

Intelligence MEMOS



From: R. Sacha Bhatia, Will Falk, Trevor Jamieson, Carole Piovesan and James Shaw
To: Healthcare Policymakers
Date: April 7, 2020
Re: **VIRTUAL HEALTHCARE IS HAVING ITS MOMENT. RULES WILL BE NEEDED**

The global COVID pandemic has forced health systems to innovate quickly to protect patients and providers. The first priority has been to diagnose and treat the virus to control its spread and fury, while providing high-quality care to others in need.

A huge shift to virtual ambulatory visits has occurred for COVID and non-COVID cases alike, key to reducing exposure for both patients and providers.

Ontario has created virtual care billing codes that allow the use of any technology clinicians deem appropriate, including phone and commercial videoconference services, with a dramatic and immediate shift to virtual.

At Women's College Hospital and Unity Health in Toronto, virtual visits now represent a majority of hospital ambulatory services. Test results are delivered online. Prescriptions are delivered electronically.

Decades of prediction have come true in a single month.

This situation will continue while the "Risks of Physical Contact" (RoPC) remain high. Experience from Asia suggests this will last months after control is established. It may be mid-2021 before RoPC lowers enough to make in-person healthcare visits viable and attractive again.

Urgent clinical needs have required flexibility around privacy and security with virtual. Bodies like the Information and Privacy Commissioner of Ontario are acknowledging that in this unprecedented situation, decision-making around privacy issues is necessarily different.

British Columbia issued a ministerial order, easing certain personal health disclosure rules to communicate, support and respond to COVID-19. The best decisions today may differ from decisions six or 12 months from now as technology matures and RoPC drops.

Care delivery has already been permanently changed. Policymakers need to shape both the urgent control period and the post-COVID world. New standards are needed that mix both physical and virtual delivery, equitably available. We need modernized standards of care for population health that seek to achieve the [IHI's Quadruple Aim](#) using both physical and virtual means. This will require addressing five issues:

1. **Patient Safety and Quality:** What healthcare issues can/should be addressed virtually, and when is in-person care required? Who decides? Each set of medical and social services should undergo a systematic review to determine the appropriateness and desirability of a virtual service option.
2. **Privacy and Security:** In the rush to meet physical distancing requirements, governments have promoted virtual with no specific standards or guidance for digitally securing sessions or protecting patient privacy. How should a provider verify identity, capture consent and ensure understanding virtually? How do these measures not compromise equitable access? Should a secure email address be a requirement to practice? Is it time for cross-provincial licences/standards?
3. **Integrated Population Health Approach:** How do we build a virtual system to ensure robust care continuity, including strong links back to primary care and needed ancillary services? How can we facilitate remote ordering and reviewing of diagnostic tests, simple referrals and even basic daily activities like nutrition and transportation? In short, how does a mixed virtual/physical system achieve high-quality population health?
4. **Billing considerations:** Ontario made a bold move by reimbursing virtual visits equally. This drives rapid adoption, but also embeds many undesirable aspects of fee-for-service medicine, including rewards for overtreatment and episodic discontinuity. Strong economic analysis and thoughtful payment reform will be critical to building systems of care that allow continued innovation.
5. **Utilization impact and outcomes:** Additional fundamental questions remain. These include chronic disease outcomes, appropriate use of diagnostic tests and prescriptions, clinical outcomes for COVID and non-COVID patients alike. A very large, and unexpected, natural health system experiment is occurring. Future research needs to examine these impacts so that we can modify practices to maximize patient and system benefit.

The pandemic is massive disruption for healthcare and society. Virtual and online delivery of services is now both expected and likely life-saving. Now that we have a virtual care system, we need to marry it with our fundamental goals for population health: quality, cost effectiveness, provider and patient experience, and risk mitigation. The IHI Quadruple Aim provides an excellent framework to do so. Our forthcoming C.D. Howe Institute paper will discuss these five areas and how to ensure the Quadruple Aim through a thoughtful system design for permanently mixed virtual-physical healthcare.

Dr. R. Sacha Bhatia is chief medical innovation officer at Women's College Hospital in Toronto, Will Falk is a senior fellow at the C.D. Howe Institute, Dr. Trevor Jamieson, is chief medical information officer at Unity Health, Carole Piovesan is a partner at INQ Data Law and James Shaw is research director of artificial intelligence, ethics and health at the University of Toronto Joint Centre for Bioethics.

To send a comment or leave feedback, email us at blog@cdhowe.org.

The views expressed here are those of the authors. The C.D. Howe Institute does not take corporate positions on policy matters.