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# Canadian Rheumatology Association Position Statement on Virtual Care

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Virtual care has become increasingly important during the COVID-19 epidemic. Virtual care, sometimes referred to as telemedicine, includes the use of video and telephone platforms.

The Canadian Rheumatology Association (CRA) supports the delivery of high-quality care for patients, regardless of the mode of healthcare delivery. Since virtual care visits will continue after the COVID-19 pandemic has ended, the CRA is in a unique position to identify opportunities where virtual care may improve care, and also establish best practices.

The CRA holds the following positions on virtual care. As the literature surrounding virtual care in rheumatology evolves, the CRA's positions may change.

- 1. Virtual care has an emerging role in rheumatologic clinical care.** Evidence surrounding the efficacy of virtual care in rheumatology is growing. Several limited studies have documented similar outcomes in stable and new rheumatoid arthritis patients seen by virtual care compared to in-person care (Taylor-Gevre R et al 2018, de Thurah A et al 2018, El Meidany Y et al 2016). The role of virtual care in managing other rheumatic diseases remains to be defined (McDougall JA et al 2017). Conditions less reliant on a physical examination may be easier to manage by virtual care.
- 2. Virtual care has the potential to improve access to care for historically underserved communities. Care should be taken to ensure that virtual care does not deepen inequities.** Rheumatologists are scarce and distributed unequally in Canada, with many practicing in urban centres (Barber CE et al 2017). Individuals from rural and inner-city locations, as well as Indigenous and marginalized individuals, frequently struggle to access rheumatologists (Ferucci ED et al 2020). Virtual care may improve access to care to these individuals. However, internet speed and access, and digital literacy can be barriers to accessing virtual care (Canadian Radio-Television and Telecommunications Commission, 2019). Virtual care practitioners should be mindful that their practice does not widen disparities in care for marginalized populations.
- 3. Further research is required to establish best practices and safe use.** Multiple questions surrounding virtual care remain unanswered. Several virtual models of care exist, including direct patient-physician encounters, encounters with allied health professionals or other clinicians assisting with physical exam, alternating in-person and virtual appointments, telephone encounters, real-time virtual care hotlines, and asynchronous encounters (Piga M et al 2017, McDougall JA et al 2016). Optimal virtual models of care remain to be defined. Effective pediatric rheumatology models of care may also differ from adult rheumatology. Within pediatrics, the role of surrogates during virtual care encounters and indications for the child being present during the encounter require clarification (Shenoi S et al 2020). Although many virtual care-specific measures of disease activity have been proposed, there is no consensus on the

best method of measuring disease activity remotely via virtual care. Further research is also required to determine the accuracy of diagnoses made by virtual care.

4. **Virtual care encounters should receive equal remuneration to in-person visits.** When used appropriately, virtual care is a tool that can provide excellent clinical care, and simultaneously improve worker productivity, reduce travel costs, and improve access to care. In this era of patient-centred care, patients consistently describe satisfaction with virtual care (McDougall JA et al 2017). Ongoing virtual care requires appropriate remuneration. A January 2021 survey of CRA members indicated that 73% of Canadian rheumatologists support equal remuneration for virtual care encounters (CRA Survey, 2021). As justification, some respondents noted that virtual care encounters may take longer than in-person visits and require more complex administrative support. Equal remuneration is also essential since overhead costs will likely remain unchanged or increase for clinicians who engage in virtual health. Software and hardware requirements for virtual care will incur further costs to clinicians, and overhead associated with ongoing in-person visits will not change.
5. **Clinicians should have choices for the virtual care platform they would like to use.** Standards for safe, secure virtual care platforms are established in the Canadian Personal Information Protection and Electronic Documents Act (PIPEDA), as well as health information and personal information protection acts in individual provinces. Multiple programs meet these standards. Technology evolves rapidly, and patient and clinician preferences for virtual care platforms will evolve over time. Restricting clinicians to a provincially-mandated virtual care platform stifles innovation. Restrictions may perpetuate inequities if accessibility to these platforms is challenging for patients and clinicians. Lastly, hospital firewalls and other security measures may worsen virtual access to care to certain clinicians.
6. **Virtual care should support local healthcare providers.** Rheumatologists practicing in underserved regions should be supported. Virtual care programs to such regions should strive to complement and augment care already being provided by these rheumatologists. In communities with no rheumatologists, joint consultations with primary care and allied health professionals may build capacity bidirectionally and thus need to be supported. Such virtual care encounters provide an opportunity for rheumatologists to share clinical knowledge, as well as physical exam and procedural expertise. Conversely, joint consultations allow local health professionals to educate rheumatologists about available resources and social determinants that impact patient care.

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