Ontario Health

June 8, 2020

To: Health System Partners

From: Matthew Anderson, President and CEO, Ontario Health

Re: Recommendations for Regional Health Care Delivery During the COVID-19 Pandemic: Outpatient Care, Primary Care, and Home and Community Care

As health care organizations and providers in home and community care, primary care, and outpatient care initiate planning for a gradual return to their full scope of services during the COVID-19 pandemic, Ontario Health is providing planning recommendations for increasing and transforming care delivery.

These *Recommendations for Regional Health Care Delivery During the COVID-19 Pandemic: Outpatient Care, Primary Care, and Home and Community Care* were created by an expert committee chaired by Dr. Chris Simpson who co-leads Ontario Health's COVID-19 clinical science response. He is also Vice-Dean (Clinical), School of Medicine, Queen's University.

The recommendations are guided by ethical principles, process principles, and planning assumptions and are important considerations to help direct local planning and decision-making.

To ensure the safety of patients, health care providers, and community members, the recommendations include information about:

- Maximizing virtual care services that appropriately reduce in-person visits
- Taking a comprehensive approach to infection prevention and control where care is provided in-person, and ensuring appropriate personal protective equipment is available to all staff wherever there is risk of exposure to an infection
- Assessing the health human resources required to increase care activity

The recommendations should be applied in partnership with the *Operational Requirements for Health Sector Restart* provided by the Ministry of Health on May 26th, along with sector-specific guidance from the Ministry of Health (for example, *Guidance for Primary Care Providers in a Community Setting*).

It is welcome news that ambulatory and other care providers can slowly begin to resume care and within it, find opportunities to transform the way care is delivered. Thank you for your patience and flexibility during this unprecedented time and for your ongoing commitment to safety and ongoing improvements as we navigate this next phase of care in Ontario during the pandemic.

As you actively plan for the resumption of health care services, health care organizations and providers are encouraged to collaborate with their Ontario Health Regions, as appropriate. To find out who they are, please contact COVIDUpdates@ontariohealth.ca.

Matthew Anderson

Ontario Health

Recommendations for Regional Health Care Delivery During the COVID-19 Pandemic: Outpatient Care, Primary Care, and Home and Community Care

Release date: June 8, 2020

Executive Summary

As outpatient care, primary care, and home and community care organizations and providers gradually return to their full scope of services during the COVID-19 pandemic—and use the opportunity to transform the way care is delivered—we recommend the following to optimize the safety of patients/clients, providers, and community members:

- Maximize virtual care services that appropriately reduce in-person visits
- Conduct an organizational risk assessment and take a comprehensive approach to infection prevention and control where care is provided in-person
- Ensure appropriate personal protective equipment is available to all staff wherever there is risk of exposure to an infection
- Assess the health human resources required to increase care activity
- Work with organizations in the community to ensure delivery of services that support patients'/clients' full continuum of care, and work to avoid unintended community-wide consequences of increasing care
- Communicate regularly with patients/clients and caregivers
- Monitor the level of COVID-19 disease burden in your community
- Apply an ethical strategy to the prioritization of patient/client care activities

These high-level recommendations support key planning criteria for gradually increasing care delivery during the pandemic. They are guided by ethical principles and planning assumptions that should be considered when using these recommendations to direct planning and decision-making.

As regions actively plan for the gradual increase of health care services, organizations and providers are encouraged to collaborate with them and participate in this planning to ensure that the delivery of services support patients/clients across the full continuum of care.

Introduction

The Chief Medical Officer of Health issued Directive #2 for Health Care Providers on March 19, 2020, mandating that "all non-essential and elective services should be ceased or reduced to minimal levels" to preserve health care providers' capacity to care effectively for patients/clients with COVID-19. Appropriately, hospital outpatient care, primary care, and home and community care responded by reducing their services and implementing virtual care where appropriate. Directive #2 was amended May 26, 2020,[1] along with operational requirements, in support of a gradual restart of deferred services.

This document outlines principles that should underpin planning and decision-making related to gradually increasing care in outpatient care, primary care, and home and community care during the COVID-19 pandemic. It was developed by the COVID-19 Response: Outpatient, Primary Care, and Home and Community Care Planning Committee, chaired by Dr. Chris Simpson. A full list of members is presented in Appendix A.

The committee was tasked with developing high-level principles-based recommendations to support the gradual increase of services offered through outpatient clinics, primary care, and home and community care during the COVID-19 pandemic. These recommendations will prioritize the health and well-being of patients, clients, and health care workers, and are based on ethical principles and planning criteria that include infection prevention and control (IPAC), personal protective equipment (PPE), integrated care, and virtual care.

The committee acknowledges that outpatient care, primary care, and home and community care differ significantly in their oversight and accountabilities, in that the Ministry of Health has oversight and direct funding relationships with physicians and the majority of primary care. There is also acknowledgment that outpatient care, primary care, and home and community care differ the ways in which they provide care to patients and clients and in the ways these groups will operationalize their plans to increase care. These differences include:

- Patient populations and the duration of the patient–provider relationship (e.g., home care clients identified as having complex or chronic needs over several months with less frequent points of contact)
- Whether care needs to be delivered in person (e.g., diagnostic imaging or laboratory medicine, assistance with personal care) or virtually (e.g., primary care remote monitoring, tele-rehabilitation provided in clients' homes)
- Organizational support for implementing IPAC measures and sourcing PPE (e.g., clinic located in a hospital vs. independent primary care office vs. care delivered in a client's home)

The high-level recommendations provided in this document may be applied to all health care organizations and providers, regardless of the differences described above, including outpatient clinics, primary care practices, and home and community care services, as well as independent health facilities, out of hospital premises, optometry, and rehabilitation services (this list is not exhaustive).

As regions actively plan for the gradual increase of health care services, organizations and providers are encouraged to collaborate with them and participate in this planning. Sector-specific plans to operationalize these recommendations may be developed by the regions or provided by other groups, such as the Mental Health and Addictions Centre of Excellence and the Provincial Primary Care Advisory Table.

This document also recognizes that the rapid implementation of virtual care has allowed many services to continue without significant interruption. Where it is applicable, virtual care should continue to be a cornerstone offering.

Principles Underpinning These Recommendations

The COVID-19 pandemic has had a significant impact on health care delivery in all settings. As health care organizations and providers consider recovery of outpatient care, primary care, and home and community care, they should also consider opportunities to transform care delivery, being mindful of local circumstances. For example:

- Which in-person services should increase? (e.g., diagnostic imaging, assessment of acute symptoms)
- Which services should we stop? (e.g., in-person services that can be delivered virtually more efficiently and safely)
- What collaborative relationships are needed to improve the patient/client and provider experience? (e.g., community–hospital)
- What innovative and transformative solutions should we continue? (e.g., virtual care)

To guide decision-making during the COVID-19 pandemic, and to act on the recommendations outlined below, the following ethical principles and planning assumptions should be considered. It will also be important to stay up to date with guidance provided by the Ministry of Health.

Ethical Principles

The recommendations provided in this document align with the following ethical principles to guide planning during the COVID-19 pandemic: proportionality, non-maleficence, equity, and reciprocity. These principles are further described in section 8.

Planning Assumptions

The recommendations provided in this document are based on the following assumptions:

- The pandemic and its impacts in Ontario may last many months to years
- Emergent care has been continuing during the pandemic; urgent care has been continuing at reduced volumes; in some settings, routine care has been continuing virtually
- The health care system is interdependent, and a change in one part of the care continuum may affect delivery of care in others
- Some regions will be better positioned to resume activity than others due to differences in capacity and/or rates of COVID-19 cases (e.g., outbreaks)
- Provision of services will follow an equitable and patient-centred approach, ensuring patients/clients and caregivers are supported across the full continuum of care
- Health care providers and organizations will consider evidence-based recommendations on which services to resume and when, as applicable (see Appendix B[2,3] for examples)
- A heightened level of oversight and flexibility will be needed in our system for some time as we move through the full course of COVID-19, as there is uncertainty about the duration and volume of the pandemic waves
- Health care organizations and providers will act as good stewards of available resources, including PPE

Recommendations for Provision of Care

Organizations and providers should consider the following key planning criteria before any increase in care activities, and determine whether they have:

1. A long-term strategy for virtual care (where applicable)
2. Policy and procedures for IPAC
3. An adequate supply of PPE
4. Adequate health human resources
5. Collaborative relationships with local health service providers, other community supports, and patients/clients
6. Capacity to monitor rates of COVID-19 in the community
7. A strategy for communicating with patients/clients and caregivers
8. A strategy for ethical prioritization of patient/client care

Where a criterion poses a barrier, organizations and providers are encouraged to collaborate with their local partners and/or their region to mitigate these. For reference, Ontario Health has provided detailed to hospitals who are resuming scheduled surgical and procedural care, while the Ministry of Health has provided guidance to primary care and home and community care providers.

The planning criteria, and their associated recommendations for implementation, are detailed below.

1. A Long-Term Strategy for Virtual Care

Recommendation: Wherever possible and appropriate, visits should be conducted virtually. In-person care should be scheduled when:

- The type of care being delivered requires it (e.g. a physical examination is required; an immunization is required; an imaging service is being delivered)
- The individual requires it (e.g., privacy is needed for the discussion; language barriers or social determinants of health necessitate it)
- The individual does not have access to technology that permits the safe delivery virtual care (e.g., a personal device, secure internet connection) or if they have low technological literacy
- The individual requires support with activities of daily living

Maximize services that appropriately reduce in-person visits using virtual care. Virtual care is defined 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."[4] Virtual care is more than video visits and phone calls. It includes digital supports for self-care (e.g., curated apps, wearables); online education and self-management tools (e.g., recreation programs); provider-to-provider supports using asynchronous messaging, e-consultation, phone backup, and specialized platforms (e.g., for specialist to primary care provider communications); provider-to-patient supports (e.g., email, asynchronous messaging with patients over email, text, or other secure platform, real-time consultation at a distance); and remote home monitoring.

There are many advantages to using virtual care besides avoiding unnecessary in-person visits. It may be a superior option for patients who find travel challenging (potentially minimizing missed appointments) and expands patients' access to specialists and clinicians whether they live in urban or rural locations. For hospitals and health care workers, virtual care reduces the costs associated with the provision of PPE and reduces the risk of infection for patients, clients, providers, and staff. However, it is important to note that although virtual care can increase access to care, it also has the potential to exacerbate inequities in access to care for vulnerable populations.[4] Use the "Six Questions to Ask" tool (Appendix C[5]) to assess potential equity impacts of your virtual care model. This tool is also applicable to models of care more generally.

During the COVID-19 pandemic, an emphasis has been on telephone and video consultations, enabled by temporary virtual codes and related procedures. In addition to virtual visits, other models of virtual care for patients and clients in the community should be considered. These include innovative solutions for pre- and post-operative surgical care, online mental health solutions, virtual emergency solutions, and remote monitoring for patients with COVID-19. Links to these resources are provided in Appendix D.

As part of a long-term strategy, virtual care offerings should be considered beyond the pandemic. This would include strategies to support high-value virtual care.

2. Infection Prevention and Control

Recommendation: An organizational risk assessment should be conducted and a comprehensive approach to IPAC should be taken where care is provided in person. A comprehensive approach to IPAC includes the application of the hierarchy of hazard controls[6]:

- Elimination and substitution of the hazard (e.g., virtual care)
- Engineering and system control measures to reduce or eliminate exposure to COVID-19 (e.g., furniture placement to maintain physical distancing in waiting areas, a plexiglass barrier at reception)
- Administrative control measures to reduce the risk of exposure to COVID-19 through the implementation of policies, procedures, training, and education (e.g., policy and procedures for passive and active screening for COVID-19, staff training on donning and doffing PPE)
- Personal protective equipment used in addition to engineering and system control and administrative control measures (e.g., appropriate PPE available to staff)

Resources on IPAC are included in Appendix E.

3. Personal Protective Equipment

Recommendation: Ensure appropriate PPE is available to staff. As the first step in IPAC routine practices[7] and as described in Directive #5 for Hospitals, a point-of-care risk assessment (PCRA) should be completed by the health care worker before every patient/client interaction in order to assess the risk of exposure to an infection, such as SARS-CoV-2. The PCRA helps the health care worker determine the correct PPE required. Evidence-based recommendations for PPE are as follows:

- Health care workers should wear a surgical/procedure mask for source control (depending on local epidemiology and if physical distancing is not possible)
- Droplet/contact precautions are to be used for all interactions with patients with suspected or confirmed COVID-19 (surgical/procedure mask, isolation gown, gloves, and eye protection)[8,9]

- Airborne precautions are used when aerosol-generating medical procedures (AGMPs) are planned or anticipated for patients with suspected or confirmed COVID-19 (e.g., N95 respirator, isolation gown, gloves, eye protection[8]; for a list of AGMPs and a list of procedures that are not considered AGMPs refer to *Personal Protective Equipment (PPE) Use During the COVID-19 Pandemic*.)
- Hand hygiene should be performed before and after contact with the patient and the patient's environment and after the removal of PPE
- Patients, clients, and essential caregivers/visitors should wear a mask for source control (cloth or surgical/procedural) and should be encouraged to bring their own if possible

Resources on PPE are included in Appendix E.

The province and regions are working to stabilize the supply chain of PPE, while all health care organizations and workers are asked to implement strategies to conserve PPE. The committee recognizes that sourcing a stable supply of PPE will be a challenge for smaller clinics and offices**. If PPE supply is a barrier in your setting, consider collaboration with community partners, an Ontario health team, or your region, as feasible.**

4. Health Human Resources

Recommendation: Assess the health human resources required to increase care activity. This includes planning for both in-office and remote staff. Consider the following:

- Is there adequate capacity of health human resources? (e.g., are you able to repatriate staff redeployed to long-term care?)
- Can some staff continue to work remotely? Are remote staff appropriately supported? (e.g., connectivity, equipment)[10]
- Do you have appropriate supports in place to support the health and well-being of staff? (e.g., stress and fatigue, child care needs)[10]

5. Collaboration With the Region, Local Health Service Organizations, Providers, and Patients/Clients

Recommendation: Regions, organizations, and health care workers should work together to ensure delivery of services that support patients'/clients' full continuum of care. Collaboration should aim to avoid unintended community-wide consequences of resuming care as well as seek to improve the integration of care between sectors and across regions. Consider the following:

- Identify partners upstream and downstream of you and the impact that the gradual increase of your services may have on their resources
- If applicable, work with your Ontario health team partners (e.g., leverage IPAC supports from a larger partner organization)
- When possible, consider working with other organizations and providers that provide overlapping services to establish single-entry models and team-based approaches
- Confirm that partners are available and, when required, care can be coordinated in a timely manner (e.g., assessment centers, community laboratory, pharmacy, home and community care, primary care, rehabilitation services, specialists)
- Consider working with patients/clients and caregivers to codesign any new processes
- Where barriers exist, work with your region to mitigate these

6. Prevalence of COVID-19 in Your Community

Recommendation: Monitor the level of COVID-19 disease burden in your community. A manageable level of disease burden or a sustained decline in the rate of COVID-19 cases is required before resuming in-person care activities. Health care organizations and providers can refer to data from the Ministry of Health, Public Health Ontario, or local data shared by their region.

As public health measures are lifted, it will be important to monitor if/how gradually increasing services impacts rates of COVID-19 in your community and adjust your service delivery appropriately.[11] An increase in outbreaks may require a ramp-down of some services again so that resources can be redirected to care for patients with COVID-19. Decreasing rates of COVID-19 may signal that is it safe to further resume deferred care.

7. Communication with Patients/Clients and Caregivers

Recommendation: Communicate regularly with patients/clients and caregivers.[10] It is up to each health care provider to determine how they will communicate to patients/clients and caregivers during this pandemic.

Take this opportunity to talk with patients/clients and caregivers about their needs, wishes, and values. Trust is paramount.[12] Some caregivers will require more information than others, and all questions must be answered thoroughly. Discussions should address patients'/clients' and caregivers' major areas of concern and expectations and what to do if a problem arises. Brainstorm potential solutions to problems and create a safe space for new ideas. Provide education or resources where possible.[13] A combination of virtual discussions by phone or other means, complemented with written information highlighting key messages, is recommended.[14]

Many community services clients rely on may be reduced or unavailable, such as transportation services and day programs—regular check-ins or monitoring may be appropriate. Caregivers are taking on more responsibility than they have in the past, and it is important to give them the information they will need to care for someone at home. Every effort should be made to provide timely and clear communication to ensure patients/clients are supported across the full continuum of care.[15]

To learn more about patient partnering, visit the resource hub at Ontario Health (Quality).

8. A Strategy for Ethical Prioritization of Patient/Client Care Activities

Recommendation: A strategy for ethical prioritization of patient/client care activities should be followed.

Overall, gradual increase of services should be guided by the ethical principles listed in **Table 1**. These guiding principles can help identify which services should be prioritized for resumption, including when and how, and the extent to which those services should be restarted or increased.

Table 1. Guiding ethical principles

Ethical Principle	Considerations
Proportionality—Decisions to resume or increase services in the community should be in proportion to the real or anticipated capacity to provide those services.	• Are patients' needs not being met where sufficient capacity exists to meet those needs? • Are the risks of deferring in-person care greater than the risks (to patient, provider, and community) of providing in-person care?
Non-Maleficence—Decisions should strive to limit harm wherever possible. Activities that have higher implications for morbidity/ mortality if delayed too long should be prioritized over those with fewer implications for morbidity/mortality if delayed too long. This requires considering the differential benefits and burdens to patients and patient populations as well as available alternatives to relieve pain and suffering.	• Do prioritization decisions consider all relevant harms to patients: mortality, morbidity, loss of quality of life or function, developmental impact, and psychological and social suffering? • Are the decisions regarding prioritizing care based on the best available evidence?
Equity—All persons experiencing the same levels of urgency should be treated in the same way unless relevant differences exist, and special attention should be paid to actions that might further disadvantage the already disadvantaged or vulnerable. This requires consideration of time on wait lists and experiences with prior cancellations. Decision-makers should strive to consider the interests between the needs of COVID-19 patients and patients who need time-sensitive treatment for other diseases and conditions.	• What are the unintended potential equity impacts (positive and negative) of decisions on specific population groups? • Is there a process to maximize equitable access to services through regional coordination (e.g., family health teams, Ontario health teams)? • Is data collected to assess outcomes of decision-making and to ensure equity/reduce vulnerability?
Reciprocity—Certain patients and patient populations will be particularly burdened as a result of our health system's limited capacity due to COVID-19. Consequently, our health system has a reciprocal obligation to ensure that those burdened by these decisions continue to have their health monitored, receive appropriate care, and can be (re)evaluated for emergent activities should they require them.	• Is there a plan in place for monitoring and supporting patients who are waiting for services? • Have strategies to mitigate the impacts of priority-setting (such as serial delays for low-priority issues) been incorporated? • Have strategies to mitigate impacts of priority-setting on clinical and academic programs, staff, physicians, and learners been incorporated?

To determine which services should be prioritized for resumption, the ethical principles described above need to be applied using a fair process. Different care contexts have unique patient/client needs (e.g., patient populations, IPAC requirements), which can nuance the application of these principles. Moreover, the application of one principle (e.g., non-maleficence) may suggest a different priority or direction than the application of another principle (e.g., equity), and trade-offs between principles may be required. Reasonable disagreement is possible. A fair process is therefore needed to ensure the legitimacy and accountability of the

application of these principles when making priority-setting decisions. **Table 2** outlines five conditions should be met during the decision-making process.

Table 2. Conditions to guide a fair process

Process Condition	Considerations
Relevance—Decisions should be based on reasons (i.e., evidence, principles, values) that fair-minded people can agree are relevant under the circumstances.	• Are the aim and scope of the priority-setting process clear to all stakeholders? • Are the criteria for decision-making explicit? Are they evidence-informed, aligned with regional/provincial directives, and grounded in the principles listed in Table 1?
Transparency—Decisions and their rationales should be publicly accessible.	• Is there a formal communications plan for this process within each organization? • Is the rationale for decisions effectively communicated to all stakeholders, including the affected patients, providers, and communities? • Is documentation of decisions completed and archived appropriately to ensure accountability?
Revision—There should be opportunities to revisit and revise decisions and a mechanism to resolve disputes.	• Is there a clear process for managing appeals (including who can make them) and resolving disagreements? • Is there a clear process for regular review of past decisions?
Engagement—Efforts should be made to minimize power differences and to ensure effective stakeholder participation.	• Have the concerns/wishes/values of patients/caregivers been incorporated into decision-making? • Are the broad range of stakeholders most impacted by priority-setting engaged in the decision-making process?
Enforcement—There should be voluntary or public regulation to ensure the other four process conditions are met.	• Are the four ethical principles in Table 1 reflected in practice, in discussions, and in decisions? • Is there a formal evaluation strategy to identify opportunities to improve the prioritization process?

Conclusion

The recommendations provided in this document are supported by ethical principles and planning assumptions, and include ensuring an ongoing strategy for virtual care (where applicable), establishing policy and procedures for IPAC, establishing an adequate supply of PPE, ensuring adequate and well supported health human resources, collaborating with the region and local health service providers, monitoring the rates of COVID-19 in your community, establishing a strategy for communicating with patients/clients and caregivers, and establishing a strategy for the ethical prioritization of patient/client care activities. These are key planning criteria that should be carefully considered before gradually increasing provision of care. Wherever possible and appropriate, care should be delivered virtually. When care is delivered in person, the appropriate precautions to optimize the health and safety of patients/clients and health care workers should be taken.

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Appendices

Appendix A: Outpatient, Primary Care, and Community Services Planning Committee

Member	Role/Organization
Chris Simpson (Chair)	Vice-Dean (Clinical), School of Medicine, Queen's University
Aaron Pollett	Provincial Head, Pathology and Laboratory Medicine Program, Ontario Health (Cancer Care Ontario)
Anthony Stone	Chief of Staff, Lakeridge Health; Lead Physician, Clarington Family Health Organization
Carrie Bernard	Assistant Professor, Department of Family and Community Medicine, University of Toronto; Assistant Clinical Professor, Department of Family Medicine, McMaster University
David Pichora	President and CEO, Kingston Health Sciences Centre
Danielle Martin	Executive Vice President and Chief Medical Executive, Women's College Hospital
Derek McNally	Executive Vice President Clinical Services and Chief Nursing Executive, Niagara Health
Edward Brown	Chief Executive Officer, Ontario Health (Ontario Telemedicine Network)
Garth Matheson	Interim President and CEO, Ontario Health (Cancer Care Ontario)
Howard Ovens	Chief Medical Strategy Officer, Sinai Health System; Ontario Provincial Lead, Emergency Medicine
Jason Bartell	Interim Executive Director/Nurse Practitioner, Chatham-Kent Family Health Team
Jennifer Everson	Vice-President, Clinical, Ontario Health (West)
Julian Dobranowski	Chief of Diagnostic Imaging, Niagara Health; Provincial Lead, Cancer Imaging, Ontario Health (Cancer Care Ontario)
Kimberly Wintemute	Family Physician, Primary Care Lead, Choosing Wisely Canada; Assistant Professor, University of Toronto
Linda Rabeneck	Vice President of Prevention and Cancer Control, Ontario Health (Cancer Care Ontario)
Mary Burnett	CEO, Alzheimer Society Brant, Haldimand Norfolk, Hamilton Halton
Paul Preston	Vice-President, Clinical, Ontario Health (North)
Robert Sibbald	Director, Ethics, Patient Experience/Relations, and Indigenous Liaison, London Health Sciences Centre
Sue Tobin	Clinic Director and Nurse Practitioner, Ingersoll Nurse Practitioner-Led Clinic
Wendy Hansson	President and CEO, Sault Area Hospital

Appendix B: Examples of Approaches to Case Prioritization

1. Primary care: Wintemute and Thériault (2020)[2] recommend continuing to use virtual care and being selective about in-person visits. They describe a phased approach to introducing clinical services that is based on the effectiveness of primary care activities. Read the article here.
2. Radiology: The Canadian Association of Radiologists has provided comprehensive guidance on ramping up services, including recommended prioritization strategies for CT/MRI, interventional radiology, breast imaging, ultrasound, nuclear medicine, and pediatrics.[3] Read the guidance here.

Appendix C: "Six Questions to Ask"

The following six questions have been developed by Women's College Hospital based on the Ontario Ministry of Long-Term Care's Health Equity Impact Assessment to guide decision-making at the program level. These questions are intended to support the identification and mitigation of potential unintended health effects (positive or negative) of a policy, program, or initiative on specific population groups.[5]

1. How will the decision/program/treatment/intervention/presentation affect health equity for vulnerable and marginalized groups (e.g., Indigenous, migrant, homeless, incarcerated, working poor, isolated seniors, women)?
2. When interacting with patients, are you considering relevant sociodemographic factors (e.g., sex, gender, age, other social determinants of health)?
3. What are the potential unintended impacts (positive and negative) of this decision/program/treatment/intervention/presentation on the health of the population it serves?
4. How could the impacts of the decision/program/treatment/intervention/presentation be mitigated?
5. How will the impacts of the decision/program/treatment/intervention/presentation be monitored?
6. Identify ways to share strategies/results/recommendations to address equity. Is the application of sex- and gender-based analysis plus (SGBA+) visible?

Appendix D: Resources for Virtual Care

Ontario Health (OTN):

- Clinical resources to support COVID-19 and the use of virtual care (includes COVID-specific information on use of virtual visits, virtual models of care during the COVID-19 pandemic, and using Ontario Health [OTN] technology for direct-to-patient video visits)
- Solutions for primary care providers , specialists and allied health professionals (including *Optimizing Elective Surgery: Virtual Care Supports in the COVID-19 Pandemic*), and Ontario health teams
- Solutions for patients (self-managed and team-managed virtual care)
- Resource library (billing guidelines, forms and brochures [e.g., consent forms, patient and family brochure], guidelines and policy [e.g., clinical protocol instructions, webcasting policy], equipment and technology)

Ontario Health (OTN) and the eConsult Centre of Excellence:

- eConsult specialty group for physicians and nurse practitioners who can ask clinical questions to infectious disease specialists electronically and receive a response within days

Ontario Health (Quality and OTN):

- *Adopting and Integrating Virtual Visits into Care: Draft Clinical Guidance*—clinical considerations for virtual visits and a listing of professional guidelines for virtual care for health care providers

OntarioMD:

- *Virtual Care and the 2019 Novel Coronavirus* (COVID-19) provides resources on virtual care during the pandemic, including templates (e.g., a statement to initiate a virtual care patient encounter, detailed information to make available to patients [including on consent], standard text on virtual care encounters to add to your EMR), and a "how to" webinar

eHealth Centre of Excellence:

- Digital health supports for COVID-19
- Digital health tools and services to support your practice

Canadian Medical Association:

- How to set up virtual care in your practice

Ontario Community Support Association:

- Community support finder to help vulnerable and isolated individuals discover and request local community care services that are available during COVID-19

Appendix E: Resources for Infection Prevention and Control and Personal Protective Equipment

Guidance and best-practice documents (Public Health Ontario):

- *Best Practice for Infection Prevention and Controls Programs in Ontario In All Health Care Settings* (outlines the structure and elements of an IPAC program)
- *Routine Practices and Additional Precautions In All Health Care Settings* (outlines the practice of routine practices and additional precautions)
- *Best Practices for Hand Hygiene in All Health Care Settings* (outlines a hand hygiene program)
- *Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings* (outlines cleaning and disinfection of the physical environment as it relates to the prevention and control of infections; it does not include cleaning a client's home when care is provided at home)
- *Infection Prevention and Control for Clinical Office Practice* (outlines the principles of IPAC in the clinical office stetting, relevant legislation, and recommendations on cleaning and reprocessing reusable medical equipment)

Online learning (Public Health Ontario):

- IPAC Core Competencies
- Reprocessing in Community Health Care Settings

Individualized support (Public Health Ontario):

- Regional IPAC support teams (respond to requests and inquiries; introduce and disseminate Public Health Ontario guidance, resources, and tools; support the implementation of IPAC initiatives to achieve best practices; facilitate client networks and collaboration)

Recommendations for use and conservation of PPE (Ontario Health):

- *Personal Protective Equipment (PPE) Use During the COVID-19 Pandemic* (outlines the effective use, conservation, and allocation of PPE)
- *Optimizing the Supply of Personal Protective Equipment During the COVID-19 Pandemic* (outlines responsible stewardship of PPE and contingency planning for any anticipated surge in COVID-19 cases when supplies may be running low or are depleted)