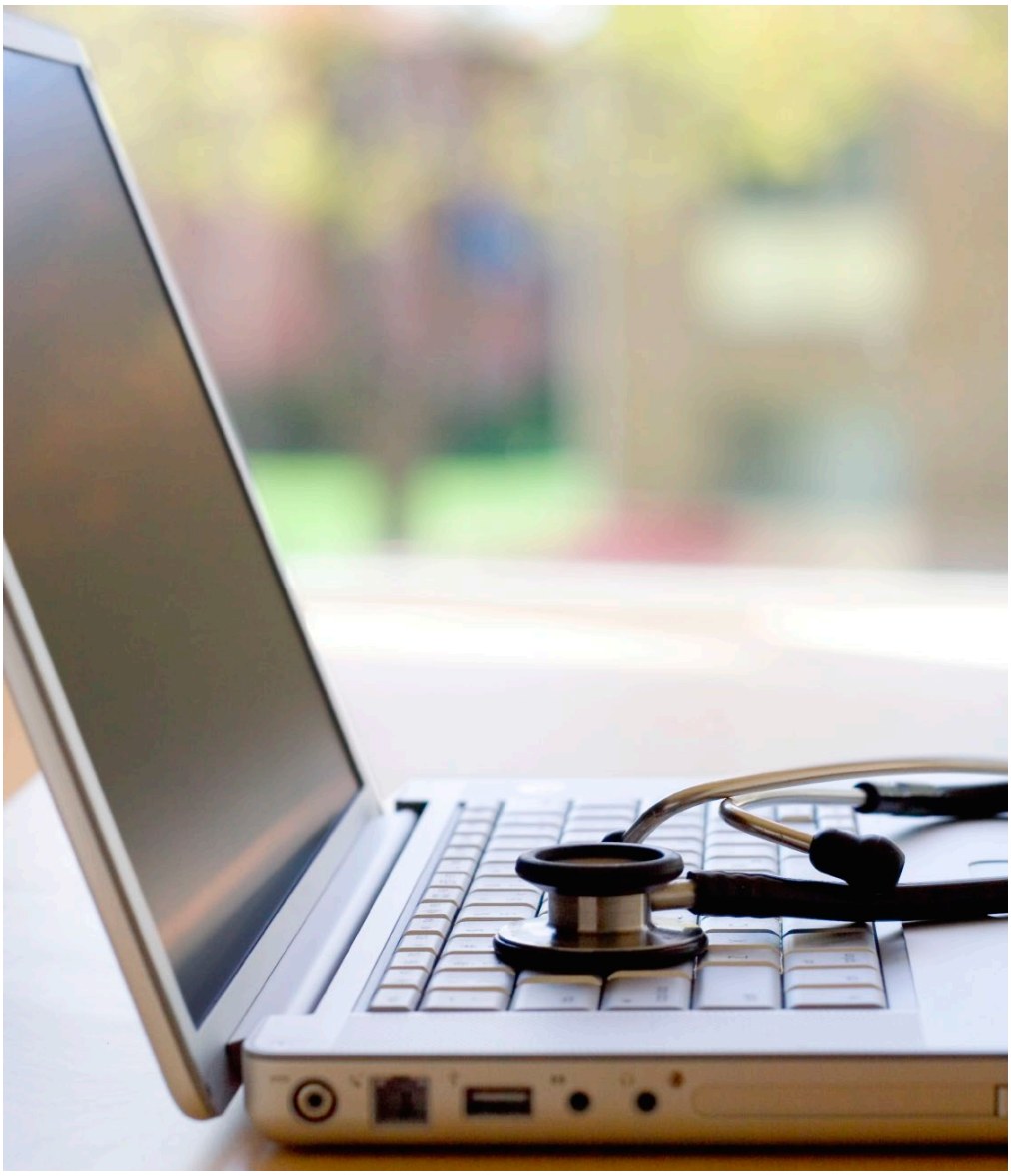
Ontario Health
Cancer Care Ontario



Clinical Guidance for Person-Centred Virtual Cancer Care

January 2022

ABOUT THIS DOCUMENT

This document is intended as additional guidance specific to the delivery of virtual care during and after the COVID-19 pandemic; it is intended to supplement government directives and public health measures. Adapted approaches may be required to address unique patient, organizational or other local conditions. Further updates may be released as clinical evidence develops and with the evolution of a long-term strategy for virtual care in the cancer system and the overall health system in Ontario.

Person-Centred Care

The concept of person-centred care should continue to be a guiding principle in the Ontario cancer system regardless of whether care is conducted in-person, or via virtual care.

The 2015 Person-Centred Care Guideline [1] lists the following as essential requirements of care:

- patients feel respected;
- patients' concerns are listened to and addressed;
- various aspects of patient care (e.g., nutrition, pain) are appropriately managed;
- patients are provided support to maintain independence; and,
- all of the above are done with patient consent.

The standard of care provided in virtual care appointments should be no different to the standard of care provided in an in-person appointment. This guidance is intended to support oncology care providers in their transition to providing virtual care while maintaining the principles of person centered care.

Intended Audience

This clinical guidance document is intended to assist any health care professional involved in providing oncology virtual care to adult patients in an ambulatory/outpatient setting. Patients are advised to consult the Ontario Health website for updates on virtual care resources.

For information or questions about this report, please contact the Person-Centred Care Program at: colleen.fox@ontariohealth.ca

DEFINITIONS

Allied Health

Allied Health refers to members of the care team including various psychosocial oncology (PSO) professionals (registered dietitians, occupational therapists, physiotherapists, psychiatrists, psychologists, social workers, speech language pathologists, and spiritual care practitioners) as well as other professionals such as audiologists, pharmacists, and radiation therapists.

Appointment

Appointment refers to a scheduled arrangement to meet and discuss care between patients and health care providers.

Care Partner

Care Partner refers to any relative, partner, friend or neighbour who has a significant personal relationship with, and provides a broad range of assistance for, a patient. In addition, they could be legally identified as next of kin or power of attorney by the patient. These individuals may be primary or secondary caregivers and live with, or separately from, the person receiving care.

Health Care Provider

Health Care Provider refers to any health care professional involved in providing oncology care. This could include, but is not limited to: allied health professionals, nursing, oncologists, physicians, radiation therapists.

Local Health Care Provider

Local Health Care Provider refers to any local health care professional (including primary care provider, oncologist, nurse practitioner, therapist, etc.) involved in providing primary medical care to a patient within their locality. Institutional administrative support will be needed to support this integrative care.

Primary Care Provider

This is a health care provider or a team who manages the patient's existing health issues and is usually the first contact for the patient seeking access to the health care system for a new health issue and includes, but are not limited to family physicians, general practitioners, nurse practitioners, and family health teams [2].

Virtual care

Virtual cancer care refers to any interaction between patients and health care providers, occurring remotely, using any forms of communication or information technologies (computer, phone (either landline or cellular)), with the aim of facilitating or maximizing the quality and effectiveness of patient care [3]. The term virtual care can be both an approach to care or a single interaction between a provider and patient. Different modalities include:

- Telephone-based care: when a patient speaks to a provider over the phone (also referred to as Telepractice or Telemedicine)
- Video-based care (also known as videoconferencing) involves a real-time encounter between one or more health care providers and a patient. The patient can be at home or another chosen location (i.e., direct-to-patient video visit) or at a patient host site (i.e., hosted video visit) that may be supported by a health care professional.
- Asynchronous communication such as secure text messaging is a written clinical encounter, typically without any visual input (except for optional image attachments), accessible by patients via web browser or mobile application. Secure messaging provides security safeguards, like patient authentication, that are not available with regular email and other unsecure forms of communication.
- Remote Patient/Care Monitoring (RCM) programs utilize remote monitoring solutions to assess a patient's ongoing health status and utilize this data to guide care plan changes, address patient education

The use of asynchronous communication and RCM were not explored as part of this guidance.

Technology

Technology refers to the telephone or computer devices, hardware or software (aka virtual platforms) required for virtual care.

BACKGROUND

The novel coronavirus, SARS-CoV-2, that causes the coronavirus disease (COVID-19), has been the foremost public health priority globally since March 2020 and has altered the delivery of clinical care. Since March of 2020, cancer patients continue to face unique challenges during the pandemic related to their care such as, physical distancing efforts hindering in-person care, increased risk of infection when attending appointments and treatments, treatment delays or unavailability (due to ramp downs of clinical care), and management of adverse effects of treatment [4]. Prior to the pandemic, cancer care was primarily provided in-person, and therefore a rapid transition to virtual care was required. Due to that rapid transition, the required processes and quality implementation were lacking. As an unprecedented number of patients with cancer receive their care remotely, identification of best practices for virtual cancer care is urgently needed to guide clinicians during the COVID-19 pandemic and beyond.

The Canadian Medical Association adopted the definition of virtual care as "any interaction between patients and/or members of their circle of care, occurring remotely, using any forms of communication or information technologies with the aim of facilitating or maximizing the quality and effectiveness of patient care." [3]

Virtual care has historically been utilized throughout the cancer care continuum for patient support, education and toxicity management by nursing and allied health.

Ontario Health (Cancer Care Ontario) identified an urgent need to develop consensus practice recommendations and struck a panel of experts to develop recommendations for the virtual management of cancer patients using a modified Delphi process with representation from across the spectrum of cancer care (For a full list of contributors and an outline of the methodology, please refer to Appendix 1 and 2).

Objectives

The expert panel was guided by the following questions:

1. What factors are essential for quality driven person-centered care cancer care?
2. What are clinical & non-clinical patient characteristics that make a patient suitable for virtual cancer care?
3. What are relative contraindications to virtual cancer care?
4. How can virtual care be used and vary during the different stages in the cancer journey?

In parallel to this work, the Ontario Health (Cancer Care Ontario) Program in Evidence-Based Care completed an Evidence Review to identify guidance available for virtual cancer care [5]. The review concluded that there exists a paucity of data for a purely evidence-based approach to widespread adoption of virtual care in the cancer system in Ontario. Given the rapid speed at which the adoption of virtual care was required due to the COVID-19 pandemic, the review emphasised the need for consensus based guiding principles to ensure quality, innovation and person-centered care.

Scope

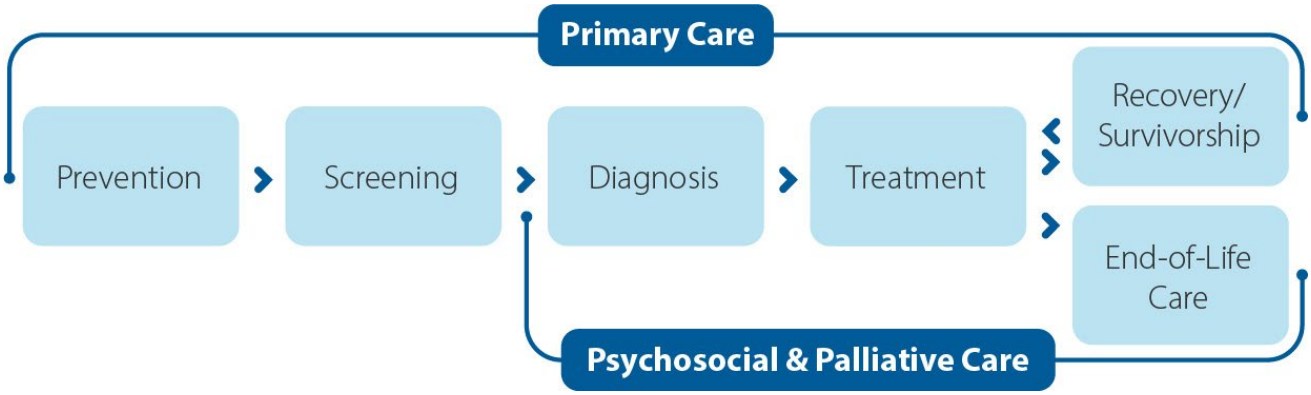
The recommendations provided here present clinical guidance to optimize the delivery of virtual care for cancer patients during different stages of their care.

The scope of these virtual care recommendations ranges from:

- selecting appropriate patients,
- delivering diagnoses,
- executing treatment plans,
- as well as follow-up appointments for patients on active treatment and/or on surveillance.

As oncology clinicians care for patients throughout the cancer care continuum (see Figure 1), across patient populations and settings, this guidance is applicable across diagnosis, through treatment, palliative care and survivorship.

Figure 1: The Cancer Care Continuum



Specific guidance for the use of virtual care for screening and end-of-life care were deemed out of scope for this work. In addition, the use of asynchronous communication (e.g., text messaging), which is often associated with the notion of virtual care, was not explored as part of this guidance.

In Summary

Providing person-centred care remains the focus of the Ontario cancer system, regardless of the modality. As evident from the recommendations in this guidance document, the use of virtual care, in clinically appropriate scenarios, can facilitate safe, continuous and convenient care, and communication, during and beyond the pandemic.

TABLE OF CONTENTS

The following sections outline the areas of care and key questions that clinicians may be concerned about when providing virtual cancer care to their patients.

CLINICAL GUIDANCE RECOMMENDATIONS

CLINICAL GUIDANCE RECOMMENDATIONS

These recommendations cover multiple phases of the disease trajectory and meeting different patient needs. They align with existing areas of evidence and contribute to emerging practice evidence to address the gaps in published literature.

Section A: Essential Requirements

A.1. Patient and provider needs

Which non-clinical patient needs, and provider characteristics, should be considered when offering virtual cancer care?

Offer the option to all patients

All patients should be considered and, if clinically feasible, offered the option of virtual cancer care regardless of demographics (e.g., gender, race/ethnicity, language spoken, income, education, rurality, physical and/or mental disabilities, indigenous identity).

To support a patient in transition from in-person to virtual care, consider providing information as to why a virtual appointment is clinically safe and feasible.

Ensure equitable access

Special effort should be made towards ensuring equitable access to virtual care (e.g., incorporating translation services).

Provide guidance on how to use virtual care

It is recommended that informational resources about virtual care be created and disseminated to all health care providers and patients to help facilitate quality virtual cancer care.

These can include written, video, and/or verbal guidance provided by a member of the oncology team (e.g., clinical administrator) either in advance of the virtual care appointment or at the point of care.

Enable access to technology

Efforts should be made to ensure that virtual cancer care modalities are made as easily accessible as possible. For example, health care providers and/or patients who may not have easy access to video-based virtual care technology should be provided the option for a telephone appointment instead, where appropriate.

Be persistent

One suboptimal or unsuccessful virtual care appointment does not exclude a patient from future virtual care appointments, as long as both patient and provider deem clinically and logistically feasible.

Incorporate care partners

Care partners should be encouraged to attend virtual care appointments, especially for patients with language barriers, self-reported lack of comfort with virtual care, hearing impairment, or cognitive impairment. Health care providers should ensure patient privacy and consent is obtained to discuss details of their care with additional people.

Allocate adequate time and space for virtual care

A pre-determined and dedicated time period should be allocated for virtual care appointments. Both health care providers and patients should ensure an environment that is distraction-free and provides confidentiality.

Adequate time for health care providers prior to and following a virtual care appointments should be planned as additional steps (e.g., electronic requests for outside labs, imaging, prescriptions) may increase the amount of time required per appointment.

Efforts should be made to ensure all relevant test results and materials are available to the clinician and the patient, in time for the scheduled virtual appointment.

A.2. Logistics

What basic logistical considerations are required to provide virtual cancer care?

Address technology requirements

Health care providers should have access to reliable internet connection and an electronic device (e.g., computer, tablet, or smartphone) if using video technology for virtual care.

Have back-up systems in place

Back-up systems, such as telephone (landline or cellular), should be available during virtual care appointments, should technical difficulties arise.

Landline telephone is preferred for call quality/stability, if available. If not, then cellular/mobile phone can be used.

Documentation standards

All virtual care appointments should be documented using the same standards as in-person assessments.

Documentation, where applicable, should state that:

1. the appointment was done virtually, and
2. the patient has consented to a virtual assessment, with the understanding of the limitations of virtual care (e.g., the lack of in-person physical examination).

Access to electronic medical records

Electronic medical record systems that allow health care providers to access system-wide investigations (including biochemical, radiological, pathological data - that may have been completed outside the institution) and relevant documentation are critical to facilitate virtual care appointments with patients.

Training

To optimize the delivery of virtual cancer care, health care providers and patients should have access to training options (e.g., virtual care modules and programs) and/or informational resources.

Virtual care training should be supported and disseminated by institutions, provincial entities, and/or in collaboration with other virtual cancer care stakeholders.

Techniques and skills for providers to practice empathetic communication in the virtual care environment may be required (see Further Resources section).

Mode of virtual care

If video-based technologies are not available and/or if telephone communication is preferred by health care providers and/or patients, then telephone communication may be reasonable.

Availability of and preference for virtual care modalities, while important elements, should not be the principle driver for choosing virtual care. Patient safety, clinical appropriateness, clinician judgement and the broader care context all need to be considered. Please consult the Further Resources section for more information on physician requirements.

Use verified tools

Providers may access virtual visit tools from a variety of systems including their electronic medical record (EMR) or hospital information system, or through stand-alone virtual visit applications from their computer and/or mobile device. Under Ministry of Health direction, Ontario Health requires virtual visit tools to adhere to minimum requirements.

A.3. Collaborative Care

Who should be consulted when providing virtual cancer care?

Integrate Information

Effort should be made to ensure that all patient results or reports are available to care providers prior to the virtual appointment.

Multidisciplinary case conferences & tumour boards

Care of patients receiving virtual care should continue to include multidisciplinary tumour boards and case conferences.

Case conferences involving oncology and allied health care providers and primary care are feasible using virtual modalities and should remain a standard of care for discussing cancer patients receiving in-person and virtual care. Confidential and secure technology should be chosen to host conferences and discussions as per standards.

Local health care providers

Involvement of local health care providers in virtual care should be supported, if possible and available. Administrative support may be required.

Most responsible clinician

If a plan of care is initiated via virtual care, an in-person health care provider must be available at the treatment centre to guide and support treatments (e.g. chemotherapy and infusion reactions).

Local laboratory

Delivery of virtual cancer care should include efforts to link patients with local laboratory (i.e., blood test) and/or imaging services when appropriate. However, test results should be available to the health care provider and comparable to previous investigations (e.g., comparing imaging scans at follow up appointments). If not available, then testing should be done at the health care provider's institution.

Primary care

Access to primary care and emergent care must be included in the discussion of risks and benefits of virtually managed cancer care. Patients receiving virtual cancer care should be counselled on possible risks specific to their care (e.g., chemotherapy toxicity, lymphedema, post-surgical complications) and cancer (e.g., visceral crisis) and appropriate avenues to reach care.

Section B: Diagnosis and Prognosis

B.1. Non-clinical patient characteristics

Which patient aspects should be considered when providing a diagnosis using virtual means?

Health literacy

Prior to and during virtual cancer care appointments (especially initial consultation), health care providers are encouraged to assess the patient's ability to understand, process and follow up on the communication of health information delivered virtually (digital and/or over the telephone).

Patient preference

When clinically appropriate, patient preferences regarding method of communication (phone, videoconference, in person) to hear diagnostic and prognostic information should be understood by the health care provider before diagnosis/prognosis is conveyed. Moreover, effort should be made to have a care partner present, depending on patient preference.

Collaborate with other health care providers ahead of time

When there is uncertainty about definitive diagnosis and/or prognosis, collaboration amongst health care providers and disciplines should occur prior to virtual care with the patient such that a clear plan of care can be shared virtually.

If after collaboration uncertainty is still present, a clear plan should be constructed to communicate to the patient how this uncertainty will be clarified. This plan can be communicated virtually to the patient by one or more health care providers involved.

Patient needs

The discussion of initial cancer diagnosis and prognosis may occur over virtual care, if that would meet the needs of the patient (e.g., more timely discussions, better family support or patient inability to travel).

B.2. Logistics for diagnostics conversations

What is the best way to communicate a diagnosis, investigations (e.g., results of staging, blood tests) and prognosis virtually?

In addition to in-person standards of communication (e.g., ensuring care partner and/or supports are available), key elements of an effective virtual interaction regarding cancer diagnosis include (but are not limited to):

Modality

Use of video over telephone, if available.

Camera placement

Placement of camera should be at eye level so that the health care provider does not appear above the patient.

Purpose of the conversation

Explain at the outset that the conversation is about diagnosis and next steps.

Introduce participants

Introduce all health care providers present and ask for an introduction of all care partners that are part of the virtual conversation.

Share visual aids

If using video-based technology (that allow sharing digital information on the screen) to conduct a virtual appointment, digital visual aids that complement the discussion (e.g., electronically-available imaging or pathology reports, prediction tool outputs) can be screen-shared with the patient, depending on patient preference and feasibility.

Pause

Allow for pauses for asking and answering questions.

Teach-back

Confirm understanding using the teach back method (e.g., ask patient to explain plan back to the health care provider).

B.3. Diagnostic and treatment plan conversations

What are the steps to facilitate safe and accurate communication of diagnosis and treatment of cancer via virtual care?

Have treatment details readily accessible

Plan for the virtual care appointments and have information on hand that patients may ask for (e.g., avenues for treatment access, potential start dates, treatment delivery site).

Referrals

Discuss and execute appropriate referrals (e.g., to allied health or drug reimbursement) dependent on patient need and treatment plan. Referrals to services that also can be conducted virtually should be considered.

Prognosis

Include prognosis information as part of the discussion in accordance with patient preference.

Educational material

All virtual care appointments about diagnosis and prognosis should be supplemented with educational material (e.g., plain language drug information sheets and disease information, or written care plan), and an avenue (e.g., incoming phone line, patient portal, follow up appointment, email) should be provided for questions after review of information and literature, for example with an oncology nurse.

B.4. Metastatic or palliative diagnosis conversations

When the diagnosis is metastatic or palliative, what aspects should be considered before conducting the conversation virtually?

The provider should consider:

- the nature of the patient/provider relationship,
- the expected response to the metastatic/palliative diagnosis, and
- the level of support available to the patient.

Exceptions to this statement may include:

- **Urgency:** Situations where there is urgency to initiate treatment and virtual care facilitates expediency.
- **Ability to attend in person:** The patient has a high symptom burden where they cannot attend the appointment in person.
- **Involvement of other health care providers:** A virtual appointment enables a local health care provider to be part of the appointment, where they will be key in co-managing patient care and treatment moving forward.

Refer to the "Leveraging Virtual Care to Support Palliative Care" for further guidance.

Section C: Active management, follow-up and survivorship

C. 1. Active Management

What are the general recommendations that apply to the management of patients with cancer using virtual care?

Assess the need for in-person physical examination

If physical examinations and/or investigations (e.g., bloodwork, imaging, pathology) essential for diagnosis/prognosis, symptom management, and/or choice of treatment could not be obtained through a virtual appointment, an in-person face-to-face appointment is required.

Appropriateness of engaging individual patients in virtual care appointments for active management depends on the health care provider, as well as patient preference when clinically appropriate.

Both curative and non-curative intent virtual management of patients with cancer is appropriate, unless in-person assessment is required by either the health care provider or the patient.

Involve other care team partners

- **Allied health:** When required, allied health care support (including rehabilitation and other psychosocial oncology services) should be offered to ensure optimal patient care.
- **Primary care:** In order to facilitate optimal longitudinal patient care, primary care providers who actively follow their patients with cancer should be engaged in the virtual discussions, if possible and appropriate.
- **Care partner:** Virtual follow-up appointements that require discussion about recurrent or progressive disease and/or change of treatment due to treatment failure should prompt the health care provider to request that the patient be accompanied on the telephone or video conference by a care partner.

Assessment

- Virtual care should continue to be used for:
    - symptom and pain management,
    - nutrition assessment,
    - drug toxicity,
    - psychosocial factors (e.g., supportive counselling, activities of daily living, etc.),
    - exercise prescriptions.
- **Frequency**:
    - When the purpose of the appointment is focused on the disease surveillance, health care providers using virtual assessment tools should ensure patients are assessed at the same frequency of appointments as in-person assessments.
    - The need for continuous communication, with non-curative patients can be assisted by using virtual means, such that a patient can flag concerns or initiate appointments when appropriate.
- **Clinical trial eligibility**: Patients assessed virtually should still be referred for clinical trial eligibility where appropriate. The need for in-person appointments, which may be needed to facilitate clinical trial participation, should be discussed with patients.

C.2. Surgical oncology patients

Which components of surgical care are suitable for virtual care?

First appointments

First appointments with potential surgical cancer patients should be held in-person if there is a requirement for in-person physical examination or other in-person investigations. Otherwise, a virtual appointment is appropriate.

Surgical planning and post-operative follow up

Surgical planning and post-operative follow up of patients with cancer could be conducted virtually, either when:

- no additional in-person physical examinations or investigations (e.g., bloodwork, imaging, pathology) are needed, or
- when these examinations and investigations could be completed locally for patients living in remote areas.

Involve local health care providers

For patients living in remote areas, virtual surgical care consultations are only appropriate if the surgeon is able and willing to utilize the assessment from physical examinations performed by local health care providers.

Post-surgical patients

Post-surgical patients can be assessed virtually unless the need for wound assessment and/or in-person physical examination is required to provide optimal care.

Involve homecare

If virtual care is performed, it is recommended to engage homecare for patients with active wound issues (i.e., wound care).

C.3. Radiation oncology patients

Which components of radiotherapy are suitable for virtual care?

First appointments

First appointments with potential radiation oncology cancer patients should be held in person if formal in-person physical examination of relevant organ system is necessary. Otherwise, virtual care, in conjunction with the relevant interdisciplinary team members, is appropriate.

Treatment discussions

Discussion of radiation treatments can be conducted virtually, as long as there is no requirement for an in-person assessment.

Assess symptoms

Patients on surveillance or observation following definitive radiation therapy with curative intent can be followed virtually, unless symptoms arise on review of systems that trigger an in-person assessment.

Toxicity and in-person assessment

Patients with cancer receiving active radiation therapy can be followed virtually. However, if in-person physical examination is necessary, an in-person appointment should be facilitated.

Involve other health care providers

Engagement of allied health and primary care providers is recommended.

C.4. Medical & hematological oncology patients

Which components of systemic treatment can be managed using virtual care?

First appointments

First appointments with potential medical and hematology oncology cancer patients should be held in-person for formal physical examination of relevant organ systems and/or any pre-treatment procedures, if necessary. If not, then virtual assessment, in conjunction with the relevant interdisciplinary team members, is appropriate.

Toxicity and in-person assessment

Patients with cancer receiving active systemic anti-cancer therapy (intravenous and/or oral) can be followed virtually in conjunction with the nursing team. However, if physical examination is necessary, an in-person appointment should be facilitated.

Surveillance/observation

Patients on surveillance/observation following definitive systemic therapy with curative intent can be followed virtually, unless symptoms arise on review of systems that trigger an in-person assessment.

Involve local health care providers

Engagement of local health care providers is recommended to arrange in-person physical examinations if indicated.

Continuation of treatment

Decisions to continue or discontinue systemic treatments that have been previously initiated could be made virtually, if deemed appropriate by health care provider and patient.

C.5. Survivorship care

What are cancer survivorship considerations during virtual care?

Assess the need for in-person physical examination

Cancer survivors under surveillance following curative intent treatment can be safely followed using virtual care, unless in-person physical examination is indicated and/or required.

Involvement of primary care

Virtual inclusion and engagement with primary care providers can be considered to optimize surveillance.

Transition to virtual survivorship care

Primary care providers and cancer survivors should be made aware of the transition to virtual survivorship care.

C.6. Rural & Remote Oncology

What are rural and remote oncology considerations for virtual care?

Geography & severity of symptoms

Virtual care could be used for urgent consultation for distant patients who are either:

- unable to access a specialist in a timely manner, or
- the severity of their symptoms prevent them from travelling long distances.

Involve local health care providers

Virtual appointments could facilitate the attendance of local health care providers.

APPENDIX 1: ACKNOWLEGEMENTS

We would like to acknowledge the tremendous contribution of all the members, who provided their valuable time and content expertise in the development of this guidance.

We would also like to thank clinical colleagues and administrative leaders who support virtual care as they pioneer and develop new and innovative ways of connecting care for cancer patients in our provincial cancer programs, as well as to acknowledge our patients who we are privileged to care for during their cancer journey.

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APPENDIX 2: METHODOLOGY

The following is an overview of the methology for developing the Expert Consensus Recommendations.

Framework

The methodology chosen was a modified Delphi process guided by the American Society of Clinical Oncology Clinical Practice Guidelines [6]. The modified Delphi method is a structured method for soliciting expert opinion about complex programs or topics, through the use of a series of questionnaires and controlled feedback, followed by a consensus meeting. The technique is a widely used and accepted method for gathering data from respondents within their domain of expertise.

Process

This Delphi was executed through a series of three rounds to gain consensus on recommendation statements generated from a comprehensive systematic review of existing and grey literature, curated by the steering committee. Using an electronic survey for the first two rounds, and an online meeting for the third, these statements were voted on by a multi disciplinary consensus committee (full list of participants is documented in Appendix 1).

Results

At the end of the process, 62 of 62 recommendations achieved consensus. Most statements reached consensus in the first round of the process. Areas of disagreement and needs for clarification included concerns regarding breaking bad news virtually and maintaining similar standards of care as in-person care, while avoiding disproportionate strain on clinicians and patients.

Publication

This work is part of a larger research study to better understand cancer care delivery amid the COVID-19 pandemic, funded by the Canadian Institute for Health Research (CIHR grant #RN-420398) [7].

FURTHER RESOURCES

The following is a selection of resources related to Person-Centred Care and Virtual Care. It is not an exhaustive list and does not represent an endorsement by Ontario Health.

Person-Centred Care

Ontario Health:

- Ontario Health (Cancer Care Ontario) (2015) Person-Centred Care Guideline
- Ontario Health (Cancer Care Ontario) (2019) Follow-Up Model of Care for Cancer Survivors
- Ontario Health (Cancer Care Ontario) (2019) Nursing telepractice standards

Other Resources:

- Including care partners resources:
  - Healthcare Excellence Canada (2020) Better Together Program and Reports
  - The Ontario Caregiver Organization (2020) What Caregivers and Healthcare Providers need to know during COVID
- Equitable access resources:
  - Centre for Addictions & Mental Health (CAMH) (2020) Digital Health Equity Framework.
  - Ontario Health (Cancer Care Ontario) (2021) Indigenous Navigators
- Empathy in virtual visits resource, see pages 43 – 47 in: Cleveland Clinic (2020) COVID-19 Response Digital Health Playbook
- Health literacy resource: Health Literacy Tool Shed (2012) Brief Health Literacy Screening Tool
- Communicating diagnosis/prognosis frameworks:
  - ASCO (2020) SPIKES Protocol in Remote Care (Setting, Perception, Invitation, Knowledge, Empathy/Emotion, and Strategy/Summarize)
  - Indian Journal of Palliative Care (2010) BREAKS Protocol (Background, Rapport, Explore, Announce, Kindling and Summarize)

FURTHER RESOURCES

The following is a selection of resources related to Virtual Care. It is not an exhaustive list and does not represent an endorsement by Ontario Health.

Virtual Care Leading Practices

Canadian/Ontario-based

- Canadian Medical Association (2020) Virtual Care Playbook
- Canadian Medical Protective Association (2021) COVID-19 Hub: Telehealth and Virtual Care
- Centre for Effective Practice (2021): Enhancing Management of Chronic Conditions Using Virtual Care During COVID-19
- College of Physicians and Surgeons of Ontario (2021): COVID-19 FAQs for Physicians
- Healthcare Excellence Canada (Canadian Patient Safety Institute) WEBside Manner Infographic
- Ontario Health (Health Quality Ontario) (2020) Adopting and Integrating Virtual Visits into Care: Draft Clinical Guidance
- Ontario Health (Ontario Telemedicine Network) (2020) Training Centre
- Ontario Health (Digital Excellence in Health) (2021) Virtual Visits Verification Program
- Ontario Health (Ontario Palliative Care Network)(2021) Leveraging Virtual Care to Support Palliative Care
- Ontario Health (Patient Education) (2021) Virtual Care: What to expect for your telephone or video
- Ontario MD (2021) Virtual Care

International

- United Kingdom National Health Service (2020): Clinical guide for the management of remote consultations and remote working in secondary care during the coronavirus pandemic

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Cancer Care Ontario is now part of Ontario Health, a new government agency that, once fully established, will be responsible for ensuring Ontarians receive high-quality health care services where and when they need them. Cancer Care Ontario's work has been taken on by this new agency.

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