**UHN Clinical Guiding Principles for Virtual Care**

**Introduction**

*Purpose:* This document is a guide for TeamUHN, including care providers, administrative staff, researchers, and learners (e.g. students, residents, fellows, etc.), to enhance the patient care experience through virtual care. It was developed and is maintained by UHN’s Virtual Care Clinical Advisory Panel. Comments and suggestions are always welcome via VirtualCare@uhn.ca.

TeamUHN should consider clinical, psychosocial, socioeconomic, cultural and social identity needs and preferences when determining suitability for virtual care. As with any important decision, ensure that all available options are provided to and understood by patients, including research study participants, so that they may have the opportunity to consider their options and participate fully in shared decision-making.

Virtual care offers opportunity for innovation – allowing for alternate models of care, alleviating pressures to health care capacity, expansion of clinician scope, incorporating multidisciplinary care teams, supports home-based care models and more.

**Part 1: Clinical Appropriateness**

When determining whether to offer virtual care, care teams should prioritize the best interest and well-being of patients. While convenience may play a role in decision-making, the primary focus should be on the quality and safety of the medical care provided.

1. **Standard of care must** be met, and virtual care should only be used if it meets the standard of care and existing legal and professional obligations as apply to in-person services and if the benefits outweigh potential risks to the patient. The CPSO’s Virtual Care Policy emphasizes that the expectation of physicians to meet the standard of care for both in-person and virtual care assessments.

2. **Determine if an in-person assessment/physical examination or in-person care is warranted.** In many cases, care will need to be provided in-person to meet standard of care or to mitigate the risk of patient safety incidents and other medico-legal risks. For example, failure to conduct a proper history and physical exam during the examination of a differential diagnosis is a widely acknowledged and prevalent cause of diagnostic errors that can harm patients. Virtual care may not adequately facilitate such examinations. Therefore, maintaining easy access to in-person visits or alternative services is crucial, particularly when deemed more suitable by care teams or preferred by patients.

Consider:

a. Whether there are symptoms or clinical concerns that require in-person assessment or care or in coordination with other appropriate care providers (e.g., need for an in-person examination, test or procedure; potential safety concerns)

b. Whether physical examination can be effectively conducted virtually (e.g. visual inspection, range of motion, tenderness to palpation, sensitive exams, etc.). If so, consider whether the patient requires specific preparation (e.g. informed of requirements, appropriate space available, access to required equipment, etc.).

Note: In-person assessment and physical exam are often standard of care for conditions including...
and not limited to:

i. Pre-operative and pre-procedural assessment

ii. Pain management assessment and evaluation

iii. Other complex clinical encounters

c. If there is a likelihood that a virtual visit will require an urgent/semi-urgent escalation to physical services and if there is a supporting process in place.

d. If the therapeutic relationship could benefit from an in-person visit.

e. If the patient has recently been seen for in-person examinations by other UHN providers, or by community-based or primary care providers within the patient’s circle of care, consider if this makes an additional in-person examination unnecessary or duplicative.

3. Virtual care may be appropriate for many patient encounters including:

a. Assessment, consultation, diagnosis, and treatment of conditions that are manageable through virtual care, including outpatient rehabilitation

b. Review of laboratory results, pathology, imaging, and consultant reports

c. Assessment, planning and coordination of in-person diagnostic and therapeutic care

d. Chronic disease monitoring and follow-up

e. Review of patient monitoring, patient-reported outcome and experience measures

f. Counselling

g. Patient and family education

h. Research study visits, referral for clinical trial eligibility

i. Home care (e.g., when used as a precursor or bridge to a timely in-home clinician visit by the home care team).

4. Establishing and maintaining patient-provider or patient-care team relationships: It may be advisable for initial assessments, consultations, or first-time clinical encounters to be provided in-person to establish patient-provider relationships and meet standards for comprehensive care but this should be assessed against patient preference, access and equity considerations for the patient, where applicable (See Part 3: Patient Considerations for more detail).

When a patient has been participating in care virtually for a period of 24 months or more, consider offering an in-person appointment to ensure delivery of comprehensive care and to maintain the patient–provider relationship.

It is important that quality of the patient-provider relationship not be compromised when using virtual care. Providers should employ efforts to maintain effective communication and trust with their patients.
Leverage virtual care to minimize the need for repeat in-person visits. This may include coordination of clinic visits, diagnostic studies, therapeutics and research study visits.

5. **Where possible, patient preferences and capacity to receive “bad news” or new diagnoses virtually should be understood by the care team before it is conveyed.** Please consider:
   a. **Timeliness:**
      - Results may be available immediately through myUHN Patient Portal and require explanation and support.
      - Treatment decisions may require expedited communication and planning.
   b. **Sensitivity of diagnosis:** Consider if patients can attain their desired degree of privacy to receive the information.
   c. **Support and comfort:** In-clinic vs in-home environment, whether or not presence of family and caregiver is desired, etc.
   d. **Complexity:** Patients may prefer in-person for more in-depth discussions.

6. **Medication Management in Virtual Care:**

   Ensure that safe medication management best practices can be followed while delivering virtual care, including, but not limited to collection of Best Possible Medication History (BPMH), medication review and reconciliation, and safe prescription transmission and receipt. Please review best practice medication management standards or guidelines defined by regulatory bodies and/or associations of their profession, as well as UHN medication policies, found [here](#).

   Note, virtual high risk prescribing must be carefully considered, especially with initial virtual consultations.

   Examples may include, but are not limited to:
   a. New prescriptions for narcotics, benzodiazepines, stimulants, cannabis or other addicting or habituating drugs.
   b. Prescriptions of controlled drugs for patients with a history of substance use disorder.

   Access barriers must be considered in clinical decision-making regarding virtual high risk prescribing. High risk prescribing should be practiced in environments where the goals of therapy are clear and patients receive ongoing interprofessional care (e.g. Palliative Care, Chronic Pain Management and Addiction Medicine).

7. **Urgent Virtual Care:**

   Urgent virtual care may differ from planned virtual care visits and should only be provided when appropriate expertise, workflows, and supporting resources have been defined (see Appendix A for examples).

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1. High risk prescribing: *Prescribing of high-alert medications.* High-alert medications are drugs that bear a heightened risk of causing significant patient harm when they are used in error. Harm is defined as a temporary or permanent impairment in body functions or structures. Includes mental, physical, sensory functions and pain. *Institute for Safe Medication Practices (2024)*
Supporting resources may include, but are not limited to:

a. Appropriate staffing model
b. Defined workflows to address evolving urgency
c. Patient support

8. Out-of-Province Patients and Patients outside Canada:

For some provinces, there are specific licensing requirements for care providers. Clinicians must comply with the individual province’s licensing requirements in the province the patient resides. Clinicians are responsible for reviewing the requirements as per that province’s respective professional colleges and must meet the requirements prior to the consultation.

Please refer to and consult with Ministry of Health, CPSO and CMPA for more information. Selected highlights for physicians are included below.

From “Advice to the Profession: Virtual Care” guideline from the College of Physicians and Surgeons of Ontario (CPSO):

**Providing Virtual Care Across Borders**

**Am I allowed to provide virtual care to Ontario patients who are temporarily out of the province or country?**

If the policy expectations can be met, CPSO permits Ontario physicians to treat Ontario patients who are temporarily located outside of Ontario or Canada, where required to support continuity of care, patient safety, or patient best interest (e.g., providing follow-up care, communicating test results, answering questions about medications, etc.).

However, many jurisdictions consider the care to occur where the patient is physically located, and physicians will also need to be aware of and comply with the licensing requirements of the jurisdiction where the patient is receiving virtual care.

There may be specific rules regarding liability protection and billing in these circumstances. Physicians with questions about liability protection and billing can contact the CMPA and the Ministry of Health respectively for more information.

Regarding the provision of virtual care to patients outside of Canada, the Canadian Medical Protective Association (CMPA) states:

If a patient is outside of Canada temporarily (e.g. on vacation, temporary employment, or students pursuing studies abroad) and phones or emails the physician’s office regarding a medical problem related to a condition the physician is managing, the member would generally be eligible for assistance, as long as any medico-legal problem or legal action is initiated in Canada. Given the potential limitations of such communication, it may be prudent to consider advising the patient to seek local follow-up.

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2 College of Physicians and Surgeons of Ontario (CPSO) (ND). Advice to the Profession: Virtual Care.
UHN International Patient Programs: Please follow policies and procedures associated with each Program. Medico-legal liability will be provided through the Program, not the CMPA.

Part 2: Provider Considerations

Care providers (including learners) must be prepared with the necessary competencies and supports required to deliver virtual care (e.g., digital literacy, equipment, physical space).

For optimal experience and security, please use a UHN device when conducting a virtual visit.

1. Care providers (including learners) must ensure that the virtual technology used is of sufficient quality to implement safe and clinically effective workflows, including the ability to:
   a. Communicate effectively, ensuring that the quality of the audio is appropriate for the planned encounter
   b. Provide safe interventions; and
   c. Form an accurate professional opinion and/or make care decisions

2. Care providers (including learners) must be prepared to deal with potential patient safety events during virtual care (Virtual Care Patient Safety Events (uhn.ca))

Part 3: Patient Considerations

Patient preference regarding virtual or in-person care must always be considered. When clinically appropriate and logistically feasible, patient/caregiver preferences should be prioritized.

If a patient prefers a virtual visit, but the care team determines an in-person appointment is most clinically and/or logistically appropriate, the patient should be compassionately informed of this decision, with the rationale/clinical judgment explained.

If the patient and provider decide on virtual care, it is important to also establish the most effective modality (e.g. telephone or videoconference). The following principles are intended to support patient-centred care and UHN’s primary value of “the needs of patients come first” (see UHN’s Patient Declaration of Values).

Patient Preference

1. Patients, substitute decision-makers, and essential care partners require the necessary information to make an informed decision regarding preference. Efforts should be made to identify a patient’s virtual care preference early in their care pathway/journey.

   In addition to identifying patient preference, informed consent must be documented (see Consent and Privacy Protection for Virtual Care).

   Patient preference may be impacted by individual, technology, or system/structural health equity challenges. Please refer to “Virtual Care Access and Equity Considerations - Access and Equity Considerations - Health and Digital Health Equity in Virtual Care” below for more information.

2. If providing virtual care, care teams must have capacity to provide both videoconferencing and
telephone visits. Consideration should be given to choosing the appropriate virtual care modalities for clinician-patient communication.

Care providers should consider patient preference, potential benefits, and technology-associated and access/equity-associated barriers/limitations with each modality. See Virtual Care Access and Equity Considerations section below for more information. Telephone may also serve as valuable technical backup for planned video visits.

3. Virtual care can allow for the inclusion of family, caregiver, essential care partners and/or support person during the virtual visit, if desired and consented to by the patient (virtually or co-located with the patient). Consider how the selected virtual care platform may affect:
   a. Family, caregiver, and/or support person experience
   b. Burden to family, caregiver, and/or support person

Access and Equity Considerations - Health and Digital Health Equity in Virtual Care

The provision and quality of virtual care should be equitable and utilized based on the alignment of clinical and patient considerations, and not limited by personal, social, economic and environmental factors and other determinants of health.

It is important to consider and address and/or avoid unintended equity-related consequences resulting from the use of virtual care, as well as consider that some patients and communities may be systemically excluded from virtual care.

The following patient populations or individual factors have been identified as having differential impacts based on the determinants of digital health (Health Canada, 2021; HEC & CHI, 2022):

- Older adults
- Racialized and/or ethnic minorities
- Immigrants and refugees
- First Nations, Inuit and Métis
- 2SLGBTQIA2+
- People experiencing homeless, under-housing or precarious housing
- People living in rural and remote locations
- Low income and/or education
- Pre-existing health conditions and disabilities
- Linguistically diverse groups

Other characteristics that can pose additional barriers to equitable access to virtual care include:

- Persons with disabilities, including cognitive, hearing, vision, mobility or other
• Mistrust in healthcare providers, systems or technology
• Lack of access to technology and/or internet/data services
• Lack of comfort with, literacy, or skill with using technology
• Culture, including but not limited to: beliefs, values and cultural norms/preferences for use of virtual care, different conceptions of help-seeking, as well as the need for culturally safe or culturally competent virtual care

The following two sections, **1. Virtual Care Access and Equity Drivers** and **2. Virtual Care Access and Equity Barriers** outline opportunities and challenges, as well as mitigation strategies for equitable access to care:

1. **Virtual Care Access and Equity Drivers**

   Consider if virtual care will enable better access to care for patients and their caregiver/essential care partners than in-person care.

   a. **Mitigates accessibility barriers/challenges** (ex. mobility issues or otherwise is constrained to place; challenges travelling to appointments).

      Consider if patients and their caregiver/essential care partners may have accessibility and/or challenges/ barriers that prevent them from attending in-person appointments that can be mitigated by virtual care including but not limited to travel distance; ability to travel independently; mobility; and overall convenience.

   b. **Mitigates economic barriers/challenges**

      Consider if patients and their caregiver/essential care partners may have economic challenges/ barriers that can be mitigated by virtual care, including but not limited to lost wages; travel expenses and parking; childcare, elder care, etc.; other economic considerations for patients, families, caregivers, and/or support.

2. **Virtual Care Access and Equity Barriers**

   Patients and caregivers need access to technology and the skills and/or supports to participate in virtual care. Consider the following:

   a. **Access to required technology for virtual care:**

      Does the patient have access to technology (e.g., telephone, mobile devices, computer, internet, applications)? Effective videoconference visits require reliable secure internet access, an email address and device(s) with video and audio capabilities.

      Potential strategies that can be employed to mitigate this:

      • Use technology that the patient is comfortable with, such as telephone calls, provided these platforms will not impact quality of care.

      • Device loaning programs if available (e.g. videoconferencing enabled tablet, home blood pressure cuffs, etc.).
b. Necessary skills and/or supports for virtual care:

Does the patient/caregiver have skills and/or support to use the required technology to participate in virtual care? Is the patient/caregiver comfortable using required devices and/or the software/platform?

Potential strategies that can be employed to mitigate this:

- If appropriate, include family, caregiver, and/or support with adequate digital literacy and access to technology.
- Connect patients/caregivers with patient resources to build digital literacy skills and outline device requirements. Additional resources and support for patients are listed on the internet: Virtual Visits at UHN

c. Culture and orientation to health-related technology

Consider if culturally safe and culturally competent care can be delivered virtually. Patients’ cultures, religions, and social environments may impact their orientation to virtual care.

d. Language and/or disability-related barriers to virtual care:

Does the patient/caregiver require support services to enable participation in virtual care related to language (e.g., translation support), vision, hearing, dexterity, or other needs? Language and communication requirements must be anticipated and optimized for virtual or in-person care and patients should not be disadvantaged due to these factors. Potential strategies to mitigate this:

- Leverage Interpretation and/or Translation Services
- Leverage aphasia-friendly services
- Use virtual care modalities best suited accessibility needs.

e. Access to safe and private space for virtual appointments.

Consider factors that may prevent a patient from communicating openly and privately during virtual care (e.g. housing status, domestic circumstances).

Virtual Care at UHN is committed to working with patient partners, clinical teams, research teams, Social Medicine Program, Integrated Care, and groups across UHN to creatively and effectively meet the evolving needs of our patients and TeamUHN.

These Clinical Guiding Principles for Virtual Care represent our current understanding of best practices in the rapidly evolving field of virtual care. However, it is essential to acknowledge that healthcare and technology continue to advance. As such, we remain dedicated to continuous learning and research in the realm of virtual care. Our commitment is to expand knowledge, enhance patient care, and support quality improvement within the ever-evolving landscape of healthcare. This document is not static; it is a dynamic resource that will be updated as new evidence is uncovered and innovations emerge, ensuring that it remains a reliable guide for TeamUHN.
Contact Information:

We encourage your comments and suggestions to help us improve the Clinical Guiding Principles for Virtual Care. The UHN’s Virtual Care Team can be reached at VirtualCare@uhn.ca.
Resources


Centre for Effective Practice & Department of Family and Community Medicine, University of Toronto. (2021). Enhancing Management of Chronic Conditions Using Virtual Care During COVID-19 | Centre for Effective Practice—Digital Tools. Centre for Effective Practice and Department of Family and Community Medicine, University of Toronto. https://tools.cep.health/tool/virtual-management-of-chronic-conditions-during-covid-19/


Appendix A: Examples of Urgent Virtual Care

Examples of urgent virtual care programs with appropriate expertise and supporting resources.

- UHN Telestroke Program [https://otn.ca/blog/telestroke-distance/](https://otn.ca/blog/telestroke-distance/)
- Rapid virtual access clinics for post emergency department discharge patients
- Crisis hotlines
- UHN Connected Care COVID Clinic
- Proactive monitoring on cancer treatment
- Post-surgery care
- UHN Virtual Emergency Department