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Canadian Association of Emergency Physicians (CAEP) Expresses Its Position on Providing Virtual Care to Emergency Departments

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The Canadian Association of Emergency Physicians (CAEP) outlines its position below on the involvement of external (non-integrated) virtual care (VC) providers and their role in provincial networks of emergency care. We emphasize the necessity of integrating clinical services planning with the rest of the healthcare system, and express concerns about the potential impact on rural emergency care.

Key Points from CAEP:

1. **Public Expectations and ED Definitions:** Public expectations for an Emergency Department (ED) include the availability of an emergency physician (EP) to competently manage unexpected and time-sensitive illnesses or injuries. Unless an EP with competencies in emergency care is available to provide in-person assessment and treatment, the facility must not be labeled an ED. The terminology used to differentiate the various health care access points must be precise, clear, and transparent for patients. To do otherwise would be misleading for the public and could undermine the ambulance service system.
2. **Clear Roles in Emergency Care Systems:** While there is a spectrum of emergency care facilities, from rural to tertiary care urban EDs, VC cannot transform a non-ED facility into a functional, full-scope ED. There are many instances in emergency care where in-person EP assessment and interventions cannot be replaced by VC. Still, EPs can play a vital role in VC for example through consultation, transportation, and coordination, assisting providers in rural/remote EDs and non-ED facilities such as nursing stations and primary care clinics.
3. **Program Design with Expert Consultation:** Designing virtual support for rural and remote clinicians, or direct-to-patient services, should involve local, regional, and provincial expertise from physicians with experience in emergency care systems. To improve rural emergency care, it is crucial to utilize the expertise of provincial emergency medicine (EM) experts as part of a cohesive, integrated plan.
4. **Partnerships with Patients and Providers:** Supporting rural EDs with VC must be done in partnership with community members and health professionals. Including these key interested parties will ensure clear problem identification and associated solutions allowing VC to supplement rather than replace or usurps other effective services. Short-

term VC “solutions” may hinder long-term sustainability and recruitment efforts if not appropriately implemented and evaluated. Conversely, well-designed VC can support recruitment and retention by providing real-time peer support and reducing health professionals' isolation.

5. **Integration with Provincial Emergency Care Service Planning:** CAEP highlights that the involvement of transactional/retail/external VC providers that are not fully integrated into provincial emergency care service planning is highly problematic. Such programs should be publicly administered and integrated, to allow coordination of finite resources (workforce, funding etc.) to meet the broader system needs and strategic plans. Episodic and fragmented VC can lead to further silos within the healthcare system and a breakdown of accountability, a crucial aspect of quality care.
6. **Maintaining Standards in EDs:** There continues to be extreme pressure to keep EDs open at any cost, which can lead to blurring of definitions and lapsing of standards. CAEP stresses the importance of maintaining standards to meet the needs of patients with unexpected/time-sensitive illness and injury. To maintain public trust, the public must know what to expect when they visit an ED. From a health equity lens, programs must consider standards of care and ensure that rural and remote patients have equitable access to high quality care. VC can be part of a hybrid approach but cannot replace in-person emergency care.
7. **Supporting Rural EDs as Part of the Broader Health System:** Rural EDs should not be considered in isolation, but as integral parts of a broader health system – one system, with many access points. We must optimize the number, distribution, and integration of EDs in the system to meet population needs. It is vital to carefully consider the workforce and programs needed to provide care in rural and remote communities, including nurses, physicians, and prehospital care providers, to optimize high quality care close to home.

CAEP remains committed to advocating for high standards in emergency care for Canadians, regardless of postal code, and ensuring that patients receive the advantages of well-designed and properly integrated virtual support systems. A more extensive Position Statement is currently being developed by our Digital Emergency Medicine Committee and will be released in the coming year.

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