Without a doubt, virtual care is here to stay. There is perhaps no health services innovation that has been more rapidly instituted and discussed within the current medical discourse. Although the existence of virtual care is clearly *un fait accompli*, the details and permutations of virtual care (or its best models) are far from settled. In this regard, it shouldn’t be surprising that the Canadian emergency medicine (EM) community has also engaged in virtual care. In November 2020, the Canadian Institute for Healthcare Information (CIHI) reported a staggering drop in emergency department (ED) attendance throughout the country1. Some centres in Canada were clearly early adopters of virtual care2–5, yet many others responded to reduced ED volumes by providing low-barrier and low-exposure ED care by instituting their own virtual services. As part of the COVID-19 pandemic response, in the Fall of 2020 the Ontario Ministry of Health approved up to $4 million to fund 14 regionally coordinated, virtual urgent care initiatives across the province. This funding was intended to support ED diversion of patients with low acuity issues and reduce the need for face-to-face contact whenever possible.

Early trials of virtual ED care are now returning results that allow us to better understand the need for operational parameters of the service. First and foremost, it should be acknowledged there is clearly a demand for this service within the population. Many of these services remain in growth trajectories over the course of the first six to twelve months. This occurs despite the lack of dedicated marketing and promotional budgets in most centres which might drive patients to the service. The reported volumes, in these early stages, are akin to opening a new moderate-sized ED in most provinces with very limited infrastructure funding. Yet some have called this comparison into question. Quite appropriately, an astute observer might ask whether these patients would otherwise have been destined for the ED in the first place.

It is without question that healthcare restrictions, across the system, have had a dramatic role in pushing patients towards this service. As stated, these reduced presentation volumes to the ED are, at least, partially responsible for the creation of these services. Yet early data suggest these virtual patient presentations have very different presenting complaints and triage scores (in those sites using triage nurses for virtual services) compared to a traditional in-person ED cohort. Early data also suggests a smaller yet significant population (nearly 20%) is referred to the ED for assessment and treatment after their virtual ED visit in addition to a smaller group (2-5%) who are referred directly to the ED for in person care during the intake processes for virtual care. This leads to a larger discussion around subgroups within the presenting ED population. Some patients are clearly in need of emergency services as early data shows a small diversion directly to the ED for care. Others are likely patient populations looking for expedited care, a proportion of which will be suitable ED presentations (which proportion is not yet clear as outcome data is not yet available for these populations). Wholesome and broad analyses of these services will begin to shed light on the answers to these questions but are unlikely to tell the whole story.

Before we are critical of patients seeking expedited care, we must be honest about the current barriers to conventional health care and see these needs as a symptom of larger and broader health systems issues that need to be addressed. After all, this behaviour should not be surprising. The market for virtual consultative services in the “urgent care” sphere is well established with private entities filling this void for many years across Canada. The reality that walk-in clinics continue to be a viable business model is an additional material acknowledgement of the shortcomings of current health care models. And these patterns are not surprising when viewed from a patient perspective. Patients may not, and should not, be expected to differentiate between ED practitioners, family physicians, virtual care providers and those working at walk-in clinics. As such, all represent areas of competence that can help with their medical need, a choice which is then made based on access to care. This should not be disdainful or reviled by the EM community. The need to have an ailment addressed in a timely way is what we would all want for ourselves and our family members. Early data would support that patients are using virtual urgent care because it is available in a short course. As a result, we should see this portion of virtual urgent care usage, however large or small, as a symptom of a larger system access problem.

Recently, there has been a welcomed shift for government and public agencies to move toward evidence-based policymaking in health care. This approach favours the use of data gathered by independent, academic evaluations conducted by qualified research scientists who work in the health sector over the opinions, anecdotes, and perspectives typically gathered from market research consulting firms. In the spirit of the purest form of evaluation of this work, we must openly state that no centres within Ontario are ready to comment or provide an analysis of the quality-of-care outcomes for the patients seen as part of this virtual service. In Ontario, the provincial evaluation committee has committed to an independent, academic evaluation of the virtual urgent care pilot program, including a robust quantitative and qualitative evaluation of patient and provider experience, patient healthcare utilization, and an economic evaluation comparing virtual urgent care to traditional emergency department ED visits. Quantitative analyses will include subsequent visits to both primary care and ED, the results of these visits, downstream procedures and even death (all sourced from provincial administrative databases). These will be compared to a matched in-person ED patient population over the same time period. The qualitative analysis will include follow-up interviews with patients and caregivers, providers, and administrative staff. Some of the topics being addressed include patient/family decision making on why they chose virtual urgent care and what their experience was, provider perspectives on the provision of virtual care, and the challenges of launching and sustaining a virtual urgent care service, including issues pertaining to physician staffing. There is also a standardized provincial survey which includes a series of questions related to patient reported outcome measures (PROMs) that focus on the results of patient care as well as the patient and caregiver experience of receiving virtual care services. It should be noted the rigor of these qualitative analyses are not met in the in-person ED setting. This analysis is slated to provide a balanced dataset that will empower more evidence-based decision-making around virtual urgent care as a service. What is most important is anchoring this work in quality-of-care endpoints.

A thorough discussion around the virtual emergency care program would also be incomplete without a discussion on equity, especially related to access to the service. Participation implies access to an Internet-capable device, a private and secure Internet connection, availability during weekday hours, English language proficiency, and a host of other assumptions that come with inherent bias. There are also important regional disparities to consider. These virtual ED services are, at times, being offered in regions of the province where access to healthcare is already abundant (e.g., the Greater Toronto Area) whereas, in other instances, this care may be one of only a few available options (e.g., northern, rural and remote Ontario). The barriers to this service remain significant for those who are typically disadvantaged by our current healthcare delivery methods. Next iterations should include collaborations with inner-city groups for technology sharing and low-barrier visits with the ED clinician, language translation services, and distributed community hubs which may permit broader access. All of this while knowing that a safety analysis for this group may be incomplete as they are not well represented in the participant population yet may be the population who could benefit the most.

It is clear the uptake has been vigorous. The challenges are many, yet so are the promises brought by this technology. The question is not whether we should keep this service or not. Instead, we should acknowledge that getting this right will require some iteration. We should commit to a laudable outcome rather than a final state, leaving the door open for innovation that brings better and more meaningful healthcare to those who would most benefit from it.

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