A practical approach to virtual ambulatory care during an impractical time

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Since its introduction in Canada, virtual care has had little uptake by ambulatory care providers.[1] Several reasons for this include poor digital infrastructure, lack of remuneration by the provincial funding systems, an inertia to change the terms of engagement between patients and providers, discomfort with technology, and concerns about privacy and security.[2] Unfortunately, given the lack of readily available virtual options for patients by their providers, a number of private companies have sprouted up to fill a growing gap in our healthcare system - easily accessible, affordable, convenient care from anywhere, at any time.

However, in March 2020 an unprecedented event occurred where providers were forced to shift their approach to providing care. The global pandemic, COVID-19, arrived in Canada. A handful of providers were ready to use virtual care to pivot quickly to meet the challenges that COVID-19 presented with; however, the majority were not.[1]These challenges included: limiting physical interactions between patients and providers in order to decrease exposure to COVID-19; maintaining access, continuity of care and ensuring a social connection was present between patients and providers; and, ensuring an adequate workforce was available despite self-imposed or policy-imposed self-quarantine.

Given the need to overcome these challenges combined with rapid investments by provincial governments into funding virtual care assessments there was an abundance of providers wanting to use virtual care.[3,4] Despite this desire, there weren't readily available practical approaches for physicians to follow when they adopted virtual tools. In a time where speed trumped efficiency, there was a need to develop a practical approach to using virtual tools in practice. In this article, we hope to provide an overview of a practical approach for any provider to follow when starting to utilize virtual care in their practice.

Virtual care in Canada has an array of definitions.[5] For purposes of this article, we will define virtual in two categories: synchronous which will include phone, real time chat and video visits and asynchronous which includes secure messaging/email.

Before The Appointment

a) Ensure your account is set up with your vendor. We suggest procuring a vendor who's solution at very least permits asynchronous messaging and video visits. Alternatively, given the different levels of aptitude patients and clinicians may have with technology, consumer-grade solutions like Zoom, FaceTime or Skype may want to be considered. Although asynchronous messaging is not covered under most provincial funding models, the value it provides should be highly considered when adopting a virtual strategy.[6]

b) Buy the necessary equipment such as a desktop camera and/or laptop with a built-in camera. Purchasing a backup headphones with a built in speaker is recommended in case the camera's built in speakers or microphone fails.

c) Run a test session with a colleague or the vendor's support team to become familiar with workflow and the user interface.

d) Ensure access to a high speed, reliable internet connection. In the event the internet connection is poor, be prepared to tether to a mobile device but beware of data fees.

e) Ensure patient consent to communicate virtually is received and documented on the chart. Written consent is preferred however verbal consent is the absolute minimum.[7] Consent should be documented if any other members are participating in the visit.

f) Let patients know that you are offering virtual visits. It's been shown that patients view these visits just as good as traditional in-person visits and would use use them again if offered.[6]

g) Try to decide with patients what modality is ideal for the visit. This can vary based on the reason for visit and/or patient and provider comfort. As a rule of thumb, we ask providers and patients to reflect and ask what they hope to accomplish during the visit. In the majority of cases, phone or asynchronous messaging may be sufficient. Knowing this, we suggest using a combination of phone and asynchronous messaging for the majority of encounters and escalate to video if the assessment warrants it.

h) Use asynchronous messaging to deliver questionnaires prior to the visit to help set the agenda and collect structured information prior to the visit. This can make the visit more efficient by getting a head start of history and documentation and allow the provider to focus on areas of concern or alert the provider to any red flag symptoms.

i) Be sure to secure a room free of any non-consented individuals which also provides privacy i.e closed door. We highly suggest patients have a secure and private room however this may not be practical. You should provide an overview or risks including a privacy breach in this case. If the patient is aware, understands and appreciates the risk of a privacy breach, and would like to continue with the visit, then please document this.

j) Ensure there's a way to communicate between the clerical team and provider of how virtual visits should be booked. To start, you may want to book phone visits at 4-5 visits per hour and video visits at 3-4 visits per hour. As your patients and your team become more familiar with workflows you can adjust this pace.

k) Try to set up your schedule so that vulnerable patient populations (prenatal, well-baby, geriatric, immunocompromised) come in only during protected time slots so that the risk of exposure to potential COVID-19 patients is limited

l) Be aware of language barriers. If a language barrier exists then consider utilizing a medical translation service during the visit. This can be achieved by 3 way tele-conferencing, 3 way video-conferencing, or having the patient on video and the translator on speaker phone. Regardless of the approach, consent should be received from the patient and documented on the chart.

m) If you do not have an automated appointment reminder system be sure to confirm the appointment with the patient ahead of time

n) If there is a recording function in the system you are using for video visits please disable it or be especially mindful to not activate it

During The Appointment

a) If starting the visit with video-conferencing be sure to have a phone nearby as back-up

b) Use start and stop times at the top of your clinical note. This may be required for billing purposes.[3] More importantly, by better understanding how much time is being spent per visit type more flexibility in scheduling

can be permitted.

c) Confirm your patient's identity

d) Look at your camera, not at the screen

e) Talk slow and clear on the phone or camera

f) Be aware of your surroundings and body language on camera

g) Understand and appreciate the limitations of the physical exam during a video visit. With the advent of smartphones and wearable devices some objective data may be available from your patients i.e. heart rate, sleep patterns, etc

h) Do not perform sensitive examinations over video-conferencing. If you absolutely must then document the rationale and document consent for this specific part of the examination. We also highly recommend the use of a chaperone if a sensitive examination is required.

i) Check-in with the patient periodically to ensure they can hear you and understand you

j) You can document as you interact with the patient however do not let this disturb the milieu of the visit

k) Summarize the details of the visit

l) Pay extra attention to educating your patients about red flag symptoms and when to check-in next

m) If the presentation warrants it, do not be apprehensive of acknowledging to the patient an in-person assessment is necessary. Virtual care does have it's limitations and at the end of the day clinicians have a responsibility to first do no harm. In the context of a pandemic, evaluate the benefit of bringing a patient in versus the risk of exposure.

After The Appointment

a) Ensure hanging up the phone or disconnecting the camera. We highly suggest keeping the camera unplugged when not in use as to avoid any unwarranted activation of the camera inappropriately.

b) Please remove the camera during any in-person encounters as the appearance of a camera to a patient may cause unnecessary confusion and privacy concerns

c) Use asynchronous messaging to send questionnaires to gather information regarding the patient experience but also to track symptom progression

d) Complete the clinical note

e) Bill for the encounter. Requirements for billing for virtual visits can vary provincially

f) Reflect on the experience: what went well, what could've been better, what can be done differently, was this modality necessary for the visit.

g) Reflect on alternate pathways for marginalized patients. As a word of caution, virtual care may be an effective and convenient tool for the masses, however there are risks in inadvertently selecting out the most marginalized patients. Efforts must be taken to balance the needs of the many and the needs of the

marginalized.

Conclusion

Evolution occurs as a response to natural forces creating competitive pressure on systems. COVID-19 forced the delivery of ambulatory care to evolve literally overnight. We hope the above practical tips will come in useful during these impractical times. The delivery of ambulatory care will never be the same in Ontario and these writers feel this is for the best.

Through numerous leadership experiences in quality improvement, information technology, patient engagement, entrepreneurship and 5+ years of front line clinical care in the Toronto area and at St. Michael's Hospital Department of Family and Community Medicine Dr. Vellani has gained a wealth of experience using digital technologies to efficiently deliver patient and population-centric care. He is also the Founder of MediCall, an Ontario based on-demand home visit and virtual care service.

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