Clinically Appropriate Use of Virtual Care for Eating Disorders

Guidance Reference Document

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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.

About This Document

This document has been developed to help health care professionals make decisions about the use of virtual care modalities (i.e., telephone, videoconferencing) for people of all ages with eating disorders. This document aligns with the *Eating Disorders: Care for People of All Ages* quality standard and can be referenced in conjunction with the quality standard.[1]

This guidance is specific to decision-making regarding the delivery of virtual care for eating disorders. It supplements – rather than replaces – all related legislation, regulation, regulatory college practice standards, policies, government directives, and public health guidance.

This guidance may need to be adapted to address the unique needs of people receiving care, families, or caregivers, as well as those of organizations or other local conditions. Further updates may be released as research and clinical evidence develop and as Ontario's long-term strategy for virtual health care evolves.

Intended Audience

This guidance has been designed for health care professionals caring for people with eating disorders and related symptoms, including but not limited to dietitians, nurse practitioners, physicians, psychiatrists, psychologists, psychotherapists, and social workers.

It may also be applicable to others providing care, such as traditional care practitioners, healers, elders,[*] and peer support workers.

This guidance applies to all age groups.

Background and Rationale

Throughout the COVID-19 pandemic, the delivery of virtual care for eating disorders grew significantly and expanded the ways in which people receive and health care professionals deliver care. Despite the availability of high-quality evidence-based treatments for eating disorders, access to timely and appropriate care can be challenging across Ontario.[1] Reasons for this include the local availability of resources, the accessibility of various types of psychotherapy, and the varying degrees of family and caregiver support available to people with eating disorders.[1] Virtual care may improve access to care for those who face barriers in terms of geography, transportation costs, mobility, or the ability to take time away from work or school. Anecdotal reports from expert panel members suggest that the use of videoconferencing may also offer the benefit of allowing health care professionals to gain insight into a person's home environment.

[*]This guidance is intended to be used where relevant to the context in which care is provided. For the care of Indigenous peoples, additional considerations may need to be made to address relationality, spirituality, and self-determination.

The Ontario Ministry of Health has funded the development of guidance on clinical appropriateness to support health care professional decision-making about the use of virtual care modalities in eating disorder care, as guidance at the provincial level is lacking.

Guidance Development

The Guidance for the Clinically Appropriate Use of Virtual Care, Eating Disorders, Expert Panel ("expert panel") was established to inform the development of this guidance. The expert panel included both people with lived experience of eating disorders and health care professionals with experience providing care for people of all ages with eating disorders, as well as families and caregivers, in hospital and community settings.

The expert panel referred to available mental health–related data, evidence from the literature, and their own experiences to arrive at a consensus on the concepts and guidance statements included in this document. Members participated in 5 meetings and completed 5 post-meeting surveys.

Ontario Health conducted a literature review to better understand the role of virtual care for eating disorders, extracting data from peer-reviewed literature and grey literature. An Ontario Health senior research associate and members of the guidance content team reviewed titles and abstracts and worked together to decide which studies to include. In total, 36 outcome studies were included, including 19 randomized controlled trials.

The randomized controlled trials all reported that virtual care interventions (i.e., virtual psychotherapy including cognitive behavioural therapy [CBT], virtual guided self-help, and a self-monitoring smartphone application) were effective for improving aspects of patient experience, including access to care and patient satisfaction.[2] Positive outcomes included significant reductions in eating disorder symptoms,[3] overall change in eating disorder psychopathology,[4] acceptability by patients,[5] patient satisfaction, and ability to reach underserved individuals.[6] Further, virtual care interventions were associated with a higher degree of improvement in outcomes than waitlist or usual care (e.g., referral to counselling, assessment only).[3,4]

Key Concepts and Definitions

This guidance addresses the clinically appropriate use of virtual care for eating disorders and decision-making regarding the use of virtual versus in-person care. The literature offers several definitions of clinical appropriateness, but all highlight the importance of equity, evidence-based care, resource use, clinical expertise, and person-centeredness.[7]

Several regulatory colleges defer decision-making regarding the clinically appropriate use of virtual care to the judgment of health care professionals.[8] Factors that may influence the clinical appropriateness of virtual care for a person with an eating disorder include the person's access to technology and internet bandwidth and their digital health literacy, personal preference (and that of family members or caregivers as appropriate), perceived cultural safety of and comfort with the proposed virtual care modality, values (and those of family members or caregivers as appropriate), and access to local supports, as well as the clinical context.[9]

Clinically Appropriate Use of Virtual Care

The definition of *clinically appropriate use of virtual care* used in this guidance and agreed upon by the expert panel was adapted from the *Clinically Appropriate Use of Virtual Care in Primary Care* guidance reference document[8]:

> Clinically appropriate virtual eating disorder care is safe,[†] timely, inclusive, equitable, confidential, evidence-based,[‡] and person/family-centred.[§] It is provided within the scope of practice of the health care professional in a setting or using modalities that permit appropriate clinical assessment of the presenting condition and/or evidence-based treatment of the presenting condition.

Virtual Care

The definition of *virtual care* used in this guidance and agreed upon by the expert panel was adapted from the *Clinically Appropriate Use of Virtual Care in Primary Care* guidance reference document[8]:

> Virtual eating disorder care is defined as a clinical interaction between a person with an eating disorder (and family members or caregivers as appropriate) and member(s) of their health care team, occurring where the person with an eating disorder and/or member(s) of their health care team are not physically in the same location, using any form of communication or information technologies, with the aim of facilitating quality, access, and effectiveness of care.

The virtual care modalities included in this guidance are telephone and videoconferencing.

While other modalities (e.g., self-guided smartphone applications, secure messaging) exist and may be helpful adjunctive tools, these do not fall within the scope of this guidance.

Virtual Groups

It is acknowledged that virtual care may be delivered to a group of individuals; this is referred to as a "virtual group." Unique privacy considerations in this context may include the requirement for members to sign a group treatment confidentiality agreement, ensuring the privacy of each person's location, wearing headphones, ensuring that group members' computer screens or monitors face a

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[†] *Safe* refers to ensuring the safety of both the person receiving care and the health care professional during virtual care encounters by minimizing preventable harm, as well as ensuring that the virtual care provided is culturally safe and accessible for individuals from marginalized populations while meeting the necessary standards for safety, privacy, and security.[10]

[‡] "Evidence-based practice involves the conscientious, explicit and judicious use of the best available research evidence to inform each stage of clinical decision making and service delivery."[11] This requires that health care professionals pair their knowledge of the best available research with their clinical experience, data, and feedback gained from each person in the context of individual characteristics, cultural backgrounds, and preferences, with family members or caregivers being involved as required.[11]

[§] Person-centred care is an 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 caregivers and recognizes that a person often experiences the health care system with a support network.[8]

wall (to ensure the privacy of other group members), and the ability to remain stationary for the duration of each session.

Hybrid Models of Care

The use of both virtual care and in-person care, known as a "hybrid model of care," has been described in the literature.[12,13] The use of hybrid models of care may be particularly relevant in the context of providing care for people with eating disorders, given the need to address both medical and mental health care.[1,10] A study of pediatric eating disorder clinicians' perspectives on virtual care in Canada reported that 88% of participants expect videoconferencing to play a permanent role in the future of eating disorders care.[12]

Depending on the clinical context and the preferences of people with eating disorders, some aspects of care may require in-person visits while others may be facilitated virtually. For example, while certain aspects of a comprehensive mental and physical health assessment may require an in-person visit (e.g., laboratory tests), others may be completed virtually (e.g., family history).

With regard to preference, some people may be comfortable measuring their weight at home with health care professional support through videoconferencing, whereas others may not (see also p. 12, "Considerations for the Virtual Delivery of Cognitive Behavioural Therapy for Eating Disorders").

Further evidence is required to gain a more comprehensive understanding of the long-term role and successful implementation of virtual and hybrid models of eating disorders care.

General Considerations

Context and Considerations for Health Care Professionals

It is important for health care professionals to consider their competencies in delivering care virtually. Such competencies include the ability to establish a therapeutic relationship, deliver culturally safe care, technical skills, and awareness of how to deliver evidence-based interventions using virtual modalities.[14] It is also important for health care professionals to recognize the potential impacts of using technology on the therapeutic relationship, confidentiality, and the privacy and safety of the person with an eating disorder.[11]

Considerations for the Preferences, Needs, and Values of People With Eating Disorders

Each person with an eating disorder is unique, and people vary in terms of their understanding of the use of virtual care modalities, their access to them (and to in-person care options), their preferences in terms of their use, and their ability to effectively use them.[1,8] When determining a person's

suitability for virtual care, the health care professional considers and discusses with the person their clinical, psychosocial, socioeconomic, cultural, and social identity needs and preferences.[9,14] Asking about the person's values, preferences, and beliefs, as well as discussing and considering collaboration with community resources and, where appropriate, traditional care practitioners, healers, or elders may further support cultural safety and the therapeutic relationship.[9,14]

Figure 1 lists some of the potential benefits of virtual and in-person care modalities to consider when determining which modality may be best for a person with an eating disorder. Figure 2 lists some of the potential limitations or challenges of these modalities.

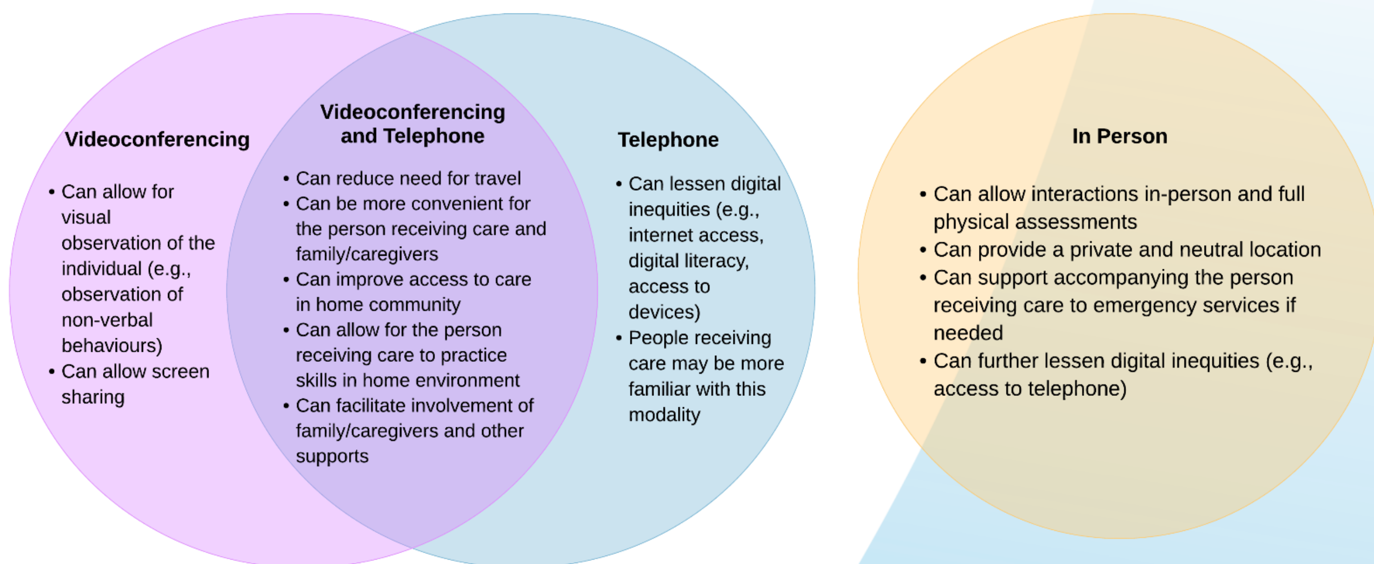

Figure 1. Potential Benefits of Virtual and In-Person Care Modalities

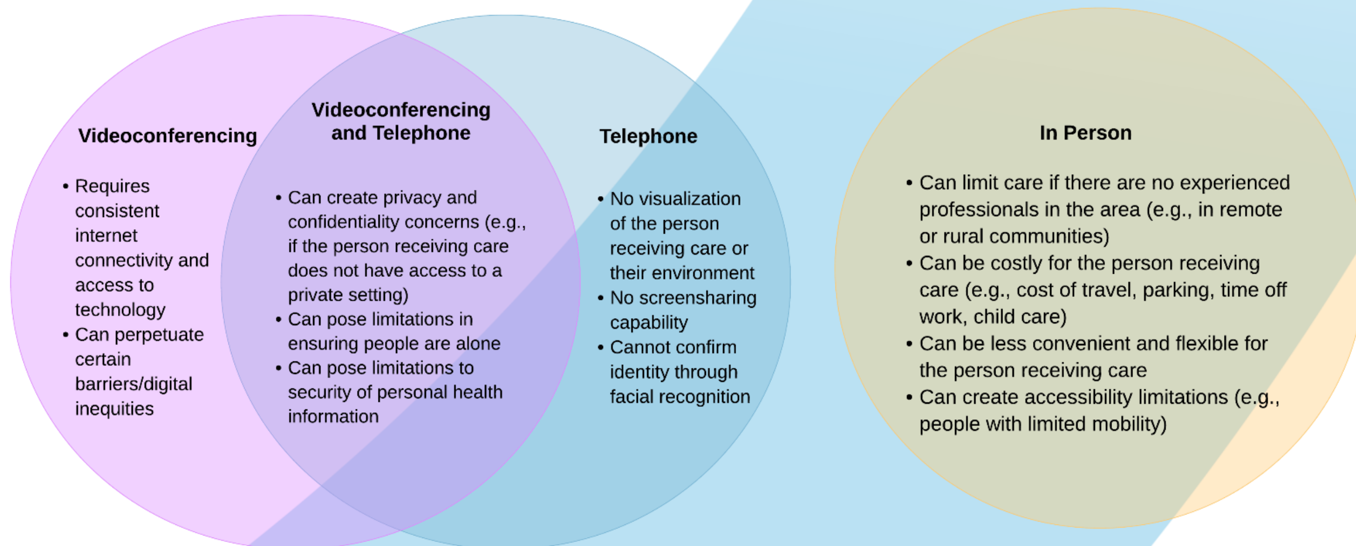

Figure 2. Potential Limitations or Challenges of Virtual and In-Person Care Modalities

Considerations for Indigenous Peoples

First Nations, Métis, and Inuit peoples and communities are distinct and constitutionally recognized in Canada, each with their own unique traditions, beliefs, cultural practices, political structures, languages, and histories. Delivering virtual eating disorders care to Indigenous, First Nations, Métis, Inuit, and urban Indigenous individuals requires an awareness of the unique strengths of these communities while also recognizing the cultural, historical, and constitutional contexts that affect Indigenous communities and individuals. Specific to eating disorders, this can involve discussing with the person with an eating disorder their definitions of health, wellness, and body image, as well as the cultural significance of food.[14,15]

It is acknowledged that there are many considerations when planning for and delivering virtual care to First Nations, Métis, Inuit, and urban Indigenous populations, including but not limited to the following:

- Connectivity and infrastructure challenges
- Cultural accessibility
- Cultural and religious beliefs
- Digital literacy and digital equity
- Experiences of systemic racism, discrimination, stereotypes, and prejudice
- Housing and safety
- Language and communication barriers (e.g., translation)
- Poverty, financial barriers, and other socioeconomic factors
- Privacy and confidentiality

Further evidence is required to better understand the gaps and needs of Indigenous peoples as they relate to seeking and accessing care for eating disorders.

Considerations for Equity, Diversity, and Inclusion

When planning for and delivering virtual care for eating disorders, many issues need to be considered for members of equity-deserving populations and populations typically underserviced in eating disorders treatment. This includes people who are Black or People of Colour, or members of other racialized populations; people who identify as 2-spirit, lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, or another sexual orientation or gender identity (2SLGBTQIA+); people living with disability; people with neurodiversity; older adults; and others.

Potential considerations to be mindful of include but are not limited to the following:

- Access to health care
- Age
- Cultural and religious influences

- Digital literacy and digital equity
- Education
- Experiences of systemic racism and other forms of discrimination
- Financial barriers, poverty, and other socioeconomic factors, including access to technology
- Housing and safety
- Internet connectivity
- Language (e.g., Francophone)
- Level of trust with health care professionals
- Personal assumptions and biases (e.g., weight biases)
- Privacy and confidentiality

Further evidence is required to better understand the gaps and needs of equity-deserving and underserviced populations as they relate to seeking and accessing care for eating disorders.

Potential Risks in a Virtual Context

A 2023 scoping review examined adverse events, risks, and mitigation strategies when delivering virtual mental health services.[16] The unique risks in a virtual context identified in this review included attrition, dropouts, and treatment adherence, as well as privacy and confidentiality. Risks may arise due to various factors, including "the health condition, the mental health care itself, or risks may be due to the modality (i.e., unique due to virtual care) or a combination of these."[16] The review concluded that virtual modalities are a safe way of providing mental health care, even for high-risk patients or clients.[16] While virtual care presents additional considerations for managing safety and potential risks, there is general alignment with what would typically be done for in-person care.[16]

Attrition, Dropouts, and Treatment Adherence

Attrition and dropouts have been cited as areas of concern in the delivery of virtual mental health care.[12] A study conducted in Ontario found that compared with in-person groups, videoconference groups for anxiety and related disorders had slightly higher rates of attendance in some cases, "with functional improvement and treatment dropout rates being comparable across the delivery formats."[17] Further, it has been suggested that virtual care may be more convenient than in-person care for certain people, which may improve adherence to the treatment program.[17]

Privacy and Confidentiality

Privacy and confidentiality are important considerations in the delivery of virtual care, including but not limited to ensuring that people receiving care have access to a safe and private location for their virtual care sessions. Measures to support privacy may include the use of headphones, password-protected devices, and a trusted internet connection. It is important to obtain consent and ensure that the health care professional and the person receiving care are aware of the risks to confidentiality that apply to the specific modality of virtual care being used, as risks may vary by modality.[18,19]

Potential Risks for People Receiving Care in a Virtual Context

Safety for people receiving care in a virtual context encompasses the objective of minimizing preventable harm to people receiving care and to health care professionals during virtual care encounters. It is also important that the virtual care offerings are culturally safe and accessible to individuals from marginalized populations while adhering to the required standards of safety, privacy, and security.[10]

An important component of both in-person and virtual eating disorders care is the appropriate assessment and management of the risks of self-harm behaviours and suicide.[16] When delivering care virtually, it may be necessary to ensure a plan is in place for how to proceed should technical issues arise. People with eating disorders are informed of situations in which local emergency authorities may need to be contacted.[14] Awareness of the location of the person with an eating disorder during a virtual care session can be beneficial for emergency planning if necessary. Familiarity with applicable laws and legislation (e.g., duty to call child protective services, when to call police) and the nearest local resources capable of managing emergencies or crisis situations (e.g., nursing station, emergency services, crisis lines, hospitals) are also important considerations.[20]

Medical Status

Virtual care for eating disorders can vary based on the unique circumstances of each person due to the differences in and complexities of eating disorders, including the potential for changes in medical status, the need for close physical monitoring, the presence of comorbid conditions, as well as individual preferences.[12] Where there are concerns about medical instability, depending on the clinical context, a hybrid model of care may be considered (e.g., virtual psychotherapy and in-person medical monitoring), whereas in other cases, it may be most appropriate to conduct all aspects of care in person.

Evidence-Based Psychotherapy in the Context of Virtual Care

The eating disorders quality standard outlines the importance of evidence-based psychotherapies for eating disorders and describes medical monitoring during psychotherapy as "an important part of care for people with eating disorders."[1] It is acknowledged that access to evidence-based psychotherapy in Ontario can be challenging due to the limited availability of programs offering such treatments, high demand, and extended waitlists, as well as the high cost associated with psychotherapy in the private sector.[1]

The following two sections provide an overview of the considerations that expert panel members deemed crucial to consider when delivering evidence-based treatment protocols virtually. It is important to note that the expert panel's discussion focused exclusively on cognitive behavioural therapy for eating disorders (CBT-ED) and family-based treatment (FBT) to align with the treatments identified in the eating disorders quality standard as current first-line treatments.[1]

Considerations for the Virtual Delivery of Cognitive Behavioural Therapy for Eating Disorders

- The preferences, values, perspectives, culture, and context of the person with an eating disorder (and those of their family members or caregivers as appropriate) are considered when making the choice of in-person or virtual care
- Virtual care can allow for the health care professional and the person with an eating disorder to collaboratively review self-monitoring records (e.g., via screen-sharing or secure messaging). However, if technical difficulties prevent this collaborative review, in-person care is encouraged
- Virtual care can allow for collaborative weighing (e.g., by the person with an eating disorder turning their camera toward the scale). The health care professional is encouraged to consider the clinical appropriateness, clinical context, potential barriers to access, and preferences of the person with an eating disorder related to collaborative weighing. The health care professional collaborates with the person receiving care to make a plan for virtual collaborative weighing that meets the persons needs.[21] If barriers to access or other challenges are identified (e.g., the person receiving care does not feel they can have a scale at home), the health care professional is encouraged to creatively problem-solve with the person receiving care or consider offering in-person care

Considerations for the Virtual Delivery of Family-Based Treatment

- The preferences, values, perspectives, culture, and context of the person with an eating disorder (and those of their family members or caregivers as appropriate) are considered when making the choice of in-person or virtual care
- Arrangements are made for the person with an eating disorder to meet with the health care professional individually in a private setting. In making this arrangement, issues such as the following are considered: the person's access to a private setting, environmental factors that could lead to distraction, and any history of abuse. Ensuring the family and home environment are experienced as safe for virtual encounters is essential throughout treatment sessions[20]
- Family members or caregivers can be encouraged to join sessions from the same device for the family portions of sessions
- For a child or adolescent with an eating disorder, parents or caregivers can assist with weighing the child or adolescent when deemed appropriate
- Parents or caregivers of a child or adolescent with an eating disorder are provided with education about the potential for and how to address weight falsification when taking weights at home[20]
- Videoconferencing for family-based meals may be a suitable component of virtual FBT and may help the health care professional better understand the context of the home environment

Other Psychotherapy Protocols

Other psychotherapy protocols for eating disorders exist but have varying levels of evidence supporting their efficacy.[1] For example, the eating disorders quality standard identifies interpersonal therapy (IPT) for adults with binge eating disorder while discussing the lower level of evidence of IPT for bulimia nervosa.[1] A recent study has offered preliminary evidence supporting the effectiveness of the virtual delivery of IPT and CBT for depression.[22] Additional protocols identified in the quality standard, with varying levels of evidence supporting their efficacy, include focal psychodynamic therapy (FPT), Maudsley Anorexia Nervosa Treatment (MANTRA), and specialist supportive clinical management (SSCM) for anorexia nervosa; IPT, integrative cognitive-affective therapy (ICAT), and schema therapy for bulimia nervosa; and brief strategic therapy, dialectical behaviour therapy (DBT), and schema therapy for binge eating disorder.[1]

Further evidence is needed on the use of virtual modalities in the delivery of other psychotherapy protocols for the treatment of eating disorders.[23]

Virtual Intensive Outpatient Treatment

Some preliminary research has been conducted on virtual intensive outpatient treatments for eating disorders.[18,19,23,24] While these studies provide early evidence that some intensive treatments can be effectively delivered virtually and may be viable alternatives to in-person treatment, further evidence is needed.

Assessing the Appropriateness of Virtual Care

The context of care may change over time, and ongoing reassessment of the appropriateness of virtual care may be required. Some changes that may prompt the need to adopt a hybrid or in-person care model may include the following:

- The severity of the illness increases such that a higher level of care is indicated
- Technical or other contextual challenges interfere with the ability to effectively provide care virtually
- Difficulties develop with the therapeutic alliance
- It becomes necessary for weights to be taken in the presence of a health care professional
- The preference for virtual care of the person with an eating disorder (or their family members or caregivers as appropriate) changes (e.g., they dislike or experience distress when receiving virtual care)
- Confidentiality or privacy risks exist
- Self-monitoring is no longer feasible
- Safety concerns indicate that virtual care is no longer appropriate

Guidance/Recommendations

The following guidance statements have been reviewed, discussed, and agreed upon by the expert panel and are current as of June 12, 2023.

These guidance statements assume the understanding that the standard of care provided in virtual care for eating disorders should be no different from that provided in in-person care.[25] All references to virtual care for eating disorders refer to clinically appropriate care that is safe, timely, inclusive, equitable, private, confidential, evidence-based, and person-centred, with family or caregiver involvement as appropriate.

1. Planning Virtual Care for Eating Disorders

A. Health Care Professional Knowledge and Ability

1. Before offering virtual care for eating disorders, the health care professional assesses their competence and readiness to deliver virtual care[9]

2. The health care professional keeps informed of emerging evidence as it relates to the virtual care modality being used or considered in their particular clinical context and with consideration of the potential benefits, limitations, and challenges of other care modalities, including both virtual and in-person

B. Considerations for the Preferences, Needs, and Values of People With Eating Disorders and for Their Families or Caregivers

1. When determining the suitability of virtual care for a person with an eating disorder, the health care professional considers the preferences, needs, and values of the person and discusses these with the person, as well as with their family or caregivers as appropriate

C. Considerations for When In-Person Care May Be Most Appropriate

1. Given the medical components of comprehensive assessments and the complications that can occur in eating disorders, virtual care is combined with in-person medical or physical assessments and follow-ups when indicated

2. When evaluating the medical stability of a person with an eating disorder, the physical assessment is done in person when possible

3. Where there are concerns about medical instability and/or safety, in-person medical monitoring may be most appropriate, and in-person treatment may also be most appropriate

D. Informing the Method of Care Delivery

1. The health care professional considers the clinical context, potential barriers to access, and the preferences of the person with an eating disorder (and those of their family members or caregivers as appropriate) when deciding whether to provide virtual or in-person care (see Figure 1)

2. For virtual care for eating disorders, videoconferencing is generally the recommended modality, especially for the initial visit or first assessment. However, telephone may also be an appropriate modality (e.g., if the person has limited internet access but is otherwise suitable for virtual care)

3. The health care professional is encouraged to assess the utility, feasibility, and effectiveness of virtual care for the person with an eating disorder in the context of comorbid physical, substance use, or other mental health conditions that may be present

4. Ongoing adherence to evidence-based care is essential, regardless of modality. If adherence to evidence-based care is not possible via virtual modalities, in-person care is considered

5. The health care professional discusses with the person with an eating disorder (and with their family members or caregivers as appropriate) privacy and confidentiality considerations as they pertain to the virtual modality being used and measures that can be employed to ensure privacy and confidentiality

6. When in-person care is considered to be the best care option but is not readily available or accessible (e.g., due to long waitlists), virtual care, if available and practical, may be an appropriate alternative to no care at all

2. Delivering Virtual Care for Eating Disorders

A. Ongoing Assessment and Management of Potential Risks

1. The health care professional regularly assesses and manages the potential safety, privacy, and confidentiality risks of providing virtual care to the best of their ability

2. Before initiating a virtual session, the health care professional and the person with an eating disorder discuss potential technical challenges and make a plan for how to proceed in the event of a session disruption

3. The health care professional is familiar with the emergency or crisis resources nearest to the person with an eating disorder, and the person is informed of the types of situations in which emergency authorities may need to be contacted

4. At the beginning of a virtual care session, the health care professional confirms the location of and emergency contact information for the person with an eating disorder

B. Ongoing Assessment of the Virtual Care Offering

1. As with the ongoing assessment of the appropriateness and effectiveness of in-person care, the health care professional assesses the degree to which the use of the virtual care offering meets the needs of the person with an eating disorder and whether this care is resulting in the intended outcomes, and the health care professional discusses this with the person

2. The health care professional discusses the virtual care modality with the person with an eating disorder over the course of the therapeutic relationship or care plan and addresses any changes in preference as appropriate, as preferences may change over time[8]

3. The health care professional is aware that the context of care may change over time and that such a change may prompt a reassessment of the appropriateness of virtual care

C. Documenting Virtual Care Encounters

1. The health care professional documents their virtual care encounters consistent with relevant legislation and practice standards

2. Documentation considerations in the context of virtual care may include referencing the technology used, the location of the person with an eating disorder during sessions, and discussions of privacy and confidentiality

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Partner Engagement

Ontario Health conducted one or more meetings with the following groups during the development of the Guidance for the Clinically Appropriate Use of Virtual Care, Eating Disorders:

- Addictions & Mental Health Ontario
- Canadian Mental Health Association, Ontario
- Eating Disorders Ontario
- Knowledge Institute for Child and Youth Mental Health and Addictions
- Youth Wellness Hubs Ontario

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Additional Resources

- Clinician Change Virtual Care Toolkit (Canada Health Infoway and Healthcare Excellence Canada, 2022)
- Culturally Safe Engagement: What Matters to Indigenous Patient Partners? Companion Guide (BC Patient Safety & Quality Council, 2022)
- Enhancing Equitable Access to Virtual Care in Canada: Principle-Based Recommendations for Equity (Government of Canada, 2021)
- Virtual Care Handbook for Residents and Faculty (University of Toronto Department of Psychiatry, 2021)
- Virtual Visits Verification Standard (Ontario Health, 2021)