Integrating virtual care in family practice

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Dear Colleagues,

At the time of writing, the Canadian Medical Association, the Royal College, and the CFPC are finalizing a report on virtual care (VC) in medical practice. *Virtual care* is "any interaction between patients and/or members of their circle of care, occurring remotely, using any forms of communication or information technologies."[1] Virtual visits offer clear benefit to people whose access is limited by geography, resource constraints, or mobility restrictions, and to those with no family doctor; they also appeal to those who delay seeking care owing to the inconvenience of face-to-face visits.

Canada has responded slowly to public interest in VC. Recent surveys show two-thirds of Canadians would like to consult with physicians virtually,[2] but only 18% of FPs consult via e-mail or text, and 5% offer video visits.[3] Physicians worry such access has privacy and licensure issues, report that they lack appropriate technology, and see that VC could negatively affect their bottom line.[4]

Adoption of VC in Canada has been largely led by the private sector. Our publicly funded system is vulnerable to disruption if it fails to incorporate this technology and support this new kind of access. Our 3 organizations believed it was important to do an environmental scan of our current status and offer suggestions on a way forward. Task force working groups on *interoperability and governance, licensure and quality of care, payment models,* and *medical education* identified principles and recommendations. Three themes are particularly relevant to family practice:

- delivering VC within the continuity of an established relationship with a physician, clinic, or health service;
- ensuring that a virtual visit is appropriate for the presenting problem and that the same standards of care apply virtually and "in person"; and
- securing the necessary technical infrastructure and payment models to support the delivery of VC.

Evidence for the benefit of attachment to a most responsible provider is strong.[5] Virtual technology needs to *support continuity* and minimize fragmentation and episodic care. The *same standards* should guide virtual and face-to-face encounters, including preparation, documentation, and effective follow-up and referral. Virtual medical services should be *publicly funded* and *compensated similarly* to in-person services. Work flows are particularly important in family practice, so *technical infrastructure and role assignments* in teams are essential. Successful innovations are well under way in British Columbia, Ontario, and Alberta.

The *Rural Road Map* (**www.cfpc.ca/arfm_rural_roadmap**)[6] points to the need to reduce *interprovincial barriers to licensure.* The Federation of Medical Regulatory Authorities of Canada is working on a *telemedicine agreement* between regulators that would allow doctors to use provincial licences to provide VC to patients in other provinces or territories, remaining accountable to regulators in their home province.

Interoperability is the ability of computer systems to exchange health information. No comprehensive metrics exist to assess this, but experience suggests there is a long way to go. In VC, the sum total of a person's longitudinal health information should be available in a *functionally single digital chart accessible to him or her and the entire circle of care* on a need-to-know basis, irrespective of location. Managed protocols should uphold ownership, custodianship, autonomy, security, privacy, data integrity, and quality of care.

A recent survey of medical schools identified a lack of common e-health language across faculties and a lack of consistency in teaching.[7] The importance of supporting *"good webside manner"* as well as good bedside manner was highlighted. Learning environments must ensure teachers are familiar with best practices and tools for VC to be certain patients are assessed and treated safely and privately. In this era of distributed medical education, supervisors' location relative to learners and patients and their ability to oversee patient assessment and care decisions are key to patient safety. The CFPC, along with the Association of Faculties of Medicine of Canada and the Royal College, is prepared to collaborate on *adapting the current CanMEDS roles and accreditation standards* to stimulate the cultural transformation required by this dynamic change in the practice environment.

Please review the task force report on our website. We need your input to ensure the expansion of VC enhances the experience of family physicians, our patients, and our learners.

Acknowledgment
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