



Transitioning to Remote Health & Wellness Services in Post-Secondary Settings: A Case Study Approach

Best Practices in Canadian Higher Ed: Making a positive impact on student mental health

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Introduction

The Best Practices Network in Canadian Higher Education (BP-Net) is a national mental health community of practice and knowledge exchange network. BP-Net works towards the development and promotion of practical program and evaluation toolkits to network members in the areas of health promotion, program and service delivery, and policy. The network focuses on informing emerging, promising, and best practices in campus mental health programming through support for practice-based evaluation projects, knowledge exchange, and Canadian-specific national benchmarking.

This project aims to support post-secondary Health & Wellness and Counselling Centres in their transition to providing remote health and wellbeing services to students. This guide is for health and mental health clinicians, healthcare administrators, and other stakeholders who have been transitioning their services from more traditional models of in-person care to the new virtual reality we find ourselves in during the COVID-19 pandemic. We report on the context of health and wellness service delivery models, prior to the pandemic, and how recent changes in service delivery positioned clinics for their new realities. This guide provides an overview of the implementation process of Health & Wellness/Counselling Clinics at five universities and their successes, challenges, and lessons learned. We offer recommendations and resources to support post-secondary clinics as they continue to navigate virtual care.

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Health & Wellness Services in Post-Secondary Settings: The Current Context

Over the past decade, post-secondary Health & Wellness and Counselling Centres have undergone rapid changes in their health promotion and service delivery models. Several institutions have been guided by the Post-Secondary Student Mental Health: Guide to a Systematic Approach by the Canadian Association of College and University Student Services (CACUSS) and the Canadian Mental Health Association (CMHA; 2013) and created institutional Mental Health Strategies and Frameworks (e.g., Best Practices in Canadian Higher Education, 2019) to guide policies, programming, and services on their campuses. Many post-secondary institutions have adopted a public health approach and have been actively creating “healthy campuses” to support students, staff and faculty in their health and wellbeing (e.g., Canadian Health Promoting Campuses, <https://healthpromotingcampuses.squarespace.com/>; Healthy Minds|Healthy Campuses BC, <https://healthycampuses.ca/>). In 2020, the Mental Health Commission of Canada and the Canadian Standards Association will be releasing the National Standard for Psychological Health and Safety for Post-Secondary Students to further support campuses towards a more unified approach for campus mental health (<https://www.mentalhealthcommission.ca/English/studentstandard>).

Health and Wellness services on campuses have undergone tremendous changes in their efforts to improve access and care for students. Several campuses have moved towards integrated medical and mental health service delivery models (e.g., Dalhousie University, 2017) and/or Stepped Care approaches to mental health services (e.g., Centre for Innovation in Campus Mental Health, 2019; Stepped Care 2.0). It is now common for clinics to offer quick triage and navigation services, walk-in or drop-in services, single-session counselling, peer support, collaborative care, and case management, as well as online health promotion and counselling services as ways to improve access to mental health supports on their campuses. These changes have necessitated strategic change management processes, communication plans, student co-design and consultation, and evaluation and assessment. In light of this, health and wellness/counselling services have become more agile, flexible, and nimble in their ability to adapt to the changing mental health needs of students as compared to decades prior, and with these changes, perhaps ably positioned to navigate the sudden impact of the COVID19 pandemic.

Post-Secondary Institutions and the COVID-19 Pandemic

On January 30, 2020, the World Health Organization declared COVID19 a public health emergency of international concern (www.who.int). Post-secondary institutions then began their pre-planning stages in order to manage the potential public health impacts on their campuses. As the pandemic spread to Canadian cities with rising incidences in March, campuses cancelled in-person classes and moved to virtual classrooms, modified academic requirements and policies, closed campus buildings, reduced student residences, and restricted their operations to critical or essential services. By March 16, Health and Wellness and Counselling Centres rapidly transitioned into virtual clinics.

Post-secondary clinics were faced with transitioning services to phone and video platforms while supporting both students and staff in their wellbeing. Managers were making decisions around selecting and implementing secure and confidential online platforms and identifying services that would maintain or be postponed or cancelled. Staff required equipment, virtual personal networks/remote connection to their electronic health record systems, tools and resources for working online, setting up home offices, with some staff managing childcare and the personal impact of the pandemic on their families. As provinces and cities initiate recovery activities, clinics are now facing another transition phase of service delivery where some in-person services may become re-initiated.

The following summarizes the implementation process of five post-secondary Health & Wellness or Counselling Centres:

1. Dalhousie University, Student Health & Wellness
2. McGill University, Student Wellness Hub
3. Queen's University, Student Wellness Services
4. University of British Columbia, Counselling Services
5. University of Toronto (St. George), Health & Wellness

All but one university had established an integrated health and mental health service delivery model, including an inter-professional practice team and a collaborative care model, prior to the pandemic. The University of British Columbia retained a separate mental health clinic. All services adopted a stepped care model for their mental health services.

Each service entered the pandemic at various stages of preparation and readiness but all quickly transitioned into virtual clinics and ensured service continuity using similar and different practices and resources. The Universities increased online and phone capabilities while keeping student and staff safety in mind. While the implementation timeline was generally within a two-week timeframe, the directives to move to remote delivery followed public health and university senior administrative directives.

The following sections outline the common themes and differences, along with recommendations for post-secondary institutions transitioning to remote service delivery. Detailed reports of their individual implementation processes are provided in Appendix A.

Service Delivery Models

All universities reduced in-person supports, with only Dalhousie, Queens and the University of Toronto offering partial in-person appointments, especially for physical health. As summarized in Table 1, all universities increased remote services for students via phone and online tools, with Zoom and Therapy Assistance Online (Zoom TAO) as the most popular options used for one-one-one appointments, group sessions and psychoeducational programming. Queens, McGill, and the University of Toronto are also leveraging social media platforms such as Facebook Live, Instagram, and Twitter for health promotion activities and events.

Table 1: Web-based Tools In Use Post-COVID

	Dalhousie University	McGill University	Queens University	University of British Columbia	University of Toronto
Individual visits medical	Zoom for Healthcare		OTN, Facetime, Zoom	Input Health Zoom	Medeo
Individual visits mental health	Zoom (via TAO)	Therapy Assistance Online (TAO), MS Teams	Zoom (via TAO), MS TEAMS, eCBT, TAO activities and mindfulness library	TAO, Zoom, Skype for Business	Medeo, OTN (psychiatry)
Health promotion events/ activities	Zoom, Brightspace/ Collaborate	Facebook Live, Cisco WebEx	Instagram, Facebook, Twitter, Zoom	Zoom, Canvas, Collaborate Ultra	Instagram, Facebook, Twitter, MS Teams
Psychoeducational workshops	Zoom, Brightspace/ Collaborate	TAO	Zoom	Zoom, Canvas, Collaborate Ultra	MS Teams
Psychotherapeutic groups	Zoom (via TAO)	TAO	Zoom (via TAO)	TAO Zoom	Considering MS Teams or

Virtual Platforms During COVID-19

Telephone was the most popular modality for booking appointments and scheduling directly with a clinician for follow-ups (see Table 2). Video was slower to be implemented, with some reporting increased usage over time. Online booking is available for Dalhousie and University of Toronto students, while Queens offered in-person and email options for booking appointments. Phone and video conferencing appointment options were available for students based on their preference.

The most common intake/triage option was by telephone. Video and phone options were available for the University of Toronto students and in-person for Queen’s students.

Implementation

The University of British Columbia implemented a phased-in approach to remote working, as well as flexible scheduling to help staff manage the pace of change. To learn more, see page 38.

Triage

Queen’s University used a triage/crisis approach to manage high-risk. To learn more about their risk management strategies, see page 31.

Table 2: Appointment Bookings and Triage/Intake

	Dalhousie University	McGill University	Queens University	University of British Columbia	University of Toronto
Booking appointments	Online and phone as per usual.	Phone for physical and mental health. Webform for Local Wellness Advisor appointments.	Phone, in-person, email	All new appointment bookings are done over the phone by administrative staff. Counsellor in Residence uses on-line booking (Input Health)	Online (medical) and phone managed by administrative staff.
Follow-ups	Scheduled as per usual	Directly with clinician at the end of the session.	Request from provider, or directly by provider. For crisis management, we also perform unscheduled phone “check-in” follow-ups.	Offered either by phone or video (client preference).	Phone, video, minimal in person for medical, as agreed upon by the student and clinician.
Triage/Intake	Via Same-day Counselling appointments as per usual.	Triage by phone for medical questions with nurse same-day. Intake	Phone, in person	Triage appointments are conducted by phone.	Intakes are booked by administrative staff, with video sessions the preferred

	paperwork completed by the student in-session with their clinician.	format, or by phone (usually by student preference or need).
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Obtaining informed consent from students and data security of confidential student information are common concerns for post-secondary institutions, especially in a new remote setting. The addition of reviewing risks with virtual care and ensuring privacy during visits, by necessity, were added to informed consent protocols. Table 3 summarizes informed consent and record-keeping practices during the pandemic. The most common practice for obtaining consent is verbal confirmation with students at the beginning of the session and documented in a secure fashion by a clinician or administrative staff member. Students can view documents in advance via email, OneDrive or other secure platforms. The University of British Columbia provides students with the option to complete the informed consent forms via a secure URL in Titanium and the University of Toronto provides and retrieves signed service agreements and consents via email. Remote access to existing electronic health/mental health record systems were set up during the pandemic.

Table 3: Informed Consent and Record-Keeping Practices During COVID-19

	Dalhousie University	McGill University	Queens University	University of British Columbia	University of Toronto
Informed consent	Consent verbally confirmed and documented by clinician.	Consent verbally confirmed and documented by clinician. Documents shared via secure platform prior to appointment.	Consent verbally confirmed and documented by front-line staff at booking for nurse, physician and psychiatrist appointments. Electronic confirmation for mental health appointments. Documents sent by email, sent back via OneDrive for remote sessions. In addition to the standard consent form, a distance consent form for the mental health services was added.	Completed online by student via secure web-based access to data forms. If not completed online prior to appointment, forms are completed verbally over the phone with clinician	Consent verbally confirmed and documented by clinician via OTN and Medeo. Service agreement and consent forms are sent and returned by U of T email.
Record-keeping / EMR	With ACCURO EHR as per usual	As per usual, electronic medical record-keeping with enhanced remote login	Remote access to Oscar via secure VPN. Record keeping and communication via EMR remained consistent.	Remote access to electronic record system (Titanium) via secure VPN.	Remote connection to ACCURO EMR as per usual.

With increased stress, anxiety, and coping with loss and/or uncertainty during the pandemic, vulnerable student populations are of increased concern among post-secondary health and mental health services/ clinics. All participating universities adapted their crisis management protocols to the new virtual reality, with some connecting students to available community and public health resources for higher risk cases.

Collaborative Care

The University of Toronto initiated virtual case conferences (via OTN or MS Teams) for multiple providers to consult on their shared student when clinical risk and acuity became a concern. This method was also used for urgent visits when a psychiatrist and other care providers met with a high-risk student. To learn more, see page 49.

Table 4: Crisis Management Practices During COVID-19

	Dalhousie University	McGill University	Queens University	University of British Columbia	University of Toronto
Crisis management	Assessed as per usual and partner with Mental Health Mobile Crisis Team and via 911	Emergency protocols are in place to ensure that students requiring higher levels of care receive the support needed. Crisis management is a shared responsibility among all clinicians.	Crisis management mostly remotely, with some in-person care offered when needed. Several players are involved (triage, crisis counsellor, counselling director, student of concern committee). Consultation with physicians and psychiatry available.	Crisis management services are limited to moderate risk assessment and intervention, conducted by phone or video. Students with high risk are referred for in-person care at the Access and Assessment Centre (AAC) or local hospital emergency department.	Crisis situations are managed via phone or video and the CCT or psychiatry becomes involved live, as needed. Clinical situations that approach this threshold could result in a joint session of two or more clinicians and one student via OTN or MS Teams.

For health promotion activities and lower intensity service options, the universities were at varying stages of development, with some transitioning pre-existing programming to online versions, as well as creating new content to support students during the pandemic. Dalhousie University created an online “Puppy Hour” and an “Ask the Nurse” offering. Queen’s University is

Virtual wellness programming

Dalhousie University has hosted several virtual wellness webinars to targeted groups that have attracted approximately 50 participants each. To learn more, see page 19.

offering virtual healthy lifestyle appointments and is creating new content around customized self-care plans and responding to students in distress while physical distancing for students, staff, faculty and alumni. The University of Toronto offered online versions of a 5 Ways 2 Wellness workshop delivered by their health promotions team and embedded counsellors, where content was adapted to their learning communities. McGill University created a series of online options with several offerings related to the COVID context.

Building resiliency through remote programming

McGill launched a suite of resilience-building remote programming adapted to the current unprecedented reality to provide students and staff with tools, support and foster a sense of community through various therapeutic modalities including mindfulness meditation, creative arts and many more. This includes a COVID-19 support group, the ArtHiveLive and ZenInTen to name a few. For a complete list visit <https://www.mcgill.ca/wellness-hub/>

Metrics

Staff mobilized across the service centres to support students during the pandemic. Despite the challenges, students and staff responded favorably to the changes. Students often reported gratitude for the services provided.

Table 5 provides a summary of the metrics collected by participating universities. Usage statistics and wait times were the most common metrics, whereas data security concerns temporarily prevented collection of outcome data for remote services.

Table 5: Metrics

	Dalhousie University	McGill University	Queens University	University of British Columbia	University of Toronto
Usage statistics	✓	✓	✓	✓	✓
Wait times	✓	✓	✓		✓
No-show statistics	✓	✓	✓		✓
Demographics		✓		✓	✓
Presenting issues				✓	✓
Satisfaction		✓	✓	✓	On-hold
Outcome measures	Suspended CCAPS during pandemic (to reintroduce shortly)	CCAPS	PHQ9/GAD7 (secure transfer of documents or verbal administration by medical staff for physician mental health appointments)	ORS PHQ9	PHQ9/ GAD7 (verbal administration by medical staff for mental health appointments) OQ-45 (On-hold)
Referral data				✓	✓

Implementation Challenges

With little time to implement the shift to virtual care, participating university health and mental health service providers rose to the challenge. However, all universities experienced challenges, to various extents, with respect to the following:

1. **Providing care outside of province:** All universities grappled with offering continuing clinical services for students who returned home to other provinces. While some mental health professional colleges have allowed for out-of-province health providers to practice in their jurisdiction, these permissions are temporary and inconsistencies exist across provinces. For medical care, physicians continued to care for these students, but were unclear as to whether they were able to bill for appointments provided to students out-of-province. For mental health care, several universities worked with external resources for counselling options, such as Keep.Me.Safe (McGill University), Empower Me (Queen's University), My Student Support Program (MySSP; University of Toronto). In addition, McGill University adopted Maple, an online platform for remote medical appointments. As academic courses remain remote and will likely continue that way into the next academic year, this issue of how to support these students' medical needs will remain a central issue, as they will likely be paying student fees and expect a certain degree of service while studying from home.
2. **Risk management:** Managing clinical risk situations proved to be challenging across the board and was approached in different ways at the various universities. Students who present with issues of self-harm and suicidal ideation or behaviours are challenging to manage in the best of times and typically require a team approach. As the university clinics went remote, the concern about keeping the most vulnerable students safe grew, with an understanding that isolation and lack of normalcy in daily life could worsen their stability. Various approaches were taken (i.e., establishment of triage system, on-site crisis support, remote crisis support, inter-professional collaboration) to ensure safety.
3. **Staff Support and Training:** This a multifaceted category. Reports from the case studies revealed many commonalities. All reported the need for regular staff check-ins and challenges with setting up for a virtual work from home environment (both from an ergonomic as well as a child-care perspective). Several offered staff training on the use of new technological tools. Practitioners reported high fatigue levels resulting from offering remote care due to challenges reading subtle client cues on video platform, increased screen time, and increased compassion fatigue. For those with on-site support, managing rotating staff schedules also presented challenges.
4. **Messaging to students:** While the clinics went virtual within a short turnaround window, students were unsure about whether they would receive ongoing access, how to access, and what services remained available. Multiple forms of communication were executed within the different university sites such as updating websites, mass emailing, social media, and university newsletters. Basically, all university communication channels were employed.
5. **Secure online platforms:** Considerable effort was devoted to ensuring that web-based video platforms were compliant with personal health information standards (including maintaining Canadian servers). Some universities struggled to identify the best online platform for video conferencing, with most adopting a system external to their electronic health records. Some limitations of these platforms include an inability for more than one clinician to join a clinical visit (particularly important for urgent visits), limited number of on-screen person displays for workshops and groups, limitations with screen share, document transfer, whiteboard, etc. capabilities, and limited group therapy options that were compliant with privacy legislation or university standards. Also, some universities were able to secure online platforms at no-cost during the pandemic but will incur costs at a later date.

Lessons Learned

The rapid shift to virtual clinics was not without lessons learned. At the forefront are issues of planning, flexibility and resilience, acceptance, strong communication, and inter-institution collaboration.

1. **Planning helps:** It became clear that any advanced planning and change management, including the development of a framework for working remotely was extremely valuable. McGill University set a solid

example of this, with planning for going remote starting in January 2020. They planned for contingencies, arranged for remote access to EMR weeks before it was required, consulted legal and IT regarding data security, reconfigured their websites and trained their staff in preparation for remote work. This preparedness made for a smooth transition.

2. **Strong teams:** We learned that even without a plan, things can happen very quickly when needed, almost as if healthcare workers are wired to ensure seamless care. Despite a lack of preparedness in some institutions, the necessary steps were taken at a rapid pace, with a similar end result. All levels of staff, from managers, to health care providers, to administrative assistants and receptionists demonstrated flexibility and were accepting of change. Collectively, and without initial coordination between universities, most followed similar steps and successfully transitioned to virtual services within days, highlighting the resilience and commitment of health centre staff.
3. **Student and staff openness:** We have learned that students and staff are accepting of virtual care. We are now asking the question as to whether this is sustainable in the long run, as there is a general sense that some changes will last long beyond the days of the pandemic. We have yet to learn how the changes in care delivery will take its toll on staff and students in the long run or the gains that will come from this experience.
4. **Strong communication:** In a rapid changing landscape, frequent communication with the health care team is critical. Regular meetings via video platform, daily email updates, and the use of communication tools (such as MS Teams) proved central to the success of the transition to virtual in the institutions polled.
5. **Inter-institution collaboration is incredibly valuable:** Once the transitions to virtual clinics were underway, sharing and collaborations amongst colleagues from other institutions proved to be very helpful (i.e., via listservs). Those who were more advanced in developing forms, communications to students, determination of methods of service delivery, etc., were able to support those less advanced. Also, it provided a safe forum to support one another through this ongoing time of uncertainty and challenges. Moving forward, these collaborations will allow for a best practices approach to unfold.

Recommendations

As a collective, the universities recommend the following promising practices for the delivery of virtual services:

1. **Technology:** An integrated electronic health record system that supports video conferencing (allowing more than one clinician if possible) and secure file transfer would be ideal. Consider a voice-over IP (VOIP) system for clinic reception, so that your reception team can continue to function like a virtual “call centre”.
2. **Business Continuity Planning:** Having a pre-established disaster recovery plan in place that is reviewed annually will facilitate smoother transitions to virtual care. This plan should include implementation steps, IT resources and supports, privacy and confidentiality policies, human resource planning and supports, and strategic communication plans.
3. **Staff Training and Ongoing Support:** Create a systematic communication plan for staff to remain up-to-date with day-to-day and fluid changes in service delivery and clinical administrative procedures, online resources and supports, regular team meetings through the transition, and continuity of regular team events. Ensure compliance with institutional human resource guidelines.
4. **Creativity:** Embrace the current context, seek new opportunities, and re-imagine new workflows and new services and programming.
5. **Teletherapy Literature:** Review current literature and research on mental health impacts of COVID19, telemedicine and teletherapy to identify promising and best practices.

Next Steps

All institutions are envisioning a Fall start that will retain remote service to students, with contingencies built in for in-person contact as restrictions lift. Planning is underway to ensure the safety of staff and students while

maximizing access to the stepped-care service options available. Due to the current lack of clarity and firm decisions from the public health departments and our institutions, detailed planning of our services has not yet crystalized.

Conclusion

In conclusion, there was remarkable commonality across the five institutions. The universities, independently, yet in tandem, were motivated by the same factors: to support our students and to ensure continuity of care. All institutions quickly implemented a significant service delivery shift, were successful in doing so, and identified similar outstanding challenges. These implementation stories are not unique. Similar themes were evident through consultations and informal conversations with other colleagues across provinces and reflects well on our sector and on the significant effort that we all contributed to the shift in context. As institutions think about next steps, most are considering a hybrid model of virtual and in-person services that have the potential to minimize barriers significantly increase access to care.

Additional Resources

Best Practices in Canadian Higher Ed: COVID-19 Resources

BP-Net has collated resources on the provision of virtual care, resources and support for clients and healthcare workers, legislation updates for healthcare professionals, online teaching resources, research literature, and research grant opportunities. Updates include resources for recovery phases.

<https://bp-net.ca/covid-19-resources/>

Guidelines for Telehealth

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Post-Secondary COVID-19 Resources

Dalhousie University Resources

<https://www.dal.ca/novel-coronavirus.html>

https://www.dal.ca/campus_life.html

https://www.dal.ca/campus_life/health-and-wellness.html

https://www.dal.ca/campus_life/health-and-wellness/services-support/student-health-and-wellness/make-an-appointment.html

McGill University Resources

<https://www.mcgill.ca/wellness-hub/about>

<https://www.mcgill.ca/studentsservices/closure-services>

<https://www.mcgill.ca/studentsservices/health-wellness>

<https://www.mcgill.ca/wellness-hub/access-care/access-virtual-services>

Queen's University Resources

<https://www.queensu.ca/covidinfo/home>

<https://www.queensu.ca/studentaffairs/covid-19>

<https://www.queensu.ca/studentwellness/home>

University of British Columbia Resources

<https://covid19.ubc.ca/>

<https://students.ubc.ca/covid19>

<https://students.ubc.ca/health/counselling-services>

<https://students.ubc.ca/covid19>

University of Toronto Resources (St. George)

<https://www.utoronto.ca/message-from-the-university-regarding-the-coronavirus>

<https://www.viceprovoststudents.utoronto.ca/covid-19/>

<https://studentlife.utoronto.ca/covid-19-updates/>

<https://studentlife.utoronto.ca/department/health-wellness/>

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Appendix A: Case Studies



Dalhousie University Student Health and Wellness

Dalhousie University, Student Health and Wellness

Contact: David Pilon, david.pilon@dal.ca

Dalhousie Student Health & Wellness (SHW) is a unit within Student Affairs that collaborates with faculty, staff and students to enhance the student experience. Student Health & Wellness is committed to providing quality primary and mental healthcare and services to promote and enhance students' good health and wellbeing. Our services are easily accessible and geared toward the unique health needs and concerns of students. The Centre's interprofessional health team include Physicians, Psychologists, Psychiatrists, Social Workers, Registered Counselling Therapists, Nurses and administrative staff. Our collaborative care model is enhanced through a shared electronic health record system in which all client records are held in a single database. We also offer a variety of health promotion activities that further contribute to the health and wellbeing of our university community.

Implementation

On March 13/20, Dalhousie President, Dr. Deep Saini announced that in-person classes were suspended, students were encouraged to leave residences if they were able to and that non-essential university-sanctioned events were to be cancelled. In less than a week, SHW transitioned services to remote telehealth, for all activities, with the exception of essential and urgent medical appointments. SHW suspended therapy groups initially, but have since identified plans to resume those. These SHW changes were broadly promoted via all university communication channels. SHW sought guidance from relevant colleagues, listservs, and the literature with respect to telehealth guidelines, patient and staff safety and security/privacy issues.

To ensure patient and staff safety within the Centre for those remaining on site, a number of protocols were put in place. These included locking the doors to the Centre to avoid walk-ins, screening calls being made in advance to all scheduled in-person appointments, spacing of chairs in the waiting room, physical distancing signage and plexiglass added at reception, a designated location and recordkeeping for PPE and review of how to appropriately don and doff as well as working with Facilities Management staff to ensure adequate cleaning schedules were maintained within the Centre.

The university was very supportive of staff working from home and having the requisite supports to do so. Staff with childcare issues were accommodated as needed (i.e., were supported if not able to work in existing duties). Specific training was not initiated for staff, but plenty of team discussion and sharing of resources was available. The most troublesome issue to coordinate involved licensure issues and permissions for counselling and psychological services staff to be working with clients in provinces where they are not presently licensed. It took some time to clarify the regulatory landscape changes for our providers from Psychology, Social Work and Counselling. There were also distinctions for some regulatory colleges with respect to existing versus new clients/patients. The implementation process was otherwise quite efficient. Necessity is the mother of invention!

Student Health and Wellness staff had significant involvement with planning and implementing protocols for students living in residence who were required to self-isolate, including documentation of daily check in calls by a nurse and providing students who were self-isolating with health and safety information, a supply of masks and information about mental health resources available to support them.

Technology

Initially, we offered services via telephone only until we could confirm the privacy protocols and requisite training for a video platform. The video platform ultimately used was Zoom for Healthcare within Therapy Assistance Online (TAO) for individual and group counselling and psychological services and Zoom for Healthcare for medical and

nursing services (as primary care services in Nova Scotia were provided the video platform by the Nova Scotia Health Authority). Students are given the choice between telephone or video counselling sessions for individual visits. Presently, partial in-person support is available only for medical services, while partial phone and video conferencing support is available for both medical and mental health support. Zoom, Brightspace/Collaborate and MS Teams are being utilized for health promotion events/activities and psychoeducational webinar workshops.

Clinical and Health Promotion Services

SHW continued all services, but transitioned to telehealth, with staff working mostly from home and reduced hours for essential in-person staff. Therapy groups were initially suspended but are just beginning to resume. In addition to regular telehealth appointments, our Social Worker is offering a weekly drop-in session and one of our psychologists is offering Puppy Power Hour via Brightspace/Collaborate. In-person visits continue to be offered for essential and urgent medical and nursing services. Our Ask a Nurse program has seen a steady increase in the online submission of questions from students. We have hosted several virtual webinars on coping with uncertainty, self-care, supporting others, etc. to targeted groups that have been well-received with approximately 50 participants each. Various other health promotion activities are being initiated including the delivery of The Inquiring Mind – Posts-secondary and embedding mental health literacy within spring and summer orientation programs.

Summary of Clinical Services and Modality

Service	Modality
Booking appointments	Online and telephone as per usual.
Triage/Intake	Via Same-day Counselling appointments as per usual.
Informed consent	Verbal and documented.
Clinical sessions with existing clients	Via telephone or Zoom for Healthcare (within Tao).
Clinical sessions with new clients	Via telephone or Zoom for Healthcare (within Tao) when allowed via provincial licensure for providers.
Crisis management	Assessed as per usual and partnering with Mental Health Mobile Crisis Team and via 911.
Record-keeping / EMR	With ACCURO EHR as per usual.
Follow-ups	Scheduled as per usual.

Outcomes

Student and Staff Feedback

Students have been quite appreciative that SHW has continued services. It seems many students expected that services might not be provided during the pandemic. With respect to telehealth, a surprising number of students have preferred phone to video platform. Some students have asked if the clinic might be able to maintain telehealth when they are back on campus. Most staff are pleased that SHW have continued to support our students and feel that the University is supporting them to do their ongoing work remotely.

Challenges

With respect to challenges during the transition to virtual care, it was important to ensure that students were aware that we continued to deliver all of our quality clinical services. Frequent communication and support of staff working remotely from home was essential. As staff used personal telephones (cell and landline), we identified a process of reimbursement for the additional charges incurred. Licensure issues for cross-jurisdictional telehealth continue to be a challenge.

Metrics

For treatment outcomes, SHW has suspended using the Counseling Center Assessment of Psychological Symptoms (CCAPS) during the pandemic but will be reintroducing it. As always, we monitor our volumes, utilization, call records, wait times, no-show rates, etc.

Lessons Learned

What might have taken tremendous effort and a two-year implementation plan with a deep dive into the literature was achieved within a week by necessity! Go Team Go!

Future Planning

On May 20/20, Dalhousie announced that teaching would be predominantly online for the Fall 2020 term. SHW is anticipating that our services will continue in a virtual environment and we have planned for this scenario.



McGill University Student Wellness Hub

McGill University, Student Wellness Hub

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The Student Wellness Hub's goal is to provide students with the right services at the right time. The Hub provides both mental and physical health services in an integrated, client-centered fashion, through a hub-and-spoke model with services offered by nurses, counsellors, psychologists, access advisors, local wellness advisors, dieticians, psychiatrists and family physicians.

The Hub's service delivery paradigm is a Collaborative Care Model that is based on Stepped Care. The Hub's mandate is to provide short-term, solution-focused episodic care, emphasizing awareness, prevention and early intervention with connections to community resources for longer-term care if needed. Anchored to the Hub, a network of [local] wellness advisors be embedded in Faculties and in other student-oriented units across campus to further enable student access to support and care.

Furthermore, the Hub's services are guided by a Service Excellence Framework which promotes best practices specifically for the following five standards or pillars of care: 1) Caring, Compassion and Inclusivity, 2) Teamwork, 3) Privacy and Confidentiality, 4) Effective Communication and 5) Maintaining Constructive Dialogue.

Implementation

McGill University's Student Wellness Hub was launched in July 2019, less than one year ago. The implementation science paradigm had brought Hub staff together and had prepared them for the Hub's original launch. This same rigorous process of launching the Hub also prepared staff for the unprecedented changes brought upon by COVID-19 and created a foundation for Hub staff to be able to smoothly transition to virtual service offerings when the call to action was announced.

The Hub's preparatory activities for going virtual started early. As early as January 2020, the Hub was deeply involved in the preparedness planning for the University. This was an important ingredient and set the stage for quick adaptations once the call to action – the University closure - was announced by Quebec's provincial government. More specifically, in order to be prepared in the event of a COVID-19 pandemic, the Hub had developed a thorough pandemic preparedness plan identifying how the unit would continue to operate during the various probable stages of a pandemic. This included emergency preparedness plans where plans to assist students in crisis were developed.

The Quebec government announced the University closure on Friday, March 13, 2020. By March 19th the Hub was virtual in a limited capacity. The week of March 23, the Hub was virtual with many of its services including several well-attended live virtual workshops.

The plan included the following:

1. **Planning Assumptions:** As a first step, planning assumptions were identified. These were hypotheses based on expected outcomes and included items such as decreases in staffing due to reasons such as public health needs (e.g. Family Doctors getting pulled into the public healthcare system); increased employee absenteeism due to illness, childcare needs; decreases in personal protective equipment, etc.
2. **Emergency Access to Information and Systems:** As a preparatory step, a few weeks before going virtual, remote access to workstations was granted to all clinical staff and existing portable devices were re-

purposed to ensure continuity of care if remote work would be required. This served to be a critical preparatory activity.

3. Critical Activities were identified and contingency plans were put in place to ensure continuity of functions such as medical results management.
4. Leadership Succession: Back-ups were named for key leadership roles if a person in a leadership role would not be able to assume their duties.
5. Key Internal Dependencies were identified such as Security Services, IT Services, Dean of Students' Office, in order for the Hub to continue obtaining support from these units.
6. Mitigation Strategies were identified, and contingency plans were established.
7. Contact Information: All Hub staff were asked to update their contact information (cell phone numbers, etc.). A master contact list was created.
8. Legal vetting and IT Data Security Risk Assessments: In order to ensure compliance with regulatory bodies and to protect data privacy, McGill's legal team and IT Data Security team were consulted throughout the process of selecting telehealth platforms and also for new Hub procedures involving consent and exchange of information.
9. Billing considerations for medical doctors: For many Hub clinicians, going virtual required that changes occur at different levels of government for telehealth to be recognized as an appropriate venue for seeing clients. More specifically, for the Hub's medical doctors, this also meant changes in billing codes by provincial insurance and by private insurance companies such as Blue Cross.
10. Re-configuration of Hub's call centre, website and dissemination of information to students: Throughout the change process, the Hub used its call centre, website, mass email and newsletters to provide students and staff with up-to-date information. More specifically, the Hub's call centre messaging was re-recorded to reflect the current realities. The Hub's website was updated with the Hub's new virtual hours, services available on-and-off campus as well as information on accessing the Hub's virtual services. Moreover, the Hub used the University's mass email system (called "What's New") to update the student-body, faculty and staff with pertinent information. Lastly, the Hub partnered with other areas of the University to disseminate information through popular newsletters such as the Teaching and Learning Services and Faculty of Education newsletters.

Staff Capacity Building

The Student Wellness Hub was launched a little less than one year ago using an Implementation Science framework with a strong emphasis on sustainable implementation and change management. In addition to formal and informal training sessions, the Hub facilitated staff coaching and connectivity sessions to ensure sustained capacity building. This multi-modal staff development model served as a foundation and facilitator for change agility which in turn eased the required staff changes in light of the pandemic. In order to help staff transition to the COVID-19 reality, one-on-one and group training sessions were supplemented with coaching to assist staff in setting up their home equipment, ironing out issues and providing scaffolding and training for the use of new technologies.

Prior to the University closure, to ensure that staff had assistance configuring their devices remotely, guides and in-person training activities were organized use remote management software including TeamViewer or Microsoft Teams which allow a user to remotely take control of a computer. This allowed McGill technicians to troubleshoot issues more efficiently. It also provided a training opportunity for staff members as demonstrations could be done remotely. Remote meeting software including Microsoft Team and Zoom were important for keeping staff up to date with constantly changing environments. Frequent communication with various stakeholders ensured staff were up to date with new policies, regulations, and changes in service offerings.

Staff members were provided lists of key contacts for the various members of the Hub services team. This ensured clinical staff were supported and readily had access to managerial staff. Individuals without hardware were

provided computers or laptops to perform their work. Headsets were provided to those who needed to create a more private space. Softphones were deployed to all members of the frontline team allowing them to make calls using their laptops. Daily check-ins to build an “online community” as staff became accustomed to a new reality and an end of week “happy hour” to share experiences and connect with colleagues. Furthermore, clinical guidelines were put in place with best practices about telehealth.

Technology

The Student Wellness Hub has moved many of its services online in order to continue offering support to McGill University’s student body. The Hub remains available to students — remotely — as much as possible, given the unprecedented limitations put in place by the Quebec government. The Hub’s virtual services include one-on-one appointments, group sessions, workshops and health promotion activities. Although the Hub’s one-on-one appointments are exclusively for students, many of the Hub’s workshops are now accessible to the general public and thus accessible to McGill staff, alumni and members of the larger community.

Regarding one-on-one appointments, the Hub’s mental health professionals, including counsellors, local wellness advisors, psychiatrists, and dietitians are offering services via TAO and MS Teams video consultation. Psychoeducational workshops and therapy groups are offered via TAO. Whereas, nurses, family doctors and case managers are offering services primarily via telephone consultation, with the option of converting to a video session should the need arise.

In terms of ratios, approximately 70% of the Hub’s one-on-one appointments are presently offered via video consultation, whereas 30% are offered via telephone consultation. All the Hub’s workshops are offered live by TAO video and are recorded for viewing at a later time. Health promotion events and activities are offered Facebook Live and Cisco WebEx.

Clinical and Health Promotion Services

Due to the Quebec Government’s decision to restrict physical access to educational institutions in Quebec, McGill University’s campus is off-limits to staff and students except for extraordinary duties. Therefore, the Hub is unable to provide in-person services during these restrictions. However, the Hub remains available to students and is offering most of its services virtually.

More specifically, students can request to meet virtually one-on-one with a Counsellor, Local Wellness Advisor, Dietitian, Nurse and Psychiatrist. In order to meet students’ medical needs, the Hub has adapted its medical service delivery model to the current realities in Quebec. Due to the unfolding public health emergency, the government has pulled many family doctors into the public healthcare system. This has reduced the Hub’s capacity to offer appointments with a family doctor. However, to address this, the Hub rapidly implemented a nursing hotline for students. Thus, students can call-in with any medical question and speak to a nurse. The Hub’s nurses perform a comprehensive telephone assessment and develop a plan that may sometimes include referring the student to one of the Hub’s family doctors for further assessment. This triage model has allowed to Hub to continue offering medical appointments to students. An important note is that the Hub’s Nurses are Nurse Clinicians with prescribing licenses and can therefore, order specific tests and prescribe medications that are within the scope of their practice.

Summary of Clinical Services and Modality

Services	Modality
Booking appointments	Students can schedule appointments by calling the Student Wellness Hub. Students wishing to meet with a Local Wellness Advisor can schedule appointments online using a webform. Lastly, in order to facilitate ease of scheduling for students, all Hub clinicians can

	<p>schedule upcoming follow-up appointments with students directly while in-session, this eliminates the need for students having to call the Hub to schedule a follow-up after their appointment.</p>
Triage/Intake	<p>Students calling the Hub with a medical question are scheduled to speak with a nurse same-day. Hub nurses perform a thorough phone assessment and a triage function. In collaboration with the student, the nurse will develop an intervention plan which can involve a myriad of interventions including referral(s) to resources or other professionals within the Hub and/or external to the Hub. Due to the sensitivity of intake paperwork, while services are presently delivered virtually, intake paperwork is now completed by the student in-session with their clinician.</p>
Informed consent	<p>A secure platform was implemented in order to collect consent from students. Prior to their appointment, students are sent detailed instructions which includes how to access this portal and how to complete the consent process. At the time of their appointment, an in-session informed consent discussion occurs with the clinician in order to ascertain that the student has read and understood the terms of their consent.</p>
Clinical sessions with existing clients	<p>Prior to a clinical session, students receive detailed instructions on how to access the virtual platform and expectations for the interaction. They are also made aware of any risks.</p>
Clinical sessions with new clients	<p>Prior to a clinical session, students receive detailed instructions on how to access the virtual platform and expectations for the interaction. They are also made aware of any risks.</p>
Crisis management	<p>The Hub has paid particular attention to increases in anxiety and depression among University-aged students. In order to increase comfort levels with interacting with students in distress, all Hub clinicians have received extensive training with intervention models such as Suicide Action Montreal's best practice training in suicide intervention and LivingWorks Applied Suicide Intervention Skills Training (ASIST). Furthermore, crisis management is a shared activity at the Hub. Significant resources have been put in place to ensure that all of our clinicians (regardless of their profession) have the capacity to intervene with students requiring crisis intervention. This is further embodied through our safety function. Each Hub clinician rotates through the safety function and thus, when on-duty, meets with students presenting in distress (that do not already have a scheduled appointment – students with scheduled appointments in distress meet with their treating clinician). Emergency protocols are in place to ensure that students requiring higher levels of care receive the support needed. Lastly, crisis management is a shared responsibility at McGill. The Hub works closely with the Dean of Students' Office and with Security Services. Regular meetings take place with these parties to ensure seamless crisis management at the University.</p>
Record-keeping / EMR	<p>As part of creating an interprofessional Hub, all Hub clinicians were transitioned to electronic medical record-keeping. Thus, even prior</p>

	to the current COVID-19 situation, Hub clinicians were already maintaining virtual records. In this new remote reality, the Hub worked closely with IT to allow secure connection to the clinical information systems. From a record-keeping perspective, the only difference for clinicians is the way in which they access the clinical information system and that they must identify that the session took place virtually. Record-keeping follows previously established guidelines using the same clinical information systems as prior.
Follow-ups	Clinicians can schedule follow-up appointments while in-session with a student.

The Hub also continues to offer remote group sessions, workshops and health promotion activities. The following group programming is presently available to students:

Workshops

Active Listening: This workshop introduces participants to the concept of active listening, provides guidance on implementing active listening in daily life and scaffolds the concept of helping dialogues.

Managing Stress in Uncertain Times: This workshop explores strategies for coping with stress and mindfulness to help manage stress and anxiety.

Mindfulness-based Stress Management for Students: This workshop introduces students to techniques to manage stress and ultimately enhance performance in their personal and professional lives. This workshop focuses on defining the construct of mindfulness, explaining how mindfulness can be used to manage stress, as well as practicing mindfulness-based activities.

Yoga for Stress & Anxiety: This workshop teaches how stress and anxiety and its impacts our bodies, minds and nervous system, and use the physical and meditation principals from yoga to practice new ways of managing and coping with stress.

Zen in 10: This program is intended to provide activities that participants can integrate into their daily routine to cope with stress and reduce feelings of anxiety. Short mindfulness exercises are hosted virtually by the Hub’s Local Wellness Advisors (LWA) team. The short time is peaceful, resourceful and provides a personal check-in for those looking for connection.

Art Hive Live: The purpose of Art Hive Live is to meet students where they are – and in this case it is safely in their homes. These accessible art projects are intended to provide creative outlets for participants by using simple household materials. The goal is to reduce feelings of isolation and build a sense of community.

Support Groups

COVID-19 Emotional Support Group: This group is meant to help students who struggle dealing with social distancing and self-isolation measures. It provides students and opportunity to come together to share common experiences and provide support.

Exercise for Wellness: This group is for students who are looking for ways to incorporate exercise into their daily routine who are living more sedentary lifestyles. This program focuses on using exercise as a tool for improving

mood and managing stress, highlights the psychological benefits of exercise, and equips participants with practical tools to help them overcome the obstacles to successfully integrate exercise into their lives.

COVID-19 Info-Session: These sessions are hosted by a nurse at the Student Wellness Hub and provides students the opportunity to ask questions about COVID-19 and obtain clarification on the implications of physical distancing and self-isolation.

PhD Support Group: This group provides graduate students the opportunity to share ideas, encouragement and fosters a sense of connectedness amongst graduate students to help them build resiliency to balance life and academics, improve focus and help students regain a sense of connection with their program.

For a list of Hub programming: <https://www.mcgill.ca/wellness-hub/get-support/wellness-and-life-skills-workshops>

Outcomes

Student and Staff Feedback

“Users appreciate having multiple complementary services available to them in one place.”

“The physician was able to facilitate a prescription at the pharmacy close to where I live.”

Students have responded very positively to our service offerings, as per our survey that was adapted to reflect the pandemic reality.

In addition to the survey, anecdotal stories reported by students to staff is that they appreciate having even limited services available. Our live and recorded online workshops have received great feedback and serve students in the comforts of the home when they want to “consume” the material. Students have voiced that they are grateful to have the opportunity to reach clinicians in a timely manner during the pandemic and to receive support and care during this period of uncertainty. Students have also voiced appreciating check-ins conducted by Hub staff.

Staff have expressed appreciation for many of the new EMR solutions that allow them to work virtually almost seamlessly. Staff have been challenged by working from home and balancing the difficulties of childcare, finding a comfortable workspace (complaints about ergonomic workspaces), learning new technologies, and experiencing difficulty consulting and staying “in the loop” as changes occurred daily.

Challenges

Clinical practice

One challenge of moving online was that regulatory bodies restrict virtual services to clients located in the same province as the clinician’s licensing authority; thus, virtual services can only be provided to students in the province of Quebec. In order to provide students outside of Quebec with services, the Hub worked closely with student groups on a student-led initiative to obtain Keep.MeSafe for students wanting to access Counselling Services who may not be eligible for Hub Services. Maple is another community resource which offers telehealth services with doctors, nurses and dietitians and is covered by McGill Student’s International Insurance. The Hub created lists of resources on its websites including both these resources to provide students with options and choices: <https://www.mcgill.ca/wellness-hub/support-campus-closure>. Another challenge was launching new programming in a very short amount of time to offer support considering COVID-19 and the impact on students at the University. Lastly, clinically, some group sessions which were typically held in-person had to be ended as they were deemed to not be best for a virtual platform.

Staffing

Due to varying comfort levels with technology, some staff members experienced some difficulties in building confidence in using information technology to accomplish tasks remotely. In some cases, this required extensive one-on-one training and sessions.

Communication

One communication challenge was ensuring that each member of the Hub (over 140 individuals in total) receive important updates in a timely manner. The Hub quickly realized that email was not always the most effective communication modality. A number of communication methods were put in place including use of video meetings, MS Teams group chats, etc. For student-facing communication, one challenge was ensuring that students receive regular updates regarding services offered. This was addressed by updating the pre-recorded call center messages, modifying the Hub's website with a new section on accessing virtual care, using the University's mass-emails to provide the student body with important updates and partnering with popular newsletters in order to disseminate key information often with links to the Hub's website. In addition, we collaborated with our student associations, who played a key role in our advisory boards to ensure that our communications with students would be enhanced during this difficult time.

Metrics

Quantitative and qualitative data continue to be collected. These include telephone wait times, appointment wait times, number of appointments, activity metrics, CCAPS outcome data, student feedback through satisfaction surveys, etc. We conduct regular surveys and preliminary results show over 90% satisfaction rates with remote clinical services. Our partner services have also provided new insights as to when students are comfortable reaching out to get help. Late afternoons are popular times of interactions between students and counsellors.

"How quickly I was able to speak with a Dr., how easy and safe it felt speaking on the phone instead of having to go to a clinic during COVID. I don't see why a lot of appointments should be in person even without COVID, the phone appointment was great. The Dr. faxed a prescription to my nearest pharmacy and I was able to get the meds I needed the same day."

Lessons Learned

1. Planning and change management are critical to the success of all projects.
2. Many functions previously believed to only be possible in-person can be conducted virtually.
3. Communication in various forms (both verbal and written) help staff stay up to date. Repetition of information is key, especially when individuals are being over-saturated with information.
4. Consolidating and creating shared online documents and workspaces facilitate collaboration and expedite document review processes allowing for an agile response to changing contexts. Within our EMR, documentation and prescriptions can be faxed directly to local pharmacies. Development of secure methods of distributing documents electronically has allowed seamless change in providing students with letters and copies of their medical records to ensure continuity of care with resources closer to their new locations. It has also facilitated access to medical records as all records are now in electronic format.

Recommendations

1. Change agility, responsiveness and adaptability should be built-in to the design of a University health and wellness centre.

2. Contingency planning and emergency preparedness should be part of all implementations. For example, when implementing a new solution, determine a back-up plan for that solution.
3. Invest resources in staff training to build comfort with information technology.
4. Invest in cloud-based solutions that facilitate working remotely.
5. Provide students with regularly updated information by tagging onto mass emails sent by the University, regularly updating the website and partnering with popular newsletters.
6. Think outside-the-box.

Future Planning

The Hub and McGill University is awaiting further directives from the provincial government in order to determine what Fall 2020 will look like. At this time, it has been announced that students will be attending most classes remotely in the Fall, however, it has not yet been determined if some services will be offered in-person on-campus.



Queen's University Student Wellness Services

Queen's University, Student Wellness Services

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Student Wellness Services (SWS) is an integrated medical and mental health centre that adopts a stepped care model to mental health services. SWS supports the personal, academic, and social development of students at Queen's University by providing a range of programs and services. Our mission is to provide a welcoming, confidential, and integrated service that is responsive to the needs of students. For health care, the interdisciplinary team consists of physicians, nurses, psychiatrists, occupational therapists, psychologists and other regulated mental health therapists. Health Promotion and QSAS accessibility services complete the services offered. Queen's Student Wellness Services offers a combination of same-day and booked appointments.

Implementation

On March 13, 2020, Student Wellness staff were advised that the university was not closing but learning was moving to online and students were being asked to leave residence. Our health services were declared essential and the direction was to transition to remote service delivery as quickly as possible. We were asked to reduce our in-clinic staff significantly and reduced it from 90 to 10 at any given time. Mental health crisis support was to continue in-person.

A priority was to ensure access to EMR by having staff bring in their personal laptops to configure for remote access and sent staff to work from home as soon as EMR access was available. For staff lacking equipment, laptops, headphones, and webcams were sourced to support staff's transition to their home offices. Information Technology Services was consulted to ensure protection of patient privacy. No formal training was offered to staff, but they were provided with resources and were encouraged to attend webinars on the topic of working remotely. Managers were offering additional time to staff to ease the transition.

A second priority was to decide on a protocol to manage risk in students presenting with suicidal or self-harming patterns of behaviour. The on-site crisis triage team (consisting of two people) responded to students both in-person or remotely who were presenting in high-distress. They also reached out to students whose responses on a counselling intake reflect high risk (i.e., "I am having thoughts of suicide and I am planning on acting on them"). The process included 1) Having the student complete a triage form; 2) Communicating with the student (in person or over the phone) to assess level of risk as well as next steps. If communication is over the phone, an assessment as to whether the student needs to be seen in person was conducted; 3) If an in person crisis appointment is needed, the crisis counsellor will provide immediate care, 4) If the student needs alternate care, it is arranged and the student is booked into a future appointment (i.e., with a physician) or referred to an external partner. Risk management for therapy groups was also elaborated, with a plan to have a co-facilitator step out of group and connect with the student in distress in a break-out group and plans to call 911 if the situation warranted it. Students at high-risk were designated as SOC (students of concern) and our a multi-disciplinary SOC team met remotely every week to manage these students, including multiple touch points, and safety planning prior to weekend.

Due to school closures, it was necessary to adjust staff work schedules around childcare needs, allowing for maximum flexibility. As such, some counsellors were offering sessions in late evenings and on weekend, which students appreciated. Rotating in-house schedules were created for in-house managers, triage/crisis, physicians and nurses, and reception. In doing so, it was necessary to train several counsellors on how to triage students presenting in crisis so that they could participate in the rotating schedule. We provide more frequent meetings with our teams, including check-ins, identifying problems and addressing them. We set guidelines and instructions for receptionists (booking and managing paperwork remotely, delivering safety plans to students) who were working

both in clinic and remotely. The management team worked collaboratively on the drafting of messaging on websites, and university publications, which was updated when needed.

After the second week of remote working, we reduced clinic hours to 10:00 am to 3:00 pm, although mental health sessions were offered outside of those hours.

The reception desk was upgraded with the quick installation of Plexiglas shields.

Technology

Zoom (via TAO) was the platform used for remote counselling sessions. There were some concerns regarding the use of Zoom after some instances of “zoom bombing” were reported. However, our ITS team assessed and concluded that Zoom offered via TAO was secure, with all the safety features added within the TAO platform. The addition of a breakout room option further allowed for the management of risk when offering therapy groups via Zoom. For physicians and the psychiatry team, the registration process for Ontario Telemedicine Network (OTN) was quickly initiated. While that was underway, some physicians and psychiatrists were using Facetime on their portable devices. MS Teams was selected as the communication system for dialogues between employees and all staff were instructed to download the software. Working groups within MS Teams were created. Services offered consist of partial in-person, phone and video conferencing support for medical and mental health supports. For mental health support, visits are 90% via video and 10% via phone. For mental health appointment that were remote, the use of video was encouraged whenever possible due to the added advantage of being able to monitor body language, especially when assessing risk. Health services are approximately distributed 60% by phone and 40% by video. Nursing appointments are offered by phone when virtual. In person appointments still continue for vaccinations, dressing changes, etc. These statistics are a gross approximation, as physicians started with phone sessions almost exclusively and eventually progressed to using video for some sessions. Health promotion events and activities occur through Instagram, Facebook, Twitter and Zoom. Psychoeducational workshops and groups occur via Zoom and online interactive mental health platforms include TAO (e.g., mindfulness) and eCBT via OPTT.

Clinical and Health Promotion Services

At Queen’s, the move to remote care was fairly sudden, with little to no advanced planning; decisions were reactive. From a mental health perspective, all services that could be maintained remotely were preserved. We maintained an onsite triage/crisis service for the rare case that could not be managed remotely. We had to terminate the psycho-educational groups abruptly (students were informed via email) but maintained the psychiatry and psychology-led therapy groups by transferring them to the online ZOOM service. The psychiatry team and mental health counsellors switched to remote care (mostly using video) rapidly and the flow of care to students was not adversely affected. From a health delivery perspective, physicians worked remotely (phone and video) and maintained daily in-person care (with nursing support) for those who required it. The demand for services decreased so the numbers of physicians working also decreased as a result. If a student requires a medical appointment, they must call to schedule it and the first contact with the physician would be over the phone. The physician decides if a face-to-face appointment is required or if the issue can be addressed virtually (video or phone). We’ve had to close our walk-in clinics for now, although some physicians continue to provide in-person care when requested. All non-essential procedures such as IUD insertions and wart treatments are not being scheduled at this time. Nurses are still available for blood work and we continue to provide TB skin testing for students who need it for their program, immunizations, allergy injections, dressing changes etc. We are no longer scheduling new Gardasil series.

Our health promotion team had to stop offering SafeTalk and Assist trainings, but are sourcing out other options and will likely be purchasing license to offer LivingWorks START (one-hour online suicide alertness program) which would be paired with a 15-30 minute debrief afterwards to discuss campus and Kingston specific resources. All

other health enhancing activities normally delivered were transferred to online platform offerings. Examples include:

Online mental health trainings: Creating a Customized Self-Care Plan while Physical Distancing and Identifying and Responding to Students in Distress while Physical Distancing. These are open to students, staff, faculty and alumni.

Virtual healthy lifestyle appointments by phone or zoom to any student who wants help changing a health habit. These interventions use a brief action planning/motivation interviewing approach.

Summary of Clinical Services and Modality

Service	Modality
Booking appointments	Phone, in person, email
Triage/Intake	Phone, in person
Informed consent	Documents sent by email, sent back via OneDrive for remote sessions. In addition to the standard consent form students review, we added a distance therapy consent form for the mental health services. For physician, psychiatry and nursing services, the reception staff conducted a verbal consent process for distance care and documented it in the chart at time of booking.
Clinical sessions with existing clients	Counsellors and occupational therapists are rebooking their own clients directly into the schedule. If they want a student to complete a triage form (for assessment of risk), they request that administrative staff send the form out to the student prior to their next session.
Clinical sessions with new clients	Students contact the clinic via the main phone number requesting an appointment. When needed, they are sent intake paperwork to complete (via email). Students return the paperwork via secure OneDrive. Once received, the mental health triage form (for mental health counselling appointments) is reviewed and if risk is high they are first sent to a triage/intake session before being connected to a provider; this is flagged to the Director of counselling.
Crisis management	This is managed mostly remotely, with some in-person care offered when needed. Several players are involved (triage, crisis counsellor, counselling director, student of concern committee). Consultation with physicians and psychiatry are available.
Record-keeping / EMR	Access to EMR via VPM secure network was made available to all treatment providers and administrative staff, permitting them to work from home. Record keeping and communication via EMR has remained consistent.
Follow-ups	These are scheduled as usual, on request from provider, or directly by provider. For crisis management, we also perform unscheduled phone “check-in” follow-ups.

Outcomes

Student and Staff Feedback

Students are responding very well to the change. Most understand the necessity to conduct services remotely and are please with the quick access into the service (due to lower demand). We have not had complaints. Our staff

have been exceptional and have responded very well overall. Staff with children struggled the most. At first, the university permitted staff to work limited hours around childcare needs. As of May, the university insisted that staff who were not working full time would receive pay for the hours worked only. This forced staff to work with children around them, and several were challenged with this shift from the university. Challenges brought forth also pertained to proper working spaces and ergonomic issues. Physicians had to tolerate delayed pay due to billing codes for remote care not being properly in place at the government level.

Challenges

Clinical practice

The most challenging aspect was arranging for everyone to have what they needed to be able to work from home, as we had not prepared. We were required to use a VPN that was not easy to set on the personal laptops of staff, especially those using Mac computers. Risk assessment of students expressing thoughts of self-harm was challenging for the counselling staff. They felt it was much more straining to do this work remotely and feeling confident in their assessments. Therefore, ensuring the psychological comfort of our counselling staff necessitated additional supervision and check-ins, far surpassing typical levels. Some counsellors stated that they were not comfortable conducting phone sessions and insisted on video only as they do not feel comfortable assessing risk without visual cues. Providing care to students who returned home to out-of-province locations was a struggle due to legislated limitations. Mental health counselling was shuffled to Empower Me when possible. Counsellors also sought permission from provincial regulatory colleges to continue care for their existing clients remotely. Temporary permissions were often granted. Physicians and psychiatrists did provide remote care to students who were out-of-province, although they remained unsure if they would be able to bill for their services. Prescriptions were sent to our local pharmacy and medications were sent by mail to students residing outside of Ontario. Billing codes for remote care of health services were complicated to sort out, and even when sorted out were sent back unpaid due to provincial delays in processing these codes.

Staffing

Staff transitioned very well for the most part. Moral remained high at first and virtual socials and check-ins were appreciated. However, after a couple of weeks there were numerous complaints from counselling team of physical distress resulting from looking at screens all day. We therefore reduced virtual socials and interspersed counsellor schedules with professional development opportunities to do other things such as read books, review articles, and build workshops that will be delivered in the Fall term. We increased one-on-one supervision with the Director of counselling and topics of self-care and coping with the conditions of the current pandemic were prominent in those discussions. Due to children of staff being home as well, many struggled to find a quiet and confidential space to conduct health care sessions, with several staff setting themselves up in closets and dark basements. There was a week of trial and error. It was also quite challenging to determine working hours for our staff, who were allowed flexibility to work weekends or evenings to make up for hours where they were not able to work due to childcare demands.

Metrics

We are tracking wait times, from time of booking, as well as wait times for referrals, and no-show appointments. We conduct satisfaction surveys, both for services accessed, as well as for therapy groups and workshops.

Lessons Learned

1. It is important to plan and have contingencies in place for emergencies that require quick shifts in service delivery.
2. It is challenging to meet the needs of students located outside of Ontario.
3. Lots can be offered online, and students are okay with it, and some even prefer it.
4. Team meetings conducted remotely are effective.

5. Need centralized communication platforms for staff (e.g., MS Teams, Google Docs). Communication with colleagues with MS Teams is seamless and we are wondering why we never used it before.
6. Counsellors find providing remote care more tiring. They require variety in their schedules and additional support from management and each other.
7. Online therapy groups might be valuable and effective, allowing for greater flexibility
8. Physicians can work remotely more so than previously believed (less clinic spaces needed in future for more physicians).

Future Planning

Some students will be returning to in-person learning (subset of medical and nursing students, law students, grad students). The majority of learning will continue remotely. Student Wellness Services will continue remotely until public health indicates otherwise. Due to uncertainty of what will be permitted in the Fall and talks of a possible “second wave of COVID-19 infections”, we have decided that all group offerings will be conducted remotely. As such, we will continue to deliver our therapy and psycho-educational groups via virtual means. Our intention is to maintain our typical “group” offerings.

In addition, ideas in development include creating an online Quarantine Kitchen as a way to build community. The idea is to have students engage with each other to share recipes, ask questions, etc.

We are also looking at how we can develop additional collaborative initiatives with Athletics & Recreation to help students be physically active. Athletics and Recreation department have been very active in providing students with virtual delivery of exercise routines; however we would like to tie that in with mental health and wellness by forming a stronger alliance with that department. We are also seeking to partner with Student Life, and have counsellors offer their mental health wisdom in different ways.

In addition to delivering one-on-one sessions, counsellors will be developing and delivering a series of workshops designed to help students cope with the issues that we expect will be more prominent than usual. Topics include finding balance, help with time management and schedule building, relationships and boundaries, loneliness and isolation, etc. We are also adding to our online CBT delivery a treatment module on coping with COVID-19.

As we transition to working back in the clinic, we will likely maintain a balance of “work from-home” hours that will allow for the delivery of services at later hours, which students appreciate tremendously. For example, work shifts may be split (9:00-12:00, and 5:00-8:00) allowing for flexibility all-around for students as well as staff. This is an example of how we may change the way we function, even once the pandemic resolves itself.

We are working on developing creative ways of having staff remain close and connected with one-another despite the need to remain apart. We are starting virtual book club, knitting club, etc.

We hope to conduct a literature review on remote health care provision to best inform our practices.



University of British Columbia Counselling Services

University of British Columbia Vancouver, Counselling Services, Student Health and Wellbeing

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Counselling Services provides a range of mental health services to support the wellbeing of a highly diverse student population. Services include initial assessment and triage to stepped care, single session and brief counselling, group counselling, crisis response, outreach and consultation to faculty and staff. A combination of same-day and booked appointments are available to optimize access to services. Counselling Services works closely with Health and Wellbeing units as well as other campus stakeholders to embed wellbeing into all dimensions of students' experience as outlined in the [UBC Mental Health and Wellbeing Strategy](#), [UBC's Wellbeing Strategic Plan](#) and the [Okanagan Charter](#). Counselling Services also extends the educational mission of the university through training and supervision of practicum students and doctoral interns in counselling psychology, social work programs, and related fields.

Implementation

In mid-March UBC transitioned to online classes and by mid-April this was extended to summer session courses as well. In March the university also transitioned to remote working. All student services moved to remote working with the exception of the Student Health Service which continued to provide limited onsite services.

Pre-Remote Working

1. Context: Prior to mid-March, the university's focus was on building awareness to support safety in line with public health directives.
2. Modality: The center continued to be open for same day drop-in appointments for students who were asymptomatic. In addition, services began to transition to phone where possible, including for students who self-identified with COVID-19 symptoms.
3. Unit programs and procedures changes:
 - a. Stepped Care: No change to levels of care provided.
 - b. Procedures were developed to minimize risk of transmission within the centre.
4. Change Management/Communication:
 - a. Information was provided via physical signage and website regarding COVID-19 symptoms and how to protect oneself-others, including asking students to self-identify at the front desk if they have symptoms and have recently traveled.

Preparation for Remote Working

1. Context: In mid-March the university transitioned to remote working where possible. Counselling Services transitioned to remote working during the week of March 16th. The Wellness Advisors were the first to transition, followed by counsellors and then reception staff. The leadership team (Director, Associate Directors, Office Manager) transitioned to remote working by March 25th.
2. Modality: Phone appointments were provided for students requesting services and students with booked appointments were called to inform them that their appointments were being converted to phone appointments. Group counselling sessions were cancelled until further notice.
3. Unit program and procedures changes:
 - a. Stepped Care: All levels of care except group counselling continued to be available.
 - b. The center's main phone line was forwarded to mobile phones assigned to front desk staff.

- c. Remote access was created to the centre's servers including its electronic record system (Titanium) via secure VPN.
 - d. Interim referral systems were created until an online fax service could be set up.
 - e. Interim student data collection procedures were created until secure web data entry could be set up.
 - f. Laptops were provided and configured for all staff. This was needed because staff home computers, installed with basic windows software, could not be set up with the required level of encryption.
4. Change Management/Communication:
- a. The campus community was notified of changes to service delivery including how students can contact the centre to request services.
 - b. Daily updates were provided to staff regarding how the transition remote working was proceeding.
 - c. Contacted regulatory bodies and professional associations regarding guidelines for providing virtual services outside one's jurisdiction. It was somewhat challenging initially to obtain the clarity needed given how quickly circumstances were changing as a result of the pandemic.

Remote Working

1. Context: By March 20th most student services had transitioned to remote working. By March 18, Counselling Services was providing all services virtually and by March 25th all staff were working remotely.
2. Modality:
 - a. Students requested services by phoning Counselling Services' main phone line which was picked up remotely by reception staff. Students were scheduled for either a triage or single session phone appointment, depending on their needs.
 - b. Students referred for brief counselling were initially scheduled for a phone appointment and then transitioned to video appointments as appropriate.
 - c. Group programs were provided via video platform.
3. New Unit programs and procedures developed:
 - a. Stepped care:
 - i. New client appointments were put on hold until secure web data entry could be established for students to enter their information. This also allowed some more time for counsellors to orient and further familiarize themselves to video counselling.
 - ii. To minimize risk, students assessed with high risk were referred to the Access and Assessment Centre, Vancouver General Hospital or to the nearest hospital emergency department rather than providing virtual care.
 - iii. Several new virtual group programs were introduced to meet emerging student needs.
 - b. Schedule changes:
 - i. Reception staff were assigned to rotations with 2 on student support, one primary and one back-up (answering calls to the main phone line and scheduling appointments) and 2 on counsellor support (responding to counsellor inquiries and providing assistance where needed and/or working on projects).
 - ii. Given lower overall demand, wellness advisors were assigned to rotations (primary, back-up) to create more uninterrupted time to focus on project work.
 - c. The following e-forms were created to support electronic storage of forms requiring student consent to share information. Also, consent to teletherapy was integrated into all consent forms.
 - i. Student Health Referral
 - ii. Release of Information
 - iii. Group Counselling Consent
 - iv. Sexual Violence Prevention and Response Office Referral
 - d. Secure web data entry was established to enable students to go on-line to enter their information.
 - e. An online fax service was established to support referral processes.

4. Change Management/Communication:
 - a. UBC implemented a phased-in approach to remote working as well as flexible scheduling to help staff manage the pace of change. The phased in approach started with phone service and expanded to video counselling as staff felt increasingly confident, with more experienced staff mentoring others who were newer to this modality. Counsellors were given the option of adjusting their schedules (e.g. creating blocks for single session therapy and creating more time between appointments as needed) to manage the unique demands of remote working create sustainable work/life balance throughout the day/week. These strategies helped staff feel that their concerns were heard and validated, enabled them to engage more fully in the transition process and move forward as a team with virtual service delivery.
 - b. Online information was updated to include new group programs.
 - c. Daily leadership team meetings were held for the first few weeks to support new procedures and systems development as well as support change management. These meetings were then reduced to 3 days a week.
 - d. Staff were kept informed daily during the first few weeks and then as new developments occurred.
 - e. Staff meetings devoted to discussion of challenges and successes were held on a regular basis to support sustainability of remote working.

Staff Training/Support

Training in online telehealth was offered to all staff. Staff who were more confident or experienced acted as mentors to those who were less experienced. Staff were encouraged to move at their own pace; there was no pressure to move to video counselling, for example, if phone was preferred and client needs were being met. Regular and daily email briefings were sent by the Assistant Director, Clinical Services, to keep the team up to with date on developments and “next directions”. Flexible scheduling was implemented on a case-by-case basis to accommodate staff (e.g., staff who had caring responsibilities, those who were finding long zoom sessions challenging/draining). Staff discussions on the shared experience of remote working occurred to identify and address challenges, including coping with the speed of change to remote working, zoom fatigue, work station privacy and ergonomics, work/life separation and balance including managing child care and dealing with losses associated with physical distancing and hospitalizations and deaths.

Technology

Our initial virtual service provision was exclusively by phone; however, our services are now are delivered about equally by phone and video. Online platforms include TAO, Zoom and Skype for individual mental health services and Zoom for psychotherapeutic groups. Health promotion events/activities and psychoeducational workshop are offered through Zoom.

Clinical Services

Our first service to transition to virtual service delivery was our Wellness Advising (Triage) appointments, which were delivered by phone. This was in part due to our technical set up, which was already in place for Wellness Advisors as part of a previous service delivery plan. At this stage, other counselling services remained face-to-face. Group program were initially put on hold during the transition. Next, single session and brief counselling services moved to remote delivery by phone. New client appointments, however, were put on hold while the centre worked to establish secure web data entry which would enable students to complete the CCAPS and other data forms on-line. Emergency appointments were redirected to our local hospital emergency services, which continued to offer in-person appointments. Third, counsellors began to integrate video appointments where appropriate in addition to phone appointments. With online data collection enabled, new client appointments were reintroduced. Full individual client services were thereby restored with the exception of emergency appointments, which continued to be directed to in person services at local hospitals. Lastly, our newly developed group programming was launched, using video conferencing, to meet the changing clinical needs of our students at the time.

Summary of Clinical Services and Modality

Service	Modality
Booking appointments	All new appointment bookings done over the phone.
Triage/Intake	All triage (Wellness Advising) appointments are done over the phone.
Informed consent	Completed online by student via secure web data entry or (if not completed online) completed verbally over the phone.
Clinical sessions with existing clients	These are offered either over the phone or by video calling (client preference).
Clinical sessions with new clients	New client appointments are offered either over the phone or by video calling.
Crisis management	Crisis management services are provided by phone or video and have been limited to students with moderate risk only. Students with high risk are referred to in-person services at the Access and Assessment Centre (AAC) Vancouver General Hospital or local hospital emergency departments.
Record-keeping / EMR	Staff access to our electronic record system (Titanium) and student access to on-line forms to complete is provided via secure VPN.
Follow-ups	These are offered either over the phone or by video calling (client preference).

Results

Student and Staff Feedback

Some students have reported difficulty connecting to the VPN to complete the on-line forms prior to their appointment. Also, not all students have cell phone plans with unlimited calling in Canada. Some students reported challenges finding confidential spaces for phone or video counselling in their home. Overall, however, students have been very positive about the changes and able to transition well to virtual appointments as well as our new online groups.

Staff initially experienced increased anxiety, as might be expected during a pandemic with high levels of uncertainty. However, over time, and with supports in place they have demonstrated high levels of flexibility, resilience, resourcefulness and commitment to the wellbeing of our staff and students. Staff have developed increased comfort and competence with providing virtual services. We are, therefore, well placed to offer students a wider range of modalities for services after the pandemic. Staff have also appreciated the increased time and flexibility in their schedules given that they have not had to commute to campus.

We had the benefit of having a comprehensive UBC IT framework in place to support systems development and address issues as they emerged. Without this, it would have been much more difficult to transition our service delivery to remote.

Challenges

The following is a summary of challenges were encountered during the centre's transition to remote working. Some of these were solvable and while others have required more ongoing attention to minimize negative impact.

1. Risk Assessment: Recognizing the limits of virtual care, procedures needed to be established for identifying and connecting students with high risk to in-person services.
2. Recording Student Consent: Counsellors initially had to review consent forms on the phone/video, obtain, and record student consent. This process took more time which had to be allotted for in schedules. This issue was addressed successfully by creating consent data forms that students could access and sign online.
3. Faxing Referrals: With staff no longer onsite, we had to notify stakeholders that we were not able to receive faxes as usual. This was addressed by developing an interim work-around procedure to use until we set up an online fax service.
4. VPN Access:
 - a. Our initial attempt to create VPN access for staff on their home computers failed due to lack of adequate levels of encryption. We then provided laptops for everyone (combination on new and borrowed from other campus departments).
 - b. Some students have experienced difficulty connecting to the VPN to complete online forms. In these cases, a counsellor needs to take extra time to review the forms verbally and record the student's responses.
5. Doctoral Internship Completion:
 - a. Some challenge has been encountered with meeting interns direct service requirements given lower than normal demand for services since classes transitioned to on-line. This has been addressed in part by prioritizing interns for new client referrals to help fill their case loads.
 - b. Supervisors have had to rely more on case discussion and file review with trainees as opposed to review of recorded sessions.
6. Cross Jurisdiction Practice: Initially it was difficult getting clarity regarding cross-jurisdiction service provision from professional associations and regulatory bodies. This remains a challenge in some areas.
7. Workspace: Creating adequate workspaces regarding privacy and ergonomics has been more challenging for some staff. This had been partially addressed by bringing office equipment and furniture home.
8. Pace of Change: The move to a virtual service delivery model was swift, involving change on multiple levels. Getting used to new technology was challenging for some staff. This was addressed in a number of ways including:
 - a. Staging the changes during the transition period as opposed to trying to change every aspect of the transition simultaneously.
 - b. Regular communication and team discussion to voice challenges and generate solutions
 - c. Documenting all new procedures for staff reference.
9. Managing Stress: All staff have been experiencing additional personal stress including isolation from friends/family/colleagues, work-life balance, zoom fatigue, managing multiple roles given childcare and home-schooling responsibilities, family illness and grief and loss. This has been addressed in part by creating flexible, yet equitable schedules that take staff circumstances into consideration, whilst meeting student need. However, supporting sustainability of remote working is dependent on helping staff manage stressors where possible, therefore, this remains an ongoing priority.

Lessons Learned

We now have a framework for working remotely if needed in the future. We also have the opportunity to try out new on-line groups tailored to students changing needs during the pandemic. We have established online access for students to complete data forms prior to their appointment and online fax service to streamline referrals. We have also experienced generosity and a sense of community (e.g., free flow and exchange of information and resources across institutions and communities).

Daily staff updates provided while we were transitioning to remote working served to keep staff well informed with information they needed to support their own transition as well as aware of upcoming steps/directions. Timely

communications to students regarding changes to service delivery was also important. To support staff, we provided opportunities via Zoom meeting discussions for staff to share experience (successes and challenges) with remote working. Additional ideas emerged out of these discussions for making remote working more sustainable for staff (e.g. adjusting schedules to create more time between sessions, etc.).

Metrics

1. Activity metrics (number of students seen in each type of service)
2. No Shows, cancellations,
3. Wait for service
4. Presenting issues
5. Demographics
6. Stepped care referral data
7. PHQ9, ORS
8. Student Feedback Survey

Future Planning

We are beginning the planning process for graduated re-opening of on-campus services in the fall.



University of Toronto (St. George) Health and Wellness

University of Toronto, Health and Wellness (St. George)

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Health & Wellness works within the Division of Student Life, partnering with student, staff and faculty to support student health and wellbeing and a healthy campus. Health & Wellness is an integrated medical and mental health service, providing collaborative care by an inter-professional team consisting of family physicians, primary care and mental health nurses, psychologists, social workers, psychiatrists, dietitians, health education coordinators, and program evaluators. In addition to supporting mental health literacy across the campus, we engage in clinical teaching and supervision across health disciplines. Health & Wellness has adopted a stepped care model for mental health services, including health promotion/education programming, psychoeducational workshops, single-session same-day counselling, brief and short-term individual and group therapy, primary care mental health, case management, crisis services, and psychiatric services.

Implementation

Pre-Planning (January)

1. Monitoring of information from the Provost Office in relation to impacts on non-academic activities and status of student residences.
2. Updated staff emergency “fan-out” list; back-ups for the managers identified.
3. While clinical staff are set-up for remote connection as new hires, we ensured all remote connections were in working order.
4. Inventory of PPE taken and orders placed. All staff underwent on-site N95 mask-fitting /training and N95 masks ordered. In-service offered to all staff on infection control measures and use of PPE.
5. Physician-in-Chief updates staff on COVID19 situation and review of current screening practices.
6. Arrangements made with caretaking staff to increase cleaning of high-touch surfaces.
7. Screening: Active screening initiated in entryway of medical clinic; passive screening initiated for mental health and medical services via signage and over the phone while booking appointments. Students who fail screening are masked, sent to ER, tracked, and follow-up contact made. Collaboration with Toronto General ER to discuss pathway for students who fail screening is established.
8. Contingency pre-planning involved tracking and forecasting of all upcoming Health Promotion events from March to end of April and determining a standard framework for responding to changes in HPP priorities.

Crisis Phase (Weeks 1-2)

On March 13, the University announces classes to transition from in-person to online as of March 16. Health & Wellness Management Team meets on March 15 to plan for transition to virtual care. On March 17, the University announces building closures. Student residences to remain open for students who are unable to leave. On March 24, Provost’s office identifies campus healthcare workers as critical staff and to have on-site presence within the clinics.

Clinical Services and Health Promotion

1. Clinicians and administrative staff transition all appointments to phone sessions. Lists of cancelled appointments are kept so that they could be re-booked when non-urgent face-to face appointments resumed.
2. Psychoeducational workshops cancelled until further notice. Ongoing therapy groups transitioned to individual phone appointments. New therapy groups on hold until an appropriate online platform is identified.

3. Students on wait list for mental health services are grouped by clinical urgency and assigned to clinicians; phone “check-ins and triage” are conducted to determine care pathways in-house, community or U of T My Student Support Program (MySPP).
4. For medical services, non-essential care deferred based on clinical judgements for care, such as periodic health visits, wart treatments, PAP’s, routine vaccinations, Gardasil.
5. Student residence staff inform nursing team of students in isolation, who then provide phone check-in and review isolation practices with consent and offer further medical services.
6. Health promotion cancels or postpones events that created a group (i.e. safeTALK, ASIST, IAR+) to end of April. Health promotion-led events are cancelled and logistical re-planning, communication to partners and audience, postponement planning and messaging are initiated. For partner-led events, constant communication with partner on event status, communication to audience as appropriate, postponement planning and messaging as needed.
7. Guidelines for virtual appointments, managing wait lists (i.e., conducting phone check-ins/triage), and the interim mental health service delivery model communicated to all staff.
8. Campus-wide communication regarding Health & Wellness remaining open via website and other campus channels.

Administration

1. Management team immediately initiates twice daily “huddles”, using social distancing.
2. Virtual team meetings initiated by managers via MS Teams or OTN (Ontario Telemedicine Network).
3. Management team provides ongoing and regular communication, providing updates/directives via email.
4. Additional office space allocated at Career Services, including IT and computer set-up and caretaking for sanitation of workstations (for on-location/embedded staff).

Health & Safety

1. Active screening initiated in front of each clinic (two screening stations), then transitioned to building entryway when university buildings close. Initiated security presence in building entryway upon university building closures.
2. Started tracking number of staff, patients and visitors in clinic three times daily, to ensure that head count remained under 50-person maximum (as set by province).
3. Initiated regular and deep cleaning of clinics, offices, and workstations by caretaking (e.g., bleach ion spray used on high-touch surfaces). Signage installed in clinics regarding handwashing, hand-rubbing and social distancing. Plexi-glass partitions installed at reception desks.
4. Ongoing monitoring of guidelines from Public Health Ontario, Chief Medical Officer of Health for Ontario, University Occupational Health & Safety (OHS), and OHS Nurse. Active screening protocol and clinic health and safety guidelines released to all staff.
5. Daily PPE counts of clinic supplies; staff continue to be encouraged to use PPE as needed; many PPE items on backorder.

Technology

1. MS Teams adopted by the Student Life Division and Health & Wellness.
2. Implementation and troubleshooting of VPN access to EMR for all staff; provision of laptops and webcams to staff, as needed. Confirmation by staff of personal cell phone usage and phone plans (long-distance calls to be reimbursed). Limited clinic phone lines moved to VOIP; new VOIP lines ordered.
3. Psychiatric staff applied for OTN accounts. Exploration into secure video conferencing platforms (Zoom, Medeo) that are PHI (personal health information) compliant. On March 18, Medeo accounts active for clinical staff.

Human Resources

1. All staff remain working on-site on March 16, with the majority of clinical staff telecommuting from March 17 onwards. Thereafter, rotating on-site schedule initiated for clinical staff.
2. Staff are advised of institutional guidelines regarding self-declaration and flexibility around childcare. Staff who recently travelled are identified and initiate 14-day self-isolation. Staff who are immunocompromised are identified (pregnancies, health conditions) and are immediately transitioned to telecommuting.
3. Professional practice and jurisdiction legislation as per Colleges are monitored to determine clinician ability to practice out-of-province with ongoing students (not new encounters).

Consultation Groups

1. Vice-Provost Office: Ongoing consultation regarding campus operations.
2. Communications Team manages website updates regarding services available during pandemic.
3. Privacy Office: Consultation regarding managing student service agreement, consent forms, consent practices via phone and video sessions.
4. IT team configures home computers and laptops for VPN; inventory of divisional laptops and webcams taken.
5. Human Resources Department: Consultation regarding managing staff childcare, illnesses, telecommuting vs. working on-site, and pay continuity for casual employees.
6. Occupational Health & Safety: consultation regarding workplace health and safety issues.

Maintenance Phase (Weeks 3+)

Clinical Services and Health Promotion

1. Clinic pilots a complete “virtual day”.
2. After-hours and weekend virtual medical care provided to students in residence. Online reporting tool developed for student residence staff to report students in isolation; nurses provide “reach-outs” to students with consent.
3. Mental health clinic closes on-site services and is fully virtual.
4. Virtual collaborative care initiated (usually via OTN, MS Teams to a lesser degree) whereby multiple clinicians partner on a visit with a student.
5. Virtual workshop program planning initiated by clinical staff.
6. Managing urgent situations protocol communicated to all staff.
7. Health promotion team collates and shares on- and off-campus resources, promotes pre-existing online workshops and e-modules (i.e. IAR), adapts existing skills-building workshop to virtual space, and identifies and develops new deliverables to meet COVID-19 knowledge gaps.

Administration

1. Management begins to rotate on-site and telecommuting schedules; management “huddles” move from once daily to three times per week.
2. Reduced administrative staff remain on-site and fully VOIP clinic phone system initiated.
3. Virtual meetings, case conferences, psychotherapy case conference, discipline-specific team meetings (e.g., nursing, psychiatry), and lunch & learn sessions resume.

Technology

During the first week of the transition, all clinical services moved from in-person visits to phone visits. Psychiatrists were the first to move towards video conferencing using OTN. The remaining clinicians moved to Medeo video conferencing (MS Teams as a back-up) starting the second week of the transition. MS Teams was used for all staff meetings, with the exception of OTN for psychiatry team meetings. About 74% of clinic visits occur by phone, followed by 16% video, and 9% in-person (for medical visits only). Psychiatrists use video conferencing the most,

estimated at 33%, though, over time, there is increased used of video conferencing overall. Health Promotions continued to use Instagram, Facebook Live, Twitter, and added MS Teams as a workshop platform. Psychoeducational workshops are delivered via MS Teams and the plan moving forward is to pilot a psychotherapy group via MS Teams (without using the chat function due to privacy issues).

Clinical and Health Promotion Services

All individual clinical appointments, including intake appointments, were transitioned to phone or video sessions. Once video conferencing became available, all first encounters were defaulted to video sessions, unless otherwise preferred by the student or staff. Non-essential medical services were deferred (periodic health visits, wart treatments, PAP's, routine vaccinations, Gardasil). Urgent psychiatric services were modified to include several clinical team members, primarily the psychiatrist-in-chief and our complex care team (CCT), unless initiated by a treating psychiatrist during a session. If an urgent visit was deemed necessary or presented itself, the CCT would be alerted (via instant messaging, phone) or would join at the beginning of a session in anticipation of a higher risk situation. This was mimicked for shared care sessions, whereby two or more clinicians would meet collaboratively with a student via OTN or MS Teams. These platforms were used for fairly immediate case conferences when a student's clinical presentation was becoming more acute. Workshops were initially cancelled, then delivered through MS Teams. We had a few groups that had one or two sessions left and these were transitioned into individual sessions; a new round of groups is currently on hold, with a plan to pilot virtual groups over the summer via MS Teams. There is an increased use of holding virtual shared care sessions, where more than one clinician meets with a student in order to ensure greater collaboration and management of higher risk or clinically complex situations. For new services, Health & Wellness offered medical services after hours and weekends for students remaining in residence. Residence staff also work with our nurses around identified students in self-isolation, to provide check-ins and education.

Summary of Clinical Services and Modality

Service	Modality
Booking appointments	New encounters are booked by administrative staff. Appointments are booked as video sessions (preferred) or phone sessions (usually student preference or need). Online booking requests for medical appointments are managed by the administrative staff.
Triage/Intake	Intakes are booked by administrative staff, with video sessions the preferred format, or by phone (usually by student preference or need).
Informed consent	Service agreement and consent forms are sent and returned by the administrative staff via U of T email. Informed consent is verbally confirmed via phone or video by the clinician at the beginning of every virtual session; consent is documented in encounter notes. OTN and Medeo are also used to securely send and receive documents.
Clinical sessions with existing clients	All visits are conducted via phone or video; minimal in-person visits remain available for limited medical services.
Clinical sessions with new clients	New encounters are scheduled as video sessions (preferred) or phone visits.
Crisis management	Crisis situations are managed via phone or video and the CCT or psychiatry becomes involved live, as needed. Clinical situations that approach this threshold could result in a joint session of two or more clinicians and one student via OTN or MS Teams.
Record-keeping / EMR	Remote connection to ACCURO EMR.

Outcomes

Student and Staff Feedback

Initial anecdotal reports from clinicians had a similar theme: students reported functioning better than pre-COVID, express gratitude for continuation of services, as well as concern over clinicians. By May, some students reported higher levels of distress related to difficulties with isolation, lack of motivation, and uncertainty. For staff, as expected, there were varied responses in terms of concerns working on/off-site, comfort with technology, comfort managing new patient encounters and anticipated clinical risk situations. Overall, the team mobilized quickly and transitioned quickly into providing phone sessions during the first week to week-and-a-half. The transition and comfort level regarding use of Medeo was slower, though psychiatrists seemed comfortable with OTN/Medeo rather quickly. Family physicians have also learned to schedule their own follow-up appointments, which in past was done by administrative staff. Over time, staff reported fatigue from providing virtual care and expressed more support around protocols for managing risk, despite a significant drop in crisis, on-call cases. Staff also expressed a desire for more support around learning MS Teams and developing virtual workshops and groups.

Challenges

Clinical practice

1. We continue to be challenged by jurisdiction issues for clinicians to practice across provinces. Typically, a clinician will conduct a non-clinical session to identify pre-existing healthcare providers and local supports. We also refer students to MySSP for immediate and ongoing counselling support.
2. Managing clinical risk virtually and arriving at guidelines.
3. Speed of transition and ability to provide immediate communication and support to staff.
4. Technology issues (home devices, webcam and laptop shortages) and connectivity issues (likely related to Wi-Fi connections).
5. Workshops and groups: re-creating content to COVID context and online formats.
6. Finding a consistent way to send/receive confidential forms that includes personal health information and converting forms into PDF fillable forms with e-signatures.

Staffing

1. Managing staff concerns around health & safety, pay continuity, childcare, possible re-deployment, and workforce planning.
2. Managing staff schedules when they self-declare (as immunocompromised, sick, self-isolation)
3. Managing rotating on-site staff schedules in an equitable manner.
4. Shifting responsibilities: Staff were given responsibilities that they would otherwise not be given (e.g., contacting clients, booking appointments, check-ins, managing wait lists, catching up on incomplete projects/tasks)
5. Providing enough staff support via video conferencing and email communication.

Metrics

Outputs:

1. Number of in-person, phone and video conferencing visits (and compared to past years)
2. Number of students seen
3. Wait times for intakes and initiation of ongoing care (as they potentially re-develop)
4. Referral patterns
5. Number of cancellations and no-show appointments

Process & Outcomes

1. Survey of staff user experience of online platforms.
2. PHQ9/GAD7: verbally administered by medical staff for mental health appointments).
3. OQ45: on hold until a suitable secure file transfer system is identified and copyright issues addressed.

Lesson Learned

The team demonstrated agility, flexibility, and resilience, particularly during the first week of transition, despite limited opportunity for team meetings. While there was some preparation to manage the impacts of the pandemic, greater preparation is key and being as proactive as possible. Having an EMR that can “do it all” would be ideal versus using multiple methods for different needs, particularly for documentation transfer. At times, there were directives to move services to virtual methods and it was necessary to manage expectations around adapting in-person to virtual programming within short timelines. Working with other departments slowed down some processes and this was likely due to the rapid changing context and not always having clear guidelines in place for new circumstances (e.g., having secure platforms in place, protocols for verifying student identification, having a secure file transfer system, not always obtaining clear recommendations from the privacy office, occupational health & safety, or HR). It was helpful to leverage the clinical context so that central departments could prioritize our needs.

We now have an ability to manage our clinical services virtually and anticipate that many services will continue to be virtual once the pandemic has resolved. There is an understanding that things will not go back to “normal” but instead, will move to a “new normal”.

Recommendations

1. When selecting an electronic health record, consider a platform that includes all the needed features to enable your clinic to operate in a fully virtual manner (e.g., integrated video conferencing, secure file transfer, fillable online forms with electronic signature capacity).
2. Consider VOIP reception lines so that staff can easily transition to a fully remote switchboard operation.
3. Consider a staff on-boarding in-service for infection control or online module, including mask-fit testing (and checking for renewal every two years). Consider at least an annual PPE inventory and refresh supplies as appropriate.
4. Provide staff with appropriate supports, including equipment, IT support, accessible tools and resources (e.g., training modules, documentation guidelines), regular communication, regular team “huddles” or “check-in” meetings, in addition to resuming regular team meetings and learning events as soon as possible.
5. Consult with colleagues, utilize listservs, and professional association guidelines and share resources with one another.
6. Review and inform on telemedicine and teletherapy research and literature and identify emerging and best practices.
7. On an annual basis, update disaster response policies, procedures and guidelines.

Future Planning

Our teams are creating new workshops to deliver both virtually and in-person for the summer and fall, including pre-recorded workshops. We plan to pilot virtual therapy groups in the summer once a secure and confidential virtual platform allows for sharing of personal health information. We are putting our minds to delivering practicum and residency training, considering in-person and virtual training opportunities. We are now at the beginning stages of developing our “recovery and adaptation” procedures: COVID19 screening, organizing physical spaces and hallway traffic, plexiglass installation where appropriate, organizing staggered appointment times for in-person

visits, consideration of rotating on-site teams, criteria for on-site appointments, mechanisms for case identification and follow-up support, etc.