



**Ontario
Health**



Clinically Appropriate Use of Virtual Care in Primary Care

Guidance Reference Document

November 2022

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This document is intended to provide guidance for the use of virtual care in clinical practice in Ontario. Physicians seeking information on how to bill OHIP for virtual care services are advised to refer to the Health Insurance Act, the regulations thereunder, including the Schedule of Benefits for Physician Services or to contact the Ministry of Health.

2 About this Document

This document has been developed in response to the rapid uptake and use of virtual care during the COVID-19 pandemic, the constraints faced by the health system in the way in which virtual care services could be planned and delivered during this period, and the acknowledgement of an ongoing need to continue to offer virtual primary care services in a clinically appropriate manner.

This guidance acknowledges that primary care must be accessible to all Ontarians and that the nature of primary care delivery within the province is broad and varied. It is not only dependent on the varied needs of the population of the province but also impacted by Ontario's geography, climate, availability of resources, and the broad nature of care that falls within the primary care purview.

This guidance is intended to be specific to the delivery of virtual primary care and to supplement rather than replace any related legislation, regulation, regulatory college practice standards and policies, government directives, or public health guidance.

This guidance may need to be adapted to address unique patient, organizational, or other local conditions. Further updates may be released as clinical evidence develops and with the evolution of a long-term strategy for virtual care in the health system in Ontario.

2.1 Scope

Focus

This guidance is specifically targeted to **primary care**, which has been defined as documented in the Ontario Primary Care Council Framework for Primary Care in Ontario published in 2016:

First-contact, continuous, comprehensive, and coordinated care provided to populations undifferentiated by gender, disease, or organ system Primary care is that level of a health service system that provides entry into the system for all new needs and problems, provides

person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions* and coordinates or integrates care provided elsewhere or by others.¹

Primary care serves to triage patient needs to more complex health care such as specialists or to acute care, if necessary.

It is acknowledged that primary care takes many different forms in Ontario, given the unique needs of the patient populations being served, broad geography of the province, and the variety of practice models that have emerged. As a result, this initial set of guidance is high level, with the understanding that there will need to be accommodation for various care settings and needs.

This guidance is targeted specifically to **decision-making related to the clinically appropriate use of virtual care modalities** (i.e., e-mail, secure messaging, telephone, video) in the delivery of primary care services. The definition of the term “clinically appropriate” is provided later in this document.

Intended Audience

The intended audience of this guidance is primary care clinicians—those who have a professional obligation to use their clinical judgement in determining which, if any, virtual care modality should be used in a given clinical context.

While targeted to clinicians, this guidance may also be useful to others responsible for planning and supporting primary care service delivery (e.g., Medical Office Assistants) and to patients receiving virtual primary care. Companion documents or tools may be developed in the future to support these other applications.

2.2 Background/Rationale

Ontario's Digital First for Health strategy was launched in November 2019 with the intent to bring the patient experience into the 21st century and help end “hallway health care” by offering more choices and making health care simpler, easier, and more convenient for patients. With the introduction of the strategy, patients were to expect:

* Generally speaking; we acknowledge that patients presenting to primary care clinicians are increasingly complex.

- More virtual care options: Expanded availability of video visits and other virtual care tools, such as secure messaging. Additionally, providers will be able to leverage a variety of virtual care technologies that best meet the needs of their patients
- Expanded access to online appointment booking: Patients will be able to book appointments that best meet their need
- Greater data access for patients: More patients will be able to review their secure health record online and make informed choices about their care
- Better, more connected tools for frontline providers: More providers will be able to access patient records stored across multiple health service providers to provide better, faster care
- Data integration and predictive analytics: Providers will face fewer barriers to integrating and using secure health information to manage health resources and improve patient care. This could lead to improvements such as earlier intervention and better management of chronic disease²

With the emergence of the COVID-19 pandemic in March 2020, the need to employ virtual care tools to keep Ontarians safe yet provide necessary health care resulted in a significant shift from “in-person” to virtual care. Ontario’s Ministry of Health instituted policy that allowed clinicians billing OHIP to use multiple modalities to deliver care and a large proportion of care shifted to delivery by telephone as it was a convenient and accessible modality for most Ontarians and practitioners alike. As of October 31, 2021, more than 50% of care delivered by primary care physicians continues to be delivered virtually.³

While at this point, it is unclear the degree to which this rapid shift to virtual care has been associated with poorer clinical outcomes, there is at least anecdotal evidence that both patient and provider experience has been impacted.

A review of existing virtual care guidance has revealed that there are many organizations developing guidance at the national, provincial, and organizational levels. As a result, there is a need to ensure that the guidance related to clinical appropriateness has been contextualized for Ontario; aligns the varied guidance into one convenient location; and is general enough to apply to broad settings in which primary care is delivered, yet provides enough direction to be helpful to the primary care sector.

The Ontario Ministry of Health has funded the development of this guidance. A primary care expert panel, with membership comprising primary care clinicians and patient partners from each of the five regions of the province, was convened to provide advice to Ontario Health in the development of this guidance (hereafter referred to as the Primary Care Expert Panel for the Clinically Appropriate Use of Virtual Care Guidance).

2.3 Guiding Principles

This guidance has been developed according to the following guiding principles:

The guidance will:

- Be aligned with the Ministry's transformation agenda focused on population health and advancement of integrated care delivery through OHTs
- Be developed with a person-centred approach, involving both people requesting care and those delivering care
- Be developed with an equity lens, understanding that constraints related to access exist in certain patient populations and geographic locations
- Acknowledge the role of clinician judgement in delivering care given various clinical contexts
- Leverage, where reasonably practical, existing national- or provincial-in-scope virtual care guidelines with which health care providers or organizations may be required to respect or comply
- Through strategic partnerships, consider the practical application of virtual care integration into clinical practice and clinical information systems

The guidance will not:

- Replace billing and payment rules or define which services are eligible to be delivered virtually
- Contradict guidelines issued by regulatory bodies (e.g., College of Physician and Surgeons of Ontario's Virtual Care Policy, College of Nurses of Ontario's Telepractice Practice Guidelines)

3 Key Concepts

This section of the reference document lays out the key concepts that are foundational to the structure and content of this guidance. Many guidance documents published in response to the rapid transition to virtual care during the COVID-19 pandemic provide general information about the implementation or use of virtual care. This document is focused specifically on *clinically appropriate use* of virtual care, which involves the clinical decision-making process concerning when and which modalities of virtual care should be used when delivering virtual primary care services.

The term “clinical appropriateness” is broad, with sub-concepts including but not limited to concepts relevant to this guidance, such as person-centred care and equitable delivery of care. Therefore, this section treats the concept of clinical appropriateness as foundational to the other relevant concepts. It includes a summary of a systematic review on the topic; compares a definition of clinical appropriateness developed by the Canadian Medical Association with another from the literature; and aligns the concept of clinical appropriateness with the dimensions of quality care that underpin the way care should be delivered in Ontario. Clinically appropriate virtual primary care, when implemented, should support the delivery of quality patient care.

3.1 Clinical Appropriateness

The term *clinical appropriateness* can be interpreted in different ways. The Canadian Medical Association Policy for Clinical Appropriateness has defined it as below⁴:

Clinical appropriateness is the right care, provided by the right providers, to the right patient, in the right place, at the right time, resulting in optimal quality care⁴ This definition has five key components:

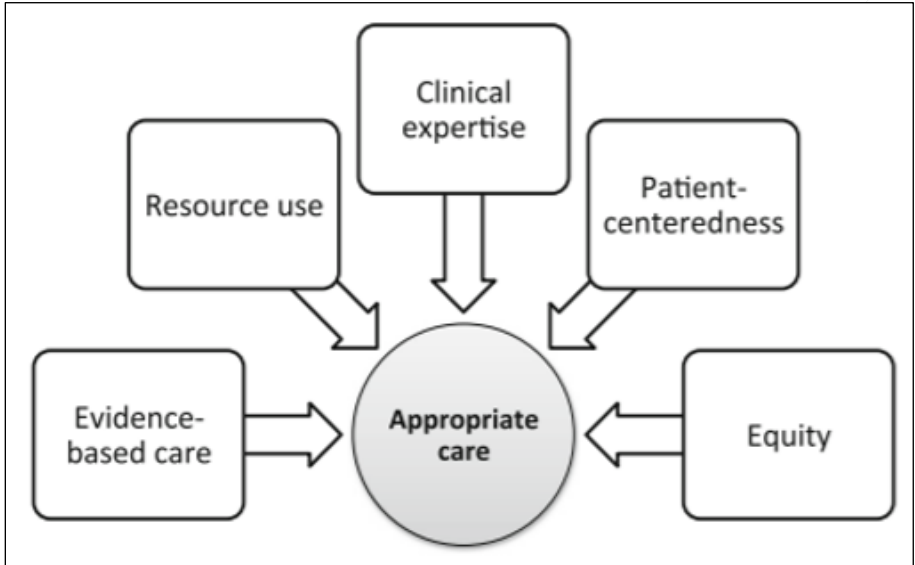
- “Right care” is based on evidence for **effectiveness and efficacy** in the clinical literature and covers not only use but failure to use
- “Right provider” is based on ensuring the provider’s **scope of practice** adequately meets but does not far exceed the skills and knowledge required to deliver the care
- “Right patient” acknowledges that **care choices** must be matched to individual patient characteristics and **preferences** and must recognize the potential challenge of reconciling patient and practitioner perceptions
- “Right venue” emphasizes that some settings are better suited in terms of **safety and efficiency** to delivering a specific type of care than others.
- “Right time” indicates care is delivered in a timely manner consistent with agreed upon benchmarks (p. 2)

Because this definition calls into question what is “right” and therefore may imply there is a wrong way to deliver care appropriately, the Ontario Health conducted a review of the literature for other definitions and elements of clinical appropriateness, summarized below.

Clinical Appropriateness in the Literature

A European study by Robertson-Preidler et al. (2017)⁵ included a review of the practices, goals, and perspectives of appropriate care in English language peer-reviewed articles published from 2011 to 2016. The following elements, neatly summarized in **Figure 1**, were identified as consistent across the 306 published materials reviewed.

Figure 1. Categories of clinically appropriate care



Source: Robertson-Preidler et al. 2017.⁵ Reprinted with permission.

Evidence-based care, for purposes of their study was defined as “care that is proven to improve health outcomes.” **Clinical expertise** referred to “adequate education and training for health care professionals, the use of expert opinion/professional consensus to guide clinical decisions, and clinician discretion to tailor treatment to patient cases and to manage uncertainty.” **Resource use** included variation in resource use generally; variation in resource use to reduce waste and unnecessary care and to ensure proper provision; and assessing equity of resources in health care delivery practices. Cost-

effectiveness was also discussed in terms of allocating resources at the health system level, with respect to making clinical decisions and decreasing cost.⁵

Of the 306 articles reviewed, 38 articles discussed the importance of **clinical expertise** in appropriate care delivery. Articles defined appropriate care in terms of adequate education and training for health care professionals, the use of expert opinion/professional consensus to guide clinical decisions, and clinician discretion to tailor treatment to patient cases and to manage uncertainty. Articles emphasized the importance of education and training in specialty medical fields, the proper use of guidelines and protocols, and cultural competence and effective communication to help clinicians identify patient-specific risks and needs, align treatment goals, and enable shared decision-making.

To ensure effective communication within the therapeutic relationship, articles also discussed the need to overcome language barriers. Professional discretion was viewed as an important element of appropriate care that enables clinicians to assess necessity; translate evidence for specific patient risks, needs, and goals; balance patient needs with costs; and manage uncertainty. Professional consensus and knowledge exchange appeared throughout the literature as tools for making appropriate care decisions to reduce variation in service use, confirm indications, coordinate care, manage uncertainty, and create standards and guidelines.⁵

Considerations related to **patient-centred care** were present in about half of the reviewed articles. Elements of patient-centeredness included providing patients with context-specific, responsive, coordinated care and supporting patient autonomy through open communication and shared decision-making. Context-specific care tailors health care services to patients' health profile, medical history, and risk factors. Responsiveness refers to culturally sensitive and respectful care that accounts for patient values, culture, needs, and preferences. Responsiveness was especially emphasized in articles that focused on categories of appropriate care providing culturally appropriate care to various groups, including immigrant minorities, LGBTQ+ veterans, and women in Afghanistan. Coordinated and integrated care involves managing health and social services across conditions and settings. Other elements of patient-centered care included shared decision-making through open communication of goals and expectations that help identify patient perceptions and acceptability of care, health literacy and patient activation and building a relationship of trust with providers. Patient-centered care requires patient empowerment and engagement through disease prevention and self-management tools, education, and effective communication.

Equity was discussed in 14 articles reviewed. This category included many themes that overlap with previously discussed themes, including demographic and geographic variation in resource use and health-related outcomes, access to health care services, and non-discriminatory care.⁵

Clinical Appropriateness and Quality Care Dimensions

Clinical appropriateness and quality of care are related. **Table 1** outlines six dimensions of quality and their meaning from the perspective of the patient and provider, which was published by Health Quality Ontario (now a part of Ontario Health).⁶

Table 1. The dimensions of quality and what they mean for patients and providers⁶

Element	For patients	For providers
Safe	I will not be harmed by the health system.	The care that my patient receives does not cause the patient to be harmed.
Effective	I receive the right treatment for my condition, and it contributes to improving my health.	The care I deliver is based on the best evidence and produces the desired outcome.
Patient-centred	My goals and preferences are respected. My family and I are treated with respect and dignity.	Decisions about my patient’s care reflects the goals and preferences of my patient and their family and caregivers.
Efficient	The care I receive from all practitioners is well coordinated and efforts are not duplicated.	I deliver care to my patients using available human, physical, and financial resources efficiently, with no waste to the system.
Timely	I know how long I will have to wait to see a doctor or for tests or treatments I need and why. I am confident this wait time is safe and appropriate.	My patient can receive care within an acceptable time after the need is identified.

Element	For patients	For providers
Equitable	No matter who I am or where I live, I can access services that benefit me. I am treated fairly by the health system.	Every individual has access to the care that they need, regardless of their location, age, gender, or socioeconomic status.

Table 2 maps the Canadian Medical Association definition elements of clinical appropriateness to the quality dimensions (above) and to the clinical appropriateness elements summarized in the systematic review (**Figure 1**). From this we can see that there is alignment across all three source documents, and the six quality dimensions can be used as a foundation for clinical appropriateness in this guidance document.

Table 2. Comparison of foundational elements of clinical appropriateness to quality dimensions

Clinical Appropriateness (CMA ⁴)	Quality Dimension (HQO ⁶)	Elements of Clinical Appropriateness (Preidler-Robertson et al., 2017 ⁵)
<i>Right care</i> is based on evidence for effectiveness and efficacy in the clinical literature and covers not only use but failure to use.	Safe Effective	Evidence-based care
<i>Right provider</i> is based on ensuring the provider’s scope of practice adequately meets but does not far exceed the skills and knowledge to deliver the care.	Safe Effective Efficient	Clinical expertise Resource use
<i>Right patient</i> acknowledges that care choices must be matched to individual patient characteristics and preferences and must recognize the potential challenge of reconciling patient and practitioner perceptions.	Patient-centred Equitable	Patient-centredness Equity
<i>Right venue</i> emphasizes that some settings are better suited in terms of safety and efficiency to delivering a specific type of care than others.	Safe Efficient	Resource use Equity

Clinical Appropriateness (CMA ⁴)	Quality Dimension (HQO ⁶)	Elements of Clinical Appropriateness (Preidler-Robertson et al., 2017 ⁵)
Right time indicates care is delivered in a timely manner consistent with agreed upon benchmarks.	Timely	Evidence-based care Resource use

Definition of Clinical Appropriateness in the Context of this Document

As a result of this review, the Primary Care Expert Panel for the Clinically Appropriate Use of Virtual Care Guidance has defined **clinical appropriateness** for the purpose of this guidance as follows:

Clinically appropriate care is safe, timely, and effective care provided within the scope of practice of the practitioner in a setting or using a modality that permits appropriate clinical assessment of presenting conditions and that is reasonable to the patient and practitioner. Person-centred care and equity considerations are critical to clinical appropriateness.

3.2 Other Relevant Definitions

Virtual Care

Virtual care is defined as any interaction between patients and/or members of their circle of care,^{7,†} occurring where the patients and/or members of their circle of care are not located in the same place, using any form of communication or information technologies, with the aim of facilitating or maximizing the quality and effectiveness of patient care.^{8,‡}

The term *virtual care* can be both an approach to care or a single interaction between a provider

† “Circle of care” refers to the health care clinicians (e.g., nurses, physicians, residents, clinical clerks, and any other health care practitioner providing care to the patient) treating a patient, who need the patient’s personal health information to provide health care. This can include employees and/or administrative staff who need the patient’s personal health information to carry out their duties. Family, friends, caregivers, the police, an insurance company, or the patient’s employer are not considered part of the patient’s circle of care, nor are health care providers to whom personal health information is provided for purposes other than providing health care to the patient (e.g., for research).⁷

‡ Adapted from a discussion paper, “Virtual care in Canada,” presented at the Canadian Medical Association Annual Health Summit, which took place in Toronto in August 2019, citing Shaw et al., 2018.⁸

and patient.⁵ Virtual primary care may be delivered using one of many different “modalities”.

Virtual care modalities included in this guidance include:

- Secure messaging
- E-mail
- Telephone
- Videoconferencing

While other modalities exist, such as “chat bots” and “remote patient monitoring,” these do not fall within the scope of this guidance.

Person-Centred Care

Cancer Care Ontario, now part of Ontario Health, developed a *Person-Centred Care Guideline* for the cancer system; however, many of its principles are relevant to health care professionals and others who interact with patients, their family members, and caregivers. Person-centred care is the evolution of patient-centred care, a shift that signals to the system the profound importance of being treated as a person first and a patient second. Use of the term “person” over “patient” is also intentionally inclusive of family members and/or caregivers and recognizes that a patient often experiences the health care system with a support network.⁹

The *Person-Centred Care Guideline* describes an approach to care that involves health care professionals partnering with people (patients) to:

- Give them a voice in the design and delivery of the care they receive
- Enable them to be more active in their journey for better health outcomes
- Support greater value through a wiser use of resources
- Improve their experience

The guideline further defines a person’s experience as the sum of all interactions, shaped by an organization’s culture, that influence their perceptions across the continuum of care (this definition is adapted from that outlined by the Beryl Institute¹⁰).

⁵ In this instance, “provider” and “clinician” are used interchangeably.

This guidance has been developed in collaboration with patient partners. The statements, while focused on clinical appropriateness, which is a clinical decision, are made with the understanding that the patient’s voice and context are important considerations when taking decisions related to the use of virtual care.

Equity

Health equity “allow[s] people to reach their full health potential and receive high-quality care that is fair and appropriate to them and their needs, no matter where they live, what they have or who they are.”¹¹

Unlike the notion of equality, which is about treating everyone the same, equity speaks to treating people fairly and justly. In health care, equitable outcomes often require differential treatment and redistribution to achieve a level playing field among all individuals and communities. This requires recognizing and addressing barriers to opportunity.

When considering the clinical appropriateness for the use of virtual care or deciding between modalities or channels, there are multiple equity-related considerations to include. These will be outlined in the section on patient considerations below.

4 General Considerations

4.1 Clinical Context and Considerations

Primary care in Ontario is delivered by a wide range of clinicians in diverse practice settings using different primary care models. Some practices are large and institutionally based while others are small, with a solo clinician delivering care. There are regional differences in the way primary care is delivered. The focus of practice may differ as well. As a result, the level of infrastructure to support virtual care—physical, technical, and human resource—is also divergent.

It is not surprising, then, that degree to which virtual care is used by primary care clinicians varies, not only in the volume of care delivered using virtual versus in-person but also in the type of virtual tools being used in their virtual practices.

Given the practice and practice setting variation, there is not a “one-sized fits all” that can be applied when it comes to clinical appropriateness of decisions related to virtual care—what may be clinically appropriate in a rural or remote setting may not necessarily be appropriate where distance and proximity to resources are not as challenging.

Furthermore, some clinicians are more comfortable than others using virtual tools for clinical care or perhaps may be more comfortable using one type of virtual care option but not another. The presenting clinical complaint may also drive clinicians’ comfort using one tool over another.

Box 1 highlights some practice variables which may make virtual care more amenable to primary care clinicians.

Box 1. Practice variables that may be drivers for virtual care
Readily available, easy to use and affordable virtual care tools.
Practice location with good bandwidth/cell coverage.
Training/experience in using virtual tools for clinical purposes.
Technical acumen.
Medical office staff with technical acumen.
On-site or readily available technical support.
Established workflows that integrate virtual care into practice.
Patient population served has high-level of digital literacy and access to virtual tools.
Ability to easily communicate virtual care arrangements with patients (e.g., website, on-line platform, e-mail distribution lists, etc.).

In short, each clinician is impacted by different variables, which may affect whether and how they incorporate virtual care into their practice. This may change over time and with the setting within which they are practising. A clinician may be very comfortable using a wide range of virtual care tools available and supported in a large, urban institutional-based practice, but may also provide locum coverage to a remote location where there is little technical support; in this circumstance, they may choose to limit their use of virtual care to telephone, when clinically appropriate.

A Note on Emerging Virtual Care Competencies and Competency-Based Medical Education

Formal education in virtual care has not yet been consistently incorporated into health care professional programs in Canada, nor is there a consistent approach to virtual care in continuing professional development programs. Competency-based education is evolving nationally and internationally. In the United States, the Association of Medical Boards¹² has developed virtual care competencies that are being incorporated into curricula and in Canada competency-based medical education is emerging. Competence by Design is the Royal College’s transformational initiative designed to enhance competency-based medical education (CBME) in residency training and specialty practice in Canada.¹³

The Canadian Medical Association has developed recommendations for virtual care that includes engaging the CanMEDS consortium in incorporating and updating virtual care competencies for undergraduate, postgraduate, and continuing professional development (CPD) learners.¹⁴

Competency-based practice is also evolving. Work on competencies for virtual care is emerging in Ontario. For example, the Centre for Mental Health and Addictions¹⁵ and Holland Bloorview¹⁶ have set out competencies for virtual care practice.

In the absence of formal education and training, regulators have required professionals to self-assess and ensure they have the necessary competencies to practice, including virtual practice. The Federation of Medical Regulatory Authorities of Canada published a Framework on Telemedicine, which states: “Physicians using telemedicine to provide medical services to patients are expected to ensure they have sufficient training and competency to manage patients through telemedicine.”¹⁷

The College of Physicians and Surgeons Ontario refreshed *The Practice Guide Medical Professionalism and College Policies* in 2021, and the first “duty of practice” now includes the following under the heading “Demonstrating Professional Competence”¹⁸:

Physicians should be skilled clinicians committed to the values of the profession. Physicians should be committed to lifelong learning and be responsible for maintaining the medical knowledge and clinical skills necessary to provide the highest possible quality of care to patients.

At all times physicians should:

- be aware of deficiencies in knowledge or ability;
- obtain help when needed; and
- ensure that their practice matches their level of competence.

In terms of individual patient care, physicians should provide medical care based on objective evidence. (p. 8)

The Canadian Medical Protective Association (CMPA) has reviewed the medical–legal risks of delivering virtual care. From 2015 to 2019, there were 45 cases reviewed by the CMPA. Among the list of items that peer reviewers retained to review these cases the following was included as an aspect of care: “[L]ack of situational awareness, including lack of self-awareness of deficiencies in a physician’s knowledge and skills in managing a medical condition via virtual care.”¹⁹

In anticipation of the development of competencies for virtual care for both formal undergraduate education and for continuing professional development, given the rapid transition to virtual care during the pandemic period, and in the absence of specific evidence to provide direction, it is important for clinicians to reflect on their use of virtual care. This includes understanding their own capabilities, the knowledge, skills, and abilities required to effectively practice virtual care, and the contextual elements that need to be considered when exercising their judgement in the application of virtual care.

4.2 Patient Context and Considerations

Every patient is unique, with different levels of understanding of the use of virtual modalities in health care, different levels of access to them (and to in-person options for care), different preferences in terms of their use, and differing ability to effectively use them. This variation has an impact on how successfully available modalities may be used for different care conditions and circumstances.

In order to optimize patient, clinician and office staff experience at the time that a patient has a concern that needs to be addressed, it would be helpful to minimize, eliminate, or address some of these variables in advance, if possible, and to agree on a general approach. Some of the patient-related variables to consider are listed in **Table 3**.

Table 3. Patient barriers and drivers to virtual care

Variable	Virtual Care Driver	Virtual Care Barrier
Patient prefers to use virtual care for some care-related needs	√	

Variable	Virtual Care Driver	Virtual Care Barrier
Patient lives at a distance from primary care practice or has limited access to transportation	√	
Patient has mobility issues or otherwise is constrained to place (e.g., small children, provides elder care)	√	
Patient has limited capacity to understand the benefits and risks of virtual care		√
Patient has limited access to connectivity/virtual care tools		√
Patient's home environment not conducive to virtual visit (e.g., no private space)		√
Patient has limited digital literacy		√
Patient speaks a language other than that normally spoken at the primary care practice		√
Patient has hearing deficits		√
Patient has vision deficits		√
Patient has a degree of cognitive impairment		√
Patient has challenges with speech or with articulating verbally		√
Patient has limited/issues with manual dexterity		√

Some patients may need accommodation to use virtual modalities or may experience a better outcome with an in-person experience. Accommodation to support the use of virtual modalities may be satisfied by inviting a third party to assist a patient, having a patient attend a site that provides patient support or by assessing for more specific needs and attending to them through a purpose-built solution. Further work is needed in developing guidance to support clinicians to assist patients who have unique needs.

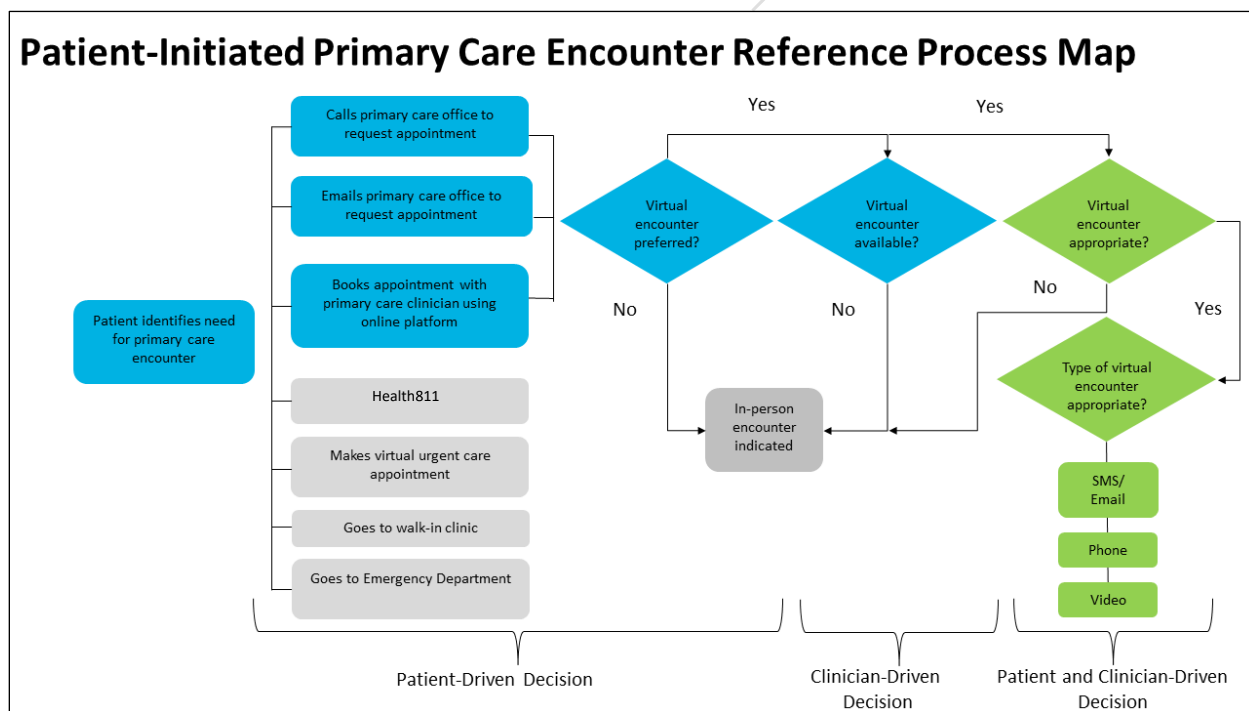
When determining a person’s suitability for virtual care, other considerations include clinical, psychosocial, socioeconomic, cultural, and social identity needs and preferences. A recent study suggests that newcomers, people living with a lower income, and those reporting poor or fair health have a stronger preference for and comfort with in-person primary care.²⁰

4.3 Considerations—Patient and Clinician Interactions

Both patients’ and clinicians’ contexts affect how successfully the two can come together in a virtual interaction, especially considering that the arrangements for an interaction are generally made without the clinician’s direct involvement—unless the clinician is initiating the care interaction.

The following two process maps (Figures 2 and 3) depict the steps and virtual care–related questions for each of the two interactions: patient-initiated and clinician-initiated interactions.

Figure 2. Patient-initiated primary care interaction process map



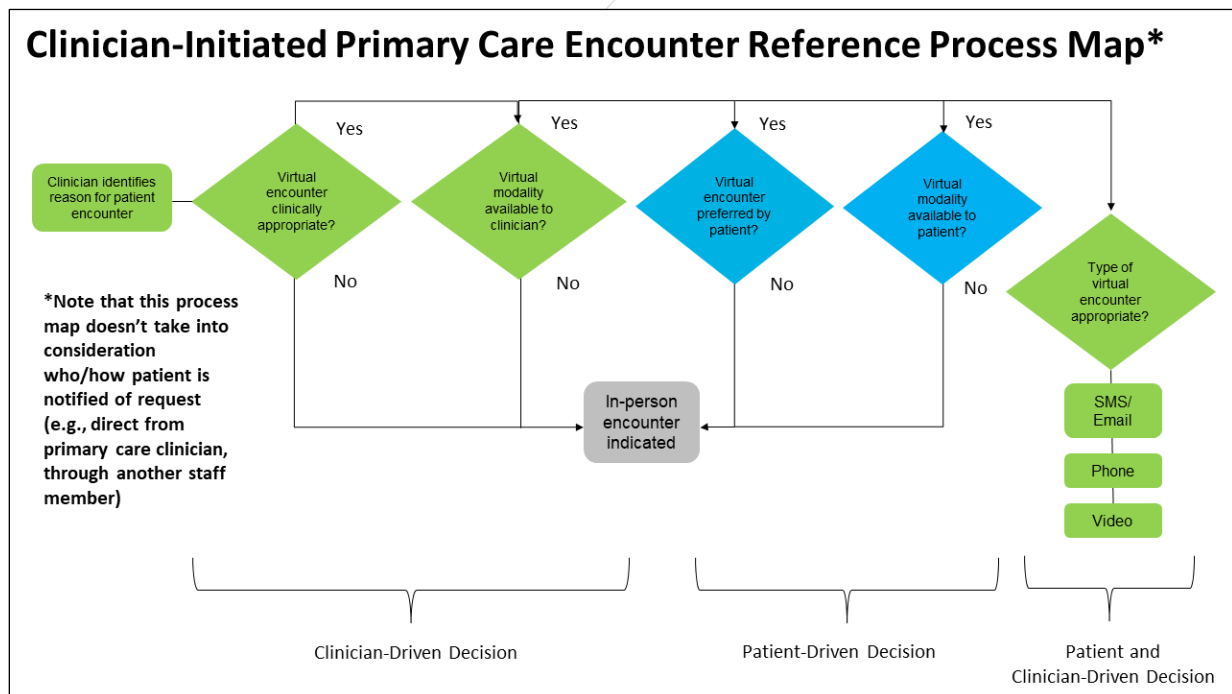
It is important to note that in a patient-initiated primary care interaction, while a joint decision needs to be made around whether and how an interaction will occur, the clinician is not generally involved in booking appointments or making decisions about which modality to use. This generally happens either

by a Medical Office Assistant coordinating the schedule or, increasingly, through an automated interface—an online scheduling system or an automated triage system, which may be available through a website or on a platform.

This means that the clinical judgement of the clinician cannot easily be applied at the time that a request is made by a patient, and the clinician must provide direction to their Medical Office Assistant to help determine the most appropriate way for the interaction to occur. Some practices have made their general approach to this decision-making available through a voice message on their office telephone or have communicated this through a website. However, not all practices operate in this manner or have made their arrangements explicit. Further, as each “reason for visit” comes with its own unique context, the combination of clinician context, patient context, the degree to which general approach has been made explicit, and the presenting complaint all make decision-making complicated.

There are times when it is the clinician’s decision to reach out to a patient. The following process map sets out the questions that need to be considered when a practitioner initiates contact with a patient.

Figure 3. Clinician-initiated primary care interaction process map



In this instance, unless the clinician is aware of patients’ preferences/ability to receive care virtually, there may be duplication of effort or a poor patient and practitioner experience. If the interaction has been delegated to a member of the team (e.g., a practice nurse or medical office assistant), and if they are not aware of the preference, there is a chance that the patient experience may be poor as well.

In each of the two above processes—patient initiated, and clinician initiated—there may be a more positive outcome if the preferences and abilities of each are known and are taken into consideration when planning the interaction.

4.4 Virtual Care Modalities and Uses

General approaches to assist clinicians in determining which virtual tools should be used in which circumstances have been documented by several organizations in Canada, including the Canadian Medical Association, the Centre for Digital Health Excellence (Ontario), the Provincial Health Services Association (British Columbia), and others. One of these is included, for reference only, below.

Provincial Health Services Authority Office of Virtual Health (British Columbia)

Table 5 contains relevant excerpts on benefits/uses and limitations of each of the modalities has been documented in the Provincial Health Services Authority (PHSA) Virtual Health Handbook for Staff. *The ‘Zoom for Healthcare’ example in table 5 (below) is a direct excerpt from the PHSA’s Virtual Health Handbook for Staff document.²¹

Table 5. Relevant Excerpts: PHSA Virtual Health Handbook for Staff

Virtual Health Solution	Benefits and Uses	Limitations
Virtual health visit audio-visual direct to patient	<ul style="list-style-type: none"> • Simulations in-person conversation and observations 	<ul style="list-style-type: none"> • Patients have responsibility to manage the solution and their

Virtual Health Solution	Benefits and Uses	Limitations
location (e.g., Zoom for Healthcare*)	<ul style="list-style-type: none"> • Allows family members and/or caregivers to be involved in the visit from different locations • Allows multiple members of the care team to join a visit from different places • Allows for eye contact and body language assessment • Can be suitable for sensitive topics • Facilitates a visual exam • Allows for clinical observations such as movement, facial expressions, and sounds • Synchronous (in real time) • Can be scheduled or on-demand • Can build trust and rapport through the visual and auditory connections • Some patients/clients can be more comfortable in their own environment • Reduces travel needs for patient/client and helps save time 	<ul style="list-style-type: none"> • own devices and may need support • Requires reliable internet connections for both patient and staff • Requires a level of competency to use the solution • Requires that both the patient and health care provider are available at the same time • Technical difficulties can arise unexpectedly
Non-secure (unencrypted) clinical digital	<ul style="list-style-type: none"> • Low barrier for patients as it does not require a login or downloading an app 	<ul style="list-style-type: none"> • Not secure: risk of interception by third party

Virtual Health Solution	Benefits and Uses	Limitations
messaging SMS (e.g., direct to phone number)	<ul style="list-style-type: none"> • Best for reminders and messages and other simple communications with out personal information • Allows for asynchronous communication (can send and receive messages at any time) 	<ul style="list-style-type: none"> • Depending on the solution used (e.g., established clinical digital messaging software vs phone to phone), there may be no tracking or record of communication unless documented in the health record separately
Telephone	<ul style="list-style-type: none"> • Patients and providers are very familiar with this modality • Can help mitigate potential inequity of virtual health access related to internet availability, digital literacy, and patient access to devices and internet • Can be effective when the provider and the patient have an established relationship and/or the visit is straightforward and for a simple request (e.g., ongoing prescription renewal, appointment reminder) 	<ul style="list-style-type: none"> • Engagement and building of relationships more difficult • No ability to visually assess patient nor cues of emotional state and understanding • Least appropriate for upsetting information or news as signals of empathy and support are more difficult

Virtual Health Solution	Benefits and Uses	Limitations
	<ul style="list-style-type: none"> • Can be a first conversation for triage to decide if a video or in-person visit is better suited • Can be effective for remote patient monitoring of blood glucose, weight, or other patient-reported symptoms for discussion • Can be helpful for reminders to increase compliance with appointments and medications • Can provide timely back-up in case of video visit failures • Can be effective when used in combination with video and in-person visits 	<ul style="list-style-type: none"> • Connecting the provider and patient at the same time may require an appointment

5 Guidance/Recommendations

The following guidance statements assume the understanding that the standard of care provided in virtual primary care should be no different than the standard of care provided in an in-person visit. All references to virtual primary care refer to clinically appropriate care that is safe, equitable, and person-centred. In this document, the use of the term ‘clinicians’ refers to ‘primary care clinicians’.

5.1 Planning Virtual Primary Care

A. Assessing Patient Population Needs and Virtual Service Capacity

- 1) Clinicians intending to deliver virtual care services assess which virtual services may benefit the patient population being served. This may vary among and within regions.
- 2) Clinicians determine their capacity (human resource, technical) to support virtual service delivery for each modality (secure messaging, e-mail, telephone, video, remote monitoring), and whether capacity could be reasonably strengthened to expand the range of modalities that can be used to offer virtual care services.

B. Assessing Primary Care Clinicians' Ability to Deliver Virtual Primary Care Services

- 1) In advance of offering virtual primary care services, clinicians assess their own competence and readiness to deliver virtual primary care.
- 2) Clinicians determine which virtual care services they are comfortable using to deliver virtual primary care; under which conditions; and using which modalities.

C. Determining the Virtual Care Offering

- 1) Those leading primary care organizations and primary care clinicians mutually decide, based on the assessment of the needs of the patient population and in consultation with patients where possible, the degree to which the practice setting can support virtual primary care and which virtual primary care modalities (e.g., e-mail, secure messaging, telephone, video) will be offered.
- 2) Clinicians decide which modalities will be used in their practice, considering any limitations for their use in the delivery of primary care.
- 3) Clinicians determine generally the approaches that may be taken if patient-related challenges to the use of virtual modalities exist or arise over time (e.g., if a patient experiences cognitive decline or loss of vision or hearing, which may influence the effective use of the modality).
- 4) Clinicians determine generally how they will approach circumstances in which a virtual care visit using a particular modality (secure messaging, e-mail, telephone, or video) either proves to be unsuitable to provide safe, efficient, quality care or does not work as intended at the time of use.

- 5) Clinicians determine how they will assess the degree to which their use of virtual care meets the needs of their patients and whether it is resulting in the intended outcomes.

D. Coordinating the Virtual Primary Care Offering Within the Practice

- 1) Clinicians communicate the intended offering to others within the practice and ensure others who are expected to support or participate in the virtual primary care offering are:
 - a. Informed about the offering and their role in supporting or participating in the offering
 - b. Have the necessary knowledge, skills, and ability to discharge their responsibilities
 - c. Primary care clinicians should periodically review their virtual care offering and update it as necessary (e.g., when a service may no longer be provided or when a new service may be made available) and communicate any updates to others within the practice.

E. Communicating the Virtual Primary Care Offering to Patients

- 1) Clinicians communicate to their patients which virtual care modalities they will use in their practice, considering any limitations that may preclude the delivery of primary care.
- 2) Any updates to the virtual care offering (e.g., if a service is no longer provided or if a new service may be made available) will be communicated to patients in a timely manner.

5.2 Assessing, Documenting, and Communicating a Patient’s Ability to Receive Virtual Primary Care Services

A. Assessing a Patient’s Ability to Receive Virtual Primary Care Services

- 1) Clinicians, with their patients/patients’ caregivers,¹¹ assess and periodically reassess:
 - a. Patients’ preferences for virtual care options that may be offered/available
 - b. Patients’ level of comfort in using the virtual care options

¹¹ Caregiver is defined as family members, friends, or other people not necessarily related to the patient but who provide support or care to the patient.

- c. Patients' level of competence in using the virtual care options
- d. Barriers/potential barriers to the successful use of virtual care (e.g., language, cognition, access to technology)
- e. Plan to accommodate the barriers/potential barriers (if possible)
- f. Back-up plan in case a virtual care option, if employed, fails

B. Documenting and Communicating Patients' Preference and Capacity to Receive Primary Virtual Care Services

- 1) Clinicians delivering virtual primary care ensure mechanisms are in place for documenting patient/caregiver preferences and their ability to effectively receive virtual primary care services.
- 2) Clinicians document patient/caregiver preferences and their ability to receive virtual care and communicate/ensure this information is accessible to others within the practice who may need to know their preferences (e.g., Medical Office Assistant, other members of the care team). The documentation should include any limitations or known risks in delivering virtual primary care services to patients/caregivers and any back-up plan that will be used in the event of a failure of the chosen modality.
- 3) Clinicians document and communicate any changes to patient/caregiver preferences and any changes in patients'/caregivers' ability to receive virtual primary care services following reassessment or when changes are observed that may affect the safe, effective use of virtual primary care.

5.3 Delivering Virtual Primary Care

A. Using Current Evidence

- 1) Clinicians keep current with the evolving nature of virtual care delivery and apply current evidence/leading practices to their virtual primary care practice.

B. Determining Use of Virtual Care Modality in Patient-Initiated Primary Care Encounters

- 1) Clinicians delivering virtual primary care services provide others interacting directly with patients with the necessary direction when screening requests for virtual primary care services. The choice of whether to offer virtual care and which modality to use should be made according to this direction and should consider:
 - a. Feasibility of use
 - b. Acceptability to both patient and provider
 - c. Whether the benefits of the virtual care choice outweigh the risks

Note: In the instance where an online system is used for booking or triage, the system should include a provision for incorporating this direction.

- 2) Clinicians who have delegated the authority to determine clinical appropriateness for use of virtual care to others, and who are made aware of uncertainty or conflict related to a clinical-appropriateness decision:
 - a. Consider which modality, if any, is feasible and allows for safe, quality care to be delivered
 - b. Provide direction to the delegate
- 3) Clinicians consider the scope of practice and which type of clinician may be best suited to address patient needs virtually when providing direction to those who may be determining whether and which virtual care modality should be used.
- 4) Clinicians consider whether the patient's request for virtual primary care is aligned with the patient's ability to receive virtual primary care services or whether any change/accommodation may be required to meet the request.
- 5) Clinicians consider whether the patient's choice of modality is consistent with the nature of the reason for contact (e.g., if it is anticipated that a diagnostic test or in-person physical assessment will be required to address the reason for contact, then the patient should be scheduled for an in-person appointment and/or make other arrangements for the diagnostic test).
- 6) Clinicians consider whether the patient's choice of modality is consistent with the level of urgency/timeliness required to address the reason for the request (e.g., if it is anticipated that the presenting complaint may need to be addressed urgently, redirecting the patient to a suitable venue may be required).

C. Determining Use of Virtual Care Modality in Practitioner-Initiated Virtual Care Encounters

- 1) Clinicians consider the following when determining the appropriate modality for a virtual care encounter:
 - a. Patients' and caregivers' stated and documented preference for virtual encounters and their choice of modality
 - b. Patients' and caregivers' ability to access a virtual care modality
 - c. Patients' and caregivers' capacity to effectively use a virtual care modality
 - d. The reason for initiating a patient contact, which may impact whether the modality will result in a positive patient outcome; for example:
 - i. Sensitive information is likely to elicit an emotional response that may impact the patient's ability to receive the information and be supported effectively
 - ii. Complex information is likely to have an impact on the patient/caregiver's ability to effectively receive and understand the information using a virtual channel
 - iii. Urgency of information may impact choice of modality (i.e., which modality is more timely)
 - iv. The need for a hands-on assessment/intervention that may not be otherwise accommodated

D. Documenting Virtual Primary Care Encounters

- 1) Clinicians ensure there is a way to document virtual primary care encounters. The documentation should be accessible to others within the practice setting as is necessary to arrange for and provide continuity of care and interdisciplinary care and to assess outcomes of the virtual primary care encounter.
- 2) Documentation of each virtual care encounter note the virtual modality used.

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7 Appendices

7.1 Process of Development

This document was developed by the Ontario Health Clinically Appropriate Use of Virtual Care – Primary Care Guidance Content Development Team. Parts of this document, including the target audience, concepts and recommendations were developed through the deliberations of and with the agreement of the Primary Care Expert Panel for the Clinically Appropriate Use of Virtual Care Guidance (see membership in ‘8.4 Acknowledgements’). The Primary Care Expert Panel met virtually on four occasions and participated in five on-line surveys between December 2021 and March 2022.

7.2 Stakeholder Engagement

Ontario Health conducted one or more meetings with the following groups during the development of the Clinically Appropriate Use of Virtual Care – Primary Care Guidance:

Alliance for Healthier Communities (AoHC)
Association of Family Health Teams Ontario (AFHTO)
Centre de Santes
Centre for Effective Practice
College of Physicians and Surgeons Ontario (CPSO)
French Language Service Planning Entities
Ontario College of Family Physicians (OCFP)
Ontario Health’s CEO Patient and Family Advisory Committee
Primary Care Collaborative (PCC)
Section on General and Family Practice -Ontario Medical Association (OMA)
Toronto Region Patient and Family Advisor’s Council

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7.4 Further Resources

Clinician Change Virtual Care Toolkit (Healthcare Excellence Canada/Canada Health Infoway) (2022) www.infoway-inforoute.ca/en/component/edocman/6378-clinician-change-virtual-care-toolkit/view-document?utm_source=website&utm_medium=hec&utm_campaign=change-management

Ontario Health Ontario Health (Ontario Telemedicine Network) (2020) [Training Centre](#)

Ontario Health (Digital Excellence in Health) (2021) [Virtual Visits Verification Program](#)
[Norme de vérification des visites virtuelles | Santé Ontario \(ontariohealth.ca\)](#)

Ontario Health (Ontario Palliative Care Network)(2021) [Leveraging Virtual Care to Support Palliative Care](#)
[Utilisation des soins virtuels à l'appui des soins palliatifs](#)

Patient assisted virtual assessment <https://link.cep.health/vc15> and <https://link.cep.health/vc17>