must be transitioned to a reliable online format.
- Faculty development will be integral to medical education — in particular, the identification of early successes and adoption of creative methods of delivery.
- Video-based learning can be challenging but also presents an opportunity for innovation in the delivery and organization of medical teaching, because geographically distant institutions or sites can engage in academic activities nationwide and international speakers can easily participate.
- Residents, who are often familiar with new technologies, may be helpful in teaching their supervisors to navigate online resources and telemedicine.

The working group believes all of these points merit more consideration.

Ironically, the necessity of transitioning to virtual teaching since the pandemic started has done little if anything to accelerate changes needed to improve how virtual care itself is taught and assessed. Toward the end of 2021, however, there were signs this situation was changing.

The Association of Faculties of Medicine of Canada (AFMC) has struck a task force on virtual clinical medical education to develop a curriculum matrix for teaching about virtual care. The specific mandate of the task force is to "focus on determining opportunities and solutions for the full integration of Canadian medical learners along the continuum in virtual clinical settings" and to be aligned with the recommendations made by the working group in the initial VCTF report.

It is anticipated a report will be forthcoming this academic year.

An updated CanMEDS framework will be released in 2025 and virtual care and other emerging technologies are being assessed to see how they will fit into this. It has been noted that while the timelines for this process are long it will help keep consideration of virtual care on the front burner.

Virtual care is being assessed by Resident Doctors of Canada (RDoC) both from a medical education and a wellness perspective.

- There is extensive variety across the country in what residents are learning about virtual care and what they are expected to provide in virtual care.
- The pandemic has meant that much residency education has been done virtually and this has had a significant impact on resident wellness. Work is being done by RDoC to ensure residents are feeling supported and are in a safe learning environment.

Another refrain that has emerged repeatedly in webinars and lectures outlining the use of virtual care in Canada since the spring of 2020 has been the need for medical students to be appropriately trained on how to use virtual platforms to deliver appropriate care. The working group feels it is important to stress that learners must be engaged in clinical medical education whether delivered virtually or in person.

Finally, the working group re-emphasized one of the principles espoused in their initial report that medical education programs ensure that learning environments in virtual care include "an experienced teacher, suitable support infrastructure and patients with health concerns that can be safely assessed and treated via virtual care."

CONCLUSION

Since the publication of the initial VCTF report and the outbreak of the COVID-19 pandemic, virtual formats almost overnight became a dominant means of delivering care for many physicians and patients. However, with what appeared to be a waning of the pandemic before the Omicron variant emerged, the "virtual first" approach recommended to protect against COVID-19 infection was being challenged in favour of considerations about delivering care in the most appropriate manner — which in many instances means in-person care.

While events since February 2020 have done much to advance many of the recommendations made by the VCTF and its working groups, incorporating virtual care optimally into the Canadian health sector requires more work on the part of the federal/provincial/territorial governments and national organizations. Specifically, there is a need for universally endorsed principles of virtual care design and deployment, and an aligned virtual care governance and policy approach across all jurisdictions.

The continued growth of private companies offering virtual care services outside of the publicly funded health care system requires urgent attention. This trend is just one of several issues that must be addressed to ensure that virtualized services improve access while maintaining safe and equitable service — something that the VCTF feels is currently lacking.

APPENDIX I

Virtual Care Task Force participants 2021

Co-chairs

Dr. Ewan Affleck	College of Family Physicians of Canada
Dr. Kenneth Harris	Royal College of Physicians and Surgeons of Canada
Dr. Gigi Osler	Canadian Medical Association

Members

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Dr. Debbie Brace	Resident Doctors of Canada
Dr. Ann Collins	Canadian Medical Association
Dr. Bernard Ho	Resident Doctors of Canada
Dr. Kendall Ho	University of British Columbia
Toni Leamon	CMA Patient Voice
Dr. Mike MacGillivary	Resident Doctors of Canada
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Dr. Geneviève Moineau	Association of Faculties of Medicine of Canada
Dr. John Pawlovich	Society of Rural Physicians of Canada
Dr. Debra Pugh	Medical Council of Canada
Dr. Jeff Sisler	College of Family Physicians of Canada
Robert Thompson	Newfoundland and Labrador Medical Association
Dr. Maureen Topps	Medical Council of Canada

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Dr. Heidi Oetter	Federation of Medical Regulatory Authorities of Canada
Dr. Dennis Desai	Canadian Medical Protective Association

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Payment models

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Claire Snyman	CMA Patient Voice
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