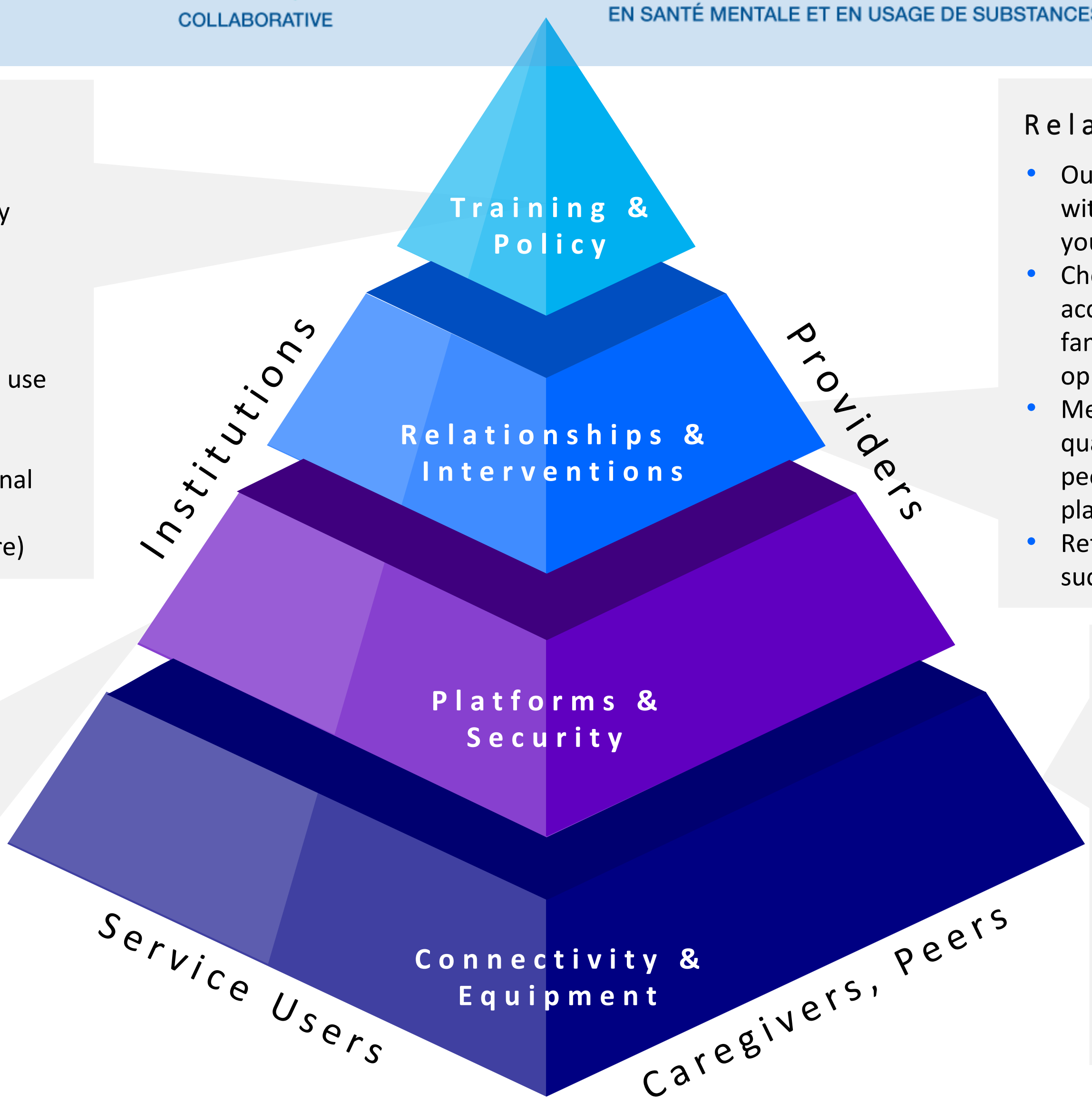
ONTARIO MENTAL HEALTH & ADDICTIONS
VIRTUAL CARE
COLLABORATIVE

REGROUPEMENT ONTARIEN POUR LES
SOINS VIRTUELS
EN SANTÉ MENTALE ET EN USAGE DE SUBSTANCES



Training & Policy

- Changes to remuneration need to be permanent to allow providers to bill for services delivered virtually
- Eligibility criteria for funding opportunities should enable capital expenses
- Ensure guidance and standards to inform ongoing virtual health care (e.g., privacy, confidentiality, informed consent, risk management, collection and use of sociodemographic data for evaluation of health equity goals, etc.)
- Mobilize provider training and continuing professional development (e.g., digital literacy, cultural safety & humility, accessible and person-centered virtual care)

Relationships & Interventions

- Outreach, check-ins, and active offer of virtual services with specific attention to priority populations (e.g. youth, disabled, parents, homeless)
- Check-ins with service users about needs related to accessing or using devices and/or platforms (e.g. enlist family, community partners for mentorship opportunities)
- Measurement of perception of care and continuous quality improvement with service user's input. Ensure people with diverse lived expertise are included in planning
- Referrals and partnerships to address structural issues such as housing, food security, etc.

Platforms & Security

- Usability considerations: platforms need to support language, various literacy levels, digital literacy, and barriers to accessibility
- Acceptability of platforms (cultural safety, cultural & generational norms, distrust in medical system and/or technology)
- Compliance with various accessibility and privacy legislations (AODA, WCAG, PHIPA & PIPEDA)
- Resources for IT/tech support
- Continuous engagement, evaluation with PWLE

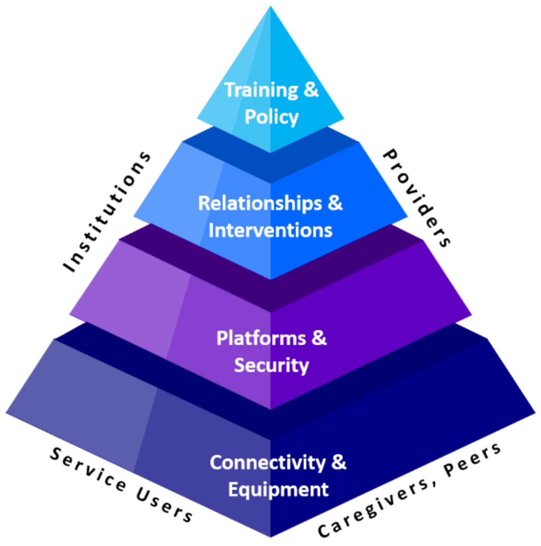
Connectivity & Equipment

- Lack of internet access (rural, remote, isolated)
- Low-quality, low speed, inconsistent/unreliable connection
- Affordability of available internet or cellular data
- Cost of devices and service plans to connect to phone or internet services
- Lack of privacy and/or confidentiality (e.g. lack of privacy in physical space, using shared device(s), using public wifi networks)

Culture-based evidence **Practice-based evidence** **Lived Experience** **Academic Evidence**

Virtual Care Equity Matrix: No One Is Left Behind

Origin & Purpose



The virtual care equity matrix highlights conditions necessary for every person to access high quality, timely, equitable and person-centred virtual care. The pyramid demonstrates a hierarchy of needs, where foundational conditions—such as having access to the internet and to a device that can connect to it—must be met before any of the other conditions of equitable virtual care can be met. The domains that form the tiers of the pyramid, however, are not completely distinct from one another and can overlap or intersect to limit or facilitate access.

The purpose of the matrix is to guide the work of the Ontario Mental Health and Addictions Virtual Care Collaborative, ensuring that health equity is centred. It was developed in consultation with the members of the collaborative's Equity and Lived Experience Working Group, and draws on the sources listed below.

Health Equity is defined as **"**the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically" (WHO). For example racialized communities, such as Indigenous and Black communities, experience avoidable poorer health outcomes due to continuing histories of racism and colonialism, including within medical systems. In a world where health equity was achieved, all communities are able to access the conditions and care they need to live their healthiest possible lives.

Domains

- **Connectivity and Equipment** is at the base of the pyramid, because whether communities and individuals have (ideally private) access to a telephone and/or to the internet and device to connect to it is the first condition that must be met to access virtual care.
- **Platforms and Security** centres the affordability, accessibility, and acceptability of virtual care platforms and whether they meet agencies', practitioners' and service users' diverse financial, digital literacy, language literacy, cultural, and dis/ability circumstances.
- **Relationships and Interventions** are key to supporting the accessibility and acceptability of virtual care; relationships built between providers and other staff at an agency and the people receiving services can help to ensure service users have what they need (equipment, digital literacy, translation services etc.) to access supports when in-person services are interrupted. Interventions must be adapted to fit virtual care, as well as the service user's cultural and social context.
- **Training and Policy** helps to support all of the other domains by making sure policies, both within agencies and at all government levels, support equitable, confidential, person-centred access to virtual care, and that practitioners have the skills needed to deliver such care.

Evidence

- **Culture-based** evidence is rooted in particular cultural contexts such as those of First Nations, Metis, and Inuit people or those of Black communities. Wisdom and traditions around mental, physical, and spiritual wellness have been understood, utilized, and passed down for millennia in Indigenous and other racialized communities. However, this knowledge has historically been, and often continues to be, marginalized within health care and medical science.
- **Lived experience** is evidence that comes from communities and individuals who have past and/or present experience as recipients of services in the mental health and addictions system and/or of social determinants of health inequity. Lived experience includes perspectives from members of the psychiatric survivor and Mad community, who may understand their experiences in ways other than the psychiatric model. Lived experience also refers to intersecting lived experiences of marginalization and discrimination such as racism, ableism, poverty, ageism, hetero and cissexism, anglocentrism etc. Communities such as immigrant communities, francophone communities, 2SLGBTQ+ communities, communities of houseless individuals, and disability communities, for example, have valuable knowledge to share based on these experiences. Lived experiences of caregivers and family members of people experiencing mental health and addictions challenges also falls under this category.
- **Academic evidence** refers to evidence collected through research and primarily disseminated through publication in peer-reviewed journals and books.
- **Practice-based evidence** is evidence from providers, based on their years of experience working in direct service mental health and addictions-related fields of practice. Practice-based evidence includes research conducted in a practice context by scientist clinicians, epidemiological studies, and some types of program evaluation and quality improvement processes.

The OVCC upholds the value of culture-based, practice-based and lived experience evidence, regardless of whether it is presented in traditionally-recognized evidence formats (such as academic literature) and the importance of giving equitable consideration to all the above forms of evidence.

Stakeholders

- **Service Users** are individuals who are seeking to access virtual mental health care services or who may do so in the future.
- **Caregivers and peers** are individuals in family and community who are providing care to each other outside of formalized institutional structures. They play an important role in helping to facilitate virtual care, especially in the context of the need for virtual care across the lifespan and across cultural and lived experience contexts.

- **Providers** refers to professionals providing mental health and addictions virtual care across a variety of settings such as hospitals, community mental health agencies, primary care clinics, community centres/service hubs, etc. Virtual care includes formal mental health treatment (e.g. psychotherapy) alongside other services supporting wellbeing (e.g. system navigation, recreation, peer support).

- **Institutions** refers to organizations and agencies providing virtual mental health and addictions services, and/or other supports related to improving the wellbeing of the communities they serve. This includes services that fall within or beyond traditional mental health services that are geared towards specific equity-seeking groups such as Black people, Indigenous people, francophones, immigrants, 2SLGBTQ+ people, disabled people, houseless people, Elders/seniors, youth etc.

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