Policy:	***Provision of Publicly Funded Virtual Health Services***
Originating Branch:	**System Innovation and Primary Health Care**
Original Approval Date:	Dec 16, 2020 ***Effective Date:***
Approved By:	**Deputy Minister Health and Wellness**

Version 1 [New]

1. POLICY STATEMENT

1.1. Publicly funded virtual health services (virtual care) will complement in-person health services and:

1.1.1. improve patient experience, quality of care, and health outcomes;

1.1.2. strengthen population health outcomes;

1.1.3. deliver better value in the delivery of care; and,

1.1.4. improve provider experience in the delivery of care.

2. DEFINITIONS

2.1. Virtual health services are defined in this policy to be any interactions between patients and/or members of their circle of care, occurring remotely, using synchronous or asynchronous forms of communication.

2.2. Synchronous methods of virtual care (e.g. real-time telephone or *Personal Health Information Act* (PHIA, 2010) compliant video platforms such as Telehealth or Zoom for Healthcare) are permitted for use and billing in accordance with this policy.

2.3. Asynchronous methods of virtual care, such as secure messaging through an Electronic Medical Record (EMR), are permitted for use in accordance with this policy. However, asynchronous methods of virtual care are not approved for billing within Nova Scotia at this time.

3. POLICY OBJECTIVES

3.1. To ensure that publicly funded health services that are provided virtually (virtual care) complement in-person care services as part of the overall model of care.

3.2. To ensure that these services are provided to Nova Scotians in a manner that is safe, equitable, of high quality, and sustainable while improving accessibility, timeliness, efficiency, patient and provider satisfaction, and appropriateness of care.

4. APPLICATION

4.1. This policy applies to all publicly funded services funded by the Department of Health and Wellness (DHW), the Nova Scotia Health Authority (NSHA), and the IWK Health Centre (IWK) as they exercise their interdependent statutory mandates, as outlined

under the *Public Service Act*, the *Health Services Insurance Act*, and the *Health Authorities Act* (HAA, 2015), including community based organizations funded by DHW/NSHA/IWK that provide publicly funded services.

4.2. This policy applies to all publicly funded virtual health services provided by regulated health professionals as defined in the *Regulated Health Professions Act* (2012) or non-regulated health professionals whether an **employee or contractor** of DHW, NSHA, or IWK (including audiologists, counseling therapists, dental hygienists, dentists, dietitians, licensed practical nurses, midwives, nurse practitioners, occupational therapists, paramedics, pharmacists, physicians, physiotherapists, psychologists, recreation therapists, registered nurses, respiratory therapists, speech-language pathologists, and social workers) or regulated health professionals in **private practice** who directly bill the government a fee through the Medical Services Insurance Plan (MSI) for their services such as dentists, optometrists, pharmacists, and physicians.

4.3. Regulated health professionals can offer publicly funded virtual health services to Nova Scotians if the health professional is licensed to practice in Nova Scotia and is physically present in the province when the virtual health service is provided. In cases where a provider has a physical office location in Nova Scotia close to the border with New Brunswick (e.g. in Amherst) but resides in New Brunswick, virtual care can be provided and billed for when the provider is in New Brunswick.

4.4. Virtual health services delivered to Nova Scotians may only be billed to the MSI Plan if the patient is physically located in Nova Scotia when the virtual health service is provided.

4.5. Services provided to non-Nova Scotian residents by regulated health professionals licensed to practice in Nova Scotia must adhere to the policies in place in Nova Scotia and those of the other jurisdiction, including the need for licensure in the other jurisdiction, virtual health standards of practice, and payment of virtual health services.

4.6. Exceptions to sections 4.3 and 4.4 may be granted on a case by case basis upon application to DHW by a regulated health professional or the professional's employer.

4.7. This policy incorporates and is subject to the following appendices, attached hereto:
   a) Appendix 1- Security and Privacy
   b) Appendix 2- Physicians

4.8. Health profession regulatory bodies in Nova Scotia, in their self-regulating role, can consider this policy when determining their approach to practice standards for publicly funded virtual health services.

4.9. This policy does not apply to non-publicly funded virtual health services.

5. ROLES AND RESPONSIBILITIES

5.1. The **Province of Nova Scotia**, through the Minister of DHW, is accountable for developing the overall provincial strategic policy direction, including provincial policies, standards, and guidelines, for the provision of publicly funded virtual health services for Nova Scotians. DHW will develop the governance structure for publicly funded virtual health services, direct the system work related to virtual care, and work with partners to audit remuneration and establish a monitoring and evaluation framework for virtual care.

5.2. **NSHA and IWK** are responsible for the provision of health services for Nova Scotians, as specified in the *Health Authorities Act*. NSHA and IWK are responsible to determine the optimal approach that will facilitate the implementation of the overall provincial strategic policy direction for the provision of publicly funded virtual health services for Nova Scotians, ensuring quality, safety, equity, and sustainable

approaches. NSHA and IWK are responsible to develop operational policies and procedures, while monitoring and providing support for virtual care. NSHA and IWK will collaborate to monitor and evaluate virtual care and report on these initiatives to DHW through existing accountability reporting requirements.

5.3. **Health professionals** (as defined in section 4.2) providing publicly funded virtual health services are responsible to practice in a safe and efficient manner, adhering to the standards developed by the health profession regulatory bodies, DHW, NSHA, and IWK for the provision of publicly funded virtual health services. Health professionals delivering publicly funded virtual health services will have the opportunity to contribute to DHW/NSHA/IWK's monitoring and evaluation efforts for virtual care.

5.4. The **health profession regulatory bodies**, in their self-regulating capacity, are responsible for developing, implementing, and monitoring adherence to practice standards, codes of ethics, and other relevant documents related to the provision of health services. The regulatory bodies can consider this policy on publicly funded virtual health services as they update their practice standards to support registrants to determine what health services can be provided virtually and the overall practice standards for the provision of virtual care.

6. POLICY DIRECTIVES

Technology, security, and privacy

6.1. Personal health information custodians, as defined in PHIA, must ensure the security and privacy of personal health information.

6.2. All stakeholders involved in the provision of publicly funded virtual health services (including DHW, NSHA, IWK, health professionals, and third party technology companies) must adhere to DHW's provincial standards that are 'at minimum' requirements for use for security and privacy.

6.3. Health professionals are responsible for costs related to set-up and maintenance, technology, and devices for the provision of virtual care. NSHA and IWK will be involved where relevant to guide set-up and provide practice supports.

Standard of Care

6.4. In person care continues to be the standard approach for patient care. Virtual care can be offered as part of this model.

6.5. The established practice standards, as set by the health profession regulatory bodies, must be met regardless of the modality used (in-person or virtual) to deliver the health service. Health professionals must have ready access to their practice's information/file/chart on the patient and must document the encounter as per standard practice.

6.6. When a virtual appointment is the first encounter between a patient and health professional, building the therapeutic relationship must be a key component of the encounter.

6.7. Health professionals are to determine a reasonable and timely course of action for follow-up with the patient, should the virtual care technology become unavailable during the appointment.

6.8. Modality of visit is chosen based on known and emerging best practices, patient circumstance, likelihood of positive outcomes, and informed discourse with the patient.

6.9. Patients have the right to choose an in-person visit and/or refuse a virtual appointment. Health professionals will work with patients to determine the best modality for the

patient encounter (in-person or virtual) while adhering to practice standards, protocols, and Public Health guidelines outlined by relevant health profession regulatory bodies/DHW/NSHA/IWK and using professional judgement, while also prioritizing patients' preferences and needs for virtual or in-person encounters. Offering virtual visits should not contribute to increased patient isolation.

6.10. Health professionals must continue to meet the legal, ethical, and professional obligations that apply to in-person care and abide by the scope of (virtual) practice outlined by their regulatory bodies.

6.11. Health professionals must adhere to PHIA, and other applicable laws of Nova Scotia in the provision of virtual care, including but not limited to obtaining a patient's consent, whether express or knowledgeable implied consent, and documenting the same in accordance with PHIA.

Accountability

6.12. Publicly funded virtual health services will be remunerated at the same rate as in-person health services, as per existing DHW policy or negotiated tariffs. Existing audit measures and functions are applicable to this policy.

6.13. Health professionals will be remunerated as per existing DHW policy or negotiated tariffs for a virtual visit done while supervising a student, resident, intern, or other learner.

6.14. For health professionals who directly bill government a fee for their services, billing for a virtual visit, in addition to an in-person visit for the same issue, is only permitted when medically necessary and the treatment/management plan discussed at each visit is well documented in the patient's chart. For greater clarity, where no treatment/management plan can be determined based on the clinical assessment during a virtual encounter and an in-person encounter is required to make a clinical assessment and decision, billing for the virtual visit is not permitted. There may be some circumstances where clinical judgement may determine the need for further in-person assessment as a follow-up to a virtual appointment and this is permitted.

6.15. Health professionals (whether an employee or contractor of DHW, NSHA, or IWK or a health professional in private practice) who are remunerated for publicly funded virtual health services are obligated to meet DHW's monitoring and evaluation requirements.

7. POLICY GUIDELINES

Enhanced access to care

7.1. Virtual care, as part of the model of care, can support access to safe and timely care by a variety of health professionals providing publicly funded virtual health services.

7.2. Virtual care will support continuity of care without compromising access to services.

7.3. Virtual care literacy for patients, along with access to technology and devices, are critical components of ensuring access to publicly funded virtual health services.

People and community centered approaches

7.4. Collaboration and the creation of a shared understanding of delivering and receiving publicly funded virtual health services will support positive outcomes (e.g. patient choice for in-person or virtual, digital equity, digital literacy and etiquette, importance of being prepared for a virtual appointment, and how to support privacy and security).

7.5. Virtual care can reduce disparities in health services in marginalized groups by increasing accessibility to services and providers, addressing inequitable access to

health services, and respectfully responding to the diversity of Nova Scotians (including race, ethnicity, language, sex, sexual orientation, gender identity, (dis)ability, spirituality, age, geography, literacy, education, income).

High-quality, safe, and appropriate care

7.6. Health professionals will collaborate with patients and other providers to ensure that the provision of virtual care does not limit access to necessary in-person care and is integrated into an overall plan of care.

7.7. Virtual care is well coordinated, promoting smooth transitions between various parts of the health care system including between providers. The provision of virtual care should not create negative consequences on other parts of the health care system (e.g. a virtual visit that results in an unnecessary referral to an Emergency Department rather than an in-person appointment with the same provider).

7.8. DHW, NSHA, IWK, and publicly funded health care professionals are stewards of the health care system and will offer publicly funded virtual health services in a cost-effective manner.

8. ACCOUNTABILITY

8.1. For the purpose of the administration of this policy, accountability is delegated to the Deputy Minister of Health and Wellness.

8.2. The Chief Design Officer, and/or designate, has responsibility for on-going monitoring and enforcement of this policy.

8.3. DHW will establish a coordinated approach to oversee the development, implementation, monitoring, and evaluation of the *Provision of Publicly Funded Virtual Health Services* policy, considering existing governance structures within the health system.

8.4. DHW will continue to consult with NSHA, IWK, health profession regulatory bodies, health professional associations, health professionals, and patients regarding virtual care.

9. MONITORING / OUTCOME MEASUREMENT

9.1. The Chief Design Officer, and/or designate, will monitor the implementation, performance and effectiveness of this policy.

9.2. DHW, working with NSHA, IWK, health profession regulatory bodies, health professional associations, health professionals, patients, and other stakeholders, will develop an approach to monitor and evaluate this policy.

9.3. DHW will continue to monitor and engage with other governments and stay apprised of the establishment of publicly funded virtual health services across Canada.

9.4. DHW will make policy updates as needed in consultation with NSHA, IWK, health profession regulatory bodies, health professional associations, health professionals, patients, and other stakeholders.

10. REFERENCES

10.1. Benefits Evaluation (2020) Prepared by MJ Hampton, Stylus Consulting.

10.2. COVID-19 CADTH Policy Insights - Enablers for Virtual Visits (September 4, 2020).

10.3. Enhanced Access to Primary Care: Project Evaluation Final Report (September 2017) Prepared by the Women's College Hospital Institute for Health Systems Solutions and Virtual Care, Prepared for Ontario Telehealth Network – The Minister of Health and Long-Term Care.

10.4. FMRAC Framework on Telemedicine 2019. Federation of Medical Regulatory Authorities of Canada. Available: http://fmrac.ca/wp-content/uploads/2019/04/Framework-on-Telemedicine-Final.pdf.
10.5. MyHealth NS VC Stipend Evaluation, Efficiency and User Satisfaction (2020), prepared by Stylus Consulting.
10.6. NSHA VC Rapid Review : Tomblin Murphy, G., Sampalli, T., Sheriko, J., Guk, J., McIsaac, K., Koto, P., Meier, D., Theriault, C., Sim, M., Embrett, M., Packer, T., Enderlein, C., Sahijwala, V., Sheppard, D., Rubenstein, D., Clegg, J., MacNeil, R., Martin-Misener, R., Sheppard-LeMoine, D., Curran, J., Cassidy, C., Christian, C., Wozney, L., Hollenhorst, H., Zelmer, J., Murdoch, J., Akbari, M. et al. (2020). A rapid review of virtual care implementation in Nova Scotia during COVID-19 to help inform a future strategy in the province. Nova Scotia Health, October 2020.
10.7. Virtual Care in Canada: Discussion Paper. Canadian Medical Association. (2019). Retrieved at: https://www.cma.ca/sites/default/files/pdf/News/Virtual_Care_discussionpaper_v2EN.pdf.
10.8. Virtual Care Playbook. Canadian Medical Association (CMA), College of Family Physicians of Canada (CFPC), and Royal College of Physicians and Surgeons of Canada (RCPSC). (March 2020). Retrieved at: http://www.royalcollege.ca/rcsite/documents/about/covid-19-resources-telemedicine-virtual-care-e.
10.9. Virtual Care Policy Recommendations for Patient-Centred Primary Care: Findings of a Consensus Policy Dialogue Using a Nominal Group Technique. Shaw J, Jamieson T, Agarwal P, et al. J Telemed Telecare 2018;24(9):608–15.
10.10. Virtual Care Recommendations for Scaling Up Virtual Medical Services, Report of the Virtual Care Task Force (February 2020) Canadian Medical Association, Royal College of Physicians and Surgeons Canada and College of Family Physicians of Canada.

11. APPENDIX 1- Security and Privacy (as of November 26, 2020)

Definitions

- Privacy Assessment – in contrast to the development of a specific, implementation targeted Privacy Impact Assessment (PIA), a Privacy Assessment (PA) assesses the privacy and access risks and considerations required for a generic implementation of a vendor's solution.
- Security Assessment – in contrast to the development of a specific, implementation targeted Threat Risk Assessment (TRA), a Security Assessment (SA) assesses security risks and considerations required for a generic implementation of a vendor's solution.

Objectives of a Privacy & Security Assessment:

- To inform DHW, custodian users of virtual care tools (NSHA, IWK, health professionals), and other stakeholders about privacy and security risks associated with the tools (including areas of potential non-compliance with NS privacy legislation).
- To provide recommendations for mitigating any identified risks.
- To identify additional considerations including best practice guidance for custodians as they implement and use the EMR virtual care tools.

FURTHER TO SECTIONS 2.2, 2.3, 6.1, and 6.2
The following virtual care tools have undergone an Operational Privacy Impact Assessment, an Oversight Privacy Assessment, or an Oversight Security Assessment and **are approved for use with virtual care in Nova Scotia**. The list of assessed tools will continue to evolve based on need, new vendor product offerings, etc. As such, DHW will review and update this appendix as required.

Operational Privacy Impact Assessments have been completed for:

- Health Myself
- Medeo Virtual Care
- Telus Virtual Visit
- Zoom
- eResults

Oversight Privacy Assessments (PAs) have been completed for:

- Telus (EMR)
- Accuro (EMR)
- Zoom
- eResults
- Thrive

Oversight Security Assessments (SAs) have been completed for:

- Telus (EMR)
- Accuro (EMR)

12. APPENDIX 2- Physicians

12.1. **FURTHER TO SECTION 4.2:** This policy applies to all publicly funded virtual health services provided by physicians as defined in the *Regulated Health Professions Act* (2012) whether affiliated with DHW, NSHA, or IWK or in private practice who directly bill the government a fee (Medical Services Insurance Plan). Clinical Academic Funding Plan (C/AFP) physicians, and Alternative Payment Plan physicians who shadow bill for their services are also included in this policy. In this Policy, references to billing include shadow billing.

12.2. **FURTHER TO SECTION 4.3:** Services which have historically been provided out of province (e.g. IWK pediatrics) and are reciprocally billed continue to be delivered as per usual. Physicians providing services in the Amherst area but residing in New Brunswick may provide virtual care to their Nova Scotia patients, provided it meets College of Physicians and Surgeons standards and the provisions laid out within this policy.

12.3. **FURTHER TO SECTION 6.3:** Responsibility for technology costs related to set-up, maintenance, technology, and devices vary depending on the physician group. As independent contractors, physicians are responsible for their overhead costs.

12.4. **FURTHER TO SECTION 6.4:** Virtual care should complement in person care. As such, it is expected that the majority of services billed, shadow billed, or claimed through sessional will be provided in person.

12.5. **FURTHER TO SECTION 6.6:** Virtual care cannot be used for physician walk-in clinics unless it is a Health Authority supported clinic approved by DHW.

12.6. **FURTHER TO SECTION 6.12:** Publicly funded physician virtual health services must be provided in accordance with the *Physician Manual, including the Preamble,* and MSI Physicians' Bulletins. Existing physician audit measures and functions are applicable to this policy.

12.7. **FURTHER TO SECTION 6.13:** Clinical Supervision rules are detailed in the *Physician Manual, Assessment Rules for Specialized Services – Clinical Supervision.* These rules apply to the supervision of residents and medical students in a virtual care setting.

12.8. **FURTHER TO SECTION 6.14:** Visit rules are detailed in the *Physician Manual, Assessment Rules for Visits and Related Services.* These rules apply to the provision of virtual care.

13. VERSION CONTROL

Version 1:	New Policy

14. INQUIRIES

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