NEWFOUNDLAND AND LABRADOR
MEDICAL ASSOCIATION

Virtual Care Strategy

June 1, 2019

PREFACE

The NLMA would like to thank the physicians and health system stakeholders who participated in the research and consultation processes that resulted in this strategy.

The NLMA used the services of Deloitte to carry out an environmental scan, a physician survey, key informant interviews, focus groups of physicians, a stakeholder workshop, and a strategy selection process.

This strategy provides a starting point for engagement with patients, physicians/members, the provincial government, the NL Centre for Health Information, regional health authorities, Family Practice Networks and other groups. Collaboration is essential in a complex environment like health care, especially when it involves introduction of new technology.

EXECUTIVE SUMMARY: NLMA'S VIRTUAL CARE STRATEGY

NLMA's Aspiration	To overcome the distance, cost, physical and other challenges faced by patients when accessing care, the NLMA will create an environment that encourages physicians to innovate with virtual care solutions to break down these barriers.		
Vision for Physicians	Within five years, we envision physicians practicing in an integrated and supported environment where the patient and the physician can determine whether a virtual or in-person interaction is best.		
Strategic Priority Areas	**Initiate Partnerships**	**Provide Practice Support**	**Provide Education, Awareness, And Advocacy**
Goals	Collaborate with system partners to create an enabling environment for physicians to utilize virtual care based on their respective practice workflows and needs of patients.	Create an environment where technology choices create better access for patients and enable operational flexibility for physicians.	Generate a greater understanding of the opportunities for improved patient, health system and physician outcomes as a result of virtual care – with a primary focus on improved access to care.
Strategies	1.1 Co-design a vision and create goals for virtual care adoption with system partners. 1.2 Address current gaps in remuneration structures that restrict virtual care use. 1.3 Collaborate within Atlantic Canada to leverage the strengths of medical associations.	2.1 Engage NLMA membership on practice areas in need of improved efficiencies that can benefit from virtual care. 2.2 Create a process for stakeholders to reach consensus on the criteria to evaluate virtual care tools and platforms that support physician practice and workflow efficiencies. 2.3 Create training and ongoing technology and practice supports for physicians and support staff with relevant virtual care tools.	3.1 Create a higher awareness of the benefits of virtual care among the patient population. 3.2 Foster a greater awareness and comfort level amongst NL physicians regarding the benefits and availability of virtual care tools and technologies. 3.3 Collaborate within NL and across Atlantic Canada by creating forums for continued dialogue with system partners to address evolving needs of physicians.
Actions	1.1 A NL system-wide virtual care vision and set of goals should be developed through dialogue with the provincial government, NLCHI and other stakeholders. The NLMA will provide physician leadership in this	2.1 The NLMA will consider providing a consulting service (e.g., a "Virtual Care Advisor") to physicians. Under such a service, physicians would submit information regarding practice and/or patient needs, and the NLMA would then	3.1 The NLMA will play a proactive role in working to increase the awareness of NL patients regarding virtual care, both in terms of its benefits and common misconceptions, as well as the virtual services that patients are able to

	dialogue, incorporating bottom-up guidance from physicians themselves. This process will create focus, accountability, cohesion, and facilitate decisions in terms of resource allocation and investment. 1.2 The NLMA will advocate for a review of remuneration models with the ultimate objective that all disincentives to provision of virtual care will be removed. The remuneration model should not be a factor in choosing whether to use virtual care tools. 1.3 The NLMA and the other Atlantic medical associations will work together to set priorities and develop a regional agenda. Displaying a united regional front will increase the strength of the medical associations' virtual care advocacy to system administrators and provincial governments.	provide recommendations on technologies, tools, platforms, practice and workflow adjustments, and other change management considerations. Consideration would be needed on how to coordinate this activity with other support programs for physicians. The NLMA will conduct additional research into the top priority areas in need of efficiency improvements that can be realized through virtual care. This could also include developing an evaluation mechanism to identify, prioritize, and update these areas of need on an ongoing basis. The NLMA will explore options to set up an online, "peer-reviewed" forum for physicians to discuss their experience with virtual care and provide support to their colleagues. There is evidence of this type of online exchange already taking place in NL, and the NLMA could formalize an online portal for physicians to collaborate on virtual care. In addition, consideration can be given to providing some virtual care support services on an Atlantic-wide basis. 2.2 The NLMA will propose a decision-making forum in which relevant stakeholders may achieve consensus	access. The Association will consider creatively addressing differing needs and characteristics across patient populations as part of awareness-building efforts. These efforts will be supported by a communications strategy that identifies optimal channels and messaging organized by population segments (e.g., older vs. younger patients, urban vs. rural). The NLMA and other stakeholders should also develop guidance for patients in terms of when virtual care is beneficial, and when in-person interactions may be more appropriate. This will empower patients to make an informed choice regarding how they interact with the health system and help properly set expectations for interactions with their circle of care. 3.2 The Association can increase awareness by reporting to its membership on virtual care use and adoption progress. Statistics on adoption, as well as examples of best practices or innovative applications of virtual care, can serve to nudge physicians who may be on the fence in terms of adoption (but will want to avoid lagging behind their peers). Examples of patient benefits realized through virtual care can also be conveyed through

		on the criteria for evaluating virtual care technologies and tools. The NLMA will work, in collaboration with NLCHI and other stakeholders, to develop and consolidate a list of available technologies that meet generally accepted standards. This could be achieved by leveraging physician champions and/or early adopters in creating shortlists of products, and in testing and evaluating technologies. The NLMA will work with system partners to encourage an environment where physician-led innovation is fostered to advance overall adoption and best-practice implementation of virtual care tools. 2.1 The NLMA will work with NLCHI and the Department on programming for training and support for physicians and their staff to complement or supplement the support from vendors. The NLMA will consider a train-the trainer program to empower and support local IT-leads in clinics (non-institutional environments), helping to provide knowledge and skills to those most likely to provide onsite support to physicians.	storytelling (i.e., a "day in the life" of a patient or physician using virtual care) in order to portray the benefits and practical applications of virtual care in NL. The NLMA's education and awareness campaigns will focus on creating understanding of guidelines and protocols, especially related to privacy and security of data. The NLMA will continue to foster and expand physician champions by encouraging "existing" champions to identify peers who could also assume this role. The NLMA should be closely supporting the efforts of physician champions and involving them in early stage programs.

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INTRODUCTION

This strategy provides the perspective of the Newfoundland and Labrador Medical Association on how the virtualization of care should unfold within the Newfoundland and Labrador health care system, particularly as it relates to care provided by physicians. The strategy recognizes that the expansion of virtual care will involve significant collaboration amongst stakeholders including the NLMA, the Department of Health and Community Services, the Newfoundland and Labrador Centre for Health Information, and the Regional Health Authorities, regulatory bodies and others. The strategy also recognizes that virtual care will play a large role in the services provided by many other health care providers and teams of providers.

Health care takes place in a complex environment and requires significant commitment by all parties to build a common vision to support innovative directions. The NLMA puts forth this strategy to guide the work of the Association and to advance a set of ideas to stimulate the adoption and spread of virtual care solutions.

Virtual Care Definition

The NLMA's virtual care strategy focuses primarily on services offered through integrated video, voice, instant messaging and email, augmented by remote patient monitoring and connected information and decision support systems.

> *Definition of Virtual Care: "Virtual care refers to any interaction between patients and/or members of their circle of care, occurring remotely, using any form of communication or information technology, with the aim of facilitating or maximizing the quality and effectiveness of patient care." (CMA, 2018)*

Virtual Care is Expanding Rapidly

Virtual care technologies and services are growing rapidly around the world. In health systems with a large private sector, virtual care is expanding because innovations and new workflow designs can be quickly integrated into patient care. An oft-cited example is Kaiser Permanente (KP) in the United States where, by May 2018, more than half of their 100 million patient encounters occurred virtually. "One benefit KP has over other health systems is that it is integrated and offers physicians capitation. Providers are paid a monthly member fee to care for the whole patient. That helps Kaiser by avoiding potential payer/provider issues involving insurers paying physicians for volume. About 95% of its more than 12 million members are covered through a capitated payment system. That makes engaging physicians less of a challenge than it might be for providers reimbursed by volume."[1]

The integration of virtual care into health systems and physician practices is consistent with the movement of many other industries online, such as banking, insurance and hospitality. While physician

[1] Masterson, Les, "Virtual care moves toward the frontline of provider-patient relations": www.healthcaredive.com/ /

care will always contain a substantial face-to-face component, there is a relentless march towards virtual care as an important channel for services.

STATUS OF VIRTUAL CARE IN NEWFOUNDLAND AND LABRADOR

In Newfoundland and Labrador, the provincial telehealth network is the main platform on which virtual care has been provided. The network is operated by NLCHI and connects hospitals and health centres. The system is used by many physician specialties and their patients throughout the province. Over 20,000 patient interactions (by physicians and other providers) were hosted on the network in 2018. Within the physician community, the provincial telehealth platform is used primarily by salaried physicians or physicians paid under Alternate Payment Plans (APP) who carry out their work within hospitals and health centres. Utilization by fee-for-service (FFS) community-based physicians is quite limited (total billings of approximately $30,000 in 2018). MCP does not pay for virtual visits or telemedicine provided by physicians outside designated health facilities.

In 2018 and 2019, NLCHI invested in the upgrading of its telehealth infrastructure, including upgrades of hardware in public facilities, plus the installation of a virtual care application on many physician desktop and laptop computers within public facilities. This system is being tested and will allow doctors to conduct virtual patient visits from their offices. Aspects of this initiative are not yet finalized, including the expansion of MCP fee codes to allow for virtual office-based services outside designated health facilities to be remunerated, and integration with the electronic medical record.

MCP DOES NOT PAY FOR VIRTUAL VISITS OR TELEMEDICINE PROVIDED BY PHYSICIANS OUTSIDE DESIGNATED HEALTH FACILITIES.

Many physicians already interact with their patients by telephone, instant message and email. Salaried and APP physicians have no impediment to using these channels as long as the physician is satisfied with the appropriateness and security of the interaction. FFS physicians have generally not used these channels because fee codes do not exist to allow for appropriate remuneration. One innovation in this regard is the introduction of a telephone fee code for participants in the Family Practice Renewal Program. This fee code started in 2018 and is limited to 225 instances per physician per year. Remote patient monitoring has been the subject of several demonstration projects.

The eConsult program allows electronic non-urgent referrals between family doctors and other specialists to obtain inter-professional feedback on the management of patient cases. It is expected that this program will convert from a demonstration project to a permanent program during 2019.

Private sector virtual care services are available in Newfoundland and Labrador. Video/virtual visits with a doctor from a private medical office to a patient's home are not currently insured under MCP, thus

private pay virtual care services can legally be provided to patients. A number of national companies have enlisted doctors within the province to provide these services, and some private insurers also use virtual care within the list of services that they cover.

REGULATORY CONTEXT

The College of Physicians and Surgeons of Newfoundland and Labrador has a standard of practice for Telemedicine published on March 22, 2017. This standard does not make reference to locations where telemedicine may be used. The College's definition of telemedicine is "the provision of medical expertise for the purpose of diagnosis and patient care by means of telecommunications and information technology where the patient and the provider are separated by distance." The College exerts its jurisdiction over physicians licensed in this province only, and will not hear complaints about physicians who may be licensed in a different jurisdiction but offer telemedicine services to patients within Newfoundland and Labrador.

Physicians using telemedicine in this province "are held to the same standard of legal, ethical, competent, and professional care as physicians providing personal face to face medical services." This includes:

- Consider the patient's existing health status, healthcare needs and circumstances, and only recommend telemedicine if it is in the patient's best interest.
- Identify what resources (e.g., technology, equipment, support staff, etc.) are required, and only proceed if those resources are available and can be used effectively.
- Ensure the reliability, quality, and timeliness of the patient information obtained via telemedicine is sufficient.
- Obtain informed consent from the patient, when applicable.
- Take reasonable steps to ensure that all medical information is transmitted in a manner which protects the privacy and confidentiality of the patient.
- Ensure the physical setting in which the medical care is being delivered is appropriate and safe and that a plan is in place to manage adverse events and/or emergencies.
- Refrain from prescribing narcotics or other controlled or regulated medications to patients whom they have not personally examined or with whom they do not have a longitudinal treating relationship unless they are in direct communication with another licensed health-care practitioner who has examined the patient.

THE NLMA HAS THREE MAJOR ROLES: 1) ADVOCACY; 2) NEGOTIATION; AND 3) SERVICES TO MEMBERS. THE VIRTUAL CARE STRATEGY TOUCHES ON ALL THREE ROLES.

Standards of practice for telemedicine and virtual care will continue to evolve. For example, the Alberta College updated its "Advice to the Profession" in October 2018. Its definition of telemedicine is, "a medical service provided remotely via information and communication technology." This definition is

intentionally broad "to acknowledge the rapid pace of technological change. While the tools will change; the principles will remain the same." The Alberta "Advice" on telemedicine addresses such issues as establishing the physician-patient relationship, verifying patient identity, assessing appropriateness, managing expectations, obtaining patient consent, responsible prescribing, continuity of care, record keeping, privacy and confidentiality, and use of social media. In regard to record keeping, the College's Advice states that the medical record must include all patient-related communications "including telemedicine communications in any format (e.g., email, telephone conversation, text message, social media exchange, and videoconference).

VIRTUAL CARE TECHNOLOGIES ARE DIFFERENT THAN OTHER INFORMATION TECHNOLOGY PROJECTS SUCH AS ELECTRONIC MEDICAL RECORDS: THEY ARE THE ACTUAL CHANNEL BY WHICH THE EPISODE OF CARE IS OCCURRING.

The Canadian Medical Protective Association issued guidance for physicians who work in virtual clinics.[2] They advise physicians to:

- Consider whether they meet any special licensing requirements that may apply.
- Be aware of other standards and guidelines concerning telemedicine, including privacy and security, consent, and online prescribing.
- Confirm with the owner or operator of the virtual clinic who is the custodian of the medical records and to ensure access to these records if needed later.

[2] CMPA, "Thinking of working with virtual clinics? Consider these medical-legal-issues": www.cmpa-acpm.ca/

THE NLMA: ROLE AND MANDATE

The NLMA has three major roles: 1) advocacy; 2) negotiation; and 3) services to members. The virtual care strategy touches on all three roles. NLMA advocacy will address our vision of how virtual care should unfold in the province in the best interests of patients and physicians, accounting for the roles and interests of other stakeholders. The NLMA negotiating mandate will be used regarding items that fall within the scope of our Memorandum of Agreement with the provincial government. NLMA services to members can include programs to facilitate adoption of virtual care.

ADVOCACY ISSUES

PHYSICIAN / PATIENT FOCUS

Virtual care technologies are different than other information technology projects, such as electronic medical records, hospital information systems, or the Pharmacy Network. These other information systems are records of patient/provider interactions. They store data and make it available for future use in formats that assist care and health planning. Virtual care tools are different because they are the actual channel by which the episode of care is occurring. It is not a record of the patient/physician interaction; it is the interaction.

This distinction is significant and must guide all the stakeholders when making decisions about how publicly insured virtual care will unfold in Newfoundland and Labrador. In particular, physicians must be able to choose the virtual care tools that will work best for their patient panel, location, specialty, and practice preferences. While virtual care tools are often adaptable to many physician/patient contexts, choosing a single application for all clinical settings is not a reasonable goal.

PACE OF ADOPTION

Virtual care holds significant opportunity for improved access for patients and operational flexibility for physicians. It may also deliver greater health system efficiency. There is a compelling case for all stakeholders to move quickly to seize the benefits that exist in the virtualization of care. The world is moving online and patients expect that health services will move at the same pace. If the pace of adoption is slow, patients will wonder “why”? Banking innovations occur in Toronto and Twillingate at the same time. Streaming television is available in Vancouver and Happy Valley- Goose Bay simultaneously. The same pace of innovation should flow through health care services.

INNOVATION: INSTITUTIONAL AND COMMUNITY-BASED PERSPECTIVES

There is a tendency in large institutions to adopt a single standard for technology projects and require all users to adopt the chosen approach. The business case for virtual care may be different because of the many different contexts in which physicians and patients interact. In its 2015 virtual care framework, the Women’s College Hospital Institute for Health Systems Solutions and Virtual Care stated that, “while some checks-and-balances in a system as critical as health are required, the twin death knells to innovation,

namely centralization and formalization, should be avoided as much as possible." [3] Allowing for technology choice will ensure that physicians can innovate within their practices to achieve the most appropriate outcomes for their patients.

Preserving the space to innovate is essential for community-based physicians. The choice of technology and approach should be limited only by the generic standards that need to be met by all virtual care systems. For example, physicians in the community must choose virtual care applications that integrate appropriately with the electronic medical record, meet the record-keeping standards of the College, fulfill the privacy requirements under the Personal Health Information Act, and comply with the audit requirements of MCP equivalent to paper records or EMR records. Beyond these types of standards, physicians should be supported in adopting virtual care tools that allow for innovation at the practice level.

Innovation and technology choice are also issues for physicians who work mainly within hospitals and health centres. More dialogue is needed on how regional health authorities can support physician innovation at the front line and avoid standardization that may limit caregiver choice and practice flexibility.

MEDICAL EDUCATION

A key stakeholder in virtual care also includes the Faculty of Medicine at Memorial University. Technology-savvy medical students and residents want to know that their future practices will include the best suite of tools to provide services to their patients. Therefore, introducing students and residents to these tools as part of their education, whether in school or during community work experiences, is essential. Decisions on virtual care need to include the interests of the medical education system.

AVOIDING VIRTUAL WALK-INS

The promise of virtual care in family medicine is best realized when it is an extension of the existing relationship between a physician and a patient. Virtual care should complement the existing relationship and give both the patient and physician additional options for care delivery. Physicians can also share patients virtually within the same practice, or affiliated practices, using a foundation of inter-professional communication and shared medical records to facilitate high quality care.

THE PROMISE OF VIRTUAL CARE IN FAMILY MEDICINE IS BEST REALIZED WHEN IT IS AN EXTENSION OF THE EXISTING RELATIONSHIP BETWEEN A PHYSICIAN AND A PATIENT.

[3] Virtual Care: A Framework for a Patient-Centric System Prepared by: Women's College Hospital Institute for Health Systems Solutions and Virtual Care (WIHV)

In Newfoundland and Labrador, we must avoid the establishment of virtual walk-in clinics where family physician practices are unfamiliar with the patient and have no access to their medical records. This type of care can result in poor outcomes for the patient and can be wasteful of system resources. In British Columbia, the College of Physicians and Surgeons examined cases of virtual care provided to unattached patients and concluded that, "Based on evidence reviewed by the Inquiry Committee to date, the care of unattached strangers in virtual walk-in clinic models is to be discouraged."[4]

In making this choice, we must be mindful of the large number of unattached patients in the province who need access to family doctors. Further dialogue is needed on how virtual care can create solutions for this part of the population.

NEGOTIATION: FACILITATING VIRTUAL CARE ADOPTION

PAYMENT MODELS

As a general principle, the way a physician is remunerated should not be a constraint on choosing the most effective way to deliver services to a patient. If a physician can offer effective, cost-efficient services, combined with operational flexibility within their practice, the payment model for the physician should not hinder these goals. It should not prevent the physician from making the right choices.

> THE NLMA BELIEVES THAT INCREMENTAL ADOPTION OF VIRTUAL CARE RULES AND FEE CODES IS THE WRONG APPROACH.

Unfortunately, the lack of MCP fee codes for non-institutional telemedicine and other forms of virtual care mean that community-based FFS physicians have little choice but to see all patients face-to-face. The restrictions on billing are the key barrier in preventing these physicians from considering virtual care tools.

Given that salaried and APP physicians do not have the same fee code constraints, and because they are physically proximate to the provincial telehealth network, it is natural that their use of telemedicine is higher. (These physicians may face other barriers in adopting the most efficient and effective virtual care tools; see "Change Management and Physician Support" on page 15.) The question, then, is how to produce the same, payment neutral approach regarding virtual care for FFS physicians?

Essentially there are two options. The first is to permit physicians to use fee codes for virtual care the same way as face-to-face care. Physicians will then make choices to adjust their practices appropriately. The second option is to create a new payment modality and bring more physicians into a capitated model (e.g., blended capitation) or an alternate payment plan where the incentive is to provide the most

[4] College of Physicians and Surgeons of British Columbia, "Telemedicine as a stand-alone episodic care service rarely meets expected standards": ttps://www.cpsbc.ca/for-physicians/college-connector/2017-V05-01/05

effective and efficient care to a given patient population rather than the care that is required by the fee codes.[5] These considerations will need to be discussed and negotiated by the NLMA with the provincial government.

FISCAL RESPONSIBILITY

The NLMA and its members are keenly aware of the fiscal position of the provincial government and the difficulties inherent in taking new directions in health care. The adoption of virtual care may be regarded as a financial uncertainty. Even though there is a promise of more efficient care, better access and less travel for patients, and the likelihood that doctors will spend the same amount of time with a patient virtually as compared to face-to-face, the possibility of cost escalation is perceived as a threat. Such a perception can result in public policies that slow the adoption of virtual care tools. While physicians have autonomy now to offer virtual care, realistically they cannot because of the MCP constraints and the desire of most physicians to offer their services without private fees.

The NLMA believes that incremental adoption of virtual care rules and fee codes is the wrong approach. Slowly opening the fee code gate to a small group of specialties and then other groups, or to a small set of medical indications and then others, will harm adoption. Doctors will not change their practice patterns for small changes to the fee code system. Furthermore, the long decision-processing times for new rules and fee codes is not consistent with the rapid pace of the virtual care world.

The NLMA believes that a broadly facilitative approach to payment models is the best course, complemented by a generic set of rules that give confidence to the government that virtual care is only incenting high value/high quality care. Given the physician shortage in the province, doctors are already working long hours, made longer by the burden of forms and other paperwork, often done at night. The likelihood that overall costs will increase is low, but the NLMA is prepared to work closely with government on reasonable rules to raise confidence on this point.

Similarly, even if all stakeholders are aligned on the goals and general strategies set out in this report, there will need to be a discussion of the most efficient way to implement the programs and activities. Each partner will need to commit resources and agree on respective roles to achieve a cost-efficient and effective set of outcomes.

PHYSICIAN COSTS

While the cost curve for information and communication technologies has resulted in improved prices for consumers, there will inevitably be capital and operating costs for physician practices and regional health authorities as virtual care tools are implemented. FFS physicians cannot absorb additional overhead. They have already absorbed incremental monthly costs and capital costs for electronic medical records, along with unexpected productivity losses for some physicians due to the increased workload of EMR.

[5] Blended capitation is a payment model for family physicians. The remaining options work well for both family physicians and other specialties.

Careful analysis of the cost of virtual care tools will be needed at the practice level, and these findings will need to be accounted for in roll-out strategies.

SERVICES TO MEMBERS: SUPPORT FOR ADOPTION OF VIRTUAL CARE

CHANGE MANAGEMENT AND PHYSICIAN SUPPORT

The successful adoption of virtual care, as with any new technology, requires support for physicians and patients in the implementation process. Physicians will need such support for installation, start-up, business workflow redesign, and online skills to optimize the experience. They will also need ongoing access to support personnel for troubleshooting and to advance to higher levels of skill and efficiency. Patients may need orientation support as well.

Support is often provided by vendors, but could also be provided by one of the Newfoundland and Labrador stakeholder groups. A consideration will be ensuring proper integration between these support services and those provided under other programs such as eDOCSNL program, the Family Practice Renewal Program.

Support for salaried and APP physicians – whether family doctors or other specialists - needs focused attention. It requires action by RHAs at an organizational level to engage these physicians in developing a plan for adoption, providing the resources and opportunity, and ensuring an environment in which ancillary services support these new directions. Appropriate technical and administrative support for physicians to adopt virtual care is necessary or else adoption and utilization will not occur.

> APPROPRIATE TECHNICAL AND ADMINISTRATIVE SUPPORT FOR PHYSICIANS TO ADOPT VIRTUAL CARE IS NECESSARY OR ELSE ADOPTION AND UTILIZATION WILL NOT OCCUR.

TEAM BASED CARE

Virtual care tools will be adopted by other health care providers in addition to physicians, and will be used in the context of team-based care. For example, follow-up nursing care in a patient's home may benefit from virtual access to a physician. The tele-rounding project in PEI links doctors in one part of the province to other health care providers at the bedside in a rural hospital. Virtual tools enable interprofessional consultation, as is the case with the eConsult program. Any programming to roll out virtual care in the province must take into account the enhanced value of these tools in team-based care, and the support requirements for each environment.

ATLANTIC MEDICAL ASSOCIATION COLLABORATION

The NLMA has access to a unique network of like-minded groups in the Atlantic Medical Associations and the Canadian Medical Association. These associations held a joint strategy discussion in May 2019 regarding virtual care and agreed to collaborate on virtual care initiatives. This collaboration could be in

the form of research, technology assessment, a network of “physician champions”, joint advocacy, and other areas. The CMA is also a partner in a Virtual Care Task Force that will produce a national perspective on virtual care by the end of 2019.

NLMA'S VIRTUAL CARE STRATEGY: CREATING VISION AND ENABLING ADOPTION

NLMA'S ASPIRATION

To overcome the distance, cost, physical and other challenges faced by patients when accessing care, the NLMA will create an environment that encourages physicians to innovate with virtual care solutions to break down these barriers.

VISION FOR PHYSICIANS

Within five years, we envision physicians practicing in an integrated and supported environment where the patient and the physician can determine whether a virtual or in-person interaction is best suited to the needs of the patient and high-quality care.

PRIORITY AREA #1: INITIATE PARTNERSHIPS

STRATEGY 1.1 CO-DESIGN A VISION AND CREATE GOALS FOR VIRTUAL CARE ADOPTION WITH SYSTEM PARTNERS

Issue / Context

An overarching vision for the future of virtual care in NL has not yet been developed or agreed upon by health system partners. This was consistently identified as a gap by both physicians and system administrators.

Such a vision would serve to create cohesion around a shared set of goals and priorities with respect to increasing virtual care adoption in NL.

Supporting analysis

Until the benefits of virtual care for both patients and providers can be clearly and comprehensively communicated through a system-wide vision, some physicians and administrators may still view virtual care as a niche area and overlook its large-scale potential.

A NL SYSTEM-WIDE VIRTUAL CARE VISION AND SET OF GOALS SHOULD BE DEVELOPED THROUGH DIALOGUE WITH THE PROVINCIAL GOVERNMENT, NLCHI AND OTHER STAKEHOLDERS.

Opinions expressed regarding this issue relate to a fundamental question of how NL as a province desires to deliver healthcare. NL's unique system characteristics and challenges offer an opportunity for the province to become a true Canadian leader in virtual care adoption.

Supporting data

There is strong agreement among NL physicians and system administrators that advancement has been restricted by a lack of a shared vision of the common needs of stakeholders with respect to virtual care.

NL physicians and administrators also highlighted the need to develop a sustainable vision for converting successful pilot programs into permanent features of the health care system.

Stakeholders identified the need for a vision for healthcare in the province (e.g., long-term thinking on how patients move through the system as their lives unfold).

System administrators also stressed the importance of attaching timelines to system-wide goals that would result from the development of a virtual care vision for NL.

Actions for NLMA

A NL system-wide virtual care vision and set of goals should be developed through dialogue with the provincial government, NLCHI and other stakeholders. The NLMA will provide physician leadership in this dialogue, incorporating bottom-up guidance from physicians themselves. This process will create focus, accountability, cohesion, and facilitate decisions in terms of resource allocation and investment.

STRATEGY 1.2 ADDRESS CURRENT GAPS IN REMUNERATION STRUCTURES THAT DISINCENT VIRTUAL CARE USE

Issue / Context

In NL, physician compensation specific to virtual care services outside hospitals is heavily restricted, which impacts adoption. An enabling environment is required to improve adoption.

The approach to fee code adjustments to-date within the NL health system has been incremental. This limits the ability of physicians to operate at best efficiency, while technology and patient expectations advance at a much faster rate.

THE NLMA WILL ADVOCATE FOR A REVIEW OF REMUNERATION MODELS

Supporting analysis

If remuneration is not carefully considered, the system risks slow adoption due to inflexible funding models.

Unaddressed compensation solutions will frustrate the potential patient, physician and healthcare system efficiencies that virtual care could help achieve.

Supporting data

Across other jurisdictions, within and outside Canada, the lack of equitable remuneration for virtual care services is consistently identified by physicians as the top barrier to adoption. Recent research in NL reinforced this view.

Different payment models and system restrictions affect the adoption of virtual care. This can be seen in the more rapid uptake of institutional telemedicine by salaried and APP physicians as opposed to FFS physicians.

Actions for NLMA

The NLMA will advocate for a review of remuneration models with the ultimate objective that all disincentives to provision of virtual care will be removed. The remuneration model should not be a factor in choosing whether to use virtual care tools.

STRATEGY 1.3 COLLABORATE WITHIN ATLANTIC CANADA TO LEVERAGE THE STRENGTHS OF MEDICAL ASSOCIATIONS

Issue / Context

Leaders of the four Atlantic Canadian medical associations have agreed to seek opportunities to collaborate in regard to virtual care. The Canadian Medical Association is also a potential partner given its current focus on virtual care adoption across Canada.

Supporting analysis

Priority collaborative actions identified by the PTMAs include issuing joint letters to membership, Premiers, and Health Ministers signaling support for virtual care, developing a comprehensive template for fee code structures for virtual services, creating an inventory of tools and best practices, identifying champions, and producing regional "continuing medical education" products with additional tailoring to each province. The suite of measures identified to date address the top barriers to adoption and enablers of success with respect to virtual care.

Communicating a sense of urgency was identified by both NL physicians and administrators as a measure to motivate government and health system partners to work to reduce barriers to adoption.

There is strong agreement by NL physicians and administrators that an increase in virtual care is inevitable given patient demand and system challenges. NL can demonstrate leadership in Canada by using virtual care adoption as a means to respond directly to system issues.

Actions for NLMA

The NLMA and the other Atlantic medical associations will work together to set priorities and develop a regional agenda. Displaying a united regional front will increase the strength of the medical associations' virtual care advocacy to system administrators and provincial governments.

PRIORITY AREA #2: PROVIDE PRACTICE SUPPORT

STRATEGY 2.1 ENGAGE WITH NLMA MEMBERSHIP ON PRACTICE AREAS IN MOST NEED OF IMPROVED EFFICIENCIES THAT CAN BENEFIT FROM VIRTUAL CARE

Issue / Context

The use of virtual care to improve efficiency (i.e., cost, time, patient volumes) requires careful consideration of its distinct practice and workflow-related impacts on different medical disciplines and specialties.

Select disciplines have seen particularly strong advancement of virtual care, while others have faced challenges. Virtual care tools can only improve efficiencies if changes to physicians' workflows and practice operations are carefully considered during implementation.

Supporting analysis

As highlighted by NL system administrators and physicians, it is important to provide clinical resourcing to support shifts from traditional to virtual interactions.

Supporting data

One NL system administrator identified cancer care as a discipline in which virtual care has seen encouraging levels of adoption. This success required practice adjustments in order to integrate these tools into existing workflows. The importance of sufficient clinical resourcing was also identified.

Process changes brought about by the adoption of virtual care can also be positive rather than representing a barrier to adoption. For example, PEI's telerounding project improved patient flow.

THE NLMA WILL CONSIDER PROVIDING A CONSULTING SERVICE (E.G., A "VIRTUAL CARE ADVISOR") TO PHYSICIANS.

One quarter of NL physician survey respondents identified virtual care not working with "current practice flow" as a barrier to adoption. A 2018 US study of over 600 physicians had similar findings: 22% of respondents identified this concern as a barrier.

Actions for NLMA

The NLMA will consider providing a consulting service (e.g., a "Virtual Care Advisor") to physicians. Under such a service, physicians would submit information regarding practice and/or patient needs, and the NLMA would then provide recommendations on technologies, tools, platforms, practice and workflow adjustments, and other change management considerations. Consideration would be needed on how to coordinate this activity with other support programs for physicians.

The NLMA will conduct additional research into the top priority areas in need of efficiency improvements that can be realized through virtual care. This could also include developing an evaluation mechanism to identify, prioritize, and update these areas of need on an ongoing basis.

THE NLMA WILL PROPOSE A DECISION-MAKING FORUM IN WHICH RELEVANT STAKEHOLDERS MAY ACHIEVE CONSENSUS ON THE CRITERIA FOR EVALUATING VIRTUAL CARE TECHNOLOGIES AND TOOLS.

The NLMA will explore options to set up an online, "peer-reviewed" forum for physicians to discuss their experience with virtual care, and provide support to their colleagues. There is evidence of this type of online exchange already taking place in NL, and the NLMA could formalize an online portal for physicians to collaborate on virtual care.

In addition, consideration can be given to providing some virtual care support services on an Atlantic-wide basis.

STRATEGY 2.2 CREATE A PROCESS FOR STAKEHOLDERS TO REACH CONSENSUS ON THE CRITERIA FOR EVALUATING VIRTUAL CARE TOOLS AND PLATFORMS THAT SUPPORT PHYSICIAN PRACTICE AND WORKFLOW EFFICIENCIES

Issue / Context

Physicians in NL need assistance to research, evaluate, and select virtual care tool(s) from a growing pool of technologies and providers – this is beyond their scope of an individual medical practice.

There exists an opportunity for a guiding body to develop a vetted list of appropriate technologies such that physicians can more easily select and adopt these tools.

Supporting analysis

Physicians generally have a trusting relationship with their associations. This trust can be leveraged as associations develop guidance on the relative effectiveness of various virtual care tools and platforms.

An approved suite of tools will also help address privacy and security concerns: tools can be reviewed and tested in a robust manner, and can be adopted if they comply with all relevant regulations and legislation.

Supporting data

NL physicians, system administrators, and other stakeholders have highlighted the need for an appropriate organization to approve a set of tools and technologies, as well as provide instruction on their use and accompanying documentation to support physicians during adoption.

US subject matter experts have suggested that an increasing number of technology companies marketing a wide range of virtual care tools and technologies can create confusion and frustration amongst physicians.

Actions for NLMA

The NLMA will propose a decision-making forum in which relevant stakeholders may achieve consensus on the criteria for evaluating virtual care technologies and tools.

The NLMA will work, in collaboration with NLCHI and other stakeholders, to develop and consolidate a list of available technologies that meet generally accepted standards. This could be achieved by leveraging physician champions and/or early adopters in creating shortlists of products, and in testing and evaluating technologies.

The NLMA will work with system partners to encourage an environment where physician-led innovation is fostered to advance overall adoption and best-practice implementation of virtual care tools.

STRATEGY 2.3 CREATE TRAINING AND ONGOING TECHNOLOGY AND PRACTICE SUPPORTS FOR PHYSICIANS AND SUPPORT STAFF WITH RELEVANT VIRTUAL CARE TOOLS

Issue / Context

A crucial component to adoption and effective usage of technology tools and platforms is proper training and support.

The learning curve associated with new technology use can be daunting for physicians and their support staff. Without proper support, physicians may feel the burden of new technology, as opposed to realizing benefits to workflows.

Supporting analysis

Physicians, especially in non-institutional settings, are reliant on their own knowledge or that of their staff to navigate onsite technology. The more that adoption increases with existing virtual care tools or expands with new platforms, the requirement for proper training will continue to grow.

Creating forums for training and support for physicians is a critical component to utilization of new tools, compliance with protocols and guidelines, and ensuring data quality.

Supporting data

When asked in a recent survey the degree to which various factors would influence their future adoption of virtual care tools, NL physicians provided a mean score of 8.2 on a 10-point scale for "ready access to a highly trained individual to support the use of virtual care tools", representing the second highest factor.

Concerns expressed by NL physicians during recent focus groups included:

- Challenges with lack of training for support staff, who are unable to provide onsite troubleshooting support.
- Needing to access many different sources for technology support depending on software platform.
- Inefficient systems and user workflows that create burdens for physicians and are seen as creating tasks "in addition to, not in place of" current activities.

Actions for NLMA

The NLMA will work with NLCHI and the Department on programming for training and support for physicians and their staff to complement or supplement the support from vendors. The NLMA will consider a train-the trainer program to empower and support local IT-leads in clinics (non-institutional environments), helping to provide knowledge and skills to those most likely to provide onsite support to physicians.

PRIORITY AREA #3: PROVIDE EDUCATION, AWARENESS, AND ADVOCACY

STRATEGY 3.1 CREATE A HIGHER AWARENESS OF BENEFITS OF VIRTUAL CARE AMONG THE PATIENT POPULATION

Issue / Context

While patient interest in virtual care is high across jurisdictions, patients may not be entirely knowledgeable regarding the availability and effectiveness of various technologies, as well as their rights and responsibilities when receiving care virtually.

Supporting analysis

Increasing patient awareness can be a means to drive physician adoption. If patients are aware of what is available to them, research suggests they will continue to demand virtual care services.

Some NL family physicians have communicated that they cannot always clearly identify the benefits of virtual care for their patients, given unique demographic characteristics (e.g., age).

Supporting data

Many NL physicians and system administrators suggest that patient interest in virtual care is high, and that their experiences are comparable to traditional interactions.

NL physicians also suggested that focusing on the benefits to patients of virtual care can be equally beneficial in increasing physician adoption. Physicians are seen to be more likely to adopt virtual care tools if they can clearly see how virtual care will benefit their specific patient populations.

Physician education is also important to properly set physician and patient expectations about the appropriate use of virtual care, the opportunity and the limitations of this channel of care, and how to best optimize its value.

Actions for NLMA

The NLMA will play a proactive role in working to increase the awareness of NL patients regarding virtual care, both in terms of its benefits and common misconceptions, as well as the virtual services that patients are able to access. The Association will consider creatively addressing differing needs and characteristics across patient populations as part of awareness-building efforts. These efforts will be supported by a communications strategy that identifies optimal channels and messaging organized by population segments (e.g., older vs. younger patients, urban vs. rural).

The NLMA and other stakeholders should also develop guidance for patients in terms of when virtual care is beneficial, and when in-person interactions may be more appropriate. This will empower patients to make an informed choice regarding how they interact with the health system and help properly set expectations for interactions with their circle of care.

STRATEGY 3.2 FOSTER A GREATER AWARENESS AND COMFORT LEVEL AMONGST NL PHYSICIANS REGARDING THE BENEFITS AND AVAILABILITY OF VIRTUAL CARE TOOLS AND TECHNOLOGIES

Issue / Context

NL physicians and administrators have highlighted that increasing physician awareness of guidelines, risks and barriers of virtual care is vital to greater adoption.

There is a belief in NL and beyond, that physicians value peer support and advice from respected colleagues. These “physician champions” have played a key role in encouraging increased adoption in many jurisdictions, and can act as crucial early adopters.

Supporting analysis

Education and awareness efforts targeted towards physicians can address concerns and answer outstanding questions. This may foster heightened adoption by reducing real and perceived barriers of new technologies.

Less populous jurisdictions such as NL may more readily lend themselves to close, trusting relationships among care providers and other stakeholders, which in turn can amplify the impact of champions on physician adoption.

Supporting data

Change management regarding physician expectations for virtual care has been an important consideration in several jurisdictions, both in Canada and internationally. While many physicians view virtual care positively, negative messaging can circulate periodically and hinder adoption.

Physician champions played key roles in the successes of both NL's eConsult program, and the telerounding pilot project at Western Hospital in PEI.

In NL, physicians are concerned about understanding regulatory guidelines and liability implications related to virtual care, and operating within appropriate standards for patient privacy and information security.

In a recent survey, privacy and security of patient information was identified as a significant issue by NL physicians.

Actions for NLMA

The Association can increase awareness by reporting to its membership on virtual care use and adoption progress. Statistics on adoption, as well as examples of best practices or innovative applications of virtual care, can serve to nudge physicians who may be on the fence in terms of adoption (but will want to avoid lagging behind their peers). Examples of patient benefits realized through virtual care can also be conveyed through storytelling (i.e., a "day in the life" of a patient or physician using virtual care) in order to portray the benefits and practical applications of virtual care in NL.

The NLMA's education and awareness campaigns will focus on creating understanding of guidelines and protocols, especially related to privacy and security of data.

The NLMA will continue to foster and expand physician champions by encouraging "existing" champions to identify peers who could also assume this role – should be closely supporting their efforts and involving them in early stage programs.

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