CMPA EDUCATION SESSION 2020

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Dr. Darren Larsen, Chief Medical Officer, OntarioMD
Daniel Boivin, CMPA General Counsel

Welcome

00:00
Dr. Guylaine Lefebvre:
Good afternoon, and welcome to our very first virtual information education session from the CMPA. I do apologize for our slight tardiness linked to the fact that we just finished our – our first-ever virtual annual general meeting.

00:22
Bonjour, je me nomme Guylaine Lefebvre.

00:24
I am the Managing Director of Safe Medical Care at CMPA, and we'll be together for the next hour and a half. I'm the moderator of this session. How appropriate that our first virtual session is actually on virtual care. I'll share with you that we actually chose the topic over a year ago, and many of you may know that there's a Virtual Care Task Force called by the Royal College, the College of Family Physicians, and the CMA about this time last year. The recommendations from the task force came out in February, and one of the authors commented on how it will take years to get to where we should be. Well, here we are, and it hasn't taken years, and it is likely related in – in large part to COVID.

01:20
We're very fortunate today to have four of Canada's opinion leaders who are joining us to provide their expertise and their insights into dealing with virtual care right now during this – this pandemic time. The formal presentations will take about an hour, and then we'll make sure to leave some time for you to be able to ask us questions, which you can do virtually through the website.

01:47
Our keynote speaker today is Dr. – is Mr. Seamus Blackmore. Seamus works with Deloitte Canada. He's a leader in digital health practice. His team delivers transformative projects globally. In addition to our keynote speaker, we're honoured to welcome a distinguished panels who will provide insight and respond to your questions on virtual care in Canada. Dr. Heidi Oetter is Registrar and CEO of the College of Physicians and Surgeons of BC, and she'll be sharing with – with us her experience in BC, and also the regulatory issues. Darren Larsen is a family physician who has extensive experience using virtual care in his own practice. Darren is Chief Medical Officer of OntarioMD. We're also pleased to have Mr. Daniel Boivin with us, who is one of our CMPA general counsel. He is a cur—currently a partner with Gowling WLG.

02:56
Moving to the next slides, these next three slides are related to the fact that the session is accredited for both the College of Family Physicians and the Royal College. You will be able to get your certificate of participation once you answer the evaluation form, and that will come to you via your own e-mail. On this first slide, we have nothing to disclose, with the exception of Mr. Blackmore. And on the next slide, Mr. Blackmore is an employee of a for-profit company, Deloitte Canada, and our scientific committee has reviewed any potential for – for bias. Moving to the third of those slides, we talk about the fact that our Scientific Planning Committee is composed of physician advisors who work at CMPA and we've reviewed all of the material.

03:55
Let's move on to get to know a little bit about you, our participants, today. We have two questions for you. And if you click on the Home button in the voting window – so this'll appear as a vote on your screen – there are two questions, and I'll invite you to click on Vote Now and answer both of those questions, please. We'll leave you a few minutes to answer the questions, and I'll go over the results a bit later in our presentation. The first question is asking whether you're currently providing virtual care, and how. And the second question really is delving into why it is that you chose to join the session with us today.

04:41
You can continue to vote, and meanwhile I'll move on with the next slide that describes our session objectives. These are ambitious objectives for this afternoon. So without further ado, we'll move ahead.

The CMPA Experience

00:00
Dr. Guylaine Lefebvre:
Now, the CMPA experience, as many of you know, at CMPA we have over a hundred thousand members. Our physician advisors here answer, on average, 200 phone calls a day. Those of you who participated in the annual general meeting were made aware of our capacity for extracting data from the calls and the medical lec—the medical legal

experience we have. And through that experience, we're able to present you with risks and education that hopefully will serve to increase the safety of medical care.

0:42
So looking specifically at calls we've received in regards to virtual care, between January of 2019 and May of this year we received 970 calls. When we extract the reasons and the – the concerns in those calls, we find that limitations of telemedicine ranks highly; issues of interprovincial and trans-border care; consent; confidentiality; appropriate documentation. Our members also had particular concerns with certain pa—patient populations: the patients we see who have mental health issues; the ability of a physician to assess without having met the patient in person; the ability to take care of our patients who are in long-term health facilities. And on both thoughts, because it may be difficult to offer those patients a visit in person, it also was difficult over a period of time for people to leave those facilities and be able to return to their homes without being quarantined.

01:58
Moving on to our medical legal experience, now, our data analysts looked back at a five-year period of closed cases from 2015 to '19. You'll realize that this is before COVID. And basically, this tells us that virtual care was not a significant issue pre-COVID for CMPA. Over that time period we found 45 cases. This is out of approximately 16,000 cases that were reviewed in detail and 36,000 cases if we count hospital, college, and civil legal actions. The physicians involved were across all specialties. They communicated with their patients through telephone, e-mail, online platforms, and also social media. (Inaudible) percent of physicians during that time period were actually using telemedicine with the phone. Ninety-one percent of these were college complaints.

03:03
Now, it – it bears attention that three-quarters of those cases, our peer experts were critical of the care that was provided. So we have room to improve here. Diagnostic issues rise to the top and make up for a quarter of the patient safety concerns in these – in these files; also issues of communication, documentation, and just not meeting regulatory restric—in—indications.

03:40
So now that you know a little bit of what gets us in trouble, or what our experience has been so far, let's move on without further ado to our keynote speaker.

Keynote Presentation - Virtual Care in Canada: Lessons from the COVID-19 Pandemic

0:00
Dr. Guylaine Lefebvre:
Mr. Cli—keynote – Mr Seam—Seamus Blackmore – excuse me – Atlantic Canada Health Consulting Leader at Deloitte. Seamus, over to you.

00:12
Seamus Blackmore:
Thank you very much. Oh, there's a bit of an echo. If you could – if you could mute your mic. There, OK. Yeah, if we could just go on to the next slide, I can begin the talk.

00:29
So I'd like to start, maybe tell you a little bit about myself, and I would also like to say thank you very much for having me here to give this discussion. It's a very big honour for me to be included in such a wonderful group, so thank you very much. A little bit about me. That's my smiling, red-haired family there, and I don't think there's any mysteries when it comes to who they look like. I'm a computer engineer by trade, and I have done quite a lot of digital health transformations over my career. I am the Atlantic Canadian Health Consulting Leader for Deloitte. I also have a few other hats that are pretty relevant to the talk I'm going to give today, one of which is I'm a National Health Technology Industry Specialist at Deloitte. People often ask me what exactly Deloitte does. I find it hard to answer, but one of the core things we do is consulting. And consulting, for me, is primarily just giving advice as an expert in certain scenarios. The expert advice that I often give is expert advice around digital health, and virtual care in particular.

01:39
The types of clients that I work with are very large government clients, so provincial governments, national governments, large regional health authorities, and other large care provider companies. I also work with private sector clients, private care providers, not so much in Canada but globally. And I work with large device companies as well, so biometric devices, remote monitoring devices, things like that. I hope I can provide a slightly different perspective than what you normally would hear. I don't have a clinical background. I'll be coming from a technology and – and engineering perspective. And my talk originally was going to be around where virtual care is going to go within the next five years. I think a lot of that has gone out the window, so hopefully we'll have a very interesting talk about the retrospective of what has occurred over the last six months.

02:33
Another key thing about myself is I'm the Chief Architect nationally at Deloitte for our Assets and Solutions. And before I joined Deloitte, I was the Chief Technology Officer at a international telemedicine company called FoneMed. Some of the relevant experience that I've had within virtual care, I've really worked on almost every aspect of virtual care in terms of the technologies that provide those services. I've done systems that do nurse advice, physician escalation, maternal wellness programs, cancer care and navigation programs, patient education systems. I've done PHRs, EHRs, EMRs, HISs, CISs. If it's got a three-letter acronym in health, there's a very, very good chance that I've implemented it or provided advice on how to implement it. So that's really where my background sits.

03:26
Some of the very relevant projects that I've worked on to this talk, particularly around COVID-19, I worked on the – the Center for Disease Control in the US, their Flu on Call system. So their Flu on Call system primarily handles epidemics and pandemics. We implemented it during Ebola, but unfortunately we had to use it here with – with COVID-19. Also, one of my largest projects, I architected the National Cancer Screening and Population Health Screening Program in New Zealand. And what was really interesting about that is that they used that technology to do their COVID-19 screening. So I'm quite proud that they were able to adapt some of the architecture that I built for them to use those systems to help the – help in the fight against COVID-19. If we could just go to the next slide, please.

04:24
And I'm sorry, but there will be a little bit of delay, so I'll just pause in between the slide breaks, if that's OK. So I want to take a moment to talk about what exactly virtual care is, what is has come to mean. It's a word, unfortunately, that has a very blurry definition, and it's a term that I really don't like. You'll hear a lot of synonyms to virtual care be passed around, things like virtual health, telemedicine, telehealth, e-health, digital health. They – they don't all exactly mean the same thing, but they've sort of become a group of terms that nobody has a very clear definition on what that means. The way that I like to think about it is any interaction with a patient that is not done in person I qualify as virtual care. But I – I tend to take the broadest perspective of it, simply because I'm a, you know, a technology nerd, and I don't think of it as purely from physician to patient, or even from, you know, nurse practitioner to patient. I think of any way that a patient is getting information provided for themselves for care over some kind of virtual medium. So I include things like remote biometric devices. I include things like decision support systems, care navigation systems, things that might not be day to day for your average physician but are very relevant to this talk, particularly in the times post COVID. If we could just go to the next slide, please.

05:56
So one of the things that I fee—feel about the virtual care word as well, and why I – I try to give a definition around it, is I don't like the word because virtual, when you use it in layman's terms or use it in language, typically means not as good as, or maybe second best. You hear things like oh, it's virtually the same, which actually means it's not the same, right? The reason I don't like that when it comes to virtual care is because very often the best way to provide the care is actually through these virtual channels. I would say that there are countless examples where virtual care has many advantages over regular care.

06:36
Some of the – the ways that virtual care can be better is that it, you know, at the simplest, is that it actually improves access to care in a way that is incredible in a very large, rural country like Canada. We have a huge population that do not live within a reasonable area to where they could access care. Particularly in my home province, the – over half the population lives within rural areas, and access to quality care is very difficult. So when I think of virtual care, I think oh, well, that's actually a solution to a

fantastic problem. And I really just think of virtual as the medium, and care as what we're talking about, so it's best point of access for care.

07:15
Another great advantage to virtual care in general is that it has the ability to make it more convenient and more accessible in ways that you wouldn't think. One of the aspects of virtual care that I like the most is it tends to remove some of the perceived shame or perceived weakness that some individuals have around their own health conditions, particularly things like mental health. The ability to – to get care without having to go and look somebody in the eye and explain a very personal situation to yourself has allowed many people to access care.

07:52
Over my career I've worked on many, many things like suicide hotlines and mental health applications where we've been tracking patients and making sure that they get the care they need proactively with outbound programs and – and nudging – behavioural nudging and things like that, where the patients have really gotten a huge benefit from the medium itself. And that's why I really don't think virtual care will be a word that even stays along for that long. I really think that over time, just like how we think of the smart phone, people don't use the word smart phone anymore; they just say phone. Over time, virtual care will become so ubiquitous that we won't even call it virtual care; we'll just call it care. And I think we're starting to see that now in a – in a post-COVID world, or a during-COVID world.

08:43
Another key aspect of virtual care that is very important, and I don't think is quite understood by most, is that, because it so dramatically can improve the utilization of the health care system through access, that there's always been a bit of a pushback politically. The reality is that the health care line item for virtually all of the provinces on their budgets is a very, very large item, typically the largest. In my province alone, it accounts for 40 percent of the budget. And since we operate at a very large deficit, it's actually 50 percent of our revenue. And so when provinces think about virtual care as a line item, they often have pushback against virtual care. And so we've had a lot of artifici—artificial barriers put in place around virtual care that I don't really think need to exist, and I think post-COVID we're going to look back and say yeah, I – I think those were bubbles. If we could just please go to the next slide.

09:49
OK, so I'm going to take a moment to talk about disruption and really where the technology is going. When I was asked to do this talk, I had given this talk a few times before, and I always pointed to what I call the ten-year rule. The ten-year rule was that if you saw it in Walmart or you saw it in the market, you know, just on its own today, well, in ten years from now you'll see that technology make its way into health care. And I usually would use those kind of market predictions to try and predict where the health care system was going from a digital perspective, and that has been a very good rule of thumb. But the truth is that, because of COVID-19, that ten-year gap has shrunken so small that it's basically not there at all anymore. We've got Public Health procurements

that are happening at the same rate as consumer electronics. Some of the examples that you would see would be things like Zoom. We've got provinces buying very large bulk licensing deals with Zoom, which is, again, a consumer market company, and they're moving at pace with the market, which is absolutely incredible.

11:05
So for this talk I had prepared, you know, fancy graphs, models to show where we were going to be three years, five years, ten years, but I don't really think much of that applies anymore. The fact of the matter is we're going to have to throw out our models because we've hit a precipice. If we could to the next slide, though.

11:25
So even though the models will no longer accurately predict the timeline, most of the concepts of the models still actually make sense. One of the key things that I like to point out that some people are not aware of is that we're actually in what they call the Fourth Industrial Revolution. And one of the key pillars of that statement is around digital health, and – and virtual health in particular. And one of the things that people don't realize is that we are today within what some people call the singularity, or within an exponential asymptote from an innovation perspective. The reason that we are in that space is because it night—might not be obvious, but many innovations actually multiply the overall ability for our population to innovate in general. And that means that, when we continue to innovate, we then innovate faster and faster and faster, and we're at one of those points right now.

12:27
There are many obvious examples of that that you'll see just in general, things like artificial intelligence, hardware manufacturing for computer electronics, things like network bandwidth, things like, you know, 3D printing, things that don't necessarily seem related, but the fact of the matter is innovations at all in any of those spaces provide easier innovation in the rest of spaces. And so what we're seeing is a very, very, very rapid innovation cycle across the board.

13:02
One of the reasons I bring that up is because virtual care sits in between the crossroads of some of those very important trends that we're seeing. So things like artificial intelligence, that come up all of the time. It does tend to be a bit of a buzzword, but it has real effect in virtual care. The core example I like to give for artificial intelligence, although there are many, is within the decision support system space. I've worked on decision support systems within virtual care for a very long time. I've actually developed some of them myself. Historically they would have been protocol driven. So you'd take things like the Schmitt-Thompson protocols, or some pest—best practice guidelines for a particular disease or a particular condition, and you would generate advice based on those protocols. So essentially what you're talking about is generating a script.

13:52
Well, in the last year to two years I've seen a very rapid adoption of a new type of technology where decision support systems are actually based on artificial intelligence,

where these intelligence platforms are digging in and understanding a patient's health state and providing real care advice at a very-near physician-level quality. There have been independent studies that I've seen on particular technologies where it's as accurate as 97 percent of a independent panel of physicians. And that's today. I genuinely believe within the next five years you're going to see that spike through the roof. And the reason why that's so important for virtual care is that virtual care is done through digital channels, and it's a very natural place for having things like access to care pyramids, where the right level of care is provided. So you don't always need to be talking to a physician or a specialist. Oftentimes a nurse will work, or even some kind of chatbot. And it's in that chatbot space where we're seeing a very, very rapid expansion of capability. And a big portion of that is due to artificial intelligence and some of the other examples I gave.

15:05
Another important one that doesn't come up enough, people don't realize how related to virtual care it is, is things like personalized medicine and genomics. Once you start understanding that virtual care will unlock the data that really allows us to understand an individual, you'll start to see things like genomics and – and someone's own DNA sequence being directly interacting into their care plan. And same thing with the pharma space as well: we're seeing personalized medicine that goes with that. Right now they all sit in separate fields, but I've actually been working on systems for clients where they start to have very big crossover. I'm seeing pharma clients who are providing concierge health service. They have their own virtual care call centres. I'm seeing provincial systems that are looking to do high-risk screening, including genetic screening. So we're seeing a real crossover and a blurring of the boundaries of what would typically have been individual aspects of virtual care. If we could go to the next slide, please.

16:11
One of the key things that I want to have take away from today is that it's not understood by most the value of the network of the people in virtual care. To the point that was made before this talk, the expansion of virtual care, I'm really quite curious to see what is answered into the survey, but from the surveys that we've done at Deloitte, we've seen a huge expansion from two, three percent of people using virtual care and – and not using it very actively, to almost, you know, the majority of Canadians at this point are using virtual care, and using it actively.

15:51
So we're talking about a network growth. And the reason why that's important is you see this in – in other technologies very often. The value of a network is proportional to the square of the – the amount of people in the network. So things like Facebook and Twitter and, you know, You Tube, and TikTok even, you know, these new systems, the value is the network itself. And something that's not understood about virtual care by most is that we have dramatically increased our network of people using virtual care, and we've done it basically overnight. The reason that's important is because there's going to be huge value to the health system in the data within that – those systems.

17:35
I do think there's quite a few moral and ethical considerations around that, but I'm here just talking from an engineering perspective, and I can tell you that there will be organizations and companies that are going to be using that data to generate things like virtual care plans and, you know, remote interactions with their patients, just automatically. So we're on a very interesting cusp, and I think the next two or three years, once both provinces and RHAs and – and large provider companies start to realize the value of that network, we're going to see a real boost to our health care system. If we could go to the next slide, please.

18:21
Oh, great. So I want to take a moment to talk about the Canadian landscape. If we could just go to the next slide. So within Canada we've had virtual health, telehealth, telemedicine, whatever you want to call it, for quite a long time. It's actually been, you know, over two decades that we've had it be commonplace. What's changed in the last while is actually that the barriers that were preventing it from going to a mainstream have been knocked down with a wrecking ball. I'm going to take a moment in a – in a few slides to talk about those specific barriers, but just the – the facts alone, we're seeing widespread, rapid adoption of virtual care across the country, every province, every territory, every RHA, and in places that you wouldn't even think. I have private clients, you know, Fortune 500 companies, that are even implementing their own virtual care systems and – and protocols. We're seeing care go into private companies. It has become a very strange landscape for the – for the country.

19:29
Historically, virtual care, because of those barriers around public policy, has created a niche where private companies in Canada have provided virtual care. And were coming to a head almost, where we're having a crossover between the private companies, the public funded provincial health care systems, and then these sort of niche technology companies that sit just outside. And their – the lines between them are blurring, particularly in Canada.

19:59
One of the good things is that we can look down south and we can look at the United States, and they have been doing things with virtual care for a long time, simply because it's a cheaper alternative and they have a private health care system. So we can actually make quite a few predictions on where virtual care is going to be going based on what happened in the US if we apply a Canadian lens of a public health care system and a provincial – particularly a provincial health care system, because we don't have a federally mandated health care system.

20:27
Some of the things that we're seeing is provinces doing very, very quick, rapid rollout of virtual care systems. I don't think that the systems that are in place today are going to last. I think that those were Band-aid solutions. But I have already seen many provinces put out RFPs and RFIs for the next wave of systems, something more enterprise, something more integrated, something with more of a provincial plan, so that all of the

data that you would be capturing through these virtual care systems are more in tune with the documentation systems that they already have in place, things like EMRs, EHRs, and – and other systems – lab systems, particularly with COVID-19. If we could go to the next slide, please.

21:20
So – OK, there we go. So again, I – I don't come into this from the typical perspective of someone who's providing care. I come in from a technology perspective and somebody who offers services globally, working with, you know, national governments and – and large companies. And one of the jobs that I've always had is to try and predict where the markets are going. And while the market itself typically is not that interesting for someone who's providing care, I think we should all be paying attention in the near term certainly.

21:57
One of the things that we're seeing is that, even though we're in a global recession and the markets are completely volatile and they're – you know, it's just very hard to predict anything from a market perspective, we're seeing huge investments in virtual care. Some of the examples are of course public. So the Canadian government, in the immediate term, you know, they invested a couple of hundred million dollars. The provincial governments, I would say, cumulatively are in the same range across Canada. But even in the private space, we're seeing things like Teladoc, which is one of the largest virtual care providers in the world. They have just had a merger acquisition for $18 billion. Companies like Zoom, I mean, Zoom was something that you would never even know the name of six months ago. Only people who were in the space would know what Zoom was, and now it's a household name. It's – it's at the kitchen table. It's something that people talk about every single day. It's one of the fastest-growing companies in the entire world.

23:01
Even the large players, so things like Microsoft, they have taken their products, like Microsoft Teams, and they've started doing huge investments to have direct integration into things like EHRs and EMRs. They're trying to bring the circle of care directly into their platforms. And this is not a coincidence. The reason why I'm talking about markets, which are normally not that relevant to care providing in Canada, I think they're extremely relevant today because, if you can – if you want to predict where technology is going, you have to try and predict where the money is going. And for once, the money is going in very obvious places. So I would expect a huge amount of innovation within virtual care, and digital health in general, over the next three or four years. It's going to be a little, mini boom within the economy itself. If we could just to on to the next slide, please.

24:00
So last year I was giving a talk on virtual care, a very similar talk to this, and one of the question I was asked was when will we see widespread adoption of virtual care. And the answer, which, for some people in the room, was quite shocking, is that we already had that. We've had that for years. It's just not the way that most of us would typically define

it, particularly those who work in the health care space. The reality of the situation is that, for many years, most of us already have virtual care in our life. It's just it's done through consumer electronics.

24:37
I would wager that well over 90 percent of the people listening to this talk today have a biometric device on their person, or in their hands even. The telephone that we have today, these iPhones, these Samsungs, the smart watches, the Fitbits, the garments for those of us who are runners, all of these things are virtual care devices by any definition. You take the iPhone, for example. It does things like track your heart rate, it does things like track your sleeping. It even provides you care plans on how you should be trying to h very preventative health and – and be a healthier person.

25:18
One of the things that really struck me the most about these devices is that they're collecting mental health information on just about everybody. They want to be able to use that information for, you know, consumer reasons. But the reality is they are doing that now. They – they're tracking your mental health by checking your screen time, by seeing what sites you're watching, by how often you're interacting with your family. I mean, the reality is we have been surrounded by virtual care devices for a very long time.

25:50
And what I think is going to happen is that that consumer electronics space, which has just sat on its own, because of COVID-19, it's going to be rapidly bridged by the provincial and federal government and care providers within Canada. We're already seeing it. Deloitte, for example, we – we implemented a COVID-19 tracking application for the phones in Alberta. That's one example, right? Again, we did the same thing in – in New Zealand. And that is a real first in a lot of ways. We're talking about the provincial government – and now of course we all know the federal government doing it as well – actually building on top of the health technology that already exists in the hands of the entire Canadian population, or for the most part, most of the hands of the Canadian population, for the point of actually implementing, you know, a health policy. And that's absolutely incredible, and I – and I don't think that that's going to change.

26:50
One of the – one of the things that I'm seeing just generally is that those barriers that would have existed and had – were so strong to hold back virtual health for, you know, 20 years or more, have just absolutely been knocked down. You know, the best example would be the fee code negotiations. First off, there – there have been provinces that had fee codes in place, particularly in – in BC, in British Columbia, and there have been other provinces that had sort of niche fee codes that you could use. In Newfoundland we had one. But there wasn't a widespread adoption, and – and certainly there was a hard negotiation that's been ongoing for years about how you would structure virtual care based on our current payment systems. And it seemed like, you know, a task that just was so gargantuan and – and couldn't be knocked over. But the

reality is, as soon as the – the, you know, political will became to – became a reality, it happened within weeks.

27:55
I was on the phone with provincial governments and colleges, and I was being asked advice around virtual care, and I was hearing that, yeah, negotiations had occurred, and it had taken, you know, one week in some cases, two weeks in other cases, but an incredibly short period of time.

28:12
Other barriers that we've seen knocked down are ideas like – that are still important but they've changed dramatically, things like patient safety, patient risk, PHI exposure. Some of these things are very relevant to the CMPA, and I hope we'll be talking about those during our – our panel. We've seen things like Zoom that have been adopted by provinces virtually overnight; widespread use for physicians across the country. And we know for a fact that Zoom has many security issues, or at least has in the past, things like being able to turn the camera on somebody who has Zoom installed without their permission. So that's an obvious risk.

28:55
But what actually happened during, you know, the – the height of the exponential explosion of the COVID-19 cases within Canada, the bigger risk would have been to do nothing. And so clearer heads prevailed, and the most important thing would be that care providers could provide care, and the fact of the matter was that Zoom, while it wasn't a mature application at the time, it was the most readily available. And so we saw widespread adoption across the country, even with those known security flaws. And we're seeing the same thing with things like Microsoft Teams, with Google Hangouts, with even the basic on-phone applications like Facetime. So a lot of those barriers, I feel, have actually been bubbles all along.

29:41
Now, I don't think that these Band-aid solutions that we have are going to last. I do think that the provinces are going to have to come back with really strong public policy, new procurements that are a little bit more robust and more integrated into the health system. But I don't think that we are going back. I think the – that the genie is out of the bottle. It granted a wish of, you know, universal health access, and I don't think the genie is going back in the bottle anytime soon. Now that it's been proven that those barriers can be removed if there's enough willpower, if there's enough, you know, political will, then, you know, there's no reason why they wouldn't stay.

30:20
One of the biggest barriers that we have seen is around the – the scare that the budget implications around virtual health could be dramatic for each of the provinces. I – I think the jury is out on that one. I do think we're going to have a blip where we will have higher health care costs for a little while. But the reality is, based on some of the things that I was talking about before, with all of the data, with all of the optimization, with all of the care navigation that we can do through virtual care – by care navigation I mean

pointing the right person to help patient – we should be able to find huge optimizations on our health care system. I – I mean dramatic. In my province alone, we were looking at things like optimizing the appointments, so they would no longer have missed appointments. Can you imagine that from a cost perspective?

31:13
There's a million ways where you can use the digital information, the optimization, the AI, all of those innovations that I talked about in the previous slide, to really tweak the health care system to the point where we're providing much better health care for all of the patients and drive simultaneously the cost of the system down. I don't think it's going to happen overnight. I do think we're going to see a blip, and I think there's going to be a pushback from a policy perspective. But as long as cooler heads prevail, I think that this will be the way forward, where we have virtual care as one of the core ways that we deliver care. Could I go to the next slide, please?

31:54
So I just wanted to wrap up with some conclusions, particularly around some of the slides that I was talking about today. One of the most interesting things for me has been the shift in the – in the client perspective. So again, I – I work for a large service company. My clients are the provincial governments, the federal governments, national health organizations. Historically these clients have been very, very risk adverse [sic] and very slow to change. That's where that ten-year rule of thumb would come when you say, well, when it's going to be in the health care system. People often safety to me my dentist will text me automatically if I'm going to make an appointment; why doesn't that happen in my – you know, in my hospital, why doesn't that happen at the ER? Why – why isn't that the norm? Well, it will be. It's just it's a delay.

32:44
What I've seen with my clients is that they have shifted their perspective so rapidly overnight. I think of one client in particular. They asked us how they could shift their entire organization to be virtual, and they wanted to do it within three weeks. Another example, we did a very large implementation for the Ontario government. Large health care projects typically take years, and they usually cost, you know, tens of millions of dollars. That project, which typically would have taken at least a year, we did it in six weeks total. We went live in three weeks. And this is with a client who normally wouldn't even have their requirements done within three weeks. So we've seen huge changes in the behaviour of the organizations that actually run and make these policy changes, so I'm hopeful that, you know, that won't change too far back. I known that they will go back to their old ways somewhat, but they've seen the light, I believe.

33:42
Another key conclusion is that those barriers have been knocked down, that the rate of change and transformation around innovation is going to continue to accelerate. It's very difficult at this point to – to even claim to understand what's going to understand within three years. I would say we have an idea what will happen within one year, but even that is very difficult to know for sure. There are huge technology drivers that are happening right now, things like quantum computing, quantum teleportation, you know,

things like cloud technology. They're – they're affecting everything we do, and virtual care is not going to be something that's not affected by that.

34:24
Another core conclusion is that – this one is an opinion, but I believe it to be true. I think there's an opportunity for huge economic boom around virtual care. It's a – it's a small – you know, a small candle light inside of a storm. Virtual care not only can be a place where Can—Canada can be a leader and can innovate; it's a place where we can actually reform our own health care system. And, as I said before, for most provinces, that's the top line item for – for their budget, right? So any area where we positively affect health care – and I think virtual care is the best way to do it – will have a huge impact on the overall health of a province.

35:09
I've always said that a healthy province is a strong – is going to be a strong economic province. And I – I truly believe that, and I think that we're at a turning point right now within Canada where a lot of provinces can make big changes within the health care system, and there'll be public will to allow it. Those barriers with risk and privacy, they're still there but they're not the same as they were before. And the leadership of these organizations have seen ways that they can act quickly and they can accelerate innovation within the care space.

35:43
Just another quick conclusion, and – and then I think I'll wrap up this talk. One of the things that I'm seeing is that – oh, I'm sorry, there's an echo. One of the things I'm seeing is that COVID-19 has created a health care shift within the entire country towards digital health transformation. And it's not just within the public health care space. We're seeing very large investment within the private care – health care space. We're even seeing companies that have nothing to do with health care at all having, you know, health advisors be hired on and creating their own health care protocols on how they do things like virtual lab tests for things like mining sites and oil rigs. It's – it's an incredible time for Canada, and it's going to be very interesting to see where we go within the next year to two years.

36:34
So thank you very much. I really appreciate the opportunity to speak to you about this, and this is a subject that's very near and dear to my heart. If you do have questions, we're going to have a chance so that you can ask them during – during the panel sessions. So I'm looking forward to some questions. Thank you very much.

36:52
Dr. Guylaine Lefebvre:
Thank you so very much, Seamus. Your – your optimism and energy is palpable. Thank you for that. We will hold the question period until after our panellists have had a chance to speak, but I'll invite you to put your questions forward if you'd like. There is a vote – you'll see that there's a Ask a Question button on your screen. You can click on that.

Please put in your name and your question, and we'll do our best to address as many of those as we can once your panellists give us their insights.

37:27
And so I will spend just a couple of minutes going over the answer to the poll. Provi—are you providing virtual care? So 81 percent of you are providing virtual care: only 36 percent by phone only; 39.8 percent are using a combination of approaches; and, 3.5 percent have answered yes via web platform. There's only one percent who say they – they use e-mail or text message only.

38:06
And our que—our second question on why you're here, the majority of you have answered B and C: you're concerned about the medical legal risk of virtual care and concerned about the safety of care in a virtual context. A third of you have no specific concerns but wanted to see if you're missing something, so hopefully we'll be able to answer that question by the end of our session today.

Virtual Care and Medical Regulation

00:00
Dr. Guylaine Lefebvre:
We'll now move on to our first panellist, Dr. Heidi Oetter, who is Registrar and CEO of the College of Physicians and Surgeons in BC. Heidi, please.

00:19
Dr. Heidi Oetter:
Can you hear me? Thank you, and it's a pleasure to be part of the education session of the Canadian Medical Protective Association. There is no doubt that COVID-19 has accelerated the widespread adoption of virtual care in Canada, and I think that we are really truly in a very interesting time in the delivery of health services in Canada. I'll take the next slide. And the next one.

00:50
So I – as Registrar of the College in British Columbia, I am a member of FMRAC, the Federation of Medical Regulatory Authorities of Canada. We are an association of regulators, and we work together collaboratively to, on the public's behalf, bring about the best that we can in the regulation of medical practice in Canada. And just to say that we do have the crisis of the Constitution in Canada, so we don't have one approach to delivering health care in Canada; we have ten provincial approaches and three territorial approaches, but we do try wherever possible to develop common standards and best practices for medical regulation. The next slide.

1:39
As I said, there's no doubt that COVID-19 really accelerated the widespread adoption of virtual care in Canada. And really, prior to COVID-19, I think much of the narrative and discussion in health care was really about telemedicine versus face-to-face care, and people being quite deliberate about saying which was the better or which – which was a

more effective platform for delivering care. And COVID really changed all of this, and, I have to say, in a very disruptive way. I think we can really say, now that there's been a taste of virtual care, both physicians and patients want to see it continuing. And as long as we continue to have waves of outbreak of COVID, virtual-first care I think is going to be an important aspect of care delivery in Canada. It's going to be there for screening patients who may have COVID-related symptoms, particularly as we enter the cold and flu season, so that people are appropriately triaged to areas for assessment. I think one of the biggest things that we've seen is that patients were often afraid to seek care during the first outbreak of COVID because they were worried simply about being exposed to COVID when they went to seek medical care.

3:07
We know that physicians can complete at least part of an assessment, if not the entire assessment, through the use of virtual technology, and that will be an important aspect of care going forward. And lastly, we are still trying to make up, I think, for care that was put off, and it's an opportunity to prioritize those patients who need to be seen in person in a risk-based fashion by using virtual means. I'll take the next slide.

03:40
So what does the College expect of you, a physician in Canada? Well, first of all, we expect you to comply with licensing requirements. And I think it's important that, when providing virtual care outside of your host jurisdiction where you are licensed, that you are aware of what the licensing requirements might be. They do vary by province. You can always contact your provincial medical regulator and they can let you know what the expectations are. Likewise, you can always call the Canadian Medical Protective Association for their expert advice.

04:12
We do expect physicians to comply with standards and guidelines for virtual care, and those are all available on each of the medical regulatory authorities' website. And just a reminder that we expect the quality of care delivered virtually to match that as if it was an in-person assessment, subject to whatever the – the local prevailing COVID expectations are. I'll take the next slide.

04:40
What we've – what we have seen from the College's perspective is that there are – there are times when patients actually do need to be seen in person, and, for that reason, we make the – the observation that virtual care, in most instances, should be in a – provided in a situation such that the person, the patient who's being assessed by the physician, can make arrangements for in-person assessment if that is what the patient needs at that time. We know that there are some times where it's simply not appropriate to provide the care entirely virtually, and we know that there are concerns related to prescribing, ordering tests, and follow-up.

05:28
The second issue that we have seen is related to just – just how skilled are physicians in actually providing virtual care. As noted previously, for many physicians, that virtual

care has simply been using the telephone to provide care. And we know that it's better if physicians can actually be using a video-enabled platform to provide their virtual care. So our questions back to the undergraduate, postgraduate, and continuing professional development departments are: how are you teaching physicians in practice to be able to deliver virtual care; and likewise, what are you doing to make sure that those people who are in the undergraduate and postgraduate programs are being taught real time the ability to provide virtual care. I'll take the next slide.

06:21
In terms of licensure issues, what we've experienced with COVID is that most of the virtual care has in fact been provided within the jurisdiction with which the physician has been licensed. We know that not all provinces developed fee codes for telemedicine. Most did, however, in the long run. But just because you may not need a licence to do – or to – hold multiple licences to do virtual care into multiple provinces, we know that that doesn't necessarily mean that you will necessarily be paid for doing telemedicine across provincial boundaries. And that, again, is the constitutional crisis that we have in Canada. And as long as health care is still a provincial and territorial matter, there may be payment issues related to licensure that have nothing to do with what the College's expectations are. The next slide.

07:19
We – we take our role of protecting the public and ensuring patient safety quite seriously, and we have put together an expedited review of our current framework on telemedicine to make sure that the quality-of-care issues that we are identifying to – can be addressed through revisions to our current expectations for telemedicine in Canada. And with that, I'd like to say next slide and thank you very much, and I look forward to the panel's discussion.

Patient Visits Reimagined by COVID-19

00:00
Dr. Guylaine Lefebvre:
(Off microphone) very much, Dr. Oetter. Our next panellist is Darren Larsen, who will speak to us on his perspective as a user of – of digital and virtual health in your – in your own practice, Darren, and also your – your leadership of OntarioMD.

00:21
Dr. Darren Larsen:
Thanks a lot, Guylaine. Can you hear me well? Awesome. Thank you. So it's a real pleasure to be here, like all of the other panellists in front of me and following behind me. It's – it's an exciting time to be talking about virtual care. And I'm always asked to discuss the on-the-ground sort of practice experience of what virtual looks like in our practices and what the future is probably going to look like, now that it came upon us so very quickly.

00:42
I work for a company called OntarioMD. We're owned by the Ontario Medical Association. We're funded by the – by the agency, Ontario Health. We have done for the last 15 years a lot of implementation of digital tools. And even though we don't own digital tools or – or actually control some of the – the rollout of these products, we think we have a – had a lot to do during the time of COVID at helping doctors implement and onboard products as quickly and efficiently as possible. I'm going to ask for the next slide, please.

01:11
So when COVID came long, we know there was a lot of stuff happening already. Doctors' practices were changing dramatically. We had digitization of medicine in ways that we'd never seen before, not just moving to EMRs but going well beyond that, with many other tools for patients, for providers at the health system level that were – that were digitized, so that we were able to access more information at the right time for the right patient and the right problem.

01:35
The health system is transforming in virtually every single province. In Ontario we have complete reorganizations of the structure of delivery of care from the highest level of government down to the organizations of family health teams. As new accountable care organizations, called Ontario Health Teams, were being contemplated and begun to be rolled out over the year prior to COVID happening, we also have seen, as we already know, an explosion of data, and the ability to use that data for care is actually one of the most paramount concerns that we had in medicine, just to know that we were offering, again, the care that was appropriate to the patient based on his or her own profile. That's the profile in their over time. That's the data that's being collected for them from the hospitals systems, from our – our own individual offices, and across the board. As they move from care environment to care environment, that data needs to follow them. We were well down the path of beginning to organize that at the time that COVID hit us.

02:31
And of course patients are getting smarter. They're getting more active, they're getting more engaged in their health care. They're monitoring every single heartbeat, blood pressure, and respiratory rate, and that's coming to us on a daily basis in – especially in primary care, but across all the professions, to help them interpret. So as docs were trying to consume all of this and gradually change their practices over, something big happened. Next slide, please.

02:53
On March 12th, March 13th, we saw the shutdown of many of our hospitals, of many of our most paramount and deeply ingrained health care structures at a time that we didn't know what this pandemic would look like. We knew there was disease happening south of the border that looked horrible. We had looked across to Europe and had been a disaster in Italy and parts of Spain and – and areas in Germany. We could not let that happen here. So immediately the health care system transformed. I like to say we went from zero to 89 in about two weeks, meaning zero is not quite where we were in using

virtual before – we were using about seven percent of our – of our time and our visits in the virtual space, including telephone calls; and we went to, according to a CFPC survey, around 89 percent of us using virtual care for – for 80 percent of our visits being virtual, in the space of about two weeks. So nothing was the same for us as doctors. Next slide, please.

03:50
But also important to remember that also nothing was the same for patients. Just as we were trying to figure this out, so were the people we were looking after. And as you know, and Dr. Oetter had already said, patients were afraid sometimes of coming to see us. Sometimes they weren't sure if they wanted to be in our offices at all for fear of coming in contact with other patients. So virtual exploded onto the scene. Next slide, please.

04:15
I had a really fun time in my job with OntarioMD to try to help doctors along. We rapidly created a new website called OntarioMD.news. It started to aggregate virtual care products in Ontario. We have over 25 of them available to us. We created webinars using our Peer Leader program to teach doctors how to use virtual more efficiently in their practices. We created, with the Ontario Medical Association and the Ontario Telemedicine Network, an Ontario virtual care clinic to get unattached patients to care. We worried particularly about 300,000 Ontarians returning home during COVID, either because they were ex—they were living away and had come back because they felt they were at risk at where they were, or they'd been travelling and came home during the time of the pandemic.

04:57
We also did a lot of work in releasing and moving data around, moving ol—COVID results through the Ontario lab information system directly to doctors in near-real time. We helped uptake – show doctors how to uptake many other digital tools, including the optimized use of their EMRs. We're getting to the certification of virtual care now with Ontario Telemedicine Network, and we're looking at the development of national standards as some of our people are involved in the task force and the – actually the multiple task forces being created right now via Health Canada and the CMA. Next slide, please.

05:30
But what does it look like to do virtual? What does a virtual visit look like? And we heard earlier then – that some of the doctors are using telephone for the majority of these cases. And – and I actually will be one of those propoments – proponents that says that's OK because what we really have to do during a time of a crisis like we've seen in the last four months is meet patients where they're at. We – we know that even a lot of homeless people, people on the street, have – may have one item in their possession that they own, and that's likely a telephone. It may or may not be a smart phone, but almost everybody in Canada now has access to a voice way of speaking to a clinician. So telephone for many in the north, where there is limited bandwidth for video is the first point of contact. And in a study that we did through OntarioMD, we saw about 90

percent of the calls that were – or the visits that were being done at the beginning were telephone, and, as the virtual care platform started to ramp up and be more integrated, video visits seemed to take on a greater and greater role.
06:26
I think that over time, as we find this new normal, we will find the appropriate mix of what can be done by phone, what can be done by e-mail or text message in a secure way, and what video has to offer. Video can be very secure, it can be private. At this point in time we still need to ask for consent using some of the platforms that are not medical grade. It can be very patient friendly if it's a click of a button and enter the system, and it can be clinician friendly. So we need to find the platforms that work in that domain. And more and more, we're understanding that the – the greater they're integrated into the point of care systems that doctors and nurses are using, the more robust they will be for the overall experience and reducing the burden, redurcin— reducing the newness of it, and hopefully leading to less of the burnout that we experience with rapid cycle change. New – next slide, please.

07:14
We also know there are a lot of items on the horizon, and – and going beyond the actual visit, as we contemplate that balance between in-person visits and what might happen on some kind of electronic or virtual space, we have to figure out how we start getting data into the systems, often by patients. Collaborative care records are probably the future of the actual integrated care record for patient, clinician, and other providers. Especially as patients move around the system from acute care to primary care to long-term care, even into palliative, end-of-life care, we need to make sure that patients have the right or the ability to access their data and – and actually contribute to their data.

07:52
I know many clinics now doing record keeping or the – the history taking in the parking lot, and only moving the patient into the examining room at the moment that they need to be examined, so as to decrease their contact with other patients and health care providers, providing more temporal spacing and physical spacing for the average clinic. This is all new for us. Add on to that we have the evolution of contact tracing apps that have actually now brought patients into our office, say this is flagged red, what do I do next? We're seeing AI-based chatbots helping with triage and the sorting of patients from one – one type of care to another. And it could be you start with a telephone call or an e-mail, you move into a video visit, and sometimes you have to come in to be seen. So the ability to put the right person in the right visit environment for the right problem is – is paramount.

08:40
We're seeing more and more clinics evolving into online scheduling systems, which allows more flexibility to maybe temporally space patients. So you might do a few visits virtually, a few visits in person, which gives them time to clean the rooms and move that whole extra space in the care environment forward without having to run into yourself or run into new patients in the interim. So the efficiency of a practice actually improves.

09:04
We're seeing remote monitoring coming along. There are a lot of virtual products now out there for the home care environment, for looking after patients. My own hospital, Women's College, had a COVID at Home program where, when you were seen to be positive with the COVID results in our testing centre, you were automatically assigned to the COVID at Home program. You'd be shipped a pulse oximeter monitor. You'd be contacted by a nurse or a physician two times every day to ask about your breathing status, your temperature, etcetera. And with that program, we had zero admissions to hospital. So there's some evidence that doing this well decreases the burden of hospitalization and acute care environments. And I've already mentioned the need for data to follow the patients. This is what's coming in front of us in the very, very near future, if not already. Last slide, please. Next slide.

09:47
The new normal for in-person visits includes of course the – the need to protect ourselves with PPE. We're limiting time spent directly in front of patients, yet we're trying to make that time the highest quality. It's difficult to be behind a mask and a face shield, and sometimes cloaked in gowns and gloves, and examining a small child with a cough. It creates a barrier between us and our patient care. And it's quite appropriate, I think, for some of the visits that we would do to be all virtual. For instance, mental health does very well with a video visit, more so than connecting with a patient in an office behind a mask and a face shield, in terms of your ability to truly connect and deliver their care.

10:25
We are creating physical and temporal space, as I said before, and – and we're trying to figure out in practice as we go how to bring these virtual tools into that same environment so that perhaps we can blend them. It may be that you are doing a history from a parking lot, using a video conference, or it may be you're using the telephone, or it may be that in fact you're able to offer really innovative programs like, you know, flu shot clinics in – in environments where it's very low touch and very quick turnaround, at the same time trying to keep patients apart, especially if we get a wave two of respiratory illness.

11:00
So the entire world has changed for us in – in primary care and specialty care. I have been incredibly proud of my peers as they have moved forward in a way that I never thought possible, although it tells me we were really ready for it. It just took a little hook, and probably a big push, to move ahead in the realm of virtual. And frankly, as Seamus said, the genie's out of the bottle. I say always the horse is out of the barn. Coming from Alberta, it's an easier one for me to say. Horse is out of the barn. Corralling it is not what we want to do, but perhaps putting a bridle and a saddle on it is the next real move as we get into the balance between virtual and in-person care over time. So on that note, I'll stop and hand over to the next speaker. Thanks so much for your time.

Medical Legal Issues

00:00
Dr. Guylaine Lefebvre:
We will move to our last-but-not-least panellist today, Maitre Boivin, who is one of our CMPA general counsel and will talk to us about some of the medical legal issues.

00:13
Daniel Boivin:
Thank you, Guylaine. It is quite a challenge to be able to define the legal framework around virtual care. And I'd like to be able to present a black-and-white checklist of everything that physicians must do, but unfortunately, law does not move that fast. Seamus was talking about how extensive the growth will be in the next few years. The law is always lagging behind that, so law will have to adjust pretty fast. The regulators have already started doing that, but I suspect that there will be a lot of precisions and – and details in those – in those reg—regulations, be it at the college level or at the – the provincial regulation level. And the courts, the courts always react. So the legal liability principles will be defined when the first cases hit the courts in five years, and – and the – the issue with the virtual care is that courts will have to decide an issue of virtual care in an environment that will be completely different from the environment that existed when the care was provided, given that the technology will have evolved tremendously in that period of time.

01:35
So I – I'm not able to provide a black-and-white list, but let's look at the framework of the l—the – the general principles. And – and one of the positive aspects of the – the pandemic is that it has forced the regulators to accelerate the thinking about virtual care and adopt basic principles that will need to be adjusted for sure, but basic principles. And also, the volume of – of virtual care that all of a sudden was necessary provided an incredible laboratory for the best practices, what works, what doesn't, in an environment where I'm betting that the judges and the regulators will – will have a degree of tolerance that's a little bit more elevated, given that physicians were really thrown into that – that environment in – in a matter of days. So that will lead to more flexibility for the evolution of the – of – of the – the principles.

02:42
So – so let's look – let's look at – at the big building blocks of – of legal principles that need to be taken into account in virtual care. And – and the first one is the issue of getting the information and maintaining it in a – in a confidential way. Now, we're moving from an environment where the care is provided in an office, where the physician knows that, once the set-up is done, that the encounter will be confidential. Other than having to worry about is the door shut or who's in the room with the patient, there's not much that the physician needs to worry about in terms of confidentiality.

03:29
With virtual care, the physician will need to worry about the – the privacy, the confidentiality of the exchange, with every patient. Because what makes virtual care good for the patient and – and acceptable for the patient is the possibility of accessing care from various locations. Darren was – was talking about the possibility of conducting certain pieces of the encounter in the parking lot. Great. Wonderful access. But the physician will have to be sure that it's an environment in which the information can be imparted in a confidential way. These confidentiality obligations are not going away.

04:13
The other aspect of confidentiality is the issue of the patient record. Where is the information kept? The – the obligation to maintain a patient record, a complete patient record, is – is not modified. But with the new applications, with – with the asynchronous poss—possibility of – of getting some information, where is that information residing? Is it transferred into the patient's medical record, the official medical record? All of these issues will have to be thought about when a certain platform or a certain way of delivering virtual care is – is being – is being adopted.

04:56
Looking at the regulatory issues, the – the jurisdiction issue is very much an issue that's front and centre, and has been in the COVID-19 experience. I'm – I'm very pleased that from – hearing from Heidi that FMRAC is looking at the possibility of – of expanding the possibility of – of providing virtual care in more than one province. Because while the patient – while the – the physical presence of the patient reassures the physician that the physician is not practising in another province, virtual care is something else completely.

05:39
From – from one day to the other, in – in border towns, for instance, or in university towns, when – when patients who, for instance, in the Ottawa region, live on the Quebec side used to access their care on the Ontario side, all of a sudden these patients are in Quebec when the physician in Ontario provides virtual care to that patient. That raises issues of is it possible for the – for the physician to – to do that. University students all of a sudden left and went back to their provinces, and – but they still wanted to access the – the care from their physician. And what to say with virtual care of all the snowbirds, who will be dispersed around – around the world, basically, and will want to continue the relationship they have with their – with their physician?

06:37
So the issue of jurisdiction is very important. It goes beyond the – the borders of Canada, but at least FMRAC is looking at resolving issues within the province. That will be – that will be a key aspect. And it's – it's difficult because the physician cannot control or verify where the patient is when the patient is accessing that virtual care.

07:03
Now, the – the other regulatory framework, basic principles have been put in place, but I – I suspect, as I was saying earlier, that, as new tools are being added to the – to the wonderful array of – of available apps and platforms, colleges will have to adapt to these very quickly because I suspect that patients will push for these – for these convenient apps quickly as well.

07:41
The issue of standard of – of practice, we need to go back to the very basic principles in order to understand what is expected of physicians at this time. There will be a – there will be a time when there will be a very specific and long list of – of things that need to be looked at, but going to the basics, the first issue is consent. Does the patient consent to the – to the use of virtual care, and does the patient understand that virtual care will imply certain limitations on – on what can be done? So obtaining and documenting the consent to the virtual care in Canada will be very important.

08:26
Does the virtual care encounter allow the establishment of an acceptable patient-physician relationship? I mean, it – I'm – I – the – that will be an issue with many of these platforms. It will be an issue with many of the asynchronous ways of getting information to the – the physician, for instance. It is an ethical obligation for the physician to establish an acceptable patient-physician relationship. I suspect that a greater access in – in many circumstances will improve the patient-physician relationship, but physicians will have to be mindful of that.

09:03
What of the quality of the information that's available to the physician? Does the application provide physicians with the – the appropriate information on which to make a diagnosis? And if we look at the experience that the Association has so far with virtual care cases, they really revolve around the – the quality of the information and the quality of the – the decision making on the basis of that information. So that will be very important. The use of bots, the use of automated decision making, does that rob the physician of certain information that should be available for the physician to make a decision? That – that will be key.

09:49
And finally, the issue of proper follow-up. We will need to ensure that the patient is – is properly followed up, that – that the – the end of the virtual encounter is not the end of what the – the – what the – the relationship will be.

10:08
Now, the other block that we'll – we'll have to look at is the issue of – of billing, because obviously physicians will want to be paid for the care they provide. And that's one aspect that often lags the development of – of the apps. I won't – I won't spend more time on the issue of billing, but it's very important for physicians to know that, if they – if they develop a novel way of providing care, they will not only have to ensure that they comply with the college and regulatory framework, but also that they comply with the

billing requirements, in order for them to – to get paid. So much, much to – to fill in to have a complete – a complete framework.

Question and Answer Period

00:00
Dr. Guylaine Lefebvre:
Just looking at the time for – for all of our participants here, we are quite happy to continue with the question period for at least 20 or 25 minutes. Recognizing that some of you may have to log off, we appreciate you participating, and we'll continue on once again. Sorry for our delay starting this. But there are a lot of questions coming through, and I look forward to the – the feedback from – from our panellists.

00:31
If I could summarize what we've heard into basically three buckets, I think I have heard that we all agree virtual care is – is about care. It's integrating virtual visits or telemedicine into face-to-face visits; it's not one or the other. And out of that, we recognize that there's a major challenge with prioritizing. Who do I actually need to see? How far can I go virtually and it's still safe? And Heidi brought up the important issue of education and making sure that we actually get our physicians able to provide that care as safely as possible. Choosing a platform, sharing data, you'll find lots of questions coming through on the ethical, privacy, and other considerations relating to actually getting this out there for all of us, out there with the scale of innovation actually growing as fast as we ever could imagine it would. And then, on a positive, like the positive effects of the pandemic, I hear a degree of tolerance to the fact that this has been a bit of a lab and – and how quickly can we learn from it.

01:45
So without further ado, I'll start with – I'll start with an easy question for Daniel which made me smile. So some patients feel it's appropriate to be in their pool or at Costco during our consultations. I'm not comfortable with this, and I reschedule these visits. Am I expected to work in these conditions?

02:02
Daniel Boivin:
I – I – that probably would not fill the requirements for a confidential, appropriate environment in which to provide – to provide a medical encounter. So the ethical obligation being to make sure that the environment is appropriate, it would certainly be appropriate to reschedule. Do it politely, explain why, but yes, rescheduling.

02:32
Dr. Guylaine Lefebvre:
(Crosstalk)

02:32
Daniel Boivin:
Yes.

02:33
Dr. Guylaine Lefebvre:
Question for Seamus. And it may actually be appropriate for our – all our panellists. What ethical/moral challenges to do you see in data mining, especially in the realm of mental health care, for example? How do we deal with these ethical challenges? And it accompanies an associated question relating to the fact that our – the data we input our – in our medical record is through EMRs, and the EMRs are meant to be private and confidential. So how do the two – those two things connect?

03:10
Seamus Blackmore:
Yeah, that's a very difficult subject, and I'm glad that it was brought up. The ethical (inaudible) on the data are quite severe, to tell you the truth. It's the reason why I've always felt that, by the provinces and public health system not being in the forefront of virtual care, that they allowed a bit of a niche for private medicine, even within Canada, to be done by private companies doing virtual care, was risky for ways that they didn't understand. And one of the biggest is that there are huge, already today there are huge troves of patient records that exist within private companies. And they are today being mined for all sorts of things: for pharma to use for clinical studies; for – for things like consumer applications.

03:39
I think one of the best examples is the DNA sequencing companies. People are worried that, when a sale of one of those companies ends up in some conglomerate, that that data can be mined and used for all sorts of nefarious, you know, consumer-driven activities. And I think they're right.

04:16
One of the things that I think we should be doing as a county, and then of course provincially, is getting in that space ourselves so that, when you think of, OK, where is the data going, it's not to some random, third-party platform, or to some – some company, that it does reside within the EMR, that it's controlled by either a province or by, you know, an RHA or some entity that we have some trust in. That's the first step, is that it should – they should be actively in that space, there should be standards federally as to how that data transfers, and there should be an understanding at a technology level. And Daniel's point about the fact that technology outpaces the law dramatically is very, very true. And we've seen that already.

04:59
My point around the consumer electronics and the consumer platforms, around the ten years, I – I like to point to Facebook and to Twitter and to all of these things. The data mining that we saw in those scenarios has had very real-world, severe consequences. And I think that we're at the point where we could have those type of consequences in

the health care system if we're not very careful. The amount of applications that exist today that are virtually unregulated, they might claim to be HIPAA compliant, for example, but there's not an audit done of them to say where and how the data's being used. Those companies are sold, so the terms on which the data is originally captured doesn't hold true for the company that buys them. It's a very scary place, and I – and I hope that it becomes a important thought for provinces from a, you know, regulation perspective and how to solve some of that problems.

05:57
Dr. Guylaine Lefebvre:
As a follow-up, what is end-to-end and crypton (ph), and how important is it, and can you comment on the se—the major security issues we need to be mindful of when we – when we set up with a particular platform?

06:11
Seamus Blackmore:
Yeah. I muted there, sorry. End-to-end encryption is – it's basically what it sounds like. When – when you're communicating with your patient, every step in between, all of the places where someone could basically hijack that conversation, it's ensured that it's secure. That's all that that means. So if you think about the way the Internet works, if – if you send me an e-mail, well, that e-mail has to hop through 200 machines before it hits my device. At any point in those 200 machines, if it's not encrypted, then some nefarious actor could take that information. And what end-to-end encryption basically means is that it ensures that along the way nobody can steal the information.

07:01
It's – the biggest problem with end-to-end encryption, though, is people think of it as a magic bullet, like a silver bullet. It's not. Over time encryption becomes weaker and weaker because computers become stronger and stronger. And so what's encrypted today and what's secure today will not be secure five years from now. So a patient record that was encrypted and captured will be vulnerable five years from now. And so I think that there is a lot of challenges and a lot of education that we need to be doing for our providers and for our regulators so that they understand the technological implications that exist. But the bare minimum we should be doing – and I really mean minimum – is end-to-end encryption on all platforms. If we don't have that, then you do not have privacy or security. That's the facts.

07:50
Dr. Guylaine Lefebvre:
Darren, I alluded to our patients getting smarter, and there's a question here for – would you have a recommendation for resources for doctors who – who want to work with their patients to find rel—reliable apps for self-management or monitoring.

08:09
Dr. Darren Larsen:
Yeah, so thank you. The – the self-monitoring applications, the self-monitoring application space is actually wide open right now. There isn't very much in Canada around the curation of these applications that – that patients are using. The closest I've seen has been one that Ontario Telemedicine put together. They – they have a practical applications store, essentially, where people can locate a few applications that have been rated by doctors and reviewed by doctors, and at least seem to be as – what they say they are. We are looking in Ontario at a new marketplace that will have all kinds of services, applications, etcetera, available to doctors, but not necessarily direct to patients. So it is unfortunately, as Seamus said, a fairly unregulated environment.

08:52
In terms of the virtual care products, our OntarioMD.news website actually does list the 25 or so companies that we've worked with. Most of those are national. So for the virtual care aspect, no matter where you are in the – in the country, most of those companies are available to you. But on the applications part, for home monitoring, it is actually still very much the wild west. So it isn't easy for us to say to a patient that one is great, that one isn't, and it is still a huge buyer-beware kind of environment, sadly.

09:22
I think one of the biggest reasons that no one really wants to take that one on is that there are so many, you know, hundreds of thousands of medical applications available to patients, and none of us seems to be able to dive deeply enough into these applications over time to say yes, this is in fact a good one, or no, it's not. We rely on the rating systems of patients in the app store to do that for us, which is probably not the best way. But because of the explosion in the availability of those various apps, I don't really see that being corralled very, very quickly, unfortunately.

09:51
Dr. Guylaine Lefebvre:
(Off microphone) this – this one's for you. How do we ensure virtual care doesn't lead to the loss of absolutely necessary in-person care? And it fits in with our global, you know, virtu—it's all care. There's a few questions that line up with this, one in – one of which is are regulators in a position to monitor issues with doctors being reluctant to return to in-person care. This – this doctor's specifically referring to maternal-infant health, which is problematic.

10:35
Dr. Heidi Oetter:
I guess I'll – I'll take a – can you hear me? Yeah, I'll – I'll take a stab at that. You know, I think that there are communities where the actual community transmission of COVID is – is higher than others, and I think that, from a regulator's – regulatory point of view, we do not expect practitioners to put themselves in harm's way to provide face-to-face care. And I think that it's always couched in "if safe and appropriate to do so". And I think that, certainly in the British Columbia context, we've – we've worked with the Public Health Office. We've put out a variety of messages at different times, depending on how

prevalent or not COVID was in the community. And you know, we've had the reality that sometimes even getting PPE, it just wasn't available to practitioners.

11:30
And I think that there's been good support from the doctors of British Columbia to encourage physicians, again, where safe and appropriate to do so, to provide face-to-face care. But it's a moving target, and as long as we continue to have what we see as moving waves of COVID, plus or minus a flu season, it's going to require careful, coordinated messaging. But bottom line is regulators do not expect practitioners to put themselves in harm's way. So for instance, if you are on immune modulating drugs, or you've just recently gone through chemotherapy, we would not be expecting you to have to see patients in person.

12:12
Dr. Guylaine Lefebvre:
Thanks, Heidi. And while I – I have you on unmute here, does FMRAC have a table or a list that would summarize what provincial licences are require—or requiring in one province to provide telemedicine in another province? Lots of questions on – on cross-border transfer or – or interprovincial care, I should say. Such a table would be helpful. (Laughs).

12:40
Dr. Heidi Oetter:
Yeah. We – we – sadly, we don't have one. And I think it does depend very much provincial by provincial because there's also, you know, expectations about, for instance, with your Manitoba licence, will you have CMPA coverage if you do telemedicine into Ontario or not. So there's so many different layers to that. So it's a great suggestion. We'll take it back to FMRAC about whether or not we could have, you know, an at-a-glance table on that. But it – but there al—are multiple layers to that, and it's really important that people at least call their local college or call CMPA to make sure that they're covered on all fronts before doing telemedicine anywhere.

13:23
And just to say BC is one of the jurisdictions that, as long as you are licensed somewhere in Canada, it's OK to do telemedicine into British Columbia. We know that you're accountable in your host jurisdiction. And – but whether or not you'll get paid for it is – is another issue.

13:41
Dr. Darren Larsen:
Guylaine, could I add to that, if you have a sec? So just on the question around, you know, are we going to actually get back to some sort of more in-person space, and I think it's important for us to remember there's a CMA survey that came out in mid-May that actually asked patients about their experiences in virtual care, and very enlightening to me. And they actually asked would you prefer a virtual or an in-person visit for your newly symptomatic problem, and 60 percent of them said, even during this COVID experience, they would prefer an in-person visit for the first visit of a new

problem, and then the follow-ups and things could be done more virtually, which is really interesting to me. So I think we always have to keep in the top of our head to remember to ask our patients what they need. And if we do that, we can pretty much never go wrong.

14:30
The next piece for us will be to figure out how to offer the right type of visit for the right problem, the right time. It might start with an e-mail or a text message, or it might start with a – with a telephone call, and then move into higher-order complexity of visits over time. So good thing to survey patients about in our own practices if we have the opportunity.

14:50
Dr. Guylaine Lefebvre:
Thank you, and I've said it before, I'll say it again: feel free to call CMPA with any individual issue that you may have. We're – we're here to – to talk to our members and – and provide as – advice, especially at this time, where things have been changing so rapidly.

15:09
Daniel, on – on that theme, when it's non-urgent, and there's adequate time to prepare for an appointment, and you have a prior relationship with the patient, should there be written or verbal consent if you do – if you move to telemedicine?

15:24
Daniel Boivin:
There should always be consent. That's clear. Consent should always be documented in the patient record. So if it's not on a written form, it should be documented in the record. And if there is time, well, CMPA obviously advises to – to obtain a written re—a written consent. And for physicians, there's – there's actually a template on the CMPA website that provides the – the – an example of the type of consent form to have with the patient. I will do something, I – I need to point out something that CMPA always points out in education session. The consent is not the form; the consent is the discussion with the patient. So what's important is the discussion with the patient that is documented by either a note in the record or, ideally, a note in the record and a consent form.

16:29
Dr. Guylaine Lefebvre:
Thanks, Daniel. And there's a couple of questions directed to CMPA that I can address. The limitations of virtual care, about how – how fulsome an assessment may be. I think we've heard clearly from – from Heidi and FMRAC that our regulators are – are expecting that the care is – is delivered along standards, whether it be virtual or in person. How can we be confident in our clinical decision without a physical exam? Again, that would be case specific. If you have any particular questions, of course phone the CMPA for – for directed advice. And many MDs that are substituting testing and examining patients and instead just going right to an antibiotic, again, that would be

an issue that choosing wisely addresses quite well. And we at CMPA would be supportive of – of members following the approved guidelines on that.

17:30
Having said that, I think, Heidi, you and I had a conversation about the reality that standards are expected to be followed, whether you're virtual at – or in person, but they – they are interpreted in the context of what we are presently living. And when it was absolutely impossible to see a patient, sometimes what you could do virtually was the next best thing.

17:55
Dr. Heidi Oetter:
Yes, I think that the standard of care is always going to be context-specific. And again, in the first – first bit of – of COVID, many of us were really in – you know, like, even the hospitals were discontinuing all ur—elective surgery, elective testing, and yet we know that many of those tests, many of those surgeries, were desperately needed by their patients. So it is always context-specific, and it's going to be specific to what was it at that time, given COVID, PPE, and a variety of other factors that would influence clinical decisions at the time. But bottom line is – is we – we expect physicians to use their professional judgment, and make a good record about why you made that decision.

18:47
Dr. Guylaine Lefebvre:
A question that probably all of you could have an opinion about. Do you have suggestions for visits with patients who are not tech savvy and who have cognitive challenges, with whom you can't examine in virtual setting, or they may not understand? I – I recognize the – the virtual task force last year actually wanted to address the fact that private virtual care was – was limited to people who had, versus servicing the people who may not have. Would any one of you want to take on how we can deliver this extended telemedicine care to people who are otherwise un—underprivileged?

19:35
Dr. Darren Larsen:
This is Darren. I – I can start a little bit. I just actually wrote a little bit about the next wave of what virtual needs to encompass. And I think that that – we have to think really carefully about some – some very vulnerable populations. So for instance, I mentioned already some of the homeless people that we have worked with through St. Mike's and Women's College Hospital, who still have access to a telephone, and making sure that we go to that telephone first for them, not expecting them to go to a video link in a public computer in a library, for instance, to do the type of care that – that we think we should be able to do virtually.

20:10
I think that there's – there are patient groups that are incredibly challenging when it comes to accessing them or translating the person-to-person visit to something that is through a camera or a video screen. Cognitive impairment is a really big one there. Also children, like little kids, it's hard to keep them contained long enough to do an examination, even if you can do it virtually, by looking in their throat or with a special otoscope. It's hard for them to be in that space. In my clinic, I'm sometimes following the patient around the examining room to try to make sure that I – I listen to the heart rate or their lungs, even while they're in motion. So you know, we do what we can with those special environments. But I think to say that they all have to go to in-person—in-person is – is – or to virtual – is wrong. Many of these can be done in person.

20:58
We're seeing a really interesting shift to virtual care now in some nursing homes. Because of the massive COVID outbreak, Ontario Health here has funded four or five projects regionally that bring virtual into the nursing home environment, and I think we'll have a lot to learn from that, what's worked well there, as you put a virtual cart in front of a patient and ask them questions, what an exam looks like. It is going to be a learning curve for all of us. And in some cases you may have to involve others, so the virtual services in nursing homes, for instance, involve a nurse with the patient – not that they're going to answer the questions for them, but to maybe help with things like physical exam, motion around if you need to examine a shoulder, you know, getting them moving.

21:35
And I should mention too that there are starting to evolve courses in how to do physical examination virtually. I've seen one recently by a group of neurologists, mostly residents, who started this, now in practice, to show doctors you can do a fairly comprehensive neurological exam remotely. And we're going to start to see more and more of those as we get into things like stethoscopes which are virtually connected and – and otoscopes and – and ophthalmoscopes, etcetera. So – so we're going to need to learn quickly. There'll be CMEs popping up on this all over the place, I'm sure, in the next year.

22:06
Dr. Heidi Oetter:
I think --

22:09
Dr. Guylaine Lefebvre:
Learning how to teach as well, I'm mindful of all of our participants listening in right now who are faculty and struggling with residents starting out in – in every specialty and primary care and how do you teach the basic, foundational medicine to – to residents who are not able to see the in-person that we were exposed to. So certainly we're having to adapt very quickly.

22:35

We just have five minutes left, and, in those five minutes, two quick questi—I mean, they're not – they could be long answers, but I'll ask you to be succinct, if you can. The first to Heidi. Lots of questions here on the movement to expedited licensure plans, agreements, basically the concept of a – of a national licence. I know FMRAC's been looking into that.

23:00
Dr. Heidi Oetter:
Yeah. Well, as we continue to have health care funded by provincial and territorial governments, that's where the licensure rides. And I'm sure that if the provincial and territorial governments could give health care back to the federal government and say here it is, they – we could probably have a – one licence to work anywhere in Canada. So we continue to work at it at FMRAC, but there is a constitutional issue that is in the way of that. And we are doing our best to try and expedite licences for those physicians who have clean certificates of professional conduct and remove barriers where we can around practising telemedicine, but it is a journey that we travel with our provincial and territorial Ministries of Health, and we're not all on the same page yet.

23:52
Dr. Guylaine Lefebvre:
I'll leave the – the last minute here for Seamus, a million-dollar question. Do you envision physical clinics will disappear and consolidate to fewer centres where we can have virtual hospitals?

24:06
Seamus Blackmore:
I would actually say no. I – I don't think that will occur. I do think there's going to be a dramatic shift across the entire landscape of how care is provided, but I wouldn't make a prediction that that's going to be completely centralized in some cases. In fact, the virtual nature and the way that bandwidth is going to be accessible rural – in rural areas from things like satellite networks, the idea of having federated and disparate and basically care provided from wherever is more likely than the centralized virtual care centres that we've seen.

24:40
Those ideas of a centralized virtual care centre have existed for a long time. We've seen those in hospitals, we've seen them in rural communities, where you come in and do your care at a particular place. I don't think that that – I don't think that aligns with where the technology is going. And I – I would hope to see that it becomes more widespread that a care provider provides care from wherever they want to. Because half of the advantage of the access to care for the patients, being able to get care from wherever they want to, should apply to the providers as well, right? So I think it'll probably go the other way. I – I don't know that every physician will want to have a brick-and-mortar shop anymore, but we'll see.

25:25
Dr. Guylaine Lefebvre:

Thank you very much. We are unfortunately out of time, but I know we could have talked for – for quite a wheel—while longer with these important considerations. In summary, very clearly, virtual care is here to stay. It will become integrated with the in-person care we know already and become care overall. I think that message has been relatively clear.

25:50
I – thank you to everyone out there who's participated. Your questions will actually serve us at CMPA to understand what questions we may have as we put forward more products. I'll invite you to check out our website. The CMPA website hosts podcasts and perspective articles and other recommendations, good practice guide, and so forth, where you may find answers to your question. And by all means, phone us if you would li—like to speak to one of our physician advisors directly.

26:23
I want to thank our panel for your generous contributions today, for your expertise, and – and sharing of your perspectives. I do look forward to continuing the conversation in the many forums we'll have moving ahead. And thank you to the fabulous team here that allowed us to produce the very first ever virtual education session as part of our AGM. Thank you, and have a very safe rest of the summer.