THE VIRTUAL CARE PIVOT

How do we avoid the pitfalls and pursue the new frontier to the next level?

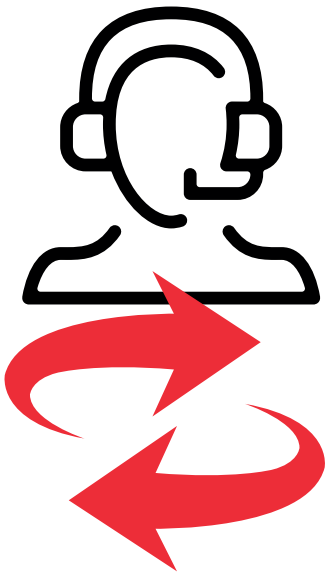
BY LOUISE LEGER

The surge in telehealth during the pandemic has been nothing short of transformative. Among Canadian doctors there is an acceptance that there is no going back. Early reports are that a majority of patients have wholeheartedly embraced the new care models. And while many physicians miss the old ways and are eyeing the future with uncertainty, they too see the advantages of virtual care.

Nonetheless, there is much to be worked out in terms of how to offer quality care over the phone, email, text or video. What are the pitfalls? How can physicians pivot to these new technologies while delivering the same or better quality of care to all patients?

In Ontario, according to an upcoming report from the Centre for Digital Health Evaluation, not surprisingly, psychiatry has had the highest weekly percentage of virtual care visits (83%) throughout the pandemic period (measured from March 2020 to January 2021). Primary care provided an average of 65% of care via virtual modalities and other specialists provided 47% of their care virtually.

For comparison, pre-pandemic, psychiatrists provided 3.4% of their care virtually, primary care providers 1.9% and specialists outside psychiatry 0.7% of their care.



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'SEISMIC CHANGE'

"I'd estimate about 50% is now virtual in my family practice clinics," said Toronto FP Chris Sun. "The walk-in clinics I do are 100% virtual—90% by phone."

Before the pandemic, Dr. Sun said, from 1% to 5% of his appointments were virtual. "So the change has been seismic. And I was a fairly aggressive virtual care adopter before," he added.

Many virtual care advocates point out that telehealth can reach patients in remote communities; and that it allows workers in urban areas to take a call on a work break and avoid missing a payday sitting in a doctor's waiting room. But others say that the shift to telehealth has also thrown up unanticipated inequities. For those who don't have internet access, those experiencing homelessness, those who are not tech-savvy (especially the elderly) and those who have cognitive challenges or limited language abilities, telehealth could be a barrier to good care.

"What's really striking in this latest research is that overall, visit volumes were mostly maintained during lockdown and there was no obvious difference between age, chronic disease or socioeconomic status at the population level," Dr. Onil Bhattacharyya said, referring to Ontario statistics from the upcoming report, in an interview with the Medical Post.

Dr. Bhattacharyya is a family physician, a scientist and director of the Centre for Digital Health Evaluation at Women's College Hospital and the lead on that organization's upcoming report.

"So often we talk about a digital divide, but we did not observe it at that high level at the population level," he said. "By and large, there was broad acceptance of virtual care by providers and patients and most patients feel that this should be a part of their care experience in the future."

In sum, Dr. Bhattacharyya said overall the experience for patients has been largely very good and the experience for providers mixed.

He pointed out that for most

appointments, virtual care has meant using the phone—but what is needed is for physicians to have a system to triage incoming requests. Some appointments still need to be assigned to in-person and some virtual—and from there, some to phone, video, email, text or other modality.

"Physicians just didn't have systems for that," he said. "So whatever they developed was labour-intensive and clunky and overall increased their workload. So that is the first challenge. The second challenge is the way a lot of the technologies are developed. They're designed for interactions between a provider and a patient and don't really facilitate interactions between members of a care team (and) with receptionists and so forth.

"So what you have is essentially doctors taking on a wider range of administrative tasks, because it's not easy to hand off," he continued.

"Because you can't hand a patient off to different people in a hallway, right? Or say, 'Oh, go see this nurse to check your blood pressure and then go book your next appointment with the secretary.'"

Dr. Sun agreed. "For patients, the advantages are convenience, accessibility and reduced infectious disease exposure from not having to visit in person. But appointments take longer and involve more administration," he said, citing time spent waiting for patients to pick up the phone or log in, getting them to perform physical exam manoeuvres or send photos, and then him sending requisitions and relying on more tests and followup.

"And the mental fatigue is worse. It's somehow more tiring to talk to someone on the phone, send their prescription, argue with the pharmacist because they say they didn't get it even though it's been confirmed as received, answer the patient online as to why their prescription is delayed, get a notice from the pharmacist later that they actually did find the prescription and they just didn't bother to check their pile of faxes, then also hear that the patient forgot something and is setting up another phone call tomorrow," said Dr. Sun, adding, "This is like a daily occurrence for me now."

WHAT'S WORKING

For psychiatry, generally, it has been easier. "I thought it would be more difficult," said Dr. Allan Donsky, a psychiatrist and clinical associate professor at the University of Calgary who now conducts his psychotherapy practice 60% through Zoom and the rest by phone. "Since the end of March last year, I've been doing all my care virtually, and that is because the risk for patients and me is too great to meet people, and the benefits (of in-person) don't outweigh the risks."

Dr. Donsky said that he believes it was made easier because he already had a relationship with most of his patients. "I'm paying incredible attention to tone of voice, to the pauses, to the effect, the feeling, the sense, and I'm able to really tune in, because I have to. (For phone) I don't have body language, I don't have facial expression. I can't see tears. That's been really interesting as a practice, and what I've discovered is I can actually tune in quite well to that, and I can pick things up. I don't think I'm missing a lot."

And of course, for Dr. Donsky's adult and youth patients, not having to travel to appointments and miss work or school is a tremendous patient advantage.

THE TIMES ARE A-CHANGIN'

Many specialties could transition easily to virtual, like those that are based on lab results (endocrinology, nephrology), which can easily be reviewed over the phone. For others, many procedures must remain in-person.

Dr. Andrew Krahn is a cardiologist and-past president of the Canadian Cardiovascular Society. For his practice, where he largely implants cardioverter-defibrillators and pacemakers, virtual is not possible. And most diagnostic testing is still in-person, he said, but his ambulatory care is somewhere between 90% and 95% virtual, including consultations with families.

Meanwhile, the pandemic has spawned a new way for patients to get wearable adhesive heart monitors. "We now essentially have COVID-friendly pickup systems for patients. It's kind of you go to the drive-through to get your heart monitor and there's no actual entry into the healthcare institution."

There is also research being done, he said, into simply mailing the heart monitor patches. The patients watch a video to see how to use it, and mail it back in a pre-paid envelope when they are finished.

Dr. Bhattacharyya said recently he had a patient have his sister manoeuvre the patient's hip over video and increasingly patients are tracking their own blood pressure, oxygen levels and weight.

Virtual options also allow for better followup, said Dr. Bhattacharyya.

"Now it's very easy to book a two-minute followup and say, how are you doing today? And how are you doing the next day? And how are you doing the day after that?"

Although he acknowledges the phone is easier to use than video, Dr. Krahn favours video: "For people who have more problems, telephone loses some of that human exchange, part of things that I think are important. I think physicians have been gravitating to the phone because that's what they're familiar with and the clerical support for it's much simpler, right? Just, 'Will you be home at 10 o'clock?' kind of thing, as opposed to 'Here's a link,' (and dealing with) who troubleshoots technical issues, etc. Telephone can be a bit more efficient . . . but I actually think video's much better for patients."

PITFALLS

"The quality of care is lower with virtual," said Dr. Sun. "I can't count how many times I've seen patients with lower urinary tract symptoms (at the clinic) who were given antibiotics without a urinalysis or urine culture even offered to the patient, which has got to be a failure to meet standard of care," said Dr. Sun.

Dr. Sun recalled a middle-aged patient whose concern was his "prostate symptoms," which ended up being end-stage liver failure. "He just didn't mention his skin had turned bright yellow for the last few weeks," Dr. Sun said.

Dermatologist Dr. Benjamin Barankin, medical director and founder of the Toronto Dermatology Centre, said he currently conducts about 5% of his

"We require triage systems and signposting—a digital front door that would allow patients to get triaged to the right modality base on their need. . . . This is the biggest need going forward."

practice using phone and photos.

From March to May in full lockdown, it was 100%. He said it works for quick followups, where a diagnosis is already made.

"For a lesion or localized rash, with good pictures and history, it can work well. . . . For a new widespread rash, it is not so effective. It's not ideal as far as not being able to biopsy or excise or do dermoscopy or other procedures. I can't do a full skin exam via phone/video. I can't properly examine the scalp unless in person. . . . Plus, it's not as warm a personal connection to my patient."

Dr. Barankin said that in some cases, for example, acne, rosacea or psoriasis followup, the level of care can be excellent and on par. "In other cases (examining scalp, extensive rash, etc.), it is very much lacking."

THE TRADEOFF

Dr. Sun sees it as a tradeoff. "I lose diagnostic accuracy in exchange for patients getting more accessibility. The fact that patients are engaging should tell doctors that they're willing to make this trade, and we should be listening. So I may see my patients more, but have to deal with more diagnostic uncertainty as well as manage issues of lesser importance."

Dr. Krahn believes virtual care has helped his practice most when he is able to talk to two or three providers and/or several family members on Zoom who are in different geographic locations. "We're doing complex (genetic) family-based care delivery and evaluating a family. So it's the difference between having three separate conversations and then the family trying to figure out what they heard, versus all being on the same call and we take a full hour to talk, and we know we don't have to repeat it three times. That enriches their ability to understand their condition."

Dr. Krahn also gives the example of a patient who lives hundreds of miles away and might get their adult child to take a day off work to fight traffic and pay for parking, etc., to take them to a 15-minute appointment. Wouldn't it be better if they could have the appointment together at home in front of a computer? "The generation of patients that are coming are going to be consumers and they will demand that we do virtual care," he said.

While Dr. Donsky feels his psychotherapy practice has successfully moved to virtual, there are downsides. "I do miss being in the presence of other people. There's nothing quite like that. Everybody knows this, I'm not saying anything new. . . . There's literally a screen, there's literally a filter physically and metaphorically between me and you. It's a little dehumanizing."

THE WAY FORWARD

Even before the pandemic, Dr. Bhattacharyya was researching and writing about virtual care—and the channels to manage it. He says that many virtual care plans and initiatives focus heavily on video visits, essentially mimicking face-to-face visits. Meanwhile, clinicians use the oldest modality, phone calls, and some use ubiquitous, asynchronous messaging (email). The latter, Dr. Bhattacharyya believes, along with live chat and chatbots, could be transformative if workflows were redesigned to incorporate them. With multiple modalities now available for use in virtual care, the central problem is to direct patient-provider interactions to the channel best suited for the interaction.

Virtual care, he said, currently impedes collaboration within teams in primary care. What's needed, he believes, is improved efficiencies and large changes in workflow and design.

"We require triage systems and signposting—a digital front door that would allow patients to get triaged to the right modality based on their need. So those systems, there are examples of them in the U.K. in primary care, but here they have not been implemented to any degree. This is the biggest need going forward, he said.

"People didn't sign up, go into medicine to work in a call centre, but a lot of time in a clinical visit is spent asking people about symptoms that we could have asked ahead of time. You could email symptom scores and questionnaires to patients ahead of time, even know what their agenda is, and then spend more time on counselling and behaviour change and helping people understand or even shared decision-making."

Dr. Bhattacharyya believes that will improve the quality of care physicians provide and make the job more satisfying. "We turned (virtual care) around in a month and obviously it's not going to look great in that time, in fact, it's pretty mediocre, right? But if we say all of these modalities are important, quality of care is important and this is the future direction of healthcare, we'll make the investments to make this a great experience for patients and providers." **MP**

COSTING VIRTUAL CARE

Picking out what virtual care fee codes will do to physician services budgets is hard with COVID changing all aspects of utilization

BY ABIGAIL CUKIER

Technologies to deliver virtual healthcare have been around for decades, but Canada has lagged in providing widespread publicly insured virtual care, despite studies showing it can improve access to care and reduce costs.

Of course, the COVID-19 pandemic has profoundly accelerated virtual care. So what have we learned about how digital healthcare costs compare to costs for in-person care? It seems this question is not so easy to answer.

Before the pandemic, about 10% to 20% of medical care in Canada was virtual. That number was up to 60% within about six weeks of the start of the pandemic, according to Canada Health Infoway, an independent, federally funded, not-for-profit organization tasked with accelerating the development and adoption of digital health solutions. The organization says that so far in 2021, about 40% of care is being delivered virtually.

IN ONTARIO

In Ontario for example, about eight million patients have received OHIP-insured virtual care since the onset of the pandemic, including about 33 million phone/video services. Physician services claimed using the pandemic virtual fee codes have accounted for about 13% of total physician payments since March 2020. In British Columbia, as of Feb. 15, 2021 there was a 1,222% increase in virtual family physician services and a 51% decrease in in-person family physician services when comparing March to December 2020 with the same time period in 2019.

Dr. Sacha Bhatia, chief medical innovation officer at Women's College Hospital in Toronto, says overall utilization of healthcare system resources is lower than before the pandemic, with an approximately 15% to 20% reduction in ambulatory visits in Ontario, as well as a reduction in hospitalizations, diagnostic testing and emergency room visits. Dr. Bhatia says this will inevitably lower the physician services budget, but other costs may be higher than usual.

"The confounder is the pandemic. It is pretty close to impossible to tease out whether the effect is due to virtual care or due to the COVID-19 pandemic," he said. "But it will be useful to look at this longitudinally, as people are vaccinated and levels of virtual care stay relatively high. We'll get a better sense around utilization and cost. We're not really going to know what's up until we really start to see a return to regular life."

The pandemic changed how physicians deliver healthcare and how they bill for their services. In response to the pandemic, provinces introduced temporary virtual care fee codes to allow patients to safely see their doctor by phone or video. These fees are generally equivalent to in-person fees. Provinces continue to extend the temporary codes, maintaining they will be reviewed after the pandemic. In June 2020, Alberta announced the fee codes introduced during COVID-19 would be permanent.

Prior to the pandemic, British Columbia had the most comprehensive approach to fee-for-service billing for virtual care. This included a video telehealth code so a physician could connect with another physician at an approved site to care for a patient, a code for telephone visits and one for email or text message medical advice to patients. These fees for family physicians were a weighted average of the age-based

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in-person fees for these services. The temporary pandemic fee is the same rate as the corresponding in-person fees.

In Ontario, prior to COVID-19, physicians could bill for visits using the Ontario Telemedicine Network (OTN) platform for direct-to-patient video visits with fees equivalent to in-person care. The plan was to expand access to secure electronic messaging and phone calls and use of non-OTN technology.

Other provinces provided fees for some aspects of virtual care and pilot projects, limited to approved telehealth sites and focused around specific health system needs. In New Brunswick for example, virtual care occurred between two hospital or clinic facilities. There was no fee code for doctor to patient visits. At the onset of COVID-19, the province opened up one code for specialists and family doctors. It later added another for specialists, as well as psychiatry codes. After a couple of months, physicians were able to bill for fees equivalent to in-person codes.

"Ontario's schedule of benefits has thousands of codes. For family doctors, let's say there are 250. All of those have been distilled down to three codes," said Dr. Alykhan Abdulla, section chair for general and family practice at the Ontario Medical Association (OMA). "When you see a person in office, you do the assessment. That's one code. But if you do a Pap smear, that's a different code. If you do an ear syringe, that's a code. But now we're restricted to three specific codes."

There is also a code for specialists, and an hourly fixed rate for physicians working in a COVID assessment or vaccination centre. The province recently added a premium for performing high-risk procedures in-hospital and a virtual care code specifically for palliative care. The temporary codes also allow physicians to use applications such as Zoom, rather than just OTN.

Dr. Bhatia has spent years researching digital health innovations to help healthcare stakeholders decide which tools to adopt, with the aim of improving efficiency and increasing healthcare capacity and quality. He believes the pandemic virtual care fee codes have been a success. "The virtual care fee codes did exactly what we hoped they would," he said. "Though we had a modest decline in ambulatory visits, we were able to maintain volume and allow people to access their care provider."

HIT PHYSICIAN PAY

But the decrease in healthcare utilization did affect physician pay. Without patients coming into the clinic and a delay in virtual care fees, fee-for-service physicians, who only get paid if they are seeing patients, were hit hard. Physicians in alternative payment arrangements, such as capitation, where physicians are paid a flat fee for each patient in their roster, could transition to virtual care without having to wait for fee codes. Community-based specialists were hit harder than those under academic-based or salaried payment models. While some specialists, such as psychiatrists, could provide virtual care, others could not.

Dr. Abdulla, who is medical director of the Kingsway Health Centre in Ottawa, works under capitation. He believes every doctor should have this opportunity. "Capitation has to be the way moving forward. You want some guarantee that doctors are going to be working all the time," he said. "You probably want capitation for surgeons. You want capitation for anyone who works in a hospital. You want academic alternate funding plans, which guarantee that you are going to get paid. If you can't do an operation, we will give you something else to do."

As the OMA continues to negotiate with the Ontario government for its new physician services agreement, Dr. Abdulla says there must be a willingness to scrap the way things used to be and work together for a better way forward. "There is going to be a balance between in-patient and virtual care. We need to plan for that future. You also want to make sure physicians have some level of stability. And we're not talking about more money. We are talking about better use of that money," he said, adding that there is a need for more virtual care codes; increased video, telephone and messaging options; and opportunities for alternate funding arrangements.

While all of these issues will affect how healthcare is delivered, they will also influence costs. So we are still left with the question, will virtual care increase or decrease healthcare costs? After years of international research, Simon Hagens, senior director of performance analytics at Canada Health Infoway, says there are no definitive answers. "At the health system level it's really hard to figure out. There is give and take on both sides," he said. For example, virtual care may provide access to citizens who might otherwise not get it, avoiding possible health complications and saving costs. But costs may go up with increased access or if a virtual visit doesn't resolve the complaint and an in-person visit is still needed. "The really important question is how do you build the right mix of virtual care and in-person services and reimbursement systems to incent the right type of care in the right situation?"

Canada Health Infoway released a study in 2017 comparing patients who had virtual visits to patients seen in person. "The early indication was that there might be an opportunity to reduce costs in primary care with virtual care. Also, for the most part, people in the virtual care group did not have additional followup visits. But the big limitation is that the data set at the time was insufficient, due to low volumes," Hagen said.

"It will be a long time before we actually know the long-term health of patients seen virtually and the costs. It often takes months or years for a course of treatment to play out and see how a virtual intervention compared to an in-person visit."

There are two areas where Hagens is certain digital health saves costs. An analysis of the Infoway Telehomecare Program, which provides remote monitoring for patients with COPD and congestive heart failure, found that for every $1 invested in these programs, the health system sees $4 in value, through reduced inpatient admissions and ER visits.

Another Infoway study examined direct patient access to their lab results. Almost 60% of patients with online

"The really important question is how do you build the right mix of virtual care and in-person services and reimbursement systems to incent the right type of care in the right situation?"

access visited their physician to receive or discuss results, while 83% of patients in a comparison group visited their doctor for that reason. In addition to reducing healthcare costs, this also benefits patients, who often have to miss work, pay for parking or find childcare to see their doctor.

In fact, Infoway's 2019/20 annual report shows that in 2019, virtual care saved patients 11.5 million hours by not having to take time off work to attend in-person appointments; avoided $595 million in travel costs to primary care visits for rural patients who used telehealth; and reduced 120,000 metric tonnes of carbon dioxide emissions when used for primary care visits and rural telehealth. Those numbers reflect the savings pre-pandemic (10% to 20% of care delivered virtually). The report states that if the number of virtual care visits increased to 50%, it would save 103 million hours, $770 million in expenses for Canadians and 325,000 metric tonnes of CO^2 emissions.

"We are increasingly looking at the benefits to Canadians being a central pillar of how we talk about virtual care and trying to convince governments that if you're saving constituents time and money, it's worth the investment and it also has a good economic spinoff," Hagens said.

Hagens calls the pandemic the first opportunity for real-world experience with virtual care. "We've had this gradual increase in the quality of the technology and of course, citizens having phones in their hands. So the conditions are right and this appears to have been the spark," he said. "So now the big question is, how do we take what's best about virtual care and make that the norm in healthcare?"

HYBRID MODEL OF CARE

Dr. Bhatia believes most patients want a hybrid model of care. "We have to figure out what that right mix is and that's going to be through a combination of clinical appropriateness and further research on healthcare quality and cost."

He cautions against making bold policy changes around remuneration and is wary of early calls for certain costs for an in-person visit vs. a video or telephone visit. "Let's look at optimal models of clinical care first, and have the reimbursement follow them, rather than build the financial model first. What's going to happen is, people are going to tailor their practice to the reimbursement model.

"I wouldn't want us to create incentives to pick one modality of communication with patients over another. I think we should resist temptation to make arbitrary funding decisions. We should first figure out what the models look like and ensure that the reimbursement follows the optimal models of care." **MP**

VIRTUAL SOLUTIONS

Some provincial governments haven't committed to continuing virtual care fee codes after the pandemic

BY KYLIE TAGGART

It really is a good news story. Virtual care fees were rolled out quickly across Canada after SARS-CoV-2 arrived on our shores, allowing patients to receive care and doctors to get paid.

Yet, as with all success stories, there's a need to reflect and figure out how to go from good to great; how to iron out the wrinkles; how to ensure that the best patient care is provided and that physicians are receiving equitable pay.

Even with clinic doors shut, or in-person care limited, doctors still have to pay for overhead costs on their practices, including salaries for staff. Were virtual fee codes high enough to keep practices going? Yes, doctors say, although, like with all big, sweeping solutions, some people fared better than others.

Provincial billing codes for virtual care varied. In some provinces, such as Nova Scotia or New Brunswick, physicians were paid the same for a virtual appointment as they were for an in-person appointment. In other provinces, like Saskatchewan, virtual care billing codes were lower, but almost equivalent to those for an in-person visit. Provinces have been adjusting codes as more small holes become apparent. For example, palliative care physicians were not initially able to bill for all virtual care services they provided in Ontario. That has been remedied.

For the most part, Ontario physicians seem to be satisfied with their virtual care billing codes. "At least the circles that I work in, and what I'm hearing from the primary care advisory table—

which has clinicians from across that province and from multiple different payment models—everyone seems to be satisfied," said Dr. David Price, professor and chair of the department of family medicine at McMaster University in Hamilton. Dr. Price also serves on Ontario's primary care advisory table.

The general satisfaction with temporary virtual care billing codes was seen elsewhere. For example, a Doctors Nova Scotia survey about virtual care drew positive feedback. "I think that the compensation was fair," said Dr. Leisha Hawker, a family physician in Halifax.

Many physicians have noticed that virtual care takes time, and billing codes need to reflect that. Alberta instituted virtual fee codes for long appointments and for short appointments, something physicians from other jurisdictions would like to see. "If it's a two-minute quickie, that is not the same as someone going through a long, complicated problem. The fees have to reflect the intensity," said Dr. Jeff Steeves, an ophthalmologist and president of the New Brunswick Medical Society.

Dr. Price said he wonders if it's the pandemic itself that may increase the length of a virtual care appointment. Where patients may have previously started the appointment by talking about the matter at hand, they now give a rundown on how they're doing with respect to COVID-19 before getting into the subject that made them call the doctor.

"I think it is too early to tell whether overall it is going to be more time-intensive or not," Dr. Price said. "Until we get well past COVID, like a year past COVID, I don't think we're going to know what the average length of time for a routine appointment is."

Dr. Hawker and her patients have been communicating by secure email through a portal, which is considered asynchronous virtual care. She said that it helps her triage messages from patients, because the information in emails is much more detailed than a simple list of names of people who called the office. She's also finding that it improves access for some of her patients who don't have a phone but can often find free Wi-Fi service to connect with her over email.

"I have a patient now who is dealing with homelessness but we've still been able to connect regularly through the portal and that's been quite helpful in between in-person visits," she said.

Nova Scotia currently doesn't have any funding stream to remunerate physicians for the asynchronous virtual care, Dr. Hawker said. "If you're salaried, the work you're doing isn't captured, and if you're fee-for-service, the work that

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you're doing goes unpaid."

Dr. Hawker would like Nova Scotia to fund asynchronous virtual care either through a per-service fee code or through a stipend. There was stipend funding for asynchronous virtual care provided through MyHealthNS, a secure app that physicians could use to contact their patients, but few physicians signed up. The MyHealthNS program stopped in March 2020.

There were some problems around pay during the virtual care rollout. One example was how physicians paid through a capitated model were compensated for virtual care. Physicians who are part of one of Ontario's Family Health Organizations (FHO) or Family Health Networks (FHN) are paid through a capitated model but also get some fee-for-service payments.

If a patient comes into the office of a FHO for a visit, the physician can bill about 10% to 15% of a regular billing fee. "But if I do a virtual visit, I get the full amount," Dr. Price explained. "In some ways it is more advantageous for family doctors to be doing virtual care compared to in-person care because we get the full amount instead of the shadow billing portion," he said.

While the pandemic saw a rapid rise in the use of virtual care by physicians, it also led to other forms of virtual care, such as virtual walk-in clinics like Maple or Babylon by Telus Health.

In Alberta, the Alberta Medical Association has raised concerns over Babylon by Telus Health. With Babylon, in-province physicians provide care and are paid by the province through an ARP (alternative relationship plan). Babylon is available in Alberta, British Columbia, Ontario and Saskatchewan. Consultations are covered by each province.

The main criticism of Babylon is that it can only provide episodic care, which, as well as being a poor way to deliver patient care, has been shown to be more expensive in the long run. "Evidence shows in comparison with care from a regular family physician, this model of care results in more tests, more referrals, generates more visits to emergency and results in more hospitalizations," wrote AMA past-president Dr. Christine Molnar on March 21, 2020. "These are impacts we could not afford in a pre-COVID economy."

Unlike a real walk-in clinic, doctors paid through capitated models don't get notice and a negation (reduction in pay) when a patient seeks out care from a virtual walk-in clinic like Babylon by Telus Health or Maple, Dr. Price said. This means that the province pays twice for these patients.

Dr. Price is also concerned with other forms of virtual care offered by private companies. He gave the example of LifeLabs, which, in certain provinces, allows patients to connect virtually with a physician to discuss lab test results. The physician is paid by the province. Again, the problem is both with the episodic nature of the patient care and that the province is paying twice for the same patient to receive care.

He said that in some cases, the service may be helpful for patients who need a second description of what the results mean, even if it is the ordering physicians' responsibility to discuss the tests with the patients.

"If it is just to get my results and to get a doctor to interpret it 12 hours earlier than I would from my doctor, then that's not good quality of care, and it's expensive for the ministry," he said. "It's expensive because it is a duplication."

UNSURE OF THE FUTURE

The biggest question physicians have about virtual care billing codes is: Will they continue?

Alberta has made them permanent, but for most provinces it is still unclear whether the virtual care fee codes as they stand now will remain once everyone is vaccinated and in-person visits become the norm again.

In British Columbia, the telehealth fee codes are permanent, but the future remains unclear for the pandemic billing codes for care delivered by phone. "Providing care by phone has been well-received by doctors and patients and we would like to keep these enhanced telephone fee codes," said Sharon Stone, senior manager of communications and media relations at Doctors of BC. "Right now, the government has not indicated its interest in keeping the telephone fee codes past the pandemic, or what that might look like."

In Ontario, fees have been extended until the end of September. The province and doctors are negotiating a new Physician Services Agreement (PSA), where virtual fee codes will be discussed.

"The expansion of—and appropriate payment for—care delivered virtually remains a top priority for the Ontario Medical Association during PSA negotiations," wrote OMA board chair Dr. Tim Nicholas in a letter to OMA members.

The government of Nova Scotia has extended the virtual care billing codes a number of times, and Premier Stephen McNeil has said the province intends to keep them, but with some fine-tuning.

Saskatchewan will review them again in 2022, and the Saskatchewan Medical Association will use that time to examine how the codes were effective, and negotiate any changes that might be needed.

Newfoundland and Labrador will give doctors 30 days' notice before they change the temporary fee codes.

In New Brunswick, Dr. Steeves looks forward to speaking with the provincial government on how to extend virtual care fee codes, and what needs to be adjusted. "It's expensive to run an office. You have to staff it, equip it, heat it, plow the snow, etc. It's not like you can set up a 1-800-Call-a-doc and never have to touch a patient. The fee code will have to reflect and balance that," he told the Medical Post. "I think there's a great opportunity of doing that, where the virtual code will leverage what a doctor can do, but does not replace what he has to do."

Physicians had to pivot quickly last March from in-person to virtual care, and temporary virtual care billing codes helped them do that. But if the billing codes are made permanent, some tweaks are needed to ensure they are fair, sustainable and encourage quality patient care. "Now that we've done it for a year, we need to make some decisions about what we're going to continue to fund and what we're not going to fund. And we need to do this on a rational basis and think about quality of care," Dr. Price said.

—With files from Abigail Cukier