Virtual Health

Standard

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Standard: Virtual Health

Introduction

HSO's Virtual Health Standard enables an assessment of the safety, quality, and efficacy of Virtual Health services.

During recent years, Virtual Health (also sometimes referred to as telehealth, telemedicine or virtual care) has become an increasingly valuable and viable method of health service delivery, communication, information transfer, and education. Virtual Health services aims to support user care and provide second opinions and consultation to individuals living in remote and isolated areas where access to health care was limited, as well as in urban settings (COACH, 2015). Virtual Health service delivery was initially developed as a site or room-based system but is now moving to more of a mobile response. Virtual Health allows users to connect with specialists to whom they would not usually have access. Additionally, with a growing and aging population, Virtual Health is also being used to fill the gap between demand and system capacity (COACH, 2015).

These factors make Virtual Health more appealing to users and their caregivers (Greenspun & Elsner, 2016). The use of Virtual Health has increased dramatically in the last few years (COACH, 2015), with a noticeable increase in the number of clinical Virtual Health sessions, defined as consultations and appointments with clinicians that took place with the use of telehealth. Another aspect of Virtual Health that is becoming more widespread is the integration of mobile applications into user care plans.

Virtual Health not only facilitates follow-up care and helps users manage chronic disease (United States Government Accountability Office, 2017), but also:

- Increases access to specialized and timely urgent care

- Increases the capacity and efficiency of specialists

- Reduces wait times for appointments and follow-up visits

- Reduces emergency department visits and the time users spend in hospitals

- Reduces the discomfort and anxiety associated with users travelling to receive services

- Reduces the costs and carbon emissions associated with user travel

- Connects care teams to provide greater continuity of care

- Connects remote family members with long-stay users

- Connects health care professionals for knowledge sharing

- Integrates with conventional care delivery models

- Keeps users in their homes and communities longer (Provincial Health Services Authority, 2017)

Despite the benefits that Virtual Health brings to users, clinicians, and the health care system, there are several barriers that are impeding the expansion of Virtual Health services. These include a lack of shared funding and a single management and governance structure, inconsistent privacy and security regulations, variations in qualifications and privileges among programs and networks, and cumbersome scheduling and booking processes (COACH, 2015). At their core, these barriers are caused by a lack of standardization in the development and provision of Virtual Health services.

It is clear that the use of Virtual Health services will continue to grow. This standard is designed to ensure that all users who could benefit from Virtual Health services have access to them and that the services they receive will be of high quality, efficient and will protect their safety. The standard encompasses all Virtual Health services - existing and future – as complementary care seamlessly integrated within the broader context of overall healthcare delivery. The standard is inclusive of mobile applications and secure texting as part of the Virtual Health service delivered by the care team.

Addendum to the 2019 publication of HSO's Virtual Health Assessment Standard

HSO has made minor modifications to HSO's Virtual Health Assessment Standard to account for the legal framework, associations and professional orders under the province of Quebec's ministerial responsibility. Modifications are noted below:

1. Definition of Telehealth: Use of information and communication technologies to provide health care services and health information to clients when the clinician and the client are not in the same location (ISO, 2014; University of Health, undated. Totten, Womack, Eden, McDonagh, Griffin, Grusing and Hersh, 2016) or when telehealth activities occur between clinicians in the health care team. These technologies are not treatments or interventions for clients, but rather tools that can be used to improve access to care, person-centered care, information sharing and care effectiveness (ISO, 2004c; Totten et al., 2016). The central element of telehealth is the transmission of voice, data, images and clinical information, rather than the physical displacement of clients or clinicians (COACH, 2015). This concept is also sometimes referred to as "telemedicine", "virtual care" or "telehomecare", among others.

    In Quebec, activities offered through the telehealth modality are integrated into all the services offered by the institution. According to the terms of reference, telehealth is described as "a modality that makes clinical services accessible remotely. These services are commonly offered in health and social services institutions as clinical programs to treat clients. Telehealth is seen as a modality for organizing and dispensing services and not as a service itself. It creates a complementary virtual network of health and social services. Each institution in the network must identify its needs in telehealth based on the health needs of its population and its range of services, and must do so in response to a clinical need rather than a technological development." [Ministère de la Santé et des Services sociaux (Ministry of Health and Social Services), 2016]

    For a full list of telehealth activities conducted in the province of Quebec, see below:

*   **Teleassistance:** Clinical activity carried out by a medical practitioner with or without the presence of one or more clients with the assistance of a second expert medical practitioner, present remotely. Examples may include surgical teleassistance, teleassistance in wound care, and teleassistance in anatomopathology (macroscopy).
*   **Tele-education:** Clinical activity used to offer information remotely to the client, increasing their knowledge of their disease, its symptoms, the actions to take and avoid to administer a particular treatment, etc. The goal of tele-education is to help clients better manage their health and condition.
*   **Tele-appearance:** Designates the court appearance of a party or witness responding remotely via videoconferencing. Note: It can happen that a health network user or health professional will appear using this modality.
*   **Teleconsultation:** Clinical activity involving remote interaction, in real time or deferred time, between a client and one or more health professionals, aimed at making or confirming a diagnosis, monitoring the course of a condition or adjusting a treatment plan.
    Note: A medical teleconsultation may be compensated by the RAMQ [Régie de l'assurance maladie du Québec (Quebec health insurance board)] if it meets the criteria provided in the framework agreement.
*   **Case tele-discussion:** Clinical activity involving remote communication, in real time or deferred time, between medical practitioners whose objective is to discuss, in the client's absence, the diagnosis, treatment plan or any other relevant information on the client's health condition.
*   **Tele-training:** Training given to health professionals remotely to transfer knowledge between professionals.
*   **Tele-interpretation:** Clinical activity aimed at interpreting images, examinations or tests remotely in order to make a diagnosis or obtain a second opinion for a client without their presence. Note: A medical tele-interpretation activity may be compensated by the RAMQ if it meets the criteria provided in the framework agreement.
    Tele-intervention: Clinical activity or treatment carried out by a medical practitioner with one or more clients or their family present remotely. Tele-intervention may include "constraint-induced therapy" in occupational therapy, and robotic surgery, for example.
*   **Telehomecare:** Health service offered remotely by a health professional to a client at home, to educate, monitor, assist and/or intervene with them according to the treatment objective followed.
*   **Telemonitoring:** Clinical activity used to monitor a client's clinical or biological data, which are transmitted electronically to the medical team to help plan the intervention required.

2. Guidelines are not binding. The Virtual Health standard has been written to keep criteria general so as not to require institutions undergoing accreditation to take charge of all strategic and operational elements. Institutions

may indicate that they have taken all means to ensure compliance with best practices based on the context, codes, laws and guidelines put in place by the province.

3. Section and criteria client applicability and accountability has been clarified accordingly. See Client Portal for table of accountabilities.

Structure of the Standard

What does this standard include?

HSO Standard

This document describes the criteria applicable to the Virtual Health Standard according to the following sections:

- Virtual Health Service Design
- Role of the Users in Virtual Health
- Ethical and Safe Virtual Health Services
- User Records

Quality Dimensions

To create its quality framework, Accreditation Canada uses eight dimensions that all play a part in providing safe, high-quality care in every health and social services sector. These dimensions are the basis for the standards, and each criterion in the standards is tied to one of the quality dimensions. The fundamental orientation of each criterion is clear, and users of the standard understand the criterion's objective.

The quality dimensions underpinning the quality framework are:

Population focus: Work with my community to anticipate and meet our needs

Accessibility: Give me timely and equitable services

Safety: Keep me safe

Worklife: Take care of those who take care of me

Client-centred services: Partner with me and my family in our care

Continuity: Coordinate my care across the continuum

Appropriateness: Do the right thing to achieve the best results

Efficiency: Make the best use of resources

Types of Criteria

Required Organizational Practices

There are no required organizational practices (ROPs) available for this standard.

High priority criteria

High priority: High Priority Criteria are criteria related to safety, ethics, risk management and quality improvement.

Normal criteria

Criteria that are not related to high-priority areas are considered to be normal priority.

Virtual Health Service Design

1.0   The Virtual Health service design is defined and documented.

1.1   The organization has a Virtual Health service design document.

Guidelines:

The Virtual Health service must have a document that describes the Virtual Health service and delivery process in the context of the health care program. The Virtual Health service design document includes at minimum the following information:

- The goals of the Virtual Health service

- To whom the Virtual Health service is available

- When the Virtual Health service is available – hours of availability for remote monitoring

- Service-level agreements

- Appropriate clinical objectives and model(s) of care or shared care

- Patients may choose which health care service they consider appropriate to access, whether delivered through Virtual Health or not

- The expected duration of service outages, when they occur

- Patient inclusion and exclusion selection criteria, such as:

    - Patient's physical and cognitive abilities

    - Economic considerations

    - The ability of a patient to travel

    - The patient's family, work, and cultural situation when determining the Virtual Health service to be offered

    - Potential barriers (such as access to computers or telecommunications) to the inclusion of the patient

    - The availability of specialists, local clinical staff, and facilities required to provide service continuity when determining the Virtual Health service to be offered

1.2   Policies, procedures, and security measures are developed when setting up the Virtual Health service.

1.3   A governance structure is established to provide oversight and direction for the Virtual Health service.

Guidelines:

The governance structure may include an Executive Steering Committee, a project team, and an experienced change management team that engage clinicians, users, and family members to manage the people and process side of change.

1.4   The organization has a quality management program to define and monitor the required quality characteristics of the Virtual Health service and to monitor outcomes.

1.5   The Virtual Health service is only offered to appropriately selected users who meet eligibility criteria.

Guidelines:

Inclusion and exclusion criteria, as outlined in criterion 1.1.1, are developed to inform the clinician's provision of Virtual Health service. User eligibility criteria may involve risk, assessment of the user's cognitive ability, financial circumstances, jurisdictional considerations, user choice, ability to access the network, and the ability to verify user identity virtually. The needs of the potential user are assessed in relation to the capacity of the care team to meet those needs.

1.6   There is a procedure to request the Virtual Health service in a timely way.

1.7   There is a procedure to respond to requests for the Virtual Health service in a timely way.

Guidelines:

Requests for service may come from clinicians, users, families, other teams, or referring organizations. There may be different processes to respond to a request based on who is requesting the service and what is being requested. Requests for service, the procedure to respond to requests, and the definition of timely will vary by type of service offered and by those who are requesting it. Responsiveness to a request for the Virtual Health service is monitored by setting and tracking response times as well as by gathering feedback from users and families, referring organizations, and other teams about their experiences. Expectations of when the user should participate in the Virtual Health service should be communicated to the user at the outset of the consultation.

1.8   An organizational process to manage Virtual Health system downtime is developed.

Guidelines:

The organizational procedure includes schedules, how and when to communicate with stakeholders and takes into consideration unscheduled downtime.

1.9   The Virtual Health service strives to ensure the continuity of the user's individualized care plan.

1.10   The organization promotes and enables the use of Virtual Health by the care team and management.

1.11   Organization procurement policies and procedures governing the Virtual Health service are developed in collaboration with users and clinicians.

Guidelines:

Policies and procedures may relate to gathering feedback from users, assessing the equipment's ability to meet user needs, following set purchasing criteria, determining the impact on the delivery of the Virtual Health service, clinician workflow, and assessing the equipment's ability to adapt to future growth and changes in the Virtual Health service.

The following criteria may be used when purchasing Virtual Health equipment:

- Upgrade path for equipment

- Two-way interfacing with peripherals

- Financial stability of the vendor

- Performance of equipment

- Acceptability to users

- Ease of use for the user and clinicians

- Price

- Speed

- Portability

- Interoperability

- Service/support

- Jurisdictional requirements for medical devices (i.e., scheduling downtime for maintenance)

- Clinical practice guidelines

- Whether the equipment conforms to national and/or provincial or territorial standards and requirements

- Means of communication (e.g., Internet Protocol, Integrated Services Digital Network, plain old telephone service).

The organization may not have control over all purchasing criteria.

Role of the Users in Virtual Health Services

2.0   Users and family member representatives are involved in all aspects of the development of the Virtual Health service.

2.1   The design, delivery, and implementation of the Virtual Health service involves users.

Guidelines:

The Virtual Health service should meet the needs of users, families, clinicians, and the Virtual Health system developers. Users are informed and, if appropriate, should be given the option to be included. At least one user representative should be involved in the design, delivery, and implementation of the Virtual Health service. The development of the Virtual Health service is based on demand and appropriateness rather than on supply and advances in technology.

2.2   The organization's strategy is developed in collaboration with users.

Guidelines:

The organization receiving or delivering the Virtual Health service should ensure that its Virtual Health service is fully defined in its overall strategy. The Virtual Health service should be an integral part of the organization's strategy and not be a separate, isolated component. The organization's strategy should at a minimum include a change management plan, a readiness plan, and assessment for Virtual Health services. The organization's strategy with respect to its responsibility for the Virtual Health service must be clearly defined and aligned with overall user-driven goals. User representatives should be involved in the development of the organization's strategy, including the definition of Virtual Health services. Continuous improvement feedback from all users should be captured at significant stages of the growth and development of the service.

2.3   The Virtual Health service assessment procedure is designed in collaboration with users.

Guidelines:

The assessment procedure continuously addresses Virtual Health design, procurement, and operation. The assessment procedure engages all stakeholders, including user representatives and clinicians, prior to the procurement of technology and includes a continuous feedback loop for ongoing input. Where applicable, an interdisciplinary or collaborative assessment may be completed with the user, family, and appropriate care team members.

3.0   All aspects of the Virtual Health service are monitored to ensure that the service meets the needs of the users and the families.

3.1   There are policies and procedures that govern the delivery of the Virtual Health service.

Guidelines:

Virtual Health policies should be integrated into existing organizational policies and designed with input from the care team, users, and families. The policies and procedures support the sustainability of the Virtual Health service and guide the delivery of the service between jurisdictions. Policies include establishing contingency plans; managing physical and human resources; liability, licensure, and credentialing; ownership of users records; protecting network security; using Virtual Health equipment; protecting users rights and privacy; maintaining appropriate documentation, and carrying out research protocols.

3.2   A procedure to report when a user's rights are violated is developed and implemented in collaboration with users.

3.3   A procedure to investigate, respond and follow up to claims that a user's rights have been violated is developed and implemented in collaboration with users.

Guidelines:

An environment where users, families, and care team members feel comfortable raising concerns or issues is promoted. The organization may provide access to a neutral, objective person from whom users and families can seek advice or consultation. Where electronic health records are used, there is a process to receive, respond and follow up to user complaints and questions regarding the privacy of the record. Claims brought forward by care team members or members of other teams are also addressed.

3.4   Incidents involving a breach in the safety of any user are reported and managed in accordance with the organization's policies, procedures, and processes.

Guidelines:

Reporting and recording is done in a timely way. User safety incidents include harmful incidents, no harm incidents, and near misses, as per the World Health Organization's International Classification for User Safety. The Canadian Patient Safety Institute provides direction to organizations about establishing policies and procedures to manage user safety incidents, and processes to proactively mitigate clinical and operational risk.

3.5   User safety incidents are analyzed to help prevent recurrence and make improvements in collaboration with users.

Guidelines:

Reviewing user safety incidents includes determining the contributing factors, taking action to prevent the same situation from recurring, and monitoring the effectiveness of those actions. The organization uses this information when developing strategies to proactively anticipate and address risks to user and care team safety.

3.6   A mechanism to prevent a breach in user safety is developed in collaboration with users.

Guidelines:

An environment where users, families, and care team members feel comfortable raising concerns or issues is promoted. The organization may provide access to a neutral, objective person from whom users and families can seek advice or consultation. Where electronic health records are used, there is a process to receive, respond and follow up to user complaints and questions regarding the privacy of the record. Claims brought forward by care team members or members of other teams are also addressed.

3.7   Quality improvement opportunities are identified in collaboration with users.

Guidelines:

Feedback and other forms of information, observation, and experience are used to identify and prioritize areas for quality improvement initiatives. This is done using a standardized process based on criteria such as the expressed needs of users and families, user-reported outcomes, clinicians, risk, volume, or cost.

3.8   Guidelines and protocols are regularly reviewed in collaboration with users.

Guidelines:

The review process includes accessing the most up-to-date research and information and determining its relevance (e.g., through literature reviews, content experts, or national organizations or associations). Research information may include intervention research, program evaluations, or clinical trials. The review process is used to inform the procedure to select evidence-informed guidelines. Although users and families may not be involved in a technical or scientific review, their perspectives on the patient's experience in receiving care that is driven by guidelines and protocols are valuable to the review process. The review process may be reviewed by user representatives.

3.9 The organization's interoperability plan is developed with comprehensive stakeholder engagement.

Guidelines:

Interoperability, developing a minimum data set, and building a user record involve collaboration among multiple stakeholders (e.g. clinicians, users, wellness vendors).

3.10 Organizational readiness to use Virtual Health equipment is determined before a consultation.

Guidelines:

Organizational readiness for use may include:

- Human resources

- Verifying that data can be sent reliably and securely

- Ensuring availability of technical support • Developing procedures to check equipment regularly

- Securing sufficient bandwidth

- Assessing the technical applicability of the equipment and the software

- Determining whether local and network sites are technically ready and compatible

- Following existing policies, procedures, standards, and guidelines for networked services (e.g., shared central services, bridges).

3.11 The Virtual Health service is developed in a way that promotes and enables interoperability.

Guidelines:

Virtual Health resources are designed with the goal of interoperability in and outside the organization. Examples of how interoperability may be ensured in an organization include testing equipment prior to buying it, buying equipment from only approved suppliers, buying equipment that complies with standards, and performing conformance and interoperability testing.

4.0   Users and family members are informed about the Virtual Health service.

4.1 Information on the Virtual Health service is available to the user and user representatives.

Guidelines:

Information provided to user representatives about the Virtual Health services addresses, at a minimum:

- Scope of the organization's services

- Costs to the users, if any

- How to access services

- Who has access to user information

- Who is monitoring user information

- How user information is used

- What safeguards are in place to protect user information

- Who may edit the data collection process

- Ownership of user information

- Contact points specified in the care plan

- The effectiveness and outcomes of service

- Other services available to address user needs

- Consideration of how the data might be used in the future

- Partner organizations involved in the Virtual Health service

- How Virtual Health appointments are conducted and what to expect

For users who have trouble understanding, information on the Virtual Health service is provided via a designated advocate or advocacy group. Advocacy involves speaking on behalf of someone else, where the designated advocate works in partnership with the user to help the user reach an appropriate level of understanding.

User representatives and partner organizations are engaged to determine what information is required or desired, and to evaluate whether the information provided meets user needs.

4.2   The user is informed about options for care delivery.

Guidelines:

Alternative options to Virtual Health could include an in-person visit with a clinician. Users should expect the same quality of care to be provided regardless of the type of appointment.

4.3   Users and families are provided with information about their rights and responsibilities when using the Virtual Health service.

Guidelines:

Delivery of the Virtual Health service is held to same standards of care as other health services. User's accessing the Virtual Health service have the following rights, but not limited to the right to:

- Receive care

- Have privacy and confidentiality protected

- Be aware of how user information is used

- Have access to their personal health information

- Be treated with respect and care

- Maintain cultural practices

- Respect spiritual beliefs

- Live at risk

- Be free from abuse, exploitation, and discrimination

- Refuse service or refuse to have certain people involved in their service

- Participate in all aspects of their service and make personal choices

- Have a support person or advocate involved in their service

- Take part in or refuse to take part in research or clinical trials

- Receive safe, competent service

- Receive safe, competent service

- Raise concerns about the quality of service

- Receive care in a language they understand or have access to an interpreter

The information is provided at intake or admission to service, designed with user representatives, and adapted to meet diverse needs such as language, culture, level of education, lifestyle, and physical or mental disability. When the information cannot be provided to the user and family on intake, it is provided at the earliest opportunity.

4.4   Users must be made aware of their right to opt out of the Virtual Health service at any time.

Guidelines:

Users understand that they have the right to opt out of the Virtual Health service and choose an alternative care plan, such as an in-person visit with a clinician.

4.5   There is a process in place to support continuity of care if the user opts out of the Virtual Health service.

4.6   Information about the Virtual Health service quality improvement activities, results, and learnings is shared with users, care teams, organization leaders, and other organizations.

Guidelines:

The information shared about the quality improvement activities is tailored to the audience and uses appropriate language. Sharing the results of evaluations and improvements helps create familiarity with the philosophy and benefits of quality improvement and engagement in the process. It is also a way for the organization to spread successful quality improvement activities and demonstrate its commitment to ongoing quality improvement. Among other benefits, sharing performance indicator data externally allows for comparisons with organizations offering a similar service.

4.7   Users are informed that their health information will be recorded in a user record.

Guidelines:

If possible, users should be informed of how they can access the information. Conventions on how personal health information should be documented and recorded

should be made explicit to the user at the onset of the consultation. Where appropriate, user information should be shared with the care team. Users are informed about what is being done with their information.

5.0   The Virtual Health service is delivered using a user-centred approach that emphasizes user engagement, the user/clinician relationship, and the quality of care.

5.1   The user's informed consent is obtained and documented before providing the Virtual Health service.

Guidelines:

Informed consent consists of reviewing service information with the user, family, or substitute decision maker; informing the user about available options and providing time for reflection and questions before asking for consent; respecting the user's rights, culture, and values including the right to refuse consent at any time; and recording the user's decision in the user record. The user is informed where their data stored, as per jurisdictional law. There is a process to obtain consent in a timely manner. Consent complies with the standard of practice for the Virtual Health service. Consent is informed and ongoing throughout the provision of the Virtual Health service. As part of informed consent, the user must be willing to accept the identified risk associated with virtual care.

5.2   When virtual care is unable to meet the needs of a potential user, the care team facilitates access to other services.

Guidelines:

When the organization is unable to meet the user's needs, the rationale is explained and access to other services is facilitated. The information is documented, for use in service planning.

5.3   The organization includes the pertinent information from the Virtual Health interaction in the user record.

Guidelines:

The information is stored securely as a part of the user record as per jurisdictional requirements. The information should be easily accessible for continuity of care.

5.4   Relevant user information is gathered as required during the Virtual Health service intake process.

Guidelines:

This process may be called admission, intake, pre-admission, screening, or the start of service. The information is validated and reviewed. It is used to determine if the organization's services fit with the user's needs and preferences, identify the user's immediate needs, and decide on service priorities.

The intake process is adjusted as required for users and families to address diverse needs such as language, culture, level of education, lifestyle, and physical or mental disability.

6.0   Users and families are actively engaged in planning and preparing for transitions in care where appropriate.

6.1   Transition planning is identified in the user care plan.

Guidelines:

Including information in the care plan about transition planning enhances coordination among teams or partner organizations and helps prepare users for the end of service. Discussions about the user's transition and post-care following Virtual Health care includes the needs and preferences of the user and informs the development of the user care plan. Discussions between the care team and the user may include post-care follow up, ability to perform self-care, referrals to community supports, or other anticipated needs or challenges.

6.2   Appropriate follow-up services for the user, where applicable, are coordinated in collaboration with the user, other teams, and organizations.

Guidelines:

Where a need for follow-up is identified by the Virtual Health service, the appropriate type and method is determined. This includes the responsibilities of the care team such as following up on testing, providing a referral to a partner organization, setting timelines for user contact, or reminding the user of an appointment. It also includes user responsibilities such as following up with other clinicians, reporting worsening or changing symptoms, and taking medications as prescribed. Responsibility for the user's care continues until service has ended or the user has been transferred to another team, service, or organization.

Follow-up services for the Virtual Health service may include primary care, home and community services, community-based rehabilitation, psychological counselling services, and recommendations for ongoing care. Working together to establish proper placement for the user helps ensure they receive the most appropriate services in the most appropriate setting, and minimizes temporary solutions or unnecessary transfers. To ensure that the user's receive seamless and continuous care, the placement and follow-up includes a process for when transitions do not go as planned.

6.3   Users are actively engaged in planning and preparing for transition

Guidelines:

Users are involved in transition planning. The care team, the user, and the family when appropriate discuss the user's care plan, goals, and preferences; the care provided; outstanding issues, clinical or otherwise; what to expect during transition; follow-up appointments; exercise and nutrition plans, where applicable; contact information for the care team members and details on when they should be contacted.

Examples of key transition moments include rounds, shift changes, handoffs, moving in or out of an organization to another community provider, or end of service.

Ethical and Safe Virtual Health Services

7.0   Virtual Health service is developed with a goal of providing quality and safe care for users.

7.1   The Virtual Health service ensures that all relevant safety laws, privacy legislation, regulations, and international standards and codes for the service are met.

Guidelines:

The Virtual Health service must meet privacy standards and protocols pertaining to the exchange of health information (e.g., International Organization for Standardization Standards 62304, 82304, and 80001 that specifically target health data security).

7.2   When possible, the Virtual Health service should incorporate available evidence and best practice in the design and delivery of the service.

Guidelines:

Evidence should guide the way the Virtual Health service is used in a care plan. Evidence must be balanced with innovation based on the needs of the population. The organization should determine the evaluation plan at the outset of the consultation and refine the program based on the evaluation after an established period.

7.3   A formal and comprehensive orientation to the Virtual Health service is provided to new care team members, users, and family members.

Guidelines:

The orientation or further training or education is provided when there are changes to legislation or after a set period of time as defined by the organization. Attendance at orientation and training is documented and stored centrally. The orientation covers, at a minimum, the following information:

- The organization's mission, vision, and values

- The care team's mandate, goals, and objectives

- The philosophy of user-centred care and how it is implemented in the organization, as well as roles, responsibilities, and performance expectations

- Privacy legislation

- Appropriate use of user information

- Competencies using the technology to practice effectively in a digital environment

- Accessing user information virtually

- The risks related to the use of technology in the delivery of the Virtual Health service

- Policies and procedures, including confidentiality

- Work-life balance initiatives

- Processes to manage system downtime

- The organization's approach to integrated quality management (e.g., quality improvement, risk management, utilization management, efficient use of resources).

8.0 **Where the stakeholders involved in the Virtual Health service are separate organizations, the Virtual Health service requires written agreements between the site that is delivering the Virtual Health service off-site and the site that is receiving direct patient care from the Virtual Health service.**

8.1 There is a written agreement with the site delivering the Virtual Health service off-site and the site of direct user care receiving the Virtual Health service.

Guidelines:

The site delivering the Virtual Health service off-site has a written agreement with the site of direct user care receiving the Virtual Health service. The consultant and local clinician must reach an agreement regarding roles and responsibilities before Virtual Health service is provided. The agreement addresses the following:

- Reimbursing clinicians

- Securing and protecting health information

- Obtaining appropriate informed consent

- Documenting and storing user health records

- Protecting user rights to privacy, confidentiality, and quality care

- Liabilities and responsibilities of each organization

- Dispute resolution

- How to prepare, transmit, and receive data

Guidelines for written agreements may be based on relevant provincial/territorial legislation or regulations.

8.2 Service-level agreements with all stakeholders are established and documented.

Guidelines:

Service-level agreements outline the expectations, rights, and remedies regarding the performance of the Virtual Health equipment and telecommunication networks. The service-level agreement must be developed to take into consideration user perspectives on use, accountability, cultural sensitivity, language preference, the context of user priorities, and expectations of the Virtual Health service.

The service-level agreement should use clear, user-friendly language on what is allowed, how it is secured, and who can access it. Stakeholders include Virtual Health equipment vendors and telecommunication providers.

8.3 Reporting relationships to support the delivery of the Virtual Health service are defined and documented.

Guidelines:

Having clear reporting relationships helps clarify the organization's structure and decision-making hierarchy. Clinicians providing the Virtual Health service understand who is accountable.

8.4 Accountability for the Virtual Health service is understood by all clinicians providing the Virtual Health service.

Guidelines:

For clinicians providing the Virtual Health service, the responsibility may fall in either the user's or the clinician's jurisdiction (i.e., as per the user's license to practice in the location where the user is receiving care). When providing clinical follow-up for a user, the responsibilities of all clinicians involved must be clear to ensure continuity of user care.

User Records

9.0 Organizations work toward interoperability and security of the user record.

9.1 User information is integrated into the user record.

Guidelines:

User records should be integrated with existing documentation processes. Users are included in the process of documenting information in their record and can provide feedback on the information being documented. Users are given the right to read and comment on information that is recorded. The charting or documentation process may be conducted in partnership with the user as part of their care, or access to their records may be provided electronically.

9.2 The Virtual Health services received by the user are communicated to the care team.

Guidelines:

Changes and adjustments to the care plan should be communicated to the care team in a timely manner.

9.3 The organization, users, and clinicians determine the elements of the consultation that should be documented.

Guidelines:

The Virtual Health service design document details how a consultation using Virtual Health is documented, and by which clinician. The Virtual Health consultation and consent is documented in the user record.

10.0 Users and members of the care team are informed about the Virtual Health service the user underwent.

10.1 The user's health status is reassessed in partnership with the user and updates are documented in the user record.

Guidelines:

Delays or failures to report a change in health status, in particular deterioration in a user's condition, are significant barriers to safe and effective care and services. Changes in the user's health status are documented accurately, in a timely manner, and communicated to all care team members.

10.2 Documentation timelines for Virtual Health consultations are consistent with, or better than, existing clinical processes for the organization's face-to-face consultations.

10.3 There is a process to give users and authorized family members access to the user's record.

Guidelines:

Users and families, if appropriate, may access all information in the user record through traditional channels (i.e., by going to the organization to get the records rather than through continuous, digital access). The process follows jurisdictionally relevant privacy governing documents.

User access to their records is facilitated in a proactive way, according to the organization's policy and applicable legislation. The processes to access records are user-centred and help users access their information. Users and families have

opportunities to discuss the information, ask questions, and provide feedback. Access can occur via an online user portal.

10.4   There is a process to give clinicians access to the user record.

Guidelines:

Clinicians can access a user record by logging into a protected account from any computer or mobile device. This can include, for example, access to user information for a remote appointment. Digital access to personal health information must comply with jurisdictional laws and organizational policies governing the privacy of access to personal information.

Glossary

To ensure consistency in the terminology used within health and social service settings and to facilitate the use of HSO standards, a glossary is provided in your virtual portal.

These are the global HSO 0400 standards that define the basic concepts, principles and vocabulary pertaining to quality health and social services and user safety that form the basis of the HSO standards.