

Department of Psychiatry Virtual Care Handbook for Residents and Faculty

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Introduction

Virtual care involves the use of technology – usually televideo or telephone – to provide direct or indirect clinical care to patients, families and caregivers through consultation with health professionals. Other commonly used terms to describe virtual care are telehealth and telemedicine. In particular specialties, such as mental health and addictions services, virtual care is often referred to as telepsychiatry, and more inclusively telemental health, which signifies the use of televideo by interprofessional team members. Virtual care is part of a larger field of e-health or digital health, often used interchangeably, which is healthcare provided and/or enhanced by technology. Throughout this handbook we will use the term virtual care, but understands that it intersects with this broader field of digital health.

Our landscape for providing virtual care changed dramatically in March 2020 with the onset of the Covid-19 pandemic. Public health measures restricted in-person care, and to sustain healthcare, most provinces in Canada, and in fact globally, loosened restrictions on virtual care, and enhanced remuneration of services rendered virtually.¹

Prior to the pandemic, less than 1% of psychiatric services were delivered via telehealth²; since then, we have seen a 3000% increase in the use of telehealth in many settings. Feedback from the public indicates that most individuals want to see virtual care as an option within our health system. Yet, there are many key issues to address as we work to make virtual care an integrated part of healthcare.³ One of these issues is ensuring that health professions students receive adequate training and support to provide virtual care.

Residents and faculty in the Department of Psychiatry nimbly shifted to virtual care, education and supervision, often with limited resources, despite variations in policies and procedures for virtual care across our clinical sites. This document gathered current best- and promising- practices in virtual care. Our goal is to enhance education in virtual care, and to ensure that guidance and resources are available to residents and faculty. This handbook is a living document, developing as we refine this modality of care. If you have feedback, would like to get involved, or have resources to suggest, please contact Allison Crawford allison.crawford@utoronto.ca.

In this document, specific CMPA guidance is presented in quotation marks. Additionally, links to CMPA and other guidance documents are found on the resources page at the end of this handbook.

Providing virtual care

Person-centered virtual care

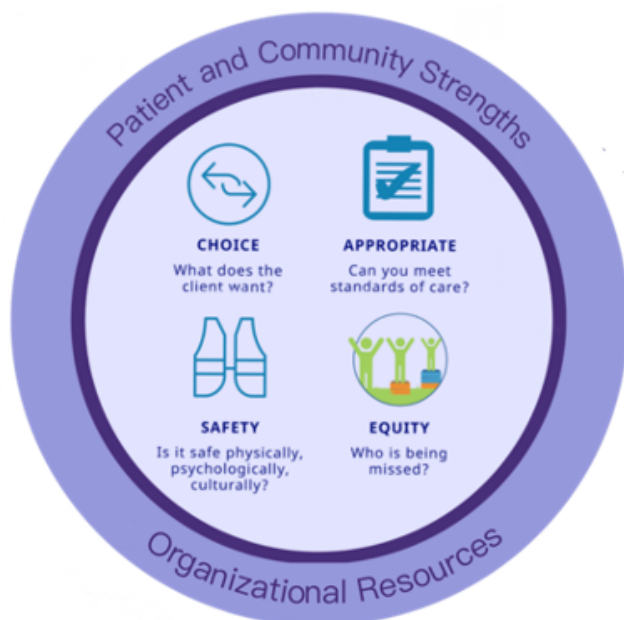
There is considerable evidence that virtual care is reliable across a range of psychiatric diagnoses, age groups, and interventions.^{4,5} Patients tend to rate virtual care highly,⁶ including the ability to develop therapeutic alliances, even for individuals experiencing severe mental illness.⁷

Although there is an emphasis on virtual care increasing access to mental health care, it is often discussed without appropriate consideration of the quality of care. The Institute for Healthcare Improvement has identified 6 dimensions of quality of care - Safety, Effectiveness, Patient-Centeredness, Timeliness, Efficiency, and Equity⁸ – which we need to achieve to within virtual care.⁹ As we move forward with virtual care post-pandemic, we will have to balance both access to and quality of quality virtual care. For example, factors to consider include: community context, including access to technology and health resources, community infrastructure to support technology, and digital health literacy.

The CASE approach, shown in the diagram below, provides a framework for achieving quality of care by considering patient choice, appropriateness of care delivered virtually, safety of virtual care, and equity in virtual care. This approach considers the context of patient and community strengths, the available organization and health systems supports and resources.

In the sections below, we highlight important practical, medicolegal, and technical considerations for providing virtual care. For optimal outcomes, these important considerations must be viewed through the lens of larger social and health systems contexts.

Patient-centered and Equity-driven virtual care: CASE by case approach that leverages patient and community strengths



Building models of integrated virtual/ in-person care that consider:

CASE

- patient Choice
- Appropriateness of virtual care
- Safety of virtual care
- Equity in access and outcomes

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Technology

There are a wide range of platforms available to provide virtual care. The Ontario Telemedicine Network (OTN), now part of Ontario Health, is the longest standing provider in Ontario, but as technology and regulations have shifted, we have seen an opening up of platforms used for patient care, including Cisco WebEx, Microsoft Teams, and Zoom. Increasingly, these platforms are being integrated into electronic health records.

The most important factor for residents and faculty to consider is what platforms are approved for use at their clinical sites. This should be confirmed prior to initiating any clinical care or supervision.

Users should also confirm what devices they are allowed to use to provide care; for example, can a personal computer be used, or must you provide clinical care from a work device.

Residents should also confirm which sites they are allowed to provide virtual care, including whether they are allowed to provide clinical care from home.

Equipment to consider for providers:

Hardware:

- **Computer:** Until quite recently, most telemedicine was provided using room-based systems secured via ethernet. Currently, most videoconferencing software is available through any computer, although this will vary by provider. Some sites may require use of a computer that is linked in with the hospital-based system. For clinical care, an important consideration is screen size. You need optimal visibility of the patient to conduct exams; therefore a full screen is recommended. It can also be helpful to have dual screen functionality to enable you to access your computer during sessions if needed.
- **Camera:** A high definition camera with microphone will allow the best experience for providers and patients. Using a laptop with integrated camera and microphone offers flexibility, but the quality may be impacted.
- **Headphones:** Quality speakers or headphones are necessary, with headphones offering the additional benefit of enhancing privacy. Factors to consider with headphones include comfort, while also considering the visual impact of some headphones, which can be obtrusive.
- **Secure USB devices:** If clinical documentation must be transferred from one computer to another, particularly across different systems (such as from home to work, or from one clinical site to another) please ensure that you are aware of the privacy policies of your current site (see below), including whether secure file transfer is available, and/or which encrypted devices (if any) are approved for storing patient data. Secure USB devices that automatically encrypt stored data, AND are secured with a strong password are a minimum requirement.

Either the care provider (resident or faculty), or a clinic administrator, should confirm with the patient that they also have the necessary equipment to participate in the virtual session.

Software:

- **Videoconferencing software:** is the foundation or platform for the provision of virtual care. It is important to know what is approved for patient care at your clinical site. Major considerations are security, usability, and integration. There are some solutions that are designed specifically for healthcare, such as through OTN or Cisco WebEx, which have a high level of security, and are often integrated in electronic health record systems (EHRs). Other more widely available solutions, such as Zoom or Microsoft Teams, have improved functionality and appearance, but lower levels of security.

Internet service:

- It is critical to have high speed internet service to ensure stable connection and quality.
- Wireless devices can be used, but are more susceptible to disruption
- Ensuring patients have adequate broadband service is also critical. A good resource is the [Ontario Internet Access Map](#)
- To conduct your own internet performance test access the [Canadian Internet Registration Authority \(CIRA\) self-test](#).

Prior to connecting with a patient, determine who you can contact for technical support.

Medicolegal Guidance

Virtual care raises unique considerations, particularly around security, privacy, appropriateness of care and consent. Some of the most important are listed below, but residents and faculty should familiarize themselves with any virtual care guidance documents or policies in effect at their clinical site.

Generally, licensure to provide virtual care for patients residing in Ontario is covered by your Ontario medical license, but check first if you are providing care to a patient residing in or visiting another province, or outside of the country.

Residents and faculty are expected to be in Ontario when providing clinical care, unless special circumstances have been reviewed and approved.

Malpractice insurance through CMPA covers you to provide care within your scope of practice and training, including virtual care, in provinces within Canada in which you are licensed. For any situations outside of these parameters, discuss with a supervisor, and/ or seek consultation with CMPA directly (see Resources).

Security

Security refers to the transmission and management of information by entities charged with processing and storing this information. In virtual care, this is the collection, transmission, and storage of personal health information (PHI).

Virtual visits involve the collection, use and disclosure of personal health information and personal information. As a result, organizations delivering virtual visits must ensure their operations are compliant with the [Personal Health Information Protection Act \(PHIPA\)](#).

In Canada, the Virtual Care Task Force (created by the CMA, CFPC and RCPSC) states: “A virtual care ecosystem should be supported by a robust privacy policy suite designed to protect the privacy and security of all patient health information in a manner that delimits access to a person’s information on a need-to-know basis to provide quality care and service based on the will of the information owner”; and recommends a national framework to regulate the safety of virtual care technology and systems.¹⁰

Security controls in virtual care are data encryption and user authentication and access control mechanisms.

However, more relational and human-centered approaches to security – sometimes called user-centered security – emphasize the engagement and education of users to enhance security.

Key considerations to enhance the security of telehealth:

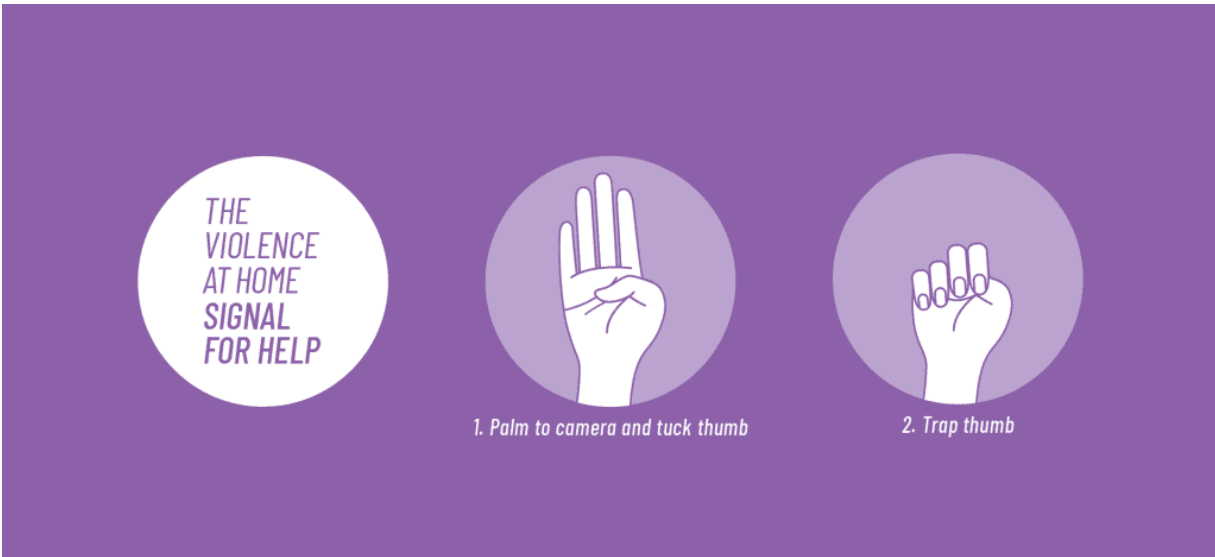
- Use a trusted, secure platform for videoconferencing – preferably one developed for health services use
- Make sure your device uses security features including passwords and two-factor authentication. Two-factor identification is one of the strongest blocks to cyber-attacks.
- Consider using a VPN – a virtual private network - VPNs use encryption to scramble data when it is sent over a Wi-Fi network.
- Your device should not store any patient data locally, but if it must, data should be encrypted.
- Ensure that your devices and software have the latest antivirus, anti-malware, and firewall software.
- Frequently update apps and operating systems, not just videoconferencing platforms.
- If your clinical site has an IT department, they should approve of and manage your device.
- Provide this information and education to patients who may not be aware of what steps and measures they can take to improve the security of their devices.
- Advise patients that the link for their appointment is their unique link and should not be shared.
- Consider using a “waiting room” to admit patients, and requiring a password for sessions, if that option is available through your videoconferencing software.

Privacy

According to the CMPA: “It is a physician's ethical and legal obligation to protect a patient's personal health information. Therefore, it would be prudent to confirm, to the extent possible, that both the patient and the physician are in physical settings that permit the patient to share personal information in a reasonably private manner. Physicians should also be satisfied that reasonable and legally compliant security protocols are in place.”¹¹

Any suspected privacy or security breaches should be reported to the Privacy Office at your clinical site, and you should inform your supervisor.

- Residents and faculty should ensure that they have private spaces to work from; their screen should not be visible to others and the sound should not be audible.
- All parties present in the room, on and off screen, should be identified to the patient. Similarly, patients should be asked to identify who is present in the room at their end.
- The use of headphones can enhance privacy
- Some other mitigation strategies for patients include utilizing more private spaces such as walk-in closets or (parked/ stationary) cars
- Often patients and providers want to mask their surroundings by using virtual backgrounds. Using a “blur background” function is preferable because it does not hide the background completely. Backgrounds can make it difficult to observe important clinical aspects of the room/ setting; whether other people are in the room; or whether additional recording devices are present.
- Ensure that all notifications on your computer are disabled so as to avoid disrupting the interaction, and to ensure that such notifications are not made visible to patients
- Ensure that if the screen sharing function is enabled that you have all documents and browser windows on your computer closed to prevent inadvertent sharing of patient information.
- There can be additional barriers for clinical situations that require privacy such as assessment of risks within a patient’s environment (e.g., child maltreatment or domestic abuse). A universal hand signal has been developed that allows patients to communicate fears for personal safety non-verbally. You can find a link to the [Signal for Help here](#), and see the image below.



Universal signal for help

A special note on recording clinical encounters: Residents and faculty should take extra care to familiarize themselves with any policies related to the recording of virtual care sessions at their clinical site, including for clinical or psychotherapy supervision. This will be covered in greater detail in the section on supervision. Policies should address the uses of recorded patient data; additional patient consents and documentation; the access to; storage; transmittal; and guidance for how and when to purge these records.

Patients' recording clinical encounters: Patients can actually record clinical sessions without physicians' consent; however, physicians can adopt policies within their practices that limit or prohibit such recordings. Patients should be informed about expectations regarding recordings as part of the consent process. Extra care should be taken to detail expectations of the privacy of other patients who may be present, such as in a group therapy setting. As part of the consent process in these situations, patients should be informed that recordings by co-patients will not be allowed, but cannot be guaranteed. [See additional guidance from CMPA.](#)

Appropriateness/ suitability for virtual care

Physicians are expected to offer the same standard of care virtually, as that delivered in-person. According to the CMPA: "Physicians should be aware of the standards and guidelines of their medical regulatory authority (College) with respect to areas of virtual care, including telemedicine and online prescribing. The decision to deliver medical services to a specific patient using virtual means will rely on professional judgment and consideration of the standard of care. Important to that consideration is whether an accurate assessment of the patient's problem can be performed, whether the patient's medical history and information about medications and allergies is accessible, and whether appropriate medication monitoring and follow-up care can be provided or arranged."¹¹

Questions to ask for each encounter:

- Does this patient have the capacity to provide informed consent to the use of virtual care (do they appreciate both benefits and risks associated with virtual care)?

-
- If the patient is not able to provide informed consent, is there a substitute decision maker available to provide consent?
 - Can I complete an appropriate assessment of the patient's chief complaint/ concern, including conducting any necessary exams, tests, or procedures, via virtual care?
 - If there are aspects of exams or tests that I cannot perform, is there a professional colleague at the patient's location who can collaborate to complete necessary aspects of the assessment?
 - Can I order and follow-up with any laboratory tests that are required?
 - Can I prescribe and monitor necessary medications for this patient, including controlled substances?
 - Can I offer first-line interventions for the patient's condition through available virtual resources?

Identification of patients and providers

Identification of patients – Prior to the start of the session use double identifiers to confirm the patient's identity. Sites differ in expectations for how this can be done. Some allow patients to hold up identification to the camera, while others require a scan or photocopy of identifying documents to be sent.

Clinicians should also identify themselves to patients, and wear any relevant hospital / clinical identification; at the outset of the session, identification can be held up to the camera to make it visible to participants. All individuals involved in and/or observing a clinical session should be identified. Patients should provide explicit permission to include 3rd parties in the virtual visits, and this consent, along with names of participants, should be documented in the patient chart.

Patient location

Prior to the start of the session, patients should confirm or provide:

- the patient's home address;
- the patient's current geographic location;
- if the patient is participating in the virtual care session from a clinic or health care setting in the community, the contact information for that location;
- an alternative phone number at which the patient can be reached during the virtual care session (if available)

Inform patients of the expectation that they remain in the same location throughout a virtual care session, and of the desirability of using a private space.

Consent

Prior to booking a virtual appointment, if you need to communicate with a patient or send links via email, you first need to obtain and document consent from the patient to use email to communicate about the virtual care session (e.g., to provide meeting link and related instructions, appointment reminders, clinic contact details, etc.).

Patient consent for virtual care must be obtained and documented. Consent is not to be implied in the use of virtual care. According to the CMPA: "Physicians should obtain consent from their patients to use virtual care. Consent should be obtained following an informed consent discussion with the patient regarding the increased privacy risks associated with electronic communications. Even if it is not possible to obtain a signed consent from the patient, consent should be documented in the patient chart."¹¹

Administrators are sometimes tasked with obtaining patient consent prior to virtual care, but remember that providers are responsible for ensuring consent to each medical procedure they provide, including virtual care.

Many EHRs now integrate consent scripts for virtual care. OMA provides a sample consent script, which is available [here](#) and has also been included in Appendix B.

Safety

One of the main dimensions of healthcare quality is safety. In virtual care, this includes physical, psychological and cultural safety.

One of the main questions that emerges for residents and other providers is around the ability to invoke the Mental Health Act through virtual care. The short answer is that in Ontario both examinations via videoconferencing and telephone are permissible for the purposes of examining patients for certification, providing the physician feels they are able to gather sufficient facts necessary for determining that criteria are met.

According to the CMPA: “The mental health statutes across Canada typically provide that a physician who signs an application for an involuntary psychiatric assessment must “examine” or “personally examine” the person who is the subject of the application and make careful inquiry into all of the facts necessary for the physician to form the opinion as to the nature and quality of the mental disorder of the person.

There is no express requirement in the legislation that the physician must be in the same location as the patient when conducting the examination. The terms “examine” and “personally examine” are also not defined terms in the legislation. We are not aware of any court that has commented on whether these terms expressly permit the use of telemedicine to conduct examinations for the purpose of completing an application for an involuntary psychiatric assessment.”

Some receiving sites differ with respect to how they will accept signed forms, i.e., whether they will permit secure FAX transmittals of forms.

At the start of each session, inform the patient of the circumstances in which you may need to contact local emergency authorities (e.g., if a concern about someone’s safety arises in the course of the session).

Other safety considerations include:

- Assessment of risks including: suicidal risk, homicide risk, child protection risks, and risk associated with operation of a motor vehicle. Often obtaining collateral is an essential element of determining risk.

Some resources for suicide risk assessment via virtual care:

Luxton DD, O'Brien K, Pruitt LD, Johnson K, Kramer G. Suicide risk management during clinical telepractice. *Int J Psychiatry Med.* 2014;48(1):19-31.

McGinn MM, Roussev MS, Shearer EM, McCann RA, Rojas SM, Felker BL. Recommendations for Using Clinical Video Telehealth with Patients at High Risk for Suicide. *Psychiatr Clin North Am.* 2019 Dec;42(4):587-595.

- Ensuring that you have the location and contact information for a patient if emergency medical services need to be contacted
- Whether safe prescribing and medication monitoring is possible in virtual care

-
- Whether both patient and provider experience the virtual care as psychologically safe

Trauma-informed virtual care is the application of trauma-informed principles to virtual care. We have to assume that anyone may have experienced trauma, and be aware that previous traumatic experiences may impact the provision of virtual care. Examples of traumatic experiences include patients who have experienced cyberbullying, social anxiety on screen, and difficulty with affect regulation without the regulating presence of the health professional. When challenges or barriers are encountered, trauma-informed care prompts us to ask, “what happened to you?” Rather than, “what is wrong with you?” As with all care, patient strengths, autonomy and choice are paramount.

Documentation

According to the CMPA: “Physicians should consider how they will document virtual visits in the patient's medical record with reference to the technology used. Accurately documenting information about a patient's medical history obtained through a virtual encounter is vital to continuity of care. Additionally, it serves as evidence of the care provided in the event of a legal action or complaint.”¹¹

Documentation should include notice that informed consent to virtual care was obtained from the patient.

Considerations for completing a virtual psychiatric assessment and intervention

In general, there are no absolute contraindications for the use of virtual care; there is a high degree of reliability in assessment and diagnosis across psychiatric conditions.^{4,5} However, the patient has to have the capacity to consent to virtual care, or a substitute decision maker that can consent. The clinician also has to determine if virtual care is appropriate in the situation. There are some resources at the end of this document, including resources that focus on the use of virtual care among different patient populations across the lifespan.

Some particular flags:

- Are both in-person and virtual options available? If so, what is the patient's choice?
- Is the clinician able to communicate in the patient's language of choice? If not, is there an interpreter available?
- Are there any barriers to communication or cognition – if so, are there augmentation strategies available (e.g., for clients who are hearing or visually impaired)?
- Is substance misuse a challenge – there is reduced reliability of assessment for substance intoxication and/or withdrawal
- Are there aspects of the mental status that are necessary to the assessment that you cannot perform virtually (e.g., an Abnormal involuntary movement exam; a cognitive screen or test)? If so, is there a distal clinician you can collaborate with to complete these?
- If laboratory or other diagnostic tests are needed, do you have a mechanism to order them and follow-up with results?
- For prescribing, especially of controlled substances, do you have appropriate monitoring and follow-up in place?

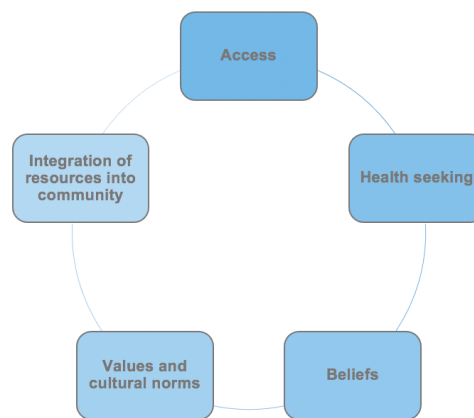
For interventions, there is increasing evidence of equivalence of in-person treatment for many interventions across many, but not all, psychiatric diagnoses. For example, cognitive behavioural therapy delivered virtually for depression and anxiety, and cognitive processing therapy for PTSD have been demonstrated to be as effective as in-person treatment.^{12,13} Where evidence does not exist, you have to weigh this with the accessibility of in-person treatment and determine risk-benefit.

Digital Health equity

Access to care is the opportunity to have one's health needs fulfilled. Access to virtual care, therefore, is the opportunity to have health needs fulfilled through virtual care. Access has multiple dimensions, including approachability; acceptability; availability and accommodation; affordability; and appropriateness.¹⁴ Each of these aspects of access to care is enhanced by corollary abilities that patient and families bring to care, including:

- Ability to perceive (approachability)
- Ability to reach (acceptability)
- Ability to seek (availability and accommodation)
- Ability to pay (affordability)
- Ability to engage (appropriateness)

Health equity in virtual care is the ability to access virtual care and to achieve equal outcomes through virtual care irrespective of age, gender, racial affiliation, dis/ability, geography, or socioeconomic circumstance. The pandemic highlighted the many barriers to digital health equity, many of which flow from larger social determinants of health, creating digital determinants of health.¹⁵



Digital determinants of health

The [Health Equity Impact Assessment \(HEIA\) tool](#) can support digital health equity by guiding the assessment of equity on patient, program, and institutional levels. Working with patients and communities, we can plan, implement and evaluate mitigation strategies that will decrease barriers to care, and improve care outcomes.

Cultural Safety

Approaching virtual care with cultural humility is important to contributing to cultural safety. Cultural humility requires that we bring an awareness of our own social location – what cultures do we belong to, including the cultures of healthcare, what biases do we bring with us? This is especially important in virtual care because we can “zoom in” to communities without knowledge of community strengths and history. Virtual care can also create fragmented, silos of care, that undermine autonomy, authority, and the integration of values, preferences, and place into health and wellbeing.

Scholars are also focusing on structural competency. This approach moves beyond identifying cultural expressions of health and illness (i.e., cultural competency) to address how institutional structures and social conditions produce inequalities. According to Metzli and Hansen (2014), “structural competency seeks to promote skills, not so much for replacing awareness of ‘culture’ in medical settings, but for recognizing how ‘culture’ and ‘structure’ are mutually co-implicated in producing stigma and inequality” (p. 128).¹⁶

Considerations for improving cultural safety:

- Be aware of your own values, beliefs and biases – practice cultural humility
- Inquire about patient values, preferences and beliefs
- Know the community and cultural context of the patient’s location
- Be aware of the history of healthcare, including the role of healthcare in colonization
- Know the [TRC Calls to Action](#), and consider how these might apply within virtual care
- Consider virtual land acknowledgments that include an acknowledgement of the history of your location, the client’s location, and virtual space
- Remember that cultural safety is defined by the patient – consider adding cultural safety to patient experience surveys and into quality improvement
- Involve patient and communities in planning, implementing, and evaluating virtual care
- Consider collaborative approaches that work with community / local agencies, including virtual integration of interprofessional resources, spiritual providers, healers and Elders

Compassionate care

There is a preponderance of evidence that a strong therapeutic alliance is central to achieving good patient outcomes in healthcare. Fortunately, there is increasing evidence that a therapeutic alliance is forged in virtual care, including in patients with severe mental illness.^{6,7} Patients tend to rate the alliance as strongly as in-person care, although it is health providers that often rate the therapeutic alliance as less strong in virtual care.

In virtual care, the conditions for forming the therapeutic alliance are sometimes referred to as therapeutic viability. Some cases where the therapeutic viability may be decreased include:

- A poor technical connection
- Asynchronous care
- Low levels of digital literacy in either the patient or provider
- Lack of provider training

Addressing these barriers can improve the therapeutic alliance. Additional strategies include:

- Providing psychoeducation around the use of virtual care – sometimes called a therapeutic

induction to virtual care - including a rationale for its use

- Being transparent and explicit around boundaries in virtual care, including any adaptations from in-person care (i.e., appropriate attire and location of assessments, booking of appointments and use of email).
- Using technology to your advantage – such as using alerts and appointment reminders
- Collaborative risk and safety planning
- Remove distractions such as alerts, other tasks
- Be aware of body position (can use picture-in picture to assess this) – leaning in can increase feelings of connection (but for some it may be intrusive) - Check-in with patients re comfort levels

Providing compassionate virtual care – our ability to “be with” another – is shaped by these technical and interpersonal factors, but it is also shaped by organizational factors that contribute to virtual care.¹⁷

Selfcare

Of course, compassion also extends to yourself! Providing virtual care comes with its own challenges, ranging from eye strain and decreased physical activity, to poor transitions in work/home, lack of breaks, professional isolation; and inadequate access to supervision.

It is important to attend to these areas for our own wellbeing and to continue providing compassionate care to patients and families.

This [infographic](#) provides tips for compassionate care and self-care.

Considerations include:

- Workspace – is your chair and desk ergonomic?; do you have privacy?; consider adding greenery, sensory stimulation
- Eye care – is your screen large enough? Do you require glasses? Focus your eyes in the distance beyond your computer to prevent eyestrain.
- Take regular breaks, including physical exercise
- Consider mindfulness to bring your attention back to your embodied self
- Seek training in virtual care and supervision
- Maintain social connectedness

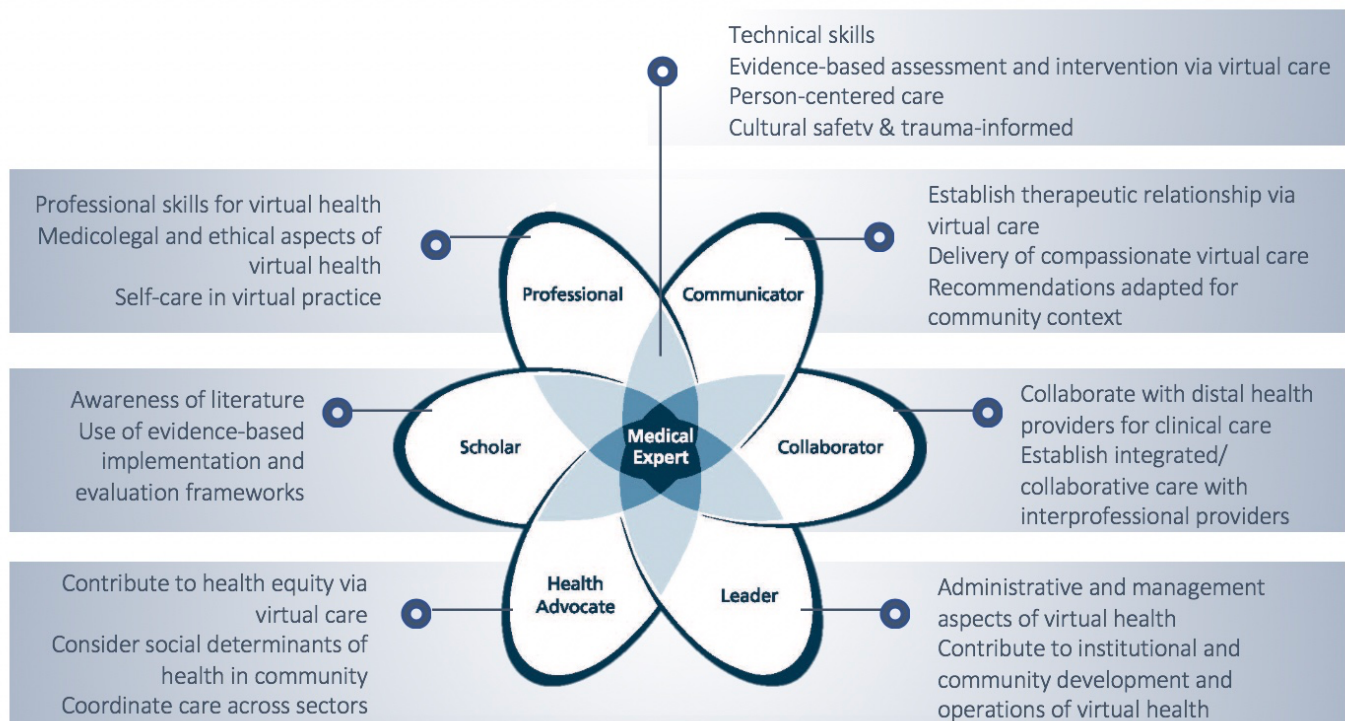
Virtual Education

The sections below cover areas for competency development in virtual care, as well as considerations for attending virtual educational sessions.

Virtual Care Competencies

Below is a diagram of virtual competencies across CanMEDs domains (used with permission of the Royal College).¹⁸ The Royal College has also added 20 new key and enabling competencies relating to e-health, which can be accessed [here](#). You can customize your search by limiting the search to “Hot topics: ehealth”.

Challenge yourself to think across your roles as a clinician within virtual care, and to seek out opportunities that will support the development of competencies. In the section that follows on virtual supervision, we encourage supervisors and residents to have collaborative discussions about areas of comfort, and areas for further development.



CanMEDS Framework © Royal College

Adapted from Crawford A., Sunderji N., Lopez J., Soklaridis S. (2015) “Defining competencies for the practice of telepsychiatry through an assessment of resident learning needs. BMC Education.

Attending educational sessions via zoom

Most teaching across the department had to adapt to virtual education over the course of the pandemic.¹⁹ The limitations of virtual teaching have, to an extent, been balanced by the opportunities afforded, and it is likely that some aspects of virtual teaching will continue into the future.

Some [tips for teachers](#) to enhance virtual learning, include^{20,21,22}:

- **Familiarize** yourself: Know how to use the technology you will be using, including the specific functions you will be using in your teaching session – do a dry run if you are uncertain
- **Lighting**: Ensure that your face is well-lit, of appropriate size (head and shoulders onscreen typically), and have a non-distracting, neutral, background, with minimized backlight where possible
- **Distractions**: Turn off alerts, notifications, your phone and reduce extraneous noise and distractions
- **Setting norms**: communicate rules for engagement – remind learners to mute themselves but be ready to participate
- **Relational connection**: get to know your learners' names and use them, have a participant list handy if needed
- **Interactivity**: review how you would like questions to be asked and answered during the session (ie. in the chat box, raise virtual hand, or unmute and ask verbally, etc.)
 - review with your learners the virtual platform features they can use to promote interactivity (ie. annotate function, raise hand, use chat box, offer reactions such as thumbs up, clapping, etc.)
 - engage your learners early and regularly throughout the session, ask questions, praise learners for expanding on the points of others, and be enthusiastic! (Shiano, 2017)
 - do something to engage your learners at least every 10-15 minutes – questions, quizzes, polls, cases, discussion groups, games, etc.
 - use breakout rooms, review with your learners the task before they breakout as they can't see the information shared in the larger group, have them select one learner to report back or designate a facilitator for the breakout group
- **Participant wellness**: respect that some learners may choose to have cameras off – due to bandwidth limitations, personal circumstances
- **Slides**: think of how your slides will translate onto a small screen – use very large font sizes, simple graphic images; avoid detailed tables/diagrams/flowcharts
 - your face is usually more engaging than your slides; switch back to your face whenever the slides are not necessary
- Consider having a **co-teacher** – while one person is the main presenter, the other can monitor chat/questions and bring these into the discussion or provide typed answers
- **Breaks**: ensure there are breaks every 45-60 minutes to mitigate against virtual screen fatigue
- **Psychological safety**: cultivate a psychologically safe environment where learners feel safe to ask questions and engage in productive struggle, where they feel respected and that their contributions are valued (Edmonson, 1999)

Some **tips for learners** to enhance virtual learning, include:

- **Distractions:** where possible, close or turn off other alerts/apps/email/messages – distractions may make you less engaged in the learning session
- **Interactivity:** where possible, have your camera on – you are more likely to stay engaged in the session and your onscreen presence provides more feedback to the presenter about the level of engagement
- **Privacy:** If you wish a greater degree of privacy, consider use of a virtual background or blurring of your background. Tips are available through the platform Zoom: <https://support.zoom.us/hc/en-us/articles/210707503-Getting-started-with-Virtual-Background>
- **Preparation:** do any suggested pre-reading/pre-work as this will likely enhance the learning you will get out of the session
- **Participation:** actively participate – ask questions, complete polls, join in discussions – you will retain more from sessions in which you participate
- **Speaker view:** use the speaker view when possible – so that the presenter is larger on your screen and thus more engaging for you
- **Breaks:** Consider your own self-care. Ensure that you are taking breaks, getting exercise, and resting your eyes by focusing beyond your computer screen frequently.

Also see the infographic in **Appendix C** that provides an overview of learning tips.

Virtual Supervision

Virtual care allows for several configurations in the supervisory relationship:

- Patient seen in person but supervision is virtual
- Patient seen virtually, and supervision either in-person or virtual
- Resident and faculty provide patient care virtually, at either same or different locations
- Supervisor uses virtual care as an opportunity for “fly on the wall” supervision

Each configuration has its own considerations. Supervisors should familiarize themselves with:

- The content of this handbook
- Any policies or procedures at their clinical site and/or at the resident’s site, if different.
- The policies around [audio or video recording of sessions for the purposes of supervision](#) – this has stringent medicolegal requirements for patient consent and the storage, transmittal, and sharing of personal health information
- Legislative and medicolegal requirements for virtual care (largely covered in this handbook)
- Virtual care competencies (above)

When supervising residents around their provision of virtual care, it is recommended that supervisors review with the resident their familiarity with and self-perceived competence and comfort in delivering virtual care. Supervisors can review the framework for virtual care competences based upon CanMEDS roles, and invite residents to set rotation objectives that include development within virtual care, across competency domains.

Ensure that when residents are providing virtual care:

- It is within their scope of practice/ skill
- The patient is appropriate for virtual care, and/or the resident knows how to proceed if the patient is not appropriate or does not consent to virtual care
- Consider joining the virtual appointment to introduce yourself to the patient and/or provide supervision
- Make sure that residents know how to contact you
- Review procedures for a patient emergency
- Have regular supervision booked

When providing virtual supervision, much as with the therapeutic alliance, be aware of the need to attend to the supervisory relationship:

- Take a trauma-informed approach to supervision – sometimes residents have had difficult online experiences and the virtual environment may not be comfortable for everyone; similarly, the pandemic has imposed hardships for many.
- Review expectations and boundaries, including around communications
- Support resident self-care

See [Appendix D](#) for tips for supervision.

Resources

Resource	Description
Accreditation Canada – Virtual Care Toolkit https://store.accreditation.ca/products/virtual-care-toolkit	Virtual Care Standards
American Psychiatric Association – Telepsychiatry Guidelines https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Telepsychiatry/APA-ATA-Best-Practices-in-Videoconferencing-Based-Telemental-Health.pdf	The “gold standard” guidelines
American Psychiatric Association – Telepsychiatry and Covid-19 https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/apa-resources-on-telepsychiatry-and-covid-19	Resource page for Telepsychiatry and Covid-19
Ontario Telemedicine Network (OTN) https://otn.ca	
Ontario Internet Access Map https://connectednorth.ca/	
Canadian Internet Registration Authority (CIRA) Internet performance test: https://www.cira.ca/improving-canadas-internet/initiatives/internet-performance-test/how-internet-performance-test	
Adopting and Integrating Virtual Visits into Care – Health Quality Ontario	Draft clinical guidance
Canadian Medical Protective Association (CMPA) – Guidance on Virtual Care: https://www.cmpa-acpm.ca/en/covid19/telehealth-and-virtual-care Royal College of Physicians and Surgeons of Canada – https://www.royalcollege.ca/rcsite/documents/about/covid-19-resources-telemedicine-virtual-care-e	A collection of resources on providing virtual care. A resource list of guidelines and practice standards available in each province.
HIPPA Guidelines on Telemedicine https://www.hipaajournal.com/hipaa-guidelines-on-telemedicine/	Contains good information on security and privacy
Ontario MD Virtual Care (part of the Ontario Medical Association) https://ontariomd.vc	Resource hub – incl. up-to-date bulletins from Ministry of Health
Compassionate care in a virtual world https://healthydebate.ca/2020/06/topic/compassionate-care-virtual-world/	Infographic on compassionate virtual care

Resources for teaching / supervision

Description

Centre for Faculty Development, UofT
www.cfdresources.ca

Best practices and key considerations in designing and teaching online curricula, as well as resources that support a shift from in person to online contexts.

Primer for Teaching and Supervision in Virtual Care
Centre for Faculty Development

An easy to use primer.

https://ofd.med.utoronto.ca/sites/default/files/assets/ofd-resource/document/primer_0.pdf

Primer: Optimizing the Synchronous Online Learning Environment
https://cfdresources.ca/files/200000169-563fb563fd/PRIMER%20for%20online%20learning%20environment_18Nov20.pdf

An easy to use primer.

Adventures in Teaching
Virtual Teaching - Facilitation Pearls in Small Group Settings

https://ofd.med.utoronto.ca/sites/default/files/assets/ofd-resource/document/adventures_in_teaching_virtual_teaching.pdf

Tips for Creating and Maintaining an Inclusive Small Group Synchronous Online Learning Environment, MD Program, University of Toronto
<https://ofd.med.utoronto.ca/resources/tips-creating-and-maintaining-inclusiveness-small-group-synchronous-online-learning>

Teaching Through a Pandemic: A Mindset for This Moment

<https://www.edutopia.org/article/teaching-through-pandemic-mindset-moment>

References

1. Kinoshita S, Cortright K, Crawford A, Mizuno Y, Yoshida K, Hilty D, Guinart D, Torous J, Correll CU, Castle DJ, Rocha D, Yang Y, Xiang YT, Kølbaek P, Dines D, ElShami M, Jain P, Kallivayalil R, Solmi M, Favaro A, Veronese N, Seedat S, Shin S, Salazar de Pablo G, Chang CH, Su KP, Karas H, Kane JM, Yellowlees P, Kishimoto T. Changes in telepsychiatry regulations during the COVID-19 pandemic: 17 countries and regions' approaches to an evolving healthcare landscape. *Psychol Med*. 2020 Nov 27;1-8.
2. Serhal E, Crawford A, Cheng J, Kurdyak P. Implementation and Utilisation of Telepsychiatry in Ontario: A Population-Based Study. *Can J Psychiatry*. 2017 Oct;62(10):716-725.
3. Gordon J.G. Asmundson, Cindy Blackstock, Marie Claire Bourque, Glenn Brimacombe, Allison Crawford, S. Hélène Deacon, Ken McMullen, Patrick J. McGrath, Christopher Mushquash, Sherry H. Stewart, Jennifer Stinson, Steven Taylor, and Marsha Campbell-Yeo. Easing the disruption of COVID-19: supporting the mental health of the people of Canada—October 2020—an RSC Policy Briefing. *FACETS*. 5(1): 1071-1098.
4. Myers KM, Turvey Carolyn, eds. *Telemental Health: Clinical, Technical, and Administrative Foundations for Evidence-Based Practice*. Elsevier; 2013.
5. Myers K, Cain S. Practice parameter for telepsychiatry with children and adolescents. *J Am Acad Child Adolesc Psychiatry*. 2008;47(12):1468-1483. doi:10.1097/CHI.0b013e31818b4e13
6. Simpson, S., & Reid, C. (2014). Therapeutic alliance in videoconferencing psychotherapy: A review. *Australian Journal of Rural Health*, 22(6), 280–299.
7. Tremain H, McEnery C, Fletcher K, Murray G. The Therapeutic Alliance in Digital Mental Health Interventions for Serious Mental Illnesses: Narrative Review. *JMIR Ment Health*. 2020;7(8):e17204.
8. Adapted from Institute of Medicine (US) Committee on Quality of Health Care in America, 2001. See Health Quality Ontario <https://www.hqontario.ca/What-is-Health-Quality/Quality-Matters-A-Plan-for-Health-Quality>
9. Serhal E., Kirvan A., Sanches M., Crawford A. Client Satisfaction and Experience with Telepsychiatry: Development and Validation of a Survey Using Clinical Quality Domains. *J Med Internet Res*. 2020 Sep 29;22(9):e19198.
10. Canadian Medical Association (2020). *Virtual Care: Report of the Virtual Care Task Force*. <https://www.cma.ca/sites/default/files/pdf/virtual-care/ReportoftheVirtualCareTaskForce.pdf>
11. CMPA. Providing virtual care during the Covid-19 pandemic. <https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2020/providing-virtual-care-during-the-covid-19-pandemic>
12. Scogin F, Lichstein K, DiNapoli EA, Woosley J, Thomas SJ, LaRocca MA, Byers HD, Mieskowski L, Parker CP, Yang X, Parton J, McFadden A, Geyer JD. Effects of Integrated Telehealth-Delivered Cognitive-Behavioral Therapy for Depression and Insomnia in Rural Older Adults. *J Psychother Integr*. 2018 Sep;28(3):292-309.
13. Stewart RW, Orengo-Aguayo RE, Cohen JA, Mannarino AP, de Arellano MA. A Pilot Study of Trauma-Focused Cognitive-Behavioral Therapy Delivered via Telehealth Technology. *Child Maltreat*. 2017 Nov;22(4):324-333.
14. Levesque JF, Harris MF, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *Int J Equity Health*. 2013 Mar 11;12:18.
15. Crawford A., Serhal E. Digital Health Equity and COVID-19: The Innovation Curve Cannot Reinforce the Social Gradient of Health. *J Med Internet Res*. 2020;22(6):e19361.
16. Metz J.M., Hansen, H., 2014. Structural competency: Theorizing a new medical engagement with stigma and inequality. *Soc. Sci. Med*. 103, 126–133. <https://doi.org/10.1016/j.socscimed.2013.06.032>

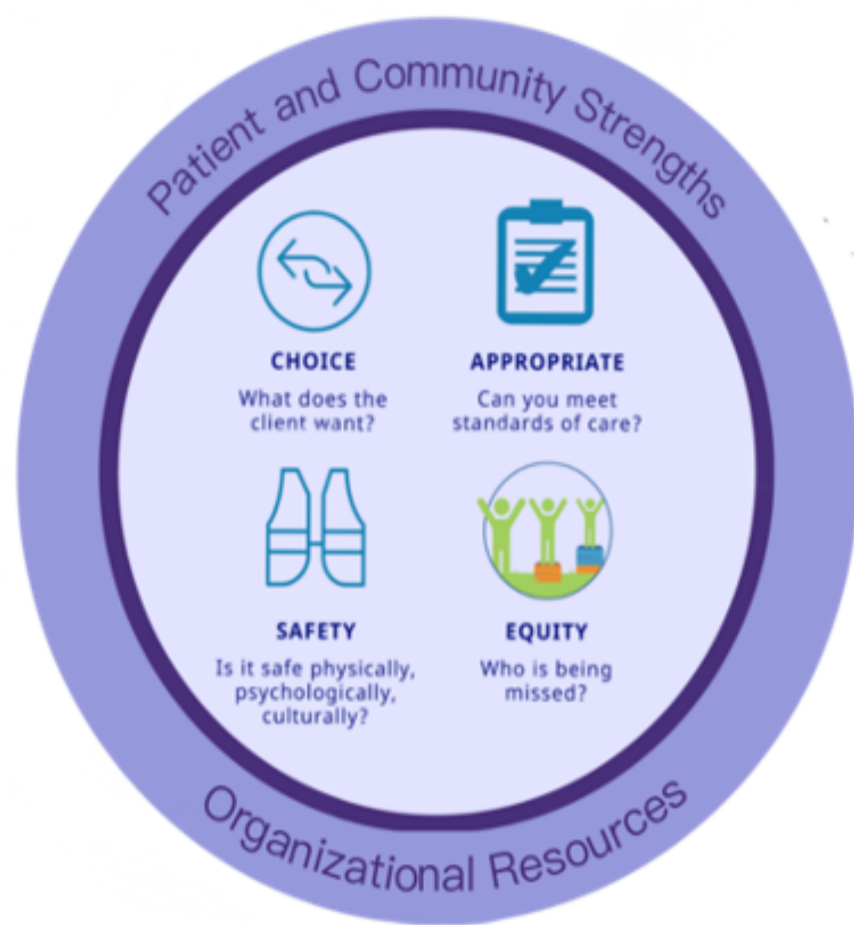
-
17. Wiljer D., Strudwick G., Crawford A. "Caring in a Digital Age: Exploring the Interface of Humans and Machines in the Provision of Compassionate Healthcare." *Without Compassion There is No Healthcare: Leading with Care in a Technological Age*. Eds. Brian Hodges, Gail Paeche, Jocelyn Bennet. McGill University Press, 2020
 18. Crawford A., Sunderji N., López J., Soklaridis S. Defining competencies for the practice of telepsychiatry through an assessment of resident learning needs. *BMC Med Educ*. 2016 Jan 26;16(1):28.
 19. Thakur A., Soklaridis S., Crawford A., Mulsant B., Sockalingam S. Using Rapid Design Thinking to Overcome COVID-19 Challenges in Medical Education. *Acad Med*. 2020 Sep 1:10.1097/ACM.0000000000003718.
 20. Schiano, Bill and Espen Anderson. "Teaching with Cases Online." Harvard Business Publishing. May 25, 2017. https://s3.amazonaws.com/he-productimages/docs/Article_Teaching_With_Cases_Online.pdf
 21. Edmonson, Amy. Psychological Safety and Learning Behaviour in Work Teams. *Administrative Science Quarterly*. Vol. 44, No. 2 (Jun., 1999), pp. 350-383. http://web.mit.edu/curhan/www/docs/Articles/15341_Readings/Group_Performance/Edmondson%20Psychological%20safety.pdf
 22. 'Adventures in Teaching: Setting up and optimizing the virtual learning environment" MD Program, uofT, Office of Faculty Development resource, Sept 2020, Susan Telarico, Yana Lazor

Preparing for Virtual Care



PRIOR TO YOUR SESSION

Patient-centered and Equity-driven virtual care: CASE by case approach that leverages patient and community strengths



Building models of integrated virtual/ in-person care that consider:

CASE

- patient **Choice**
- **Appropriateness** of virtual care
- **Safety** of virtual care
- **Equity** in access and outcomes

The CASE approach achieves quality of virtual care by considering the following: patient choice; appropriateness of care delivered virtually; safety; and equity. These must all occur within the context of patient and community strengths, and by ensuring adequate organization and health systems supports and resources.

- Consider each virtual **CASE**:
Choice
Appropriate
Safe
Equity

- Familiarize yourself with virtual care **policies** and procedures at your clinical site

Has your program considered ways to enhance equity? Do all patients have access?

- Patient preparation:** Have they consented to receive email? Do they have necessary hardware, software, internet, privacy? Digital literacy?

- Do you have appropriate **hardware**? (Screen size, camera, headphones)

- Do you need to **register** for the platform or download software?



DURING VIRTUAL CARE SESSION

- Is this patient concern **appropriate** to address using virtual care?

- Obtain patient **consent** for virtual care:
 - Is patient capable to consent
 - Obtain consent, including consent for any other participants
 - Document consent

- Attend to **security**: transmittal, sharing, storage of personal health information

Recording of sessions should be approached with caution

- Confirm patient **identity**

- Confirm patient **location**, address, phone number, emergency contact

- Support patient **privacy**

- Arrange for safe prescribing, lab tests, and diagnostic tests and exams and appropriate followup

- Safety:** Be aware of how to contact supervisor during session, and have f/u supervision

Inform patient of circumstances that will require you to call EMS

Ensure patient is in a stationary location

- Take a **trauma-informed** and **culturally-safe** approach to virtual care



APPENDIX B: SAMPLE CONSENT SCRIPT FOR VIRTUAL CARE FROM OMA

Consent for Virtual Care

Initiating a Virtual Care Encounter

OMA Legal has prepared a short paragraph statement (which can be sent by email or verbally communicated) to initiate a Virtual Care patient encounter, which has also been vetted by the CMPA:

“Virtual Care has some inherent privacy and security risks that your health information may be intercepted or unintentionally disclosed. We want to make sure you understand this before we proceed. In order to improve privacy and confidentiality, you should also take steps to participate in Virtual Care in a private setting, use an encrypted email service if available, and you should not use an employer’s or someone else’s computer/device as they may be able to access your information.

If you want more information, please check the [website/confirmation email/etc.]. If it is determined you require a physical exam you may still need to be assessed in person. You should also understand that virtual care is not a substitute for attending the Emergency Department if urgent care is needed. If you continue, you consent to the use of electronic communication to provide you with care, are you ok to continue?”

Patients need only consent once for ongoing Virtual Care. This consent can be obtained by administrative staff in advance of the encounter.

Note: If Prescriptions are to be Sent by Email

*CPSO, CNO, and OCP have made an exception to allow the use unencrypted email for the purpose of sending prescriptions to a pharmacist during the declared emergency. **If you wish to use unencrypted email to send prescriptions to a pharmacist, then you must obtain the consent of the patient for this purpose that explains unencrypted email may not be secure.***

You might ask:

“Do you consent, understanding that unencrypted email carries an inherent risk of disclosure to third parties, to the use of such email for the purpose of communicating your prescription with a pharmacist?”

*You must also add a sentence to the record of consent in the EMR (below) indicating:
The patient’s consent was obtained to use unencrypted email for the purpose of communicating their prescription with a pharmacist.*

Detailed Information to Make Available to Patients

The more detailed information below is included for your use and must be made available to patients:

COVID-19 is placing stress on Canada’s public health system. Our clinic is starting to offer virtual care to make sure that we can continue to care for our patients safely and effectively. This means that we will be using electronic communications for some patient visits rather than asking all patients to come into our office. Some of these technologies are provided by the Province. Others have been provided by vendors such as Google, or Apple to help make discussions with

your care provider as easy as possible during these difficult times. Some health concerns can be addressed with virtual care alone, but in some cases your doctor may ask you to visit a hospital or other health-care facility, if necessary, for a physical examination.

We do our best to make sure that any information you give to us during virtual care visits is private and secure, but no electronic communications tools (such as audio, video, email, text) are ever completely secure. There is an increased security risk that your health information may be intercepted or disclosed to third parties when using such electronic communications tools. To help us keep your information safe and secure, you can:

- *Understand that electronic communications (such as audio, video, email, text) you receive are not secure in the same way as a private appointment in an exam room.*
- *Use a private computer/device (i.e., not an employer's or third party's computer/device), secure accounts, and a secure internet connection. For example, using a personal and encrypted email account is more secure than an unencrypted email account, and your access to the Internet on your home network will generally be more secure than an open guest Wi-Fi connection.*

You should also understand that virtual care is not a substitute for in-person communication or clinical examinations, where appropriate, or for going to an Emergency Department when needed (including for any urgent care that may be required).

If you are concerned about using electronic communications for virtual care, you can ask our office to attempt to arrange a potential alternative. However, please note that visiting a health care provider in person comes with a higher risk of coming into contact with COVID-19 and the possibility of spreading the virus.

By providing your information, you agree to let us collect, use, or disclose your personal health information through video, audio, email, or text communications (while following applicable privacy laws) to provide you with care. In particular, the following means of electronic communication may be used [(identify all that apply): audio, video (including Skype, Facetime, etc.), email, text, etc.].

Paragraph to Make a Note in EMR

The following paragraph was constructed for inserting into an EMR during (or in advance) of a virtual care encounter:

Informed consent was obtained from this patient to communicate and provide care using virtual care electronic communications tools. [(If you are using email for prescriptions) *The patient's consent was obtained to use unencrypted email for the purpose of communicating their prescription with a pharmacist.*] This patient has been explained the risks related to unauthorized disclosure or interception of personal health information and steps they can take to help protect their information. We have discussed that care provided through electronic communication cannot replace the need for physical examination or an in person visit for some disorders or urgent problems and patient understands the need to seek urgent care in an Emergency Department as necessary.

Consentement pour les Rencontres Virtuelles de Soins

Organisation de rencontres virtuelles de soins

Le Service juridique de l'Ontario Medical Association (OMA) a préparé un court paragraphe de déclaration (qui peut être envoyé par courriel ou communiqué oralement) concernant l'organisation de rencontres virtuelles de soins auprès des patients, rencontres qui ont également été approuvées par l'Association canadienne de protection médicale (ACPM) :

« Les soins virtuels comportent certains risques inhérents associés à la vie privée et à la sécurité, soit les risques que les informations sur votre santé soient interceptées ou divulguées accidentellement. Nous voulons nous assurer que vous compreniez cela avant que nous procédions. Pour améliorer les conditions liées à la vie privée et à la confidentialité, vous devriez participer aux rencontres virtuelles de soins dans un cadre privé et utiliser un service de courriels chiffrés, si possible. De plus, vous ne devriez pas utiliser l'appareil ou l'ordinateur d'un employeur ou d'une autre personne, car ceux-ci pourraient être en mesure d'accéder à vos informations personnelles.

Pour en savoir plus, veuillez consulter [site Web ou courriel de confirmation, etc.]. Si vous devez subir un examen physique, vous devez toutefois le faire en personne. Sachez aussi que les soins virtuels ne remplacent pas les visites au service d'urgence si vous avez besoin de soins urgents. En continuant, vous consentez à ce que nous vous envoyions des communications électroniques concernant la prestation de vos soins, souhaitez-vous continuer? »

Les patients n'ont besoin de donner leur consentement qu'une seule fois pour le suivi de soins virtuels. Le personnel administratif peut obtenir ce consentement avant la rencontre.

Remarque : Si les ordonnances doivent être envoyées par courriel

*L'Ordre des médecins et chirurgiens de l'Ontario (OMCO), l'Ordre des infirmières et infirmiers de l'Ontario et l'Ordre des pharmaciens de l'Ontario ont exceptionnellement accepté l'utilisation de courriels non chiffrés pour l'envoi d'ordonnances aux pharmaciens pendant la situation d'urgence déclarée. **Si vous souhaitez utiliser des courriels non chiffrés pour envoyer des ordonnances à un pharmacien, vous devez donc obtenir le consentement du patient à cette fin indiquant que le courriel non chiffré comporte des risques liés à la sécurité.***

Voici quelques questions que vous pourriez poser :

« Sachant que les courriels non chiffrés comportent un risque inhérent de divulgation à des tiers, consentez-vous à ce que nous utilisions ce type de courriel pour transmettre votre ordonnance à un pharmacien? »

Vous devez aussi ajouter une phrase au document de consentement du dossier médical électronique (ci-dessous), en indiquant :

Le patient a consenti à l'utilisation de courriels non chiffrés aux fins de transmission de son ordonnance à un pharmacien.

Informations détaillées à offrir aux patients

Les informations plus détaillées suivantes vous sont destinées et doivent être mises à disposition

des patients :

La COVID-19 cause un stress dans le système de santé publique du Canada. Notre clinique commence à offrir des soins virtuels pour que nous continuions d'offrir des soins sûrs et efficaces à nos patients. Cela signifie que nous utiliserons les communications électroniques pour certaines visites de patients plutôt que de demander à tous les patients de se rendre à notre cabinet. Certaines de ces technologies sont offertes par la province. D'autres sont offertes par des fournisseurs tels que Google ou Apple pour faciliter le plus possible la tenue de discussions avec votre prestataire de soins pendant cette période difficile. Il est possible d'aborder certaines préoccupations en matière de santé dans le cadre de soins virtuels uniquement, mais dans certains cas, votre médecin pourrait vous demander de vous rendre dans un hôpital ou dans un autre établissement de soins de santé si vous avez besoin de subir un examen physique.

Nous faisons de notre mieux pour assurer la confidentialité et la sécurité des informations que vous nous transmettez pendant les visites virtuelles de soins. Toutefois, aucun outil de communication électronique (p. ex., outil audio ou vidéo, courriel ou texte) n'est entièrement sûr. Lorsque vous utilisez ces outils de communication électronique, les informations sur votre santé sont assujetties à un risque pour la sécurité accru et pourraient être interceptées ou divulguées à des tiers. Pour nous aider à assurer la confidentialité et la sécurité de vos informations, vous pouvez :

- *Comprendre que les communications électroniques (p. ex., les communications audio ou vidéo, les courriels ou les textes) que vous recevez ne sont pas aussi sécuritaires qu'un rendez-vous privé dans une salle d'examen.*
- *Utiliser un ordinateur ou un appareil privé (c'est-à-dire un appareil ou un ordinateur qui n'appartient ni à l'employeur ni à un tiers), des comptes sécurisés et une connexion Internet sécuritaire. Par exemple, il est plus sécuritaire d'utiliser un compte de courriel personnel et chiffré qu'un compte de courriel non chiffré. De plus, votre accès à Internet à partir d'un réseau à domicile est en général plus sûr qu'une connexion sans fil ouvert aux invités.*

Vous devez aussi savoir que les soins virtuels ne remplacent pas les communications ou les examens cliniques en personne, le cas échéant, ni les visites au service d'urgence lorsque nécessaire (y compris pour obtenir des soins urgents).

Si vous avez des inquiétudes concernant l'utilisation de communications électroniques à des fins de soins virtuels, vous pouvez demander à notre cabinet de vous proposer une autre solution. Sachez toutefois qu'une visite en personne auprès d'un prestataire de soins de santé s'accompagne d'un risque accru de contracter la COVID-19 et de propager le virus.

En fournissant vos informations, vous consentez à ce que nous recueillions, utilisions ou divulguions des informations sur votre santé au moyen d'outils audio ou vidéo, de courriels ou de communications écrites (en respectant les lois en vigueur sur la vie privée) dans le cadre de la prestation de vos soins. Nous pourrions notamment utiliser les moyens de communication électronique suivants [(veuillez indiquer tout ce qui s'applique) : communications audio ou vidéo (y compris Skype, Facetime, etc.), courriels, textes, etc.].

Paragraphe à insérer dans le dossier médical électronique

Le paragraphe suivant a été formulé en vue d'être inséré dans un dossier médical électronique pendant (ou avant) une rencontre virtuelle de soins :

Le patient a fourni son consentement éclairé concernant les communications et la prestation de soins au moyen d'outils de communication électronique dans le cadre de soins virtuels. [(Si vous utilisez les courriels à des fins d'ordonnance) *Le patient a fourni son consentement quant à l'utilisation de courriels non chiffrés aux fins de transmission de son ordonnance à un pharmacien.*] Ce patient a reçu des explications sur les risques associés à la divulgation non autorisée ou à l'interception d'informations sur sa santé et des explications sur les étapes qu'il peut suivre pour protéger ses informations. Nous avons mentionné que les soins fournis dans le cadre de communications électroniques ne peuvent remplacer les examens physiques nécessaires ou les visites en personne en cas de certaines maladies ou de problèmes urgents. De plus, le patient comprend qu'il doit obtenir des soins urgents au service d'urgence, si nécessaire.

AM I ZOOMING IT RIGHT?

A GUIDE TO ZOOM ETIQUETTE AND ENGAGEMENT

PRESENTERS

Set the Frame

- How should participants ask questions: raise hand, start talking, or write in the chat?
- Is discussion reserved for the end or will there be interactive elements throughout?
- Remind participants to mute their microphones.

Address participants by name.

Look at the camera when speaking.

Pause after asking questions so participants have time to unmute and respond.

Mute participants with disruptive background noise.

Screen share specific applications instead of your entire desktop.

Send slides to participants ahead of time so they can take notes.

Allow time for scheduled breaks.

PARTICIPANTS

Set Up

- Set your name to how you would like to be addressed.
- Pick a quiet place to minimize background noise.
- Mute your microphone.
- Use headphones if working in a space with other people.

Hold down the space bar to temporarily unmute.

Minimize multitasking. Consider turning off notifications.

Eat if you would feel comfortable doing so if the session was being held in-person.

Consider using a virtual background if you would like to have the camera on while maintaining privacy.

Take breaks. Zoom burnout is real.

VIDEO ON OR OFF?

Presenters can indicate preferences about video use when setting the frame.

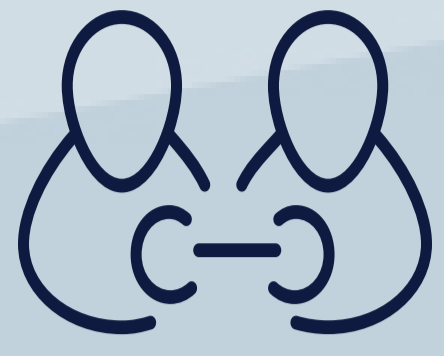
Participants should assume presenters appreciate when cameras are on, especially during interactive components.

Making visual contact will help people feel more connected and engaged!

Circumstances when it may be necessary to have the camera OFF include:

- You are in a public clinical setting.
- You do not have access to a webcam or a charger .
- You are taking a well deserved break to stretch, snack, or refresh before returning to the session.

Virtual Supervision



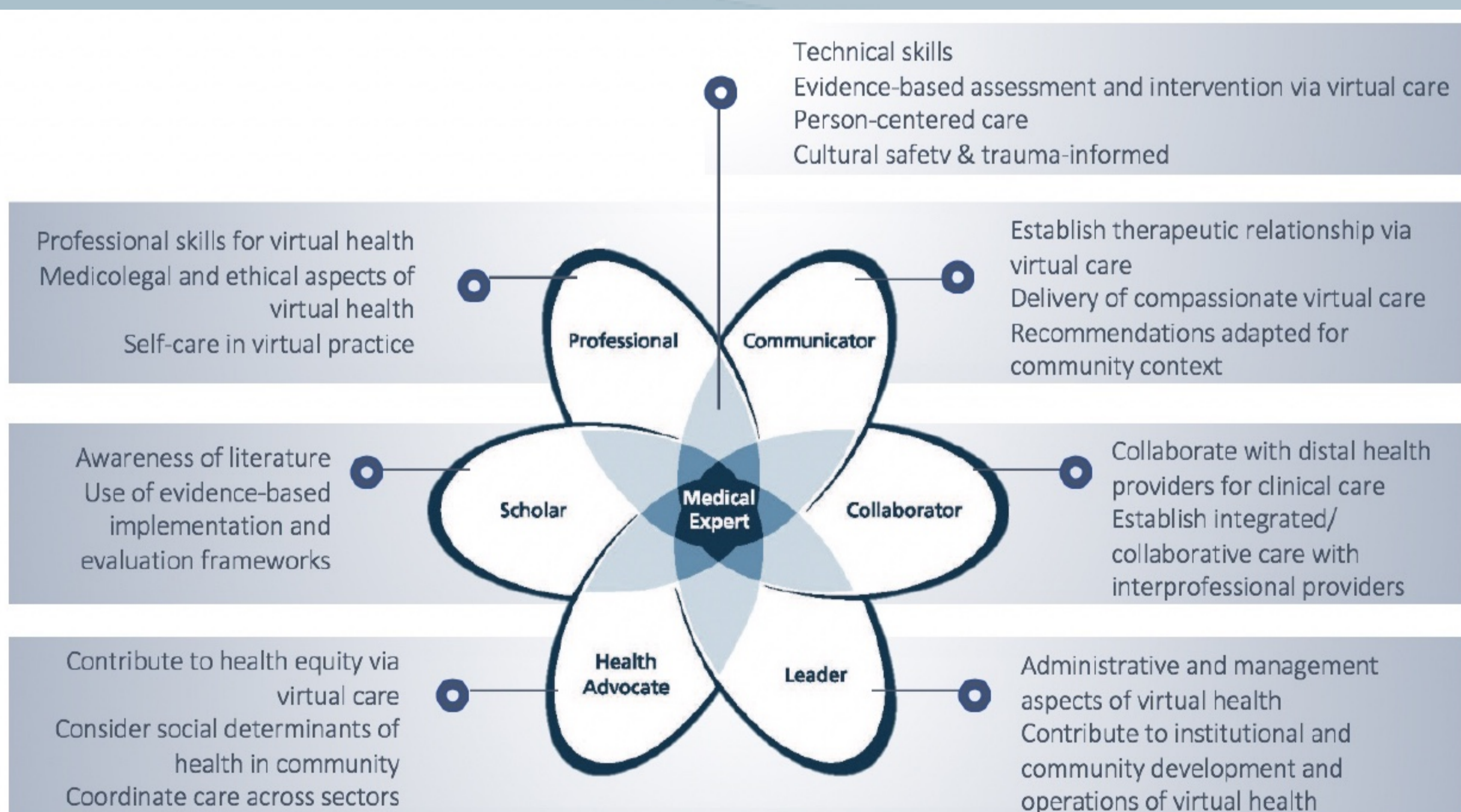
PROVIDING VIRTUAL SUPERVISION

Virtual supervision may be configured in different ways: the patient is seen in person, but the supervision is virtual; the patient is seen virtually and the supervision is either in-person or virtual; the resident and faculty supervisor provide patient care virtually at the same or different locations; or, the supervisor observes a virtual session directly for the purposes of supervision. Important considerations for supervision, include:

- Will there be any **audio or video recording** of patient(s) for the purpose of supervision? Do you know your site's related policies for recording, storage, sharing, and destruction of recordings?
- Consider joining a virtual session to introduce yourself to the patient and/or to provide direct supervision
- Review expectations and boundaries in virtual care** - for both supervisory relationship and resident-patient relationships
- Take a **trauma-informed approach** to supervision - understand potential impacts of the virtual environment on learners and patients
- Has the patient given informed consent** for the virtual care and supervision?
- Support resident **selfcare** and wellbeing
- Be aware of virtual care policies at relevant clinical sites



SUPERVISING VIRTUAL CARE



CanMEDS Framework © Royal College

Adapted from Crawford A, Sunderji N, Lopez J., Soklaridis S. (2015) "Defining competencies for the practice of telepsychiatry through an assessment of resident learning needs. BMC Education.

- Discuss resident **experience and learning needs** in virtual care, across roles. Set learning objectives
- Is the **patient appropriate** for virtual care and for the resident's current scope
- Safety:** Have you reviewed safety in virtual care with the resident?
 Does the resident know how to contact you?