The integration of virtual care: Where to go from here?

As we transition out of the pandemic, we need a collective effort and thoughtful, deliberate planning about the role of virtual care in British Columbia and the future of work for BC physicians.

Renee Fernandez, MD, CCFP

In March 2020, patients and physicians quickly adapted to the new realities of medical care in a global pandemic. Virtual care was implemented nearly overnight as a stopgap emergency measure to meet the immediate health care needs of British Columbians. There was no time for thoughtful, deliberate planning about the role of virtual care then, but we have an opportunity for that now.

Changes over the last 2 years have resulted in a permanent shift to virtual-enabled health care, accelerating transformation of BC's health care system faster than we ever imagined possible. As we begin pandemic recovery, now is the time to reflect on the lessons of COVID-19 to build a more sustainable health care workforce and system in BC. We have the opportunity to reimagine the future of care for British Columbians and the future of work for BC physicians.

This is not a simple undertaking. The integration of virtual care has far-reaching implications, including updating regulatory standards, care guidelines, patient education, and funding. Simply put, we need a province-wide integrated approach for the future of virtual care based on the vision of an equitable, modern health care system in a province recovering from a multiyear global pandemic.

Dr Fernandez is a practising family doctor in Vancouver and the executive director of BC Family Doctors. She believes in the power of physician advocacy and community to achieve meaningful change.

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Priorities for the future of virtual care

I believe that our approach to virtual care needs to be based on shared values and priorities for patient care. As the executive director of BC Family Doctors, I have worked with our Board and members to determine our priorities for the future of virtual care. While our conversations have focused on family medicine, I believe these priorities extend beyond our specialty.

Equity

Every virtual care policy decision must be made with an equity-first lens so that it does not exacerbate inequities among underserved and marginalized communities. For example, physicians learned during the pandemic that the telephone is an important modality of care, providing equitable access and reducing the digital divide. We learned that the patients who most stand to benefit are also those least able to use technology such as video platforms.

Patient and physician experience of care

COVID-19 reinforced the lesson that "one size fits no one." Patients need different levels and types of health care services at different times of their lives. The integration of virtual care provides an opportunity to design a health care system that is truly focused on the needs of the patient. In addition, many physicians are experiencing significant strain on their mental health, professional work, and personal lives. Coming out of the pandemic, virtual care can be one element that helps with creating more humane working environments for physicians.

Care is care

It's time to recognize that care is care, whether it is delivered in person or via telephone, video, or another modality. What is important is the ability to meet a patient's needs, not the delivery modality. The choice of modality needs to be made by the patient and physician together, with physicians supported to use the tools that best fit the clinical, social, and cultural needs of their patients.

Quality and safety

The pandemic has shown that virtual care is best used as a complement to in-person care. As we move from pandemic-appropriate care to postpandemic-appropriate care, the use of virtual care will change as we learn how to use various modalities of care outside of a public health emergency. We must develop a shared understanding between patients, physicians, and other stakeholders about how in-person and virtual care can together support safe, high-quality care.

The longitudinal care relationship

Clearly, virtual care cannot replace in-person visits in many clinical situations. However, the integration of virtual and in-person care over time within a longitudinal doctor-patient relationship is vastly different from the use of virtual care by episodic virtual care providers. Episodic care has an important role to play, especially for the more than 750 000 British Columbians who do not have a family doctor. We cannot, however, consider episodic care in the same light as longitudinal care, given the limited knowledge of the patient's health and social situation and the lack of access to the patient's continuing care record in those settings.

PREMISE

A new era of care

COVID-19 forced the modernization of our health care system; however, physicians, patients, and policymakers are still struggling to manage the evolving changes in the way we deliver care. As we transition out of the pandemic and into our next normal, we need a collective effort and phased approach to virtual care. Taking a phased approach will smooth the transition through the COVID-19 recovery period for both patients and physicians. It will give physicians time to recover from the strain of providing care during the pandemic. It will allow us to stabilize and support the health care system as we emerge from this collective disruption to our lives.

I believe we need to consider the future of virtual care alongside the reforms necessary to ensure the sustainability of our profession. We need time to focus on system modernization, with associated reform of fee-for-service and other payment models. The pandemic and the resultant explosion in the use of virtual care highlight the need to modernize the Medical Services Commission Payment Schedule to align with current standards of care, advancements in technology, and contemporary service delivery. Maintaining the current virtual care fee codes during the initial postpandemic period will allow for thoughtful decisions about the future of care, by virtual and in-person means.

We cannot go back to our prepandemic normal in health care, because normal wasn't good enough for patients or for physicians. Yet, I do have faith that it is possible to design a modernized health care system based on shared values and priorities. Each small action that we take as we emerge from the pandemic will add up to the world that we're creating.

Now is the time to rebuild, to foster new ways of working together, and to establish new supports for the delivery of health care. The collaborative efforts of physicians, government, and patients are required for the many changes and challenges ahead. Together, we can create a better tomorrow for all British Columbians. ■

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If we do this, the foot-voting will turn back in the direction of family practice, particularly longitudinal comprehensive family practice. If we further increase the satisfaction level of family physicians with business support, with a funding system that rewards comprehensive care while maintaining physician independence, with our primary care networks' efforts of team-based care again, and with a funding and communication system that promotes this teamwork, our chronic problems of access and attachment will naturally start to resolve themselves.

I believe that at this point in time our government understands these issues and is open to addressing our critical needs in family medicine. As our General Practice Services Committee grapples with this and as we negotiate our Physician Master Agreement, please lend your support to the voice of family doctors and fix this crisis in health care that is eroding its foundation.

Let us make family practice an irresistible choice and confirm that we value ourselves and the essential role we play in a system that could not function without us.

We may just start to find real joy again in the amazing work we do.

—Rob Lehman, MD, CCFP, MCISc, FCFP(LM)
Roberts Creek

Re: The crisis that COVID-19 exposed, highlighted, and worsened (but did not cause)

I have been working as a family physician for 45 years, mostly in Nanaimo, BC. I agree with Dr Day's editorial in the March issue of the *BCMJ* [2022;64:53-54]—having to deal with a shortage of hospital beds, overcrowded emergency rooms, long wait lists, and needing to fight for my patients to get proper medical care.

I am frustrated with the several BC governments that have not done anything to address these problems, not taken responsibility for their actions, and not listened to doctors about how to improve our health system.

—Barbara Macleod, Licentiate
Nanaimo

PRESIDENT'S COMMENT

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key stakeholder partners. A working group through the Council on Health Economics and Policy is working on a policy statement on gender equity that will be coming to the Board later this year, part of our commitment to address equity, diversity, and cultural safety/humility.

We are fierce in our advocacy for you and your patients. We are doing this on many different fronts. Let's use our anger to seek solutions together and promote change. We all have a role to play in navigating the challenging terrain ahead of us. We can no longer be silent; our voices will not be muffled, for what we speak of and stand for is the betterment of all our patients and British Columbians. When we mobilize together and act as one, we have our biggest opportunity to make positive change. We must seize the moment, together, now. ■

—Ramneek Dosanjh, MD
Doctors of BC President