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Co-Designing Together through Crisis: Development of a Virtual Care Guidance Document to Support Providers, Older Adults, and Caregivers

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Résumé

La COVID-19 a eu un impact particulièrement important et dévastateur sur les personnes âgées. Les ressources en soins de santé ont soudainement été réorientées en vue d'une planification de mesures d'urgence, et de nombreux services de santé et de soutien communautaire ont été annulés, repoussés ou transférés dans un mode virtuel. Cette transformation rapide des soins gériatriques a engendré un besoin immédiat de conseils pratiques en matière de prise de décision dans un contexte de soins virtuels, ainsi que concernant leur planification et la prestation de ces soins auprès de personnes âgées et de proches aidants. Cet article décrit le processus de co-conception accéléré qui a permis l'élaboration de lignes directrices visant à guider les prestataires de services de santé et de services communautaires. Les données ont été recueillies lors de séances de consultation, de sondages et d'une revue rapide de la littérature, et analysées à l'aide de méthodes qualitatives et quantitatives adaptées. Bien que ces travaux aient été réalisés dans le contexte de la pandémie de COVID-19, le document produit et les enseignements tirés, qui sont liés à l'impact collectif, à la co-conception, à la planification populationnelle et aux technologies numériques, pourront être appliqués plus largement.

Abstract

COVID-19 has had a disproportionate and devastating impact on older adults. As health care resources suddenly shifted to emergency response planning, many health and community support services were cancelled, postponed, or shifted to virtual care. This rapid transformation of geriatric care resulted in an immediate need for practical guidance on decision making, planning and delivery of virtual care for older adults and caregivers. This article outlines the rapid co-design process that supported the development of a guidance document intended to support health and community support services providers. Data were collected through consultation sessions, surveys, and a rapid literature review, and analyzed using appropriate qualitative and quantitative methods. Although this work took place within the context of the COVID-19 pandemic, the resulting resources and lessons learned related to collective impact, co-design, population-based planning, and digital technologies can be applied more broadly.

Introduction

In March 2020, the World Health Organization deemed the novel coronavirus (COVID-19) outbreak a worldwide pandemic. Since then, more than 26 000 Canadians have died, with older adults 60 years of age and older accounting for 94.3 per cent of COVID-19-related deaths (Government of Canada, 2021b). COVID-19 has had a disproportionate and devastating impact on older adults, especially those living with frailty and living in long-term care (LTC). Data have shown that mortality is higher with increasing age and medical co-morbidities (Government of Canada, 2020b; World Health Organization, 2020).

Because of the pandemic and ensuing crisis, we saw health care programs, services, and patient/client appointments delayed, cancelled, or severely restricted across Canada, and all health care resources shifted to COVID-19 emergency response plans (Government of Canada, 2020a). The Ontario Ministry of Health recommended that health care providers reduce in-person visits where it was appropriate, possible, and safe to do so (College of Physicians & Surgeons of Ontario, 2020; Ontario Ministry of Health, 2020). For older adults with complex conditions, cancellation of health care and community support services, including home and

community care and specialist appointments, greatly impacts quality of life and health status (Steinman, Perry, & Perissinotto, 2020). As a result of the changing landscape, and the focus on pandemic emergency response, providers and physicians had to quickly reorganize and adopt their practices to serve their older adult patients/clients (Triana, Gusdorf, Shah, & Horst, 2020). Specifically, the need to optimize virtual care strategies emerged as an urgent priority among those who provide health care and community support services to older adults and caregivers; however, at the beginning of the pandemic, many of these providers had little to no prior experience with virtual care (Wong, Bhyat, Srivastava, Lomax, & Appireddy, 2021).

Behavioural response teams, ambulatory and outreach specialized geriatric services, community support services, and provincial partners in geriatrics have all grappled with how to best care for older adults and caregivers during this rapidly evolving and uncertain time. As a result of Ministry of Health guidance in Ontario, the provision of geriatric care rapidly transformed from in-person visits to primarily virtual care (telephone/video) quite literally overnight (Ontario Ministry of Health, 2020, p. 2). Health care and community support services providers working with older adults and caregivers were tasked with navigating these uncharted waters.

In Ontario, the Ministry of Health required health care providers to "conduct an initial consultation over the phone, video, or secure messaging *to determine* if a virtual/telephone consultation is appropriate or whether an in-person appointment is necessary" (Ontario Ministry of Health, 2020, p. 2). As a result of this provincial guidance, providers and services were faced with the pressing need to develop "virtual first" approaches to care that leveraged the best available evidence in order to utilize virtual technology in a way that maximized quality of care and minimized inequities, knowing that there would be populations who would face barriers in accessing health care through virtual care technologies (Shaw, Brewer, & Veinot, 2021).

This article describes in detail the rapid co-design process used to develop an evidence- and experience-based virtual care guidance document intended to support health and community support services providers working with older adults and caregivers during the COVID-19 pandemic and beyond.

Methods

This project employed principles of experience-based co-design (Point of Care Foundation, 2018). The method of experience-based co-design is a participatory research approach that brings older adults and providers together to co-create resources, tools, and health system improvements (Donetto, Pierri, Tsianakas, & Robert, 2015). Specifically, the South West Frail Senior Strategy (SWFSS) team was intentional and proactive in engaging and bringing together organizations, sectors, and disciplines, as well as older adults and caregivers, to identify collective needs in the southwestern Ontario region, and to co-develop tools and resources for providers. Taking this approach enabled providers, older adults, and caregivers to come together, share their lived experiences, and work in partnership to co-develop solutions together. Experience-based co-design helps to ensure that the solutions developed meet the needs of those whom it is trying to serve (Point of Care Foundation, 2018).

A mix of qualitative and quantitative methods were used to gather feedback and input from health and community support

Table 1. Methods used in each phase of the project

Phase 1	• Consultation with regional working group to understand experiences and identify needs and gaps in virtual care
Phase 2	• Rapid literature review to review evidence • Consultation with regional working group to review literature • Focus group with regional patient & family caregiver advisory group • Online survey
Phase 3	• Document co-development • Consultation with regional working group and regional patient and family advisory group • Preliminary evaluation survey

services providers, older adults, and caregivers (Creswell & Creswell, 2017). As the intention of this project was quality improvement and improving care for older adults and caregivers across the region, research ethics was not necessary as per the Western Research Ethics Board (Western Research, 2018).

Aligned with the co-design approach, this work was performed in three phases: (1) understanding experiences and identifying needs and regional priorities through consultations with stakeholders, (2) a rapid scan of the literature, and (3) document development and implementation (Table 1). Detailed explanation of the data collection process is described subsequently.

Forming the Regional Working Group

In collaboration with the SWFSS Regional Patient and Family Caregiver Advisory Group, a cross-sector regional working group was convened in August 2020. Participants were recruited through existing partnerships and committees in the region. Representation included 17 partners from outpatient and regional specialized geriatric services, Alzheimer Societies, adult day programs, a community health centre, LTC, behavioural support services, and a caregiver from the SWFSS Regional Patient and Family Caregiver Advisory Group (see Table 2 for more information). The SWFSS team provided the backbone support to the regional working group to advance the work forward in between meetings.

Data Collection

Phase 1: Understanding experiences and identifying needs and regional priorities through consultations with stakeholders
In phase 1, a consultation meeting was held with the regional working group members ($n = 15$). The consultation was conducted virtually and focused on identifying regional priorities and the collective needs of older adults, caregivers, and health care and community support services partners, by understanding their current experiences. The meeting commenced with exploring "what matters most" to each member with respect to virtual care. "What matters most" is one of the five core competencies in geriatric care. (Tinetti, Huang, & Molnar, 2017). This core competency helps to guide care, recognizing that an older adult or patient is at the centre of geriatric care delivery and that understanding "what matters most" to them is essential (Tinetti et al., 2017).

The current state of the provision of geriatric virtual care across the region was discussed. Time in the first meeting was also dedicated to discussing the learnings to date, and opportunities to explore going forward. Members had the chance to share what was and what was not working well, impart unexpected surprises, and hear everyone's experiences with virtual care to date. This

Table 2. Participant Information

Participant	Role/Perspective	Sector	Region
Participant 1	Caregiver/Older adult	Community	
Participant 2	Physiotherapist	Hospital	Middlesex London
Participant 3	Administrative leader	Community	Elgin
Participant 4	Nurse	Community	Middlesex London
Participant 5	Administrative leader	Long-Term Care	Grey Bruce
Participant 6	Quality improvement & evaluation staff	Hospital	Middlesex London
Participant 7	Quality improvement & evaluation staff	Hospital	Grey Bruce
Participant 8	Social worker	Long-Term Care	Middlesex London
Participant 9	Navigator	Community	Elgin
Participant 10	Nurse practitioner	Hospital	Middlesex London
Participant 11	Administrative leader	Hospital	Middlesex London
Participant 12	Quality improvement & evaluation staff	Hospital	Middlesex London
Participant 13	Manager	Community	Grey Bruce
Participant 14	Nurse	Community	Grey Bruce
Participant 15	Social worker	Community	Oxford
Participant 16	Administrative leader	Community	Middlesex London
Participant 17	Mental health worker	Community	Grey Bruce

discussion helped to shape further reflection on what was missing in the region and to identify collective needs as partners. The consultation was facilitated by a SWFFS team member and lasted 90 minutes. Field notes were completed after the meeting, documenting participant involvement, meeting outcomes, general impressions, and next steps (Phillippi & Lauderdale, 2017).

Phase 2: Rapid scan of literature and synthesis of evidence from multiple sources

The first phase resulted in understanding the needs of older adults and providers and the knowledge gaps related to virtual care. As the pandemic created an urgent need for guidance and support for providers on the subject of virtual care, a rapid scan of literature was selected as an accelerated evidence synthesis approach (Ganann, Ciliska, & Thomas, 2010). The literature review identified existing documents that could be leveraged in our work, in an effort to reduce duplication of resources and guidelines. A modified scoping review process was used to complete the review, which occurred September through November 2020; the review was iterative in nature (Arksey & O'Malley, 2005). Multiple databases were used including PubMed, MEDLINE® and Cumulative Index to Nursing and Allied Health Literature (CINAHL). Keywords searched included geriatrics, virtual care, older adults, telemedicine and COVID-19. To maximize comprehensiveness, grey literature including clinical, best practice guidelines, key recommendations, and reports from professional organizations and associations provincially, nationally, and internationally was also reviewed. Given the rapidly evolving nature of information on virtual care, recently published articles written in English were the focus; however, articles spanning 2010–2020 were included given the timeliness of the subject. Titles and abstracts were reviewed for relevance based on consultation from the regional working group and their identified needs. Included articles were reviewed in detail and information was extracted using an extraction table. Articles were excluded if the topic did not align with the themes identified in

phase 1, if the article did not come from a trusted source (e.g., Accreditation Canada), and if the article did not provide references or evidence for the content provided.

A draft outline for a guidance document was co-designed by the working group during the second consultation meeting leveraging the available literature.

During this phase, a short online survey was also distributed to frontline health and community support services providers to gather additional experience-based data. The survey was distributed through regional working group members to their respective health and community care organizations and agencies.

To enhance the rapid literature review, and in alignment with a co-design approach, a focus group was also held with members of the SWFSS Regional Patient and Family Caregiver Advisory Group ($n = 10$). Ensuring older adults and caregivers' voices, expertise, and lived experience is at the heart of the SWFSS and was a guiding principle of this work. A member of the SWFSS team met in advance of the focus group with co-chairs of the advisory group to develop an agenda and co-develop an interview guide. Questions pertaining to equity, successful and challenging virtual care experiences, possible reasons for patient/clients currently refusing care, and circumstances which are and are not appropriate for virtual care were explored. The focus group was 60 minutes in length and field notes were documented by the SWFSS team member.

Phase 3: Document co-development and dissemination

In alignment with Arksey and O'Malley's consultation phase (Arksey & O'Malley, 2005), a meeting was held with the regional working group ($n = 15$) to review the results of the rapid scan of literature and co-develop an outline for the resulting guidance document. Following the creation of the virtual care guidance document, a final consultation meeting with the working group and the larger SWFSS Regional Patient and Caregiver Advisory Group ($n = 25$) was held to review the final document together and discuss implementation and dissemination plans.

A survey was also distributed in the final phase to gather preliminary feedback. The survey included four questions using a four-point Likert scale. A comment box was also provided to gather other open-ended feedback from participants about the document.

Data Analysis

Qualitative consultations and focus group

Field notes and documents from the consultations and focus group were reviewed using a modified line-by-line coding process (Saldana, 2016). Common ideas were clustered together creating themes. Two team members reviewed the codes and themes and came to a consensus on the final set of themes. These themes and ideas formed the elements for the virtual care guidance document. The themes from the consultation in phase 1 also became the basis for the rapid literature review.

Rapid literature review

The SWFSS team member reviewed the extraction table, carefully, line by line. The team member highlighted common statements, words, and elements among the extracted articles and policy documents. The team member then reviewed all of the highlighted content and categorized the information into common themes. The team was conscious of not wanting to duplicate existing resources, but rather leverage already-existing resources and fill in the gaps specific to caring for older adults and caregivers using virtual modalities.

Online survey

Results from the online surveys were uploaded into Microsoft Excel. Mean ratings were calculated. For open-ended questions, qualitative analysis, as described, was applied. Thematic analysis was also completed with the results of the survey and the second consultation with the working group.

Trustworthiness in research

Trustworthiness was established through credibility and transferability of the data (Creswell & Creswell, 2017). Data were collected through survey, a literature scan, and focus group interviews, establishing credibility through triangulation of data collected. Credibility was also achieved as a result of the prolonged engagement with stakeholders to co-design the virtual care document. After each phase of work, the team members debriefed with older adult partners and stakeholders to ensure that the correct information was captured. Second, participants represented a diverse group of individuals. A detailed description of the local health system context and the participants involved in this work has been documented. The results of this work are transferable to other regions with similar populations and health system experiences. Together, these strategies ensure the quality and rigor of the data being collected and the resulting product.

Results

Phase 1: Understanding Experiences and Identifying Needs and Regional Priorities through Consultations with Stakeholders

During the first consultation, a number of themes emerged that related to the goals of providing best practice, high quality, equitable, and seamless virtual care to older adults and caregivers.

Theme 1: A gap in practical guidance on virtual care related to serving older adults and caregivers

Members relayed complex journeys in navigating virtual care decision making, planning, and operationalizing virtual care work flows with patients/clients, while still trying to provide services and support safely during this challenging time. Specifically, participants cited gaps in practical guidance on virtual care with older adults and caregivers.

> A number of working group members discussed their current struggles with virtual care. One outstanding issue remained for the group: when and under what clinical circumstances should providers use virtual care and/or see patients/clients in-person. The group seemed to be aware of available evidence outlining various virtual care platforms and their associated utilities, but many participants acknowledged there was limited knowledge and literature to guide their virtual care practice with older adults and caregivers (Source: Field Note, Meeting #1).

Moreover, working group members indicated that as professionals they did not have the time or the resources to research and stay abreast of this rapidly evolving topic.

Theme 2: Lack of time and resources needed to understand virtual care best practices

Time emerged as another important theme in this discussion. Participants were primarily focused on trying to effectively navigate the technical aspects of virtual care. During this time of crisis, they expressed that they did not have time or the resources to review and understand best practices for decision making and/or conducting virtual care appointments/visits. For most providers, virtual care was a new practice and an unfamiliar model of care delivery. Providers articulated the importance of providing virtual care in alignment with the best available evidence; however, frontline providers found this challenging during the early months of the pandemic.

Theme 3: Building partnerships and learning together in a time of crisis

Members cited the importance of intentionally coming together, in partnership with older adults and caregivers, to learn from each other's experiences of receiving and delivering virtual care across the region. As virtual care practices varied widely across partners, the regional working group shared their learnings to date. This discussion also served to engage partners, build relationships, and raise awareness about the current provision of geriatric virtual care.

> It was inspiring to see participants share freely and offer reflections on their current experiences with virtual care during this time of crisis. I feel that this forum has created an environment where we can learn from one other as equal partners. Participants seemed comfortable, including the caregiver representative who contributed greatly to the conversation (Source: Field Notes Meeting #1).

Participation by older adults and caregivers provides a unique lens through which to view the conversation, and encourages health care and community providers to think differently about how to provide care.

Theme 4: Redesigning care delivery to serve older adults using multiple methods

Because COVID-19 limited the number of in-person visits, providers had to be flexible and innovative in redesigning the provision of care and services for older adults. First, participants shared that

telephone calls to older adults and caregivers are an effective way to obtain important collateral information in advance of virtual video visits and/or in-person visits. A virtual tool in and of itself, telephone calls to patients/clients, are effective in collecting information to facilitate triaging, deciphering which components of care may be offered now or in the future, and identifying circumstances that require in-person assessments or visits. Given COVID-19 government restrictions on care delivery, baseline information on patients'/clients' functioning, including recent changes, is even more important to gather, as frailty can have adverse and devastating consequences. Second, community support services reported positive feedback from older adults and caregivers on their virtual group recreational programming, especially virtual cooking programs. These particular programs have allowed older adults living with dementia and their caregivers to participate in and share a meaningful activity together, despite COVID-19 restrictions. Similarly, this programming resulted in positive experiences for providers. Furthermore, for those older adults and caregivers who did not have the ability, access, or the technology to participate in virtual care, the working group members discussed the importance of brainstorming collectively about how they might pool resources or coordinate appointments with mutual patients/clients.

> Upon reflection of the meeting, it was fascinating to see organizations dedicated to working together to optimize care for older adults and caregivers in the community. It was evident that multiple tools are being used to provide care and services, such as telephone calls, video visits and virtual group programming. However, participants acknowledged that not everyone has access to, or the ability to use, technology. This will be an important topic to discuss in future meetings (Source: Field Notes Meeting #1).

Across all themes, there was an underlying focus on working together to provide the best quality care for older adults and caregivers.

The working group acknowledged that a virtual care guidance document, including recommendations and key considerations, was an important need in the region. They agreed that whatever resource was created, it would need to be practical, rapidly deployable, timely, and in alignment with government recommendations during COVID-19. It also would need to be grounded in the best available evidence and informed by the experience, insight, and learnings of older adults and caregivers, as well as health care and community providers. Consultation raised the awareness that although partners did indeed have some similar needs, they also had distinct needs, so the resource created would need to be co-designed with this in mind.

Phase 2: Rapid Scan of Literature and Synthesis of Evidence from Multiple Sources

A rapid scan of the literature yielded more than 100 journal articles, reports, and clinical practice guidelines, which were reviewed and extracted by a member of the SWFSS team. A number of themes emerged from the extraction table, such as barriers to technology use (Frank, St. John, & Molnar, 2020; van Ineveld, Huang, Varshney, & Merkley, 2020); issues around privacy (Canadian Medical Association, The College of Family Physicians of Canada & Royal College of Physicians & Surgeons of Canada, 2020); determining urgency (College of Physicians & Surgeons of Alberta, 2020; Regional Geriatric Program of Toronto, 2020); virtual care versus in-person care (Alberta Health Services, 2020; Ontario College of

Table 3. Focus Group Interview Guide – Regional Patient & Family Caregiver Advisory Group

1. What matters most to you about virtual care (telephone/video visit)?
2. What has made your virtual care experience successful or unsuccessful?
3. What circumstances are appropriate and not appropriate for a video visit (with a provider)?
4. What circumstances are appropriate and not appropriate for a telephone call (with a provider)?
5. What reasons might you refuse a virtual care telephone visit? Virtual care video visit?
6. Not everyone has access to technology – what strategies can we come up with to promote health equity and how could we address this challenge?
7. Based on experience with virtual care (or someone you know), what challenges are faced especially with people living with dementia – how can we best serve the caregiver and patient/client?

Family Physicians, 2020; Ontario Health, 2020; OTN, 2020); using a patient-centred approach (Health Standards Organization & Accreditation Canada, 2019); obtaining informed consent (Agency for Healthcare Research and Quality, 2020) and equity (British Columbia Ministry of Health, 2020; Donaghy et al., 2019; Shaw et al., 2019). Also, it was noted that there were many resources on virtual care in general, but none that were solely focused on decision making, planning, and delivery of virtual care to this specific population. The review of the literature identified areas for further exploration with the working group, including health care providers, patients, and family caregivers.

A focus group with the SWFSS Patient and Family Caregiver Advisory group ($n = 10$) was also conducted in Phase 2. Seven questions were co-designed with a member of the SWFSS team and the co-chairs of the regional patient and family caregiver advisory group in advance (Table 3).

Theme 1: Using a person-centred approach to care

The theme of taking a patient-centered approach to virtual care was important to the advisory group. There needs to be greater emphasis placed on an older adult and caregiver's situation and unique needs, as well as directly involving them in the decision-making process when a provider is planning care. For some older adults and caregivers, travelling long distances and/or the energy expended in preparing for and attending an in-person appointment is exhausting, especially for those older adults living with frailty. In addition, the expense of travelling and other associated costs can be prohibitive. Receiving care and support in the comfort of one's own home was deemed a benefit.

Virtual care affords more choice for the older adults and caregiver and depends on their unique needs and circumstances. Advisory group members stated that they wished that their providers would explore this choice with them as an option, as not all providers were delivering care virtually as the default practice during the pandemic.

Theme 2: Privacy and confidentiality considerations

Privacy and confidentiality also emerged as a theme identified by older adult and caregiver participants. Providers needed to take privacy into consideration when planning care. If virtual care was to be used, the group felt that good communication skills were very important, as well as having a senior-friendly environment in which to conduct a virtual care appointment or visit. A quiet and

confidential space is essential and most important when dealing with issues of abuse. With respect to factors contributing to a successful virtual care experience, group members raised the theme of comfort for older adults and caregivers, and demonstrating patience as a provider.

Theme 3. Use of technology and comfort with it

Another theme that emerged was related to using technology. Technology may be unfamiliar to some patients/clients, so they said that it was important for providers to show empathy during this new experience, especially at the beginning of a virtual encounter, and make sure that patients/clients and caregivers are heard. The older adult patients/clients stated that it is helpful and comforting if there is consistency in the staffing of those who provide virtual care to them. Engaging with multiple people can feel overwhelming. Although the patient and family caregiver advisory group cited many positive experiences with virtual care, and specifically spoke of support and recreational groups, they acknowledged that older adults and caregivers had been experiencing "virtual fatigue" months into the pandemic.

The group indicated that if an older adult or caregiver was not comfortable, did not have technology or access to technology, or lacked digital literacy skills, they would refuse a video visit. Participants also added that if they felt a video visit could potentially confuse or agitate an older adult, they would refuse virtual care. For those older adults who do not have access to technology or equipment, the group said ideally, they would like to see organizations and agencies provide refurbished equipment to loan to patients/clients. They also thought it would be useful if volunteers or caregivers could assist older adults in using this equipment and teach them digital literacy skills.

Theme 4: Communication considerations

Delivering a significant diagnosis or conveying bad news were viewed as circumstances in which providers should meet with older adults and caregivers in person. They stated that virtual care would be appropriate, in their opinion, for circumstances such as follow-up appointments, medication issues, "straightforward" interventions, or simple test results. The group further added that communication challenges can create inequities in the experience of virtual care; for example, if an older adult did not have adequate hearing to have a meaningful conversation by telephone or lacked the ability to understand or comprehend, they would refuse virtual care (telephone visit).

Theme 5: Importance of including caregivers in virtual care delivery

Lastly, focus group members discussed the importance and value of including caregivers in virtual care visits, as long as proper consent was obtained. Collateral information, collected in advance virtually by providers, was a theme that emerged amongst the group and was appreciated. Group members also stated that providers should be sensitive to and considerate of the timing of virtual care appointments, especially for those older adults living with dementia and their caregivers. Honoring the older adult and caregiver preferences for morning or afternoon appointments could make a difference in whether the virtual care experience was positive or negative for everyone.

Summary of Phases 1 and 2

Together, the literature and focus group discussion highlighted important areas to consider in a virtual care guidance document such as: having a person and family-centred care approach, privacy and confidentiality, including family caregivers, use of technology, and comfort and communication.

The online survey (Table 4) provided further experience-based data on factors affecting decision making related to virtual care.

There was a total of 16 respondents who completed the survey. Survey respondents were representative of the following sectors: 43.75 per cent community support services providers, 18.75 per cent primary care providers, 18.75 per cent regional specialized geriatric care providers, 12.5 per cent home and community care providers, and 6.25 per cent behavioural supports services.

The survey identified the top five reasons which influenced a provider's decision to provide in-person geriatric care (Table 5). With respect to how an in-person visit might change a provider's treatment/intervention/plan of care, the survey respondents described that in-person visits provided the best comprehensive picture, in their opinion, in that a home environment provided an opportunity to complete valuable cognitive testing and for non-verbal body language of patients/clients/caregivers to be observed, as well as to perform important physical assessments that aid in diagnostics and medical recommendations.

Results from the second consultation with the regional working group, as well as responses to the online survey, revealed themes regarding factors affecting virtual care decisions

Providers' considerations and recommendations for virtual care can be found in Table 6.

Together, results from the literature review, focus group, consultations and the survey, informed the development of the guidance document.

Phase 3: Document Development and Dissemination

The virtual care guidance document for providers

The consultations, focus group, survey, and rapid literature review contributed to the development of a 27-page virtual care guidance document intended to support health and community support providers. This document is online and was developed using the best available evidence and lived experiences of older adults, caregivers, and providers. Providers indicated that they wanted simple, easy-to-use tools. As such, each topic in the document is meant to be a stand-alone resource for use in clinical practice. The document includes information and direction on the following topics.

- Virtual First Geriatric Model of Care decision-making tool

  Step 1: Determining Feasibility of Virtual Care with a Patient

  Step 2: Matching Patient's Needs with Visit Modality and Clinical Circumstance

- Obtaining Informed Consent from Older Adults for Virtual Care: Tips for Geriatric Care Providers
- Creating a Senior-Friendly Virtual Care Environment; Hybrid Approach to Virtual Care (Telephone/Video + In-person)
- Cognitive Screening of Older Adults in the setting of COVID-19: Why, What, and How?
- Virtual Recreational Programming for Older Adults Living with Dementia and their Caregivers

Table 4. Survey questions for health care and community support services providers

1. Please select the top five factors which would currently influence your decision to provide in-person geriatric care to a patient/client instead of virtual care (telephone/video visit). ☐ Risk of patient/client declining medically/physically ☐ Patient/client/caregiver discomfort with technology ☐ Patient/client does not have an established relationship with the provider (never met before) ☐ Language/communication difficulties ☐ Lack of support/staff to set up virtual technology ☐ Patient/client/caregiver lack of transportation ☐ Patient/client requires physical assessment (please indicate type of assessment required)
2. How would seeing the patient/client in-person change your treatment/intervention/plan of care compared to virtual care? Please describe.
3. What factors do you consider in deciding between providing a video visit or a telephone call when you are assessing/treating a patient/client?
4. Reflecting on your experience throughout COVID-19, at what point in a patient/client's journey of care (initial assessment, follow up) does: a. A phone call works best b. A video visit works best
5. Please describe a recent patient/client scenario when you thought in-person geriatric care was the "only option."
6. What are the reasons patients/clients currently refuse care? What do they tell you? ☐ Does not have device required (smart phone, tablet, computer, laptop) ☐ Does not have technology required (Internet, bandwidth) ☐ Language/communication difficulties ☐ Patient/client prefers to meet in person ☐ Patient/client feels uncomfortable using technology ☐ Privacy concerns
7. Throughout the pandemic, what have you found works best in creating an excellent, senior-friendly virtual care environment and experience for older adults and caregivers? (e.g., how to build rapport on video visit, any special instructions or considerations, collecting information, obtaining consent)
8. Is there anything else you would like to share with us about your experience in providing virtual care (telephone calls/video visits) to older adults and caregivers to date?

Table 5. Top five reasons influencing provider to provide in-person geriatric care

Percentage of Respondents	Considerations for In-Person Appointments
91.6%	Language/communication difficulties
83.3%	• Risk of patient/client declining medically/physically • Patient/Client/Caregiver discomfort with technology
58.33%	• Patient/Client does not have an established relationship with the provider • Patient/Client requires physical assessment
50%	Lack of caregiver
16.67%	Provider's discomfort in using technology
*	Providers also indicated if a patient/client lived alone and was isolated or if there were any issues of abuse, they would want to meet with the patient/client in person.

- Equitable Access to Care: Considerations for Geriatric Care Providers
- Virtual Care: Lessons Learned in the Provision of Geriatric Care during COVID-19
- Additional Resources

Dissemination and preliminary evaluation

The guidance document has been disseminated through local committees, organizations, and agencies across Southwestern Ontario as an online resource. Specifically, the document was emailed to the SWFSS Distribution Network, which contains more than 600 e-mail contacts for individuals working in LTC homes, home and community support services providers, primary care providers, and hospitals. The document was also promoted on social media, which reached more than 4500 people.

The team has undertaken a preliminary evaluation; however, further evaluation is needed. An online survey was created to gather feedback from frontline individuals about the usefulness of the document, its ease of use, and its practicality and applicability to the professional's work. The survey was completed by 22 individuals. Ninety-six percent of respondents agreed very strongly/ strongly that the resource had been useful in their virtual care decision-making process. Respondents also felt strongly (91%) that the document was easy to use. Eighty-two percent have used or intend to use this resource in the future. Providers responded they very strongly agreed/strongly agreed (91%) that this resource was applicable to their work.

A number of participants left feedback including one primary care physician who commented

> What an incredible document! It will be invaluable to anyone offering care to our seniors! Weekly phone visits with one of my older patients in a retirement home were key to fine tuning their pain meds and minimizing side effects. Used wisely, virtual care can be an incredibly powerful tool going forward. These guidelines will help me to make sure I can continue to use virtual care safely for both my patients and myself.

One of the working group participants, who represents the patient/ family caregiver perspective, also commented

> I see this as an excellent document to help guide health care providers in their decision-making. The guide is well organized and a wealth of information and tools with information/assessment on (emotional,

Table 6. Themes emerging from second consultation with working group and online survey

Themes	Details
Factors in deciding between video visit or telephone call	• Access to and availability of technology • Patient/client/caregiver comfort with technology • Ability to communicate and comprehend • Language/communication barrier • Patient/client/caregiver's needs or concerns • Clinical appropriateness for the modality • Pre-existing relationship with older adult/caregiver • Patient/client's preference
When video visits work best	• Transportation and mobility challenges • Travelling is too difficult for older adult/caregiver – frailty • Caregiver involved in older adult's life • Initial assessments
When telephone calls work best	• Patient/client/caregiver uncomfortable with technology/no access to technology • Patient/Client/Caregiver well known to provider • Follow-up care • Obtaining collateral information *in advance* from older adult/caregiver
In-person geriatric care is the "only option" in specific situations (office appointment/home visit)	• Older adult has advanced Parkinson's Disease • Issue of abuse • Older adult lives alone, is socially isolated, and has no caregiver • Older adult/caregiver experiencing significant emotional distress • Safety/risk issues
Current reasons for refusal of virtual care	• Lack of comfort with technology; lack of access • Communication difficulties • Patient/client's preference to meet in-person • Caregiver feels it would be too confusing or agitate older adult
Creating a senior-friendly virtual care environment	• Offering practice sessions in advance of scheduled appointment to increase comfort and confidence of older adult • Establishing safety plan or a back-up plan should technology fail • Provider being on time • Speaking clearly; using short sentences • Outlining what to expect in advance is essential • Special instructions such as visiting toilet in advance of video visit; having a snack/drink within reach – comfort is important
Successful strategies	• Using two staff to facilitate virtual care groups (one to assist with technology; one to facilitate group) • Call upon older adults one at a time to share in a virtual group – lessens confusion and improves experience • Maintain light atmosphere; laughter is important when facing technological challenges • Use headphones with microphone attached – makes for better sound quality for older adult/caregiver • Be kind, patient, and remember to thank older adult and caregiver for trying their best if using virtual care for first time

mental, physical, chronic disease and limitations of the senior) to assist with making decisions for using virtual care options. I am so very grateful that patients and caregivers have had an opportunity to share their experiences in helping with the design of this document. In my long career I have never seen this opportunity for the recipients of care/support persons have an opportunity like this one.

Discussion

This article describes, in detail, our process of co-developing a regional virtual care guidance document by conducting a rapid review and multiple stakeholder consultations. In partnership with health care providers and older adults, this work resulted in a document for health and community support services care providers to use while deciding when and under what circumstances virtual health care appointments should be completed with older adults and caregivers. In alignment with government recommendations during COVID-19, providers needed to rapidly shift to a "virtual care first" approach in caring for older adults and caregivers (Ontario Ministry of Health, 2020). In adapting to this model of care delivery, it quickly became apparent that providers required

practical guidance on incorporating evidence-based virtual technologies into the care of older adults in a way that maximized quality and minimized inequities.

The SWFSS Team was in a unique position to respond to this need among partners, given the existing regional networks already in place. This allowed the SWFSS team to rapidly engage regional stakeholders and leverage experience with a collective impact approach in real time (Hanleybrown, Kania, & Kramer, 2012) to tackle this issue.

Although the SWFSS was uniquely positioned in this particular instance, learnings from this experience have broader application. The need for practical guidance to inform evidence-based virtual care was one of many instances in which disparate teams and services found themselves facing similar challenges and identifying similar needs during the COVID-19 pandemic. Although this global pandemic was unique in the scale of associated disruption, the challenges associated with system change will continue to be a reality, as provinces across Canada work toward the development of more coordinated, population-focused health systems (e.g., Ontario Health Teams). Learnings and strategies from this work (presented subsequently) should be considered for future health system design

Leveraging Evidence and Experience-Based Data to Understand the Population

In alignment with a population-based approach, solutions need to take into consideration the specific impact that current conditions may have on the population of focus. The work to develop this virtual care guidance document was grounded in the evidence related to older adults within the context of both the current situation (COVID-19) and the specific clinic process (virtual care). As discussed in the Canadian Journal on Aging/La Revue canadienne du vieillissement (CJA/RCV) Joint Statement, it is imperative to involve the voices and lived experience of older adults and caregivers, as well as of health care providers (Meisner et al., 2020). Starting with this population-focused data allowed for the development of solutions that took into consideration salient clinical realities. such as the increased risk of mortality associated with older age (World Health Organization, 2020) and avoided erroneous assumptions (e.g., experience data that made clear that it is erroneous to assume that older adults are unlikely to have access to or be comfortable with technology). A thorough understanding of the unique needs of the population within a given context will help ensure the practical utility of solutions generated.

Leveraging Co-Design Principles

The involvement of older adults and caregivers, along with health care and community support services providers from disparate geographic locations and with experience within different sectors and levels of care ensured that planning took into consideration the heterogeneity within the population and allowed for the identification of common challenges and needs. A key enabling factor in ensuring representation from these varied perspectives was to create a space and structure in which to engage, inquire, learn, and co-design together with older adults and caregivers (Change Foundation, 2020). McNeil et al. (2016) highlight the importance of creating a welcoming environment and building relationships with patient and family caregiver partners, to meaningfully engage in co-design activities. Individuals' experiences strengthened the end product to ensure relevancy to those it was trying to serve.

Benefits of "Backbone Support"

With any system change or disruption, busy clinicians and providers do not have the extra time needed to thoughtfully develop approaches and solutions to best meet the needs of patients within evolving circumstances, especially during times of uncertainty (Change Foundation, 2020; Collective Impact Forum, 2015). In developing this guidance document, the SWFSS provided the support to ensure the work moved forward to create a useful resource.

Success Strategies and Strengths

Utilizing population-focused research evidence and experience-based data, leveraging co-design principles, and establishing backbone support were key success strategies and strengths of this work. These learnings align with the call to action presented in the CJA/RCV Joint Statement by Meisner et al. (2020) "we strongly encourage the adoption of interdisciplinary approaches in the response to COVID-19 because of the value added when connections between and across disciplines are made" (p.334). The learnings and strategies that emerged through this work are likely to be informative for future population-based collaborative health system improvement efforts.

Much as the learnings gleaned from developing the document can be applied beyond the context within which it was created, the guidance document itself will continue to be a valuable resource beyond the COVID-19 pandemic. Even as vaccines are rolled out across Canada, many health care and community support services continue to employ virtual care. As is the case with influenza, even with the availability of effective vaccines, COVID-19 will continue to pose a significant risk to older adults. Many services previously offered in larger group settings are planning for long-term utilization of virtual care in order to balance access to service with infection prevention and control.

Virtual care also provides more options for extending access to limited specialized resources. Health human resource planning research tells us that our system has far fewer geriatricians and geriatric psychiatrists than is needed to adequately support the aging population (Borrie et al., 2020). Virtual and remote care strategies, such as shared care, clinical case reviews, and e-consult, have been and will continue to be critical in advancing equitable access to any type of service in which specialized resources are limited. Leveraging technology within health care was a priority in Canada prior to the COVID-19 pandemic. In 2018, within their approach to digital health technologies, the government of Canada acknowledged that "adoption and use of digital health technologies has the potential to make the delivery of health care more accessible, convenient and cost-effective" (Government of Canada, 2018). In 2019, Ontario announced its Digital First for Health strategy to develop a more modern, patient-centred health system (Government of Canada, 2021b). The COVID-19 pandemic only accelerated existing efforts toward integrating virtual care into health system planning and clinical pathways. The resources in this guidance document will support providers across sectors as they continue to employ virtual care as one of the many tools and approaches required to meet the varied needs of older adults.

Limitations

Some limitations in broad applicability of both the document itself, and the lessons learned, should be acknowledged. Within the context of the COVID-19 pandemic, older adults over the age of 60 were easily identifiable as a high-risk group of patients. A significant amount of data were available that illustrated the clear risk of severe illness and mortality from COVID-19 for this population. Additionally, the common challenges experienced by the disparate services and providers within this context were the result of provincial guidance that applied uniformly across sectors and services – reducing non-essential in-person patient interactions. Outside of this specific context, system changes are unlikely to impact all services and sectors in such similar ways, which may necessitate a slightly different approach to identifying common challenges and needs. Through the use of co-design principles and working directly with communities, this challenge can be eliminated.

Second, the availability of backbone support should also be addressed. The SWFSS Team was uniquely positioned to be able to provide backbone support to this work because of the collective impact approach already established within regional system improvement work for older adults. Existing resources able to quickly step into this role may not always be so readily available. However, backbone support is an essential element of successful

collective impact (Collective Impact Forum, 2015) and proactively establishing these types of supports will be critical to the successful development of collaborative health care systems.

The limitations of the guidance document include the utilization of a rapid scan of the available literature. Although this rapid scan may not have been exhaustive, it did allow for the timely development of a resource to support virtual care through subsequent waves of the COVID-19 pandemic. Additionally, evidence related to virtual care has evolved rapidly during the pandemic. As such, the most up-to-date research evidence is not reflected in the current version of the guidance document.

Future research may focus on evaluating the implementation of the guidance document and updating the resource to reflect the most up-to-date research and learnings.

Conclusion

The need to respond rapidly during the COVID-19 pandemic has resulted in many examples of disruptive innovation. This process demonstrated the strength of using collective impact and co-design principles to achieve a necessary outcome. The SWFSS team was uniquely positioned to lead a collaborative effort to develop practical resources to support evidence-based virtual care for older adults and caregivers. Although this resource was developed within rather unique circumstances to support a critical need during the COVID-19 pandemic, the resulting resource and lessons learned can be applied beyond that specific context. Moving forward, digital technologies, such as virtual care, will be critical to leverage as provinces recover from the COVID-19 pandemic, and build toward more integrated and patient- and family-centred systems of care.

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