

Policy 101 Virtual Care: Policy and Practice Implications for Wound Management

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"In a chronically leaking boat, energy devoted to changing vessels is likely to be more productive than energy devoted to patching leaks." —Warren Buffet

The shortage of health-care professionals (HCPs), the high cost of care and the demand for overall cost efficiencies have helped drive the development and use of health technologies. The ability to integrate and analyze data and effect policy change remains a challenge for HCPs and funders. Patients, funders and HCPs are desperately looking for a new (and better) boat! Health technologies offer HCPs the ability to access timely, comprehensive, accurate and real-time patient information.¹

Health technology, telemedicine, eHealth, telehealth, virtual care, medical informatics, mHealth and health informatics—these are terms used over the last 50 years to describe the field of digital health.² Today, the umbrella term digital health encompasses the evolving range of devices and equipment, data analytics, artificial intelligence and diagnostic treatment services that are changing the way health care is delivered.^{1,3} This article will focus specifically on virtual care—a key initiative for improving access to care. irtual care is described as any interaction between a patient or care partner and any member of their circle of care that occurs remotely using a variety of modes of communication or information.² In theory, virtual care reduces highly inequitable access for patients from rural, remote and Indigenous communities, reduces economic hardship for patients who would otherwise have to attend face-to-face visits, improves timely access to specialist care and reduces wait times.²

Canada was an early pioneer in the development of virtual care, providing telephone consultation to remote sites in Newfoundland in the 1970s.⁴ Despite this early innovation, however, uptake of virtual care technologies has been dismal: approximately 0.5% of billable service hours (approximately one million patient visits) were completed virtually in 2018–19.⁵ To put this into perspective, by comparison, in England 14% (23 million) general practitioner visits were completed by phone.^{2,6}

Newfoundland has taken and is continuing to take a leadership position in virtual care. The province has led strategy summits and completed a dynamic strategy document focusing on adoption, the addressing of gaps, and evaluation criteria for virtual care platforms.⁷ Ontario's health system transformation includes virtual care strategies to reduce wait times with aggressive yearone targets for newly formed **Ontario** Health Teams.³ Canada as a whole still has a lot of catching up to do. Globally, virtual care

is a success, prompting the private sector to make available a number of virtual options. In Canada, a number of companies provide services in this sector. These online services require user fees, and private health insurers are starting to offer partial coverage. But patients with low socio-economic status or those without thirdparty health insurance may not be able to access these services. And, unfortunately, wound care is not a focus for any of the currently available programs.

A recent survey shows that two-thirds of Canadians are interested in more choices in how they interact with their health-care systems, including visits through a virtual platform and easier access to health-care providers.⁸ Digital capabilities are critical to system integration, information sharing and seamless care provision and are discussed in more detail below. Virtual care eliminates barriers to access—especially the negative economic impact of the current systems, resulting in improved patient and caregiver adherence.⁹

What are the barriers to increasing virtual care usage?

Implementing technology involves changes at the organization level (meso) and at the HPC and patient/care-partner levels (micro).¹⁰ According to Watson (2010), any digital health strategy is much more complex and time-consuming than anticipated.¹¹ With that in mind, the brief list of barriers and facilitators discussed below touches on the complexity of integrating virtual care into Canada's publicly funded health-care systems:

 Connectivity for all health-care delivery access points (e.g., lab/diagnostic test facilities, pharmacy, home care, public health, specialists, most responsible physician, hospital): The current methods of sharing patient information have numerous challenges and gaps. For example, information is shared by fax, email, paper exchange, phone, or not at all. A shared electronic health record is a necessary component for connectivity across all care delivery access points. Without a way to provide communication and information, there will continue to be flow fragmentation and uneven access to care delivery. Said a different way, shared electronic patient records are required to make virtual care work.¹

• Physician and nurse practitioner compensation: The Canada Health Act approves coverage only for emergency care out of province. Any other treatment needs must be pre-approved in order to be paid. Provincial/territory payment systems are based on a "personal encounter." Despite changes made to incorporate telemedicine visits, generally if the patient is not seen in person, the physician doesn't get paid. Licensure variability across Canada limits where physicians can work. With the pending physician shortage, a change from a provincial to a national licence (similar to that in Australia) would facilitate virtual care adoption.³ Access for rural and

> remote locations: Virtual care meets the needs of those most difficult to reach; therefore, parameters for rural/remote care delivery must meet the unique requirements, including access to equipment (e.g., connectivity, data, smart phone, laptop) and supplies (e.g., products) to reduce or eliminate economic hardship for those living in these areas.

- Education and training: Digital health platforms and technologies must be incorporated into all HCP course curricula, core competencies and ongoing professional development to ensure effective virtual care.¹²
- Protection of personal health information: Protection of personal information, including sharing of information, security of transmission, and data governance, is beyond the scope of this paper. It is important, however, to keep privacy in the forefront when developing virtual care policies.

What are the benefits and challenges for patients with wounds using virtual care?

The scope of this article precludes a detailed discussion on the benefits and multiple challenges Canadian health-care systems face in implementing virtual care. Table 1 contains some this author believes impact patients dealing with chronic wounds.

Benefits

- Timely access to wound specialists and interdisciplinary teams: There continue to be prolonged wait times for access to the right treatment by the appropriate health-care professionals specializing in wound care. Virtual care has the potential to reduce wait times and expedite specialized care.
- Access to personal health records for patients and HCPs: Ready access for ALL members of the circle of care will enhance timely communication, expedite care and improve access across all care settings.

Table 1. Virtual Care benefits and Chanenges	
Benefits	Challenges
Timely access to wound specialists and interdisciplinary teams	Lack of access to shared electronic health record for all members of patient's circle of care
Access to personal health records for patients and HCPs	Differences in digital health literacy across patients and care partners
Improved access through digital health technology	Inequitable access to technology, irrespective of income

Table 1: Virtual Care Benefits and Challenges

 improve communication, and increase physician and other health-care professionals' productivity. For example, using virtual care, England showed an 80% increase in patient follow-up visits without requiring additional support staff.²
Challenges
Shard electronic health record for all members of patient's circle of care: Patient records currently have multiple redundancies (each organization having their own patient record),

Improved access through digital health

technology: Electronic appointment schedul-

ing, secure emails and video calls will improve

patient access to HCPs. Currently less than 10%

of physicians offer these services.² Improvement

in this area will reduce delays in treatment,

- organization having their own patient record), delayed information (information shared by fax or mail) and limited access to a patient's own health information. A shared electronic health record that provides information across and within health-care sectors continues to be a challenge in many areas across Canada (e.g., data access, urban, rural, remote geography, organizational readiness).
- Digital health literacy: Digital health literacy may present a new challenge for patients especially for those with low health literacy. Similar skills are needed to use technology to navigate the health-care system. Individuals with low health literacy levels are more likely to encounter issues when attempting to use any health technology, particularly patient self-management applications. Any effective digital health project must offer alternatives for these patients.
- Equitable access irrespective of income: User fees, co-pays, or the need to provide one's own mobile device will perpetuate inequitable access. Patient adherence is directly dependent on access to treatment and security of resources. Requiring co-pay for equipment and products has been shown to increase patient length of stay, delay wound closure rates and increase risk of complications.¹³

Conclusion: A Window of Opportunity

Virtual health, one of many technologies within the digital health platform, has a history of successful implementation. The benefits for Canada's rural and remote communities and patients with complex wounds cannot be overstated. However, the current model is not working. A window of opportunity exists to align with the Canadian Medical Association's task force to increase adoption of virtual care across the continuum of care in Canada. It is time to change boats.

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RECOGNIZING HS

DO YOU RECOGNIZE PATIENTS WITH HIDRADENITIS SUPPURATIVA (HS)?



DR. NEIL SHEAR Head of Dermatology, Sunnybrook Hospital

"HS is a chronic, painful, inflammatory skin disease that affects 1-4% of the general adult population. It is characterized by boils usually occurring where certain sweat glands are located, such as under the breasts, buttocks, and inner thighs." "People with HS come to the emergency room in severe pain and discomfort requiring assistance with the draining of the boils during a flare-up. It's not unusual for patients to go home undiagnosed."



DR. VU KIET TRAN ER physician at University Health Network



DR. RALPH GEORGE Associate Professor, University of Toronto, Division of General Surgery

"There is currently no cure for HS. Early diagnosis and proper management is important for a patient's quality of life. The first step for those with HS is to speak to their dermatologist to get an accurate diagnosis."

To learn more about HS from these specialists, go to www.RecognizingHS.com/HS10

WHEN YOU SEE THESE LESIONS, DO YOU SUSPECT HS? DO YOU ASK ABOUT RECURRENCE?



Photo compliments of Dr. Afsaneh Alavi.

ASSESSING PATIENTS WITH RECURRENT BOILS

Most HS cases can be recognized with high reliability by the presence of 3 main features:¹⁻³

- 1. Typical lesions: nodules, sinus tracts, abscesses, scarring
- Typical anatomical location: axilla, groin, genitals, under the breasts, others (perianal, neck, abdomen, buttocks)
- **3. Relapses and chronicity:** \geq 2 times per 6 months



Photo compliments of Dr. Marc Bourcier.

Questions to ask your patients with suspected HS:² 1. Have you had outbreaks of boils during the last 6 months? 2. Where were the boils and how many did you have?

To confirm an HS diagnosis, please refer your patient to a dermatologist.

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