Virtual care in inflammatory bowel disease

Lessons learned in the CaNVAS-IBD Program

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Access to gastroenterologists who specialize in treating inflammatory bowel disease (IBD) remains a concern across Canada, as the prevalence of IBD in this country is among the highest in the world, and it has been predicted that more than 400,000 individuals in Canada, or about 1% of the population, will be living with IBD by 2030.[1] That predicted prevalence is a rise of roughly 50% from 2018, when 270,000 Canadians were reported to be living with IBD.[1] Alongside this upward trend, geographic disparities in access to IBD care persist in Canada.[2,3] For instance, in some regions in Ontario the ratio of gastroenterologists to the population is less than 1.23 per 100,000, whereas in Toronto, Ont, the ratio is 6.21 per 100,000. Evidence suggests that patients cared for by gastroenterologists have better outcomes as well as lower risks of hospitalization and surgeries.[2] Reducing inequities in access to IBD care will avoid prolonged symptoms due to inappropriate or late diagnoses, improve quality of life for patients, and potentially lead to better health outcomes.

Bridging the urban-rural gap in care: a pilot study

While clinical guidelines recommend that patients with IBD who have active symptoms wait no longer than 2 weeks to see an IBD specialist, in practice the wait time is typically longer, with about 27% of patients waiting between 3 and 12 months and 6% waiting for more than 1 year.[3] In an effort to bridge that gap in care, the Crohn's and Colitis Canada PACE (Promoting Access and Care through Centres of Excellence) initiative piloted the first Canadian IBD telemedicine program, which used IBD specialists at Mount Sinai Hospital in Toronto to provide care for patients in Ontario who lived in areas with limited access to IBD specialists.

After triage of the referral, a telemedicine nurse coordinator arranges the telemedicine appointment and connects with the family doctor or referring physician for additional IBD-related health information. This contact ensures that IBD records for the patient are comprehensive, which is essential for dictating management and follow-up. Having clear documentation of the patient's IBD phenotype, history of complications, and extraintestinal manifestations, an IBD specialist can make any adjustments to the patient's medical management in a timely way, including any potential referral to surgeons.

Shorter wait times for new consultations

The virtual consultation follows the same procedure as an in-office visit, with appropriate time spent in discussion with specialists. After the consultations, patients are provided a summary with their plan of care to facilitate continuity of care and reduce loss to follow-up. This process reduced mean wait times for new consultations to 31.78 days from 279.04 days. Eighty-three percent of patients with active symptoms were seen within the recommended 2-week wait time.[3]

Need for flexibility: telephone versus video visits for IBD care

Video visits are often considered the "standard" alternative to in-person care because seeing patients can provide health care providers with useful clinical information as well as build rapport and improve patient-provider communication, as a 2021 study by Barsom et al found in comparing the benefits of and barriers to video consultations from the perspectives of patients with colorectal disease and of their health care providers.[4] However, providers did acknowledge that video visits alone can exacerbate a "digital divide" favouring those with more access to technology.[4] For instance, having a poor Internet connection or limited access to devices with a camera are constraints for holding video visits. Telephone visits, on the other hand, can provide better flexibility, privacy, and feasibility for patients with limited access to these technologies. Key advantages and disadvantages of telephone versus video consultations are summarized in **Table 1**.[4]

Outpatient visits for IBD need to respect the patient's wishes, limitations, and clinical requirements. Recommended uses of telephone (audio-only) visits versus video visits are summarized in **Table 2**.[4] Overall, patients report feeling that telephone visits are more comfortable when they are used for communicating good news or for routine follow-ups; videoconferences might be more helpful for conversations communicating issues such as endoscopic recurrence, the need to change management, dysplasia, and so forth. Patients with language barriers might derive greater benefit from video consultations, which give both parties more opportunity to ensure understanding. As discussed earlier, people who have difficulty with accessing technology or limited technological literacy might benefit from telephone visits. Video visits are also helpful with certain presentations such as skin and ostomy concerns. We also found video visits to be key in building better rapport with flaring and newly diagnosed patients with IBD and in cases where family members and caregivers of elderly patients are integrated into the care team.

Table 1. Advantages and disadvantages of telephone versus video consultations for outpatients with IBD

TYPE OF VIRTUAL IBD VISIT	ADVANTAGES	DISADVANTAGES
Telephone consultation	• Useful in areas with limited access to technology • Greater privacy, feasibility, and ease of use • Allows patients greater flexibility around where and when the visit can be conducted	• Often earlier call termination and shorter time of assessment • Difficult to involve interpreter or caregiver • Unable to read nonverbal cues
Video consultation	• Patients are often more satisfied with visual feedback • Providers appreciate visual cues to communicate patient's understanding, quality of life, and pain • Easier to engage family members and caregivers • Useful in cases that require visual assessment (eg, extraintestinal manifestations of IBD)	• Not practical in very remote communities or for patients with technological constraints

IBD—inflammatory bowel disease.
Data from Barsom et al.[4]

Table 2. Recommended uses for telephone versus video visits for outpatients with IBD

TELEPHONE VERSUS VIDEO USE	TELEPHONE VISIT	VIDEO VISIT
Recommended use	• Patients with constraints to successful video consultations (eg, no Wi-Fi, lack of access to devices, limited data plans, low technological literacy) • Routine follow-up or informing patients about normal results of diagnostic tests	• Requiring visual examination (eg, skin and ostomy concerns) • Flaring and newly diagnosed patients • Discussion about IBD management • Engaging with family members and caregivers (eg, often during pediatric patients' transition to adult care and when caring for seniors supported by caregivers)

IBD—inflammatory bowel disease.
Data from Barsom et al.[4]

Better access to care for patients with IBD

The PACE Telemedicine Program pilot demonstrated a number of benefits for patients living in rural areas without easy access to IBD specialists. Building on the success of the Ontario pilot, CaNVAS-IBD (Canadian Network for Virtual Access to Specialists in IBD) has expanded to 5 additional provinces: Alberta, Manitoba, Nova Scotia, Quebec, and Saskatchewan. For more information about the CaNVAS-IBD program, please contact Dr Geoffrey C. Nguyen (**Geoff.Nguyen@utoronto.ca**) or visit the website (**https://www.canvasibd.ca/**).

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Competing interests
None declared

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