Making Telemedicine Policy for Ontario First Nations

A KO Telemedicine Proposal to Initiate Ontario-wide Collaboration on a Strategy for Integrating First Nation Telehealth/Telemedicine with the Ontario Telemedicine Network

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Executive Summary

Ontario First Nations have demonstrated national leadership in the delivery of comprehensive on-reserve Telehealth/Telemedicine services. For 25 remote and northern First Nations, KO Telemedicine (KOTM), the pioneer First Nations Telemedicine integrator in northwestern Ontario, has created a community-based videoconference and store-forward point-of-entry to clinicians, health educators, administrators, and trainers. This service demonstrably improves on-reserve access to federal and provincial health services.

KOTM provides an integrated approach to health human resource development and anticipates First Nation capacity to take advantage of improvements in the Canadian health system, such as the electronic health record. These issues are foregrounded in two sections. The first section surveys federal and provincial health policy and highlights Telemedicine capacities to meet longstanding First Nations access, ownership, and resourcing objectives. The latter section describes the development of First Nations Telehealth/Telemedicine in Ontario and identifies service model requirements and options moving forward. Recommendations for collaborative development of a strategy for integrating First Nation Telehealth/Telemedicine with the Ontario Telemedicine Network are included at the end of this section.

Telehealth/Telemedicine Investment in First Nations

During the past five years, the development of First Nations Telehealth/Telemedicine in Ontario has demonstrated a collaborative approach to meeting health needs without unnecessary duplication or creation of parallel health care systems. Its growth has been facilitated by strong relationships with member First Nations and among KOTM, the Ontario Telemedicine Network (OTN), the Ministry of Health and Long-term Care (MOHLTC) and First Nation and Inuit Health (FNIH). The net result has been the establishment and maintenance of a high quality and cost-effective Telehealth/Telemedicine service for Ontario’s most isolated communities. The service model is rooted in First Nations requirements, directed by community leadership and focused on First Nation health and wellness priorities. The use of information and communications technology supports a wide range of health, social, and economic development needs and anticipates First Nations development of complementary health initiatives such as clinical information systems and their use in population health and pandemic planning.

KOTM contributes to improved health outcomes for on-reserve populations. It provides a contemporary counterpoint to the historic failure of federal and provincial health policy and programs to close chronic health service access gaps for remote First Nations communities. First Nations Telehealth/Telemedicine in Ontario has substantively improved community-based choice of health service providers and frequency and

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1 Telehealth is a general term that describes a number of services such as tele-learning, tele-homecare, tele-triage (phone help lines). Telemedicine refers directly to technology-enabled clinical services via videoconferencing and store-forward (digital imaging) platforms. These terms are complementary and have distinct human resource, network, and integration requirements. Generally, federal (FNIH) investments are focused on non-clinical Telehealth and provincial agencies deliver Telemedicine.

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proximity of health service access. It has also demonstrated how culturally safe and competent health services can be delivered across large geographic and culturally diverse territories by First Nations. In this manner communities’ capacities are being built and strengthened while providing health workers with the resources they need to do their jobs effectively. Still First Nations telehealth/telemedicine development in Ontario is uneven. First Nations that are not served by KOTM neither have access to provincial common services and medical/allied health professional resources on-reserve, nor are they able to engage local site coordinators to support community uptake and health professional acceptance.

**Addressing Challenges/Engaging Opportunities**
First Nations-driven Telehealth/Telemedicine in Ontario, while successful, is at a crossroads. Growth of First Nations Telehealth/Telemedicine in Northeastern, Central and Southern Ontario has ceased as a result of jurisdicational uncertainty and misalignment of federal and provincial policy and program priorities. This important tool for equalizing First Nations access to health and wellness resources, faces pressures from many sides. Looking ahead, the development of a successful First Nations Telehealth/Telemedicine service in Ontario proposes several important requirements. These include:

- Existing services must continue to respond to community health and wellness needs and contribute to the well-being of First Nations through the provision of high quality, comprehensive Telehealth/Telemedicine services.
- FNIH must work with mandated First Nations Health organizations to develop a First Nations Telehealth/Telemedicine policy that enumerates the *business-* and the *value-case* for First Nations services and establishes a program base that will make these services available in all Ontario First Nations.
- Service delivery must be planned, implemented and managed by First Nations.
- First Nations Telehealth/Telemedicine must continue to grow. Priority must be given to geographically remote First Nations.
- A service model must be developed to address the needs of First Nations in rural, southern and more urbanized settings.
- Governance of First Nations Telehealth/Telemedicine must be collaborative, reflect the geographic and cultural diversity of Ontario First Nations and respect pre-existing alliances, partnerships and operational structures and synergies.

**Assumptions and Principles**
This paper highlights three lessons learned from five years of KOTM operational experience. First, Telehealth/Telemedicine is empowered by First Nations decision-making and ownership. This assumption situates community-based health needs at the centre of the network and provides a way to ensure long-term acceptance and growth of Telehealth/Telemedicine services among highly diverse and geographically disparate First Nations. Second, investments in First Nations Telehealth/Telemedicine must accommodate the needs of each individual First Nation. Broad based investments in Telehealth/Telemedicine need to be made in a systematic way that acknowledges resource gaps within communities and accommodates these gaps by ensuring that all First Nations have access to the same positive and sustainable outcomes. Finally, telemedicine systems must be scalable to all First Nations contexts. Improvements made in
infrastructures – such as access to telecommunications – must demonstrably improve the opportunities for large, small, remote and urban communities to meaningfully participate in First Nations Telehealth/Telemedicine services.

**Options Moving Forward**

Ontario First Nations are leading the way in the development of a comprehensive Telehealth/Telemedicine system that contributes to community well-being and enhances local access to health and wellness services. In moving forward, three change themes inform how First Nations Telehealth/Telemedicine will develop in Ontario:

1. the type of service model(s) that will be conceived and adopted in Ontario First Nations;

2. the capacity of the First Nations, federal and provincial health systems to adequately resource and sustain First Nations Telehealth/Telemedicine, and;

3. the ways and means by which these services will be delivered, supported and governed.

Each of these themes proposes specific challenges and will require focused time and money resources. Each is described in the section below.

**SERVICE MODEL**

<table>
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<tr>
<th>Service Model Requirements</th>
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<tr>
<td><strong>Comprehensive and Clinical Telehealth/Telemedicine</strong></td>
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<tr>
<td>▪ <strong>Community Requirements</strong> – local coordination: enhances cultural interoperability, builds local capacity, ensures local ability to set service priorities, enables community development, ensures the broadest range of potential uses (medical, wellness, education, training, health administrative meetings), supports community uptake and service provider acceptance</td>
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<td>▪ <strong>Operational Requirements</strong> – shared common services: promotes ease-of-use, captures economies of scale, supports service quality and continuous improvement, enables cultural, technical, clinical and organizational interoperability, ensures network security and privacy, facilitates capacity building and introduction of new 2nd and 3rd generation telehealth/EHR services</td>
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<td>▪ <strong>Strategic Requirements</strong> – partnerships; with federal, provincial and private sectors support multiple levels of sustainability, facilitates broad base of health program participation, enables seamless integration with the provincial Telehealth/Telemedicine network, and leverages access to allied agencies</td>
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<tr>
<th>Health Videoconferencing</th>
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<tr>
<td>▪ <strong>Community Requirements</strong> – Limited local training primarily supports technology end of the service (turning units off/on), supports health worker access to health education/training and health administrative meetings</td>
</tr>
<tr>
<td>▪ <strong>Operational Requirements</strong> – Outsourced managed services (scheduling, bridging) or small in-house staff.</td>
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<tr>
<td>▪ <strong>Strategic Requirements</strong> – strong relationship with one lead funder and ongoing links with local health leadership</td>
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**Sustainability**

Sustainability of distributed systems requires strategic and broadly based partnerships that are linked to policy objectives and program outcomes. Regardless of the service model that is adopted, a First Nations Telehealth/Telemedicine program ultimately must be led by First Nations, be accountable to community- and health service provider needs and take a system-wide approach to change management, service development and continuous improvement. The two models presented represent a service continuum. The health videoconferencing model is sometimes a transitional stage in achieving comprehensive Telemedicine services.

**Comprehensive Service Model**

The comprehensive Telemedicine service model is a complex system. It is horizontally and vertically linked with federal/provincial health systems and has the potential to support many outcomes and mandates. The community-based orientation of the comprehensive service model secures a central role for First Nations in setting the service agenda and achieving a wide range of highly localized objectives. Essentially, this model enables on-reserve access to more than a hundred medical specialties, sub-specialties and allied health professionals, delivery of laddered educational programming, provision of focused and on-going training opportunities and support for intra- and inter-regional health administrative collaboration.

Higher capital investment is required to provide clinical services on-reserve. This model requires that interoperable network security devices, enhanced videoconference units and on-board medical/diagnostic peripherals are procured to meet community-based demand for improved access and health outcomes. Accordingly, comprehensive services also require strategic alliances and the development of service level agreements with provincial systems to ensure end-to-end integrated access to all Telemedical points-of-care. In addition, this model requires an integrated First Nations common service capacity (help desk, training, bridging, installation) to make more effective use of existing health human resources, provide on-demand troubleshooting and encourage community uptake and health professional acceptance.

**Health Education and Videoconferencing Model**

The health videoconferencing model primarily requires a strong relationship with a single funder and with communities receiving the health education, training and administrative meeting services. Because dedicated Telehealth staff is not required, this model has significantly lower operating costs and capacities. This model also provides a great deal of flexibility to participating First Nations. They are able to develop independent and autonomous networks (that reflect cultural or regional affiliations) without negotiating access and service level agreements or adopting service standards or interoperability requirements with provincial or federal agencies.

Implementing this network requires investments in mostly low-cost videoconference technology and investment in shared services. This model does not support the clinical component of health care delivery or build community capacity to deliver Telehealth/Telemedicine services. Because investments in creating a dedicated service...
desk would be significant, the health videoconferencing model would likely outsource key shared service (help desk, scheduling, videobridging, service installation) functions. Similarly, the network model requires less expensive/lower bandwidth connections.

**Connectivity**

Significant investments already have been made to ensure community-based access to province-wide network service. Smart Systems for Health (SSHA), a provincial agency mandated to connect Ontario health facilities is required to provide secure broadband connectivity for all health services across the province. To reach rural and remote First Nation health centres there is a need to make these connections by working in partnership with K-Net. Keewaytinok Okimakanak (K-Net Services) negotiated a Service Level Agreement with Ontario's Smart Systems for Health Agency (SSHA) in 2006. The three-year agreement appoints K-Net to be the connectivity provider for all Aboriginal facilities that deliver health care services for Aboriginal people across Ontario.

**GOVERNANCE**

**First Nation Telehealth/Telemedicine Governance**

A model of governance that respects the unique realities of First Nations within Ontario is required for developing and sustaining First Nation Telehealth/Telemedicine services. The development of a governance model for First Nations Telehealth/Telemedicine services should provide direction and ensure accountability to mandated First Nations Health Organizations, First Nations members and system partners. It should also interface with the operational entity that will operate the service and coordinate community-based access to different service providers. The governance model must respect the inherent jurisdiction, authorities and roles of First Nation governments in the delivery of health services to their membership. Service governance must be based on the following characteristics:

- **Collaboration:** the model respects and balances the jurisdictional authorities of First Nations, the province and the federal government.
- **Interoperability and scalability:** provides the basis for an integrated and comprehensive service, and is able to link with existing and mature networks such as the Ontario Telemedicine Network and Manitoba Telehealth.
- **Effectiveness:** delivers services closer-to-home based on regional needs and captures efficiencies and economies of scale in the delivery of Telehealth/Telemedicine programming.
- **Community-directed:** regionally based service delivery that respects geographic and cultural diversity and service requirements of community members

Expansion of First Nation Telehealth/Telemedicine services requires that member communities endorse a governance structure.

**Telehealth/Telemedicine Benefits Summary**

A sustainable Telehealth/Telemedicine program must be responsive to community-based health and wellness needs and priorities and ultimately must provide a direct and seamless link to the provincial and federal health systems. Similarly, it must secure ongoing resources to meet these needs. A successful First Nations Telehealth/Telemedicine
program will be guided by a business- and a value-case. Features of these cases include:

- Removes geographic barriers to accessing essential health care services;
- Facilitates the integration of local, provincial and federal health services and programs based on First Nations health needs;
- Supports full integration with the largest Telehealth/Telemedicine network in Canada (the Ontario Telehealth/Telemedicine Network offers access to over 700 hospitals and health centres in Ontario);
- Reduces patient and system travel burden – particularly for the elderly and for parents with young children who have to travel long distances for access to specialized medical services.
- Improved community-based health service training and education capacity;
- Enhanced scope of regional health professional retention and recruitment strategies;
- Enhanced community capacity to coordinate and deliver services through certified Site Coordinators;
- Supports technological advancements in health (i.e., Digital imaging, store-forward, electronic health record/public health surveillance);
- Access to clinical and educational sessions benefiting individuals and community health workers;

**Recommendations Moving Forward**

The existing KOTM First Nations service is highly valued by its 25 member nations. It is anticipated that this type of service will be similarly valued by all Ontario First Nations. A region-wide First Nations Telehealth/Telemedicine program must…

a. Contribute to on-going delivery of a useful and responsive telehealth service that addresses the needs of all NAN communities\(^\text{2}\) as a priority using the KOTM model and run by KOTM

b. Enable a federal government program that supports (a) above and meets the full integration requirements of the OTN and SSHA.

c. Provide funding to support the expansion to all northern and isolated communities

d. Utilize KOTM expertise and resources to support and accelerate First Nations Telehealth/Telemedicine development in other Ontario First Nations

1. The Chiefs of Ontario political organization will work with KOTM in addition to all other First Nations currently engaged in Telehealth activities and those wishing to participate in the development of a province wide strategy to benefit all First Nations in Ontario.

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\(^2\)The position includes all of NAN, because NAN represents the bulk of the most remote and rural communities in the province and because there is a natural connection between KO and NAN (i.e. it makes some jurisdictional sense for the Deputy Grand Chief to lobby on behalf of NAN).
2. KOTM should continue to work with representatives from individual First Nations; mandated regional First Nations health authorities – such as the Sioux Lookout First Nations Health Authority and Weenebayko Health Ahtuskaywin; culturally-appropriate service providers, for instance, Aboriginal Health Access Centres and similar AHWS entities; and, political territorial organizations such as COO, NAN and Treaty 3 – and engage federal (FNIH, CHI) and provincial (MOHLTC, OTN, SSHAs) stakeholders and service providers in the development of a province-wide Telehealth/Telemedicine Collaborative.

3. The First Nations Telehealth/Telemedicine development Collaborative should engage in a service governance dialogue as a first priority. The governance model should acknowledge the special multi-partite character and requirements of Telehealth/Telemedicine services, provide direction and ensure accountability to mandated First Nations Health Organizations, First Nations members and system partners. It should also interface with the operational entity that will deliver Telehealth/Telemedicine services and coordinate community-based access to service providers. The governance model must respect the inherent jurisdiction, authorities and roles of First Nation governments in the delivery of health services to their membership. Service partnerships and respect for all levels of government must be based on the following characteristics:

   a. Collaboration: the model respects and balances the jurisdictional authorities of First Nations, the province and the federal government.
   b. Interoperability and scalability: provides the basis for an integrated and comprehensive service, and is able to link with existing and mature networks such as the Ontario Telemedicine Network and MBTelehealth.
   c. Effectiveness: delivers services closer to home based on regional needs and captures efficiencies and economies of scale in the delivery of Telehealth/Telemedicine programming.
   d. Community-directed: regionally based service delivery that respects geographic and cultural diversity and service requirements of community members.

4. The First Nations Telehealth/Telemedicine development Collaborative should initiate a business planning process to determine the financial and human resources required to implement a province-wide First Nations Telehealth/Telemedicine service.

5. KOTM’s extensive experience implementing, delivering and supporting First Nations Telemedicine services should be leveraged to lead the development of the business planning process.

6. Business planning for implementing a First Nations Telehealth/Telemedicine service in Ontario should…

   a. assume community-based access to comprehensive telemedicine services in all 142 First Nations, 10 Aboriginal health access centres, six healing lodges, nine women’s shelters and family healing programs
   b. anticipate the need to engage site coordinator services in each of the 142 First Nations sites
c. provide a distributed common services solution that complements and augments existing KOTM and OTN operations and infrastructure

d. expect that K-Net – through their service agreement with Smart Systems for Health Agency (SSHA) will deliver Telemedicine-grade circuits in each First Nation point-of-care

e. ensure that the First Nations Telehealth/Telemedicine services respect historical referral patterns and enable community-based access to high priority health professionals and service providers

f. ensure that the First Nations Telehealth/Telemedicine service is fully integrated with the provincial public health system.

g. approach or reach completion within five years of its official launch.
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Introduction

Many definitions of Telehealth/Telemedicine exist. Tele like the Ojibway word washa means far away or distant. When it is joined with health it refers to treating and supporting people and communities that are physically distant from care providers. The Canadian Society of Telehealth (http://www.cst-sct.org) adopts a definition of telehealth that highlights both the ways Telehealth/Telemedicine are used and the capacity to address longstanding gaps in health service access. For the CST, telehealth is the “use of information and communication technology (ICT) to deliver health services, expertise and information over distance, geographic, time, social and cultural barriers” (Reid, 1996). This paper engages these terms to define a Telehealth/Telemedicine landscape that is shaped by the community and clinical requirements for achieving First Nations health and wellness.

Why a First Nation Telehealth/Telemedicine Program

This paper demonstrates the historically complex character of health access for First Nations and how Telehealth/Telemedicine improves and facilitates the delivery of health and well-being services to achieve best possible outcomes for First Nations. It will be argued that First Nation Telehealth/Telemedicine must be delivered through a sustainable program that is supported by the necessary federal, provincial/territorial and First Nations authorities. The governance of First Nation Telehealth/Telemedicine must adhere to the political position of First Nation leadership, and thus respect the jurisdictional authority of all First Nations in Ontario. Continued incremental and project-based investments to telehealth/Telehealth/Telemedicine from other health programs and services will not facilitate a strategic approach that ensures reasonable access to essential health services, nor will it reduce multiple and longstanding barriers to comprehensive First Nations access to timely health and wellness services. Adopting a strategic investment strategy is especially critical for closing health service gaps in geographically remote First Nations, which constitute nearly 40% of the 134 First Nation communities in Ontario.

Access to Health Services

Since the inception of the reserve system, access and delivery of health care to First Nations in Ontario has been a continued challenge. The ability to balance the medical needs of First Nations people with the community’s capacity to deliver appropriate services remains an ongoing concern for governments at all levels. The continued deterioration of First Nations health status, the higher hospitalization rate and lower utilization rate for referral care sensitive procedures is a clear indication that there are grave and critical concerns that focus primarily on access to appropriate health care. The continuing decline in First Nations health status suggests that historic, current and new investments in First Nation health programs and services must incorporate wholistic strategies to facilitate access to services in a coordinated and cohesive manner.

Challenges in the delivery of health care services remain regardless of a First Nation’s location. To date innovative mechanisms have been initiated that focus on overcoming the barriers to accessing health services, and Telehealth/Telemedicine remains an area of service delivery whereby improvements to health services has been demonstrated. This
is evidenced by the KOTM evaluation, as well as ongoing formal and informal management review processes to continually increase effectiveness of KO Telemedicine.

**EXTERNAL POLICY INFLUENCES**

The current political initiatives of the provincial/territorial and federal governments to account for investments in health care focus on improving outcomes within the public health system and are based on assessing timely access. The most recent iteration of the health access investment cycle is embedded in the Patient Wait Times Guarantees, which facilitate expedited access through strategic investments in the public health system. Access to health services can be defined as “the timely use of personal health services to achieve the best possible outcomes.” (The Institute of Medicine, United States) Access to health services is a concern for all Canadians and there are many social and economic mechanisms which ensure that there is accountability to report on the delivery of provincial and federal health services for Canadians. Unfortunately, these accountability mechanisms are outside of the health care model currently delivered to First Nations.

**ACCOUNTABILITY TO ONTARIO FIRST NATIONS**

The development of a First Nation Telehealth/Telemedicine Strategy must ensure that all First Nations benefit from investments to improve access to essential health services for all Canadians. A First Nation specific Strategy must be developed in a regional context that ensures that Ontario First Nation leadership are supportive of the principles and objectives and are engaged in the reporting structure of any bilateral or trilateral initiatives. First Nations must ensure that tangible benefits are realized and accountability mechanisms are included that reflect First Nations priorities and capacities and do not create a burden for existing health care providers. As the regional First Nation political organization, Chiefs of Ontario would be the organization that provides the mandate and/or support to move a First Nation Telehealth/Telehealth/Telemedicine Strategy forward.

**OPPORTUNITIES FOR FIRST NATION LEADERSHIP**

Specific initiatives that leverage existing federal and provincial health programs and services for First Nations must be used to target improvements in community-based health outcomes and facilitate access to services that achieve physical, emotional and mental well-being for First Nations. Involving political leadership of First Nations in Ontario is essential to effectively engaging the provincial and federal governments through a trilateral process. Participation by all levels of governments (F/P/FN) must be incorporated into a Regional First Nation Telehealth/Telemedicine Strategy. This level of participation will ensure that the political and technical needs of First Nations are met and incorporated into a comprehensive strategy for the Ontario region and that it is based on an equal partnership between all levels of governments.

**Benefits for all First Nations**

Currently, twenty-five remote Ontario First Nations are directly benefiting from Telehealth/Telemedicine services, delivered by KOTM. These communities are overcoming cultural and geographic barriers that characterize health service delivery in
the north. Communities who are neither northern nor isolated would also benefit from a comprehensive and strategically linked Telehealth/Telehealth/Telemedicine program. Some of the tangible benefits of a comprehensive First Nations Telehealth/Telemedicine program for all Ontario First Nations include: improved access, increased coordination of services, sustained human resources, reduced travel burden and improved community capacity. In addition, First Nations and federal and provincial partners would also benefit from an integrated networking approach that captures economies of scale and introduces protocols, procedures and policies that are culturally interoperable with First Nations and non-First Nations patients, professionals and service providers.

Conclusion
It is essential that First Nations develop a sustainable Telehealth/Telemedicine Strategy that enables and facilitates their community members to take advantage of system-wide improvements in health care. Whether these benefits are manifested as technological innovations, service improvements or human resource enhancements, they enable a more equitable view of health service access for First Nations communities. The benefits of Telehealth/Telemedicine services also have the potential to increase health status for on-reserve populations and to improve community-based health outcomes. A strategic investment in Telehealth/Telemedicine services enables new health programming and ensures that First Nations are well served by their own government, the provincial government and the federal government in the area of health service delivery.
1. Provincial First Nations Health Access Policy

Amongst the political jurisdictions in Canada, Ontario is acknowledged as a leader in the development and implementation of progressive and inclusive Aboriginal health processes and programs. Situated within Ontario is Canada’s largest and most diverse Aboriginal population, including 25% of Canada’s First Nation population. Ontario recognized in the early 1990s the need to develop initiatives that engaged self-determination, recognized social, cultural, economic and geographic barriers and broadly addressed Aboriginal access to health and wellness resources. And while Ontario has achieved success within the policy boundaries of the Aboriginal Health Policy and its companion Aboriginal Healing and Wellness Strategy, these initiatives purposively attach themselves to place-bound notions of access and service delivery that are often exclusively in urban centres, and are less responsive to First Nation people who choose to exercise their rights to steward their land base, pursue traditional activities and grow their capacity to express themselves in inherently indigenous ways. For a large portion of the First Nation population in Ontario geographic factors also contribute to their inability to take advantage of specialized urban programming designed to assist Aboriginal people in accessing mainstream health services.

THE 1994 ABORIGINAL HEALTH POLICY: HEALTH STATUS, ACCESS TO SERVICES, PLANNING AND REPRESENTATION

The goal of the Aboriginal Health Policy is to improve the health of Aboriginal individuals, families, communities and nations through equitable access to health care, the creation of First Nation/Aboriginal health care facilities, improved standards of care, the provision of culturally appropriate health services and promotion of a healthy environment. Yet for many First Nations people living within their isolated or remote communities, a majority of the funded programs through this policy is not accessible. In order for the objectives of this policy and the Initiative’s programming to be met, a tangible link between First Nations on-reserve and targeted programming provided in urban settings, must connect all First Nations in Ontario.

First Nations leadership and control of programming is a principle embedded in the Aboriginal Health Policy and aligned with the self-determination model that is expressed within this policy statement.

Self-determination in health will be supported by appropriate levels of financial and human resources for Aboriginal-designed, developed and delivered programs and services which respect and promote community responsibility, autonomy and local control.

Maintaining the three strategic directions of the Aboriginal Health Policy ensures its effectiveness in achieving positive increases in health outcomes. An improvement in the
health status of First Nations is linked to their involvement and representation in the planning and developmental stages of targeted health programming, as well as ensuring that there is access to all provincially insured health care services. Telehealth/Telemedicine is an essential component to meeting these targets and facilitating the planning, communication and access to all programs and services funded through the Aboriginal Health Policy. For rural, isolated and northern First Nations, Telehealth/Telemedicine in Ontario is creating a link with urban Aboriginal health facilities and specialized health service providers. Specifically, it has demonstrated its potential to achieve the goals of the Aboriginal Health Policy in 25 of Ontario’s most remote First Nations communities.

…The Aboriginal health policy will assist the Ministry of Health to address access inequities in First Nation/Aboriginal health programming, respond to Aboriginal priorities, adjust existing programs to respond more effectively to needs, support the reallocation of resources to Aboriginal initiatives and improve interaction and collaboration between ministry branches to support holistic approaches to health.

The expansion of First Nations Telehealth/Telemedicine resources throughout Ontario will ensure that all First Nations in Ontario benefit from technological advances that guarantee access to health services and programs (including educational and training) is available to First Nations citizens and health care providers delivering services to First Nation people.

THE 2004 AHWS RENEWAL

The Aboriginal Healing and Wellness Strategy (AHWS) is a partnership between the Ontario government and 15 Aboriginal organizations, including First Nation political organizations and community representatives. The AHWS initiative provides funding and services for aboriginal people in Ontario residing on-reserve and in urban and rural areas. It is a model of what can be accomplished when Aboriginal people are engaged in the development and delivery of health policy, programs and services. With its focus on the issues facing Aboriginal families, the Strategy has a direct and beneficial impact on First Nation children and youth.

AHWS has enabled the creation of more than 250 community-based health and healing programs both on- and off-reserve, including a network of 10 Aboriginal health access centres, six healing lodges, nine women's shelters and family healing programs, crisis intervention teams focused on preventing youth suicide in 47 northern First Nations and delivery of the Aboriginal Healthy Babies Healthy Children program. While comparable to those provided to other Ontarians, AHWS programs and services have been designed to make them more effective for Aboriginal clients. The Strategy has also created more than 650 jobs in Aboriginal communities. The McGuinty government recognizes that AHWS has improved access to primary health care and achieved concrete results in addressing family violence.

In recognition of its success, AHWS has been renewed and an increase in its funding for a third five-year term has been secured. First Nation communities have expressed the need for culturally appropriate and distinct services to achieve positive health outcomes for their membership and deal with their concerns. As part of the Strategy’s new
approach, Ontario has recognized the need to continue to seek ways to help those who need distinct services. Telehealth/Telehealth/Telemedicine provides a medium for achieving this aim despite the serious fiscal challenges facing the province. Five years of First Nations Telehealth/Telehealth/Telemedicine delivery has highlighted the capacity of this service to make more effective use of existing health human resources, to improve and enhance access to services and to respect and adhere to the cultural uniqueness of Aboriginal communities.

THE 2005 ABORIGINAL FRAMEWORK: ONTARIO’S NEW APPROACH TO ABORIGINAL AFFAIRS

In 2004, the Ontario Native Affairs Secretariat undertook an engagement with Aboriginal people. The engagement represented a renewed commitment by the province to work with First Nations leaders and communities on health and education initiatives that will help children and youth stay healthier, do better at school and enjoy improved opportunities throughout their life. The outcome of the engagement was a Framework that charts a new course for building partnerships and creating positive change. Specifically, Ontario’s new approach called for “working with Aboriginal people to build this relationship and through it, develop productive partnerships, collaborate on key initiatives and achieve real progress on shared goals.”

Entitled Ontario’s New Approach to Aboriginal Affairs: Prosperous and Healthy Aboriginal Communities Create a Better Future for Aboriginal Children and Youth, the 2005 Framework asserts that establishing meaningful relationships is the basis for improving the quality of life for Aboriginal children and youth and identifies six principles for securing and sustaining positive relationships with Aboriginal people in Ontario. Importantly, the Framework affirms a government-wide commitment to improving access for First Nations, Métis and Aboriginal agencies and programming.

<table>
<thead>
<tr>
<th>Principle</th>
<th>Context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respectful Relationships with First Nations, and Aboriginal Service Providers</td>
<td>Ontario recognizes the importance of programs delivered by Aboriginal service providers across Ontario. The province will continue to partner with them to support and improve, where possible, the delivery of these programs.</td>
</tr>
<tr>
<td>Different Circumstances – Different Needs</td>
<td>Ontario's Aboriginal population is the largest and most diverse in Canada. There are different cultural communities, political groups and organizations – each with unique needs and perspectives. Ontario recognizes this diversity, and the need for flexibility in order to implement meaningful changes that reflect community priorities. 25% of the First Nation population in Canada reside in Ontario.</td>
</tr>
<tr>
<td>Aboriginal Participation</td>
<td>First Nations will have greater involvement in matters that directly affect their communities, including where applicable in programs and service delivery.</td>
</tr>
<tr>
<td>Federal Roles and Responsibilities</td>
<td>Ontario will work to establish clearer roles and responsibilities in keeping with the federal government's special relationship with Aboriginal people. The province will work with the federal government to foster a more constructive and co-operative relationship on matters affecting First Nations.</td>
</tr>
</tbody>
</table>
### Exhibit I: 2005 New Approach Framework

<table>
<thead>
<tr>
<th>Principle</th>
<th>Context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal and Treaty Rights</td>
<td>- Ontario respects Aboriginal and Treaty rights protected by Section 35 of the Constitution Act, 1982, and is committed to meeting the province's constitutional and other legal obligations in respect of Aboriginal people.</td>
</tr>
<tr>
<td>Inclusiveness</td>
<td>- Where appropriate and beneficial, Ontario will seek input from non-Aboriginal stakeholders on matters that affect their interests.</td>
</tr>
</tbody>
</table>

**Provincial Initiatives: Ontario Telemedicine Network**

Ontario recognizes the strategic link between health care renewal and enhancements made by Telehealth/Telemedicine to facilitate access to health service providers and improve the delivery and coordination of health services. The Ontario Telehealth/Telemedicine Network (OTN) was created in 2006 to address these issues by providing province-wide access to Telemedicine services. OTN is an amalgam of three legacy networks (NORTH [north and central], Videocare [southwest], and CareConnect [eastern]) and is core funded by the Ministry of Health and Long-term Care (MOHLTC). OTN provides comprehensive access to Telehealth/Telemedicine at multiple points of care—hospitals, clinics, Family Health Teams—throughout the province. This includes the most densely populated area of Ontario: Toronto and the Greater Toronto Area (GTA). OTN does not view point of service as a determining factor in the utilization and benefits of Telemedicine. Rather, they see Telehealth/Telemedicine as a way to make more effective use of scarce health human resources to ensure that all Ontarians have reasonable access to needed health services closer to home.

Access to on-reserve Telehealth/Telemedicine services is the single exception to this rule. Outside of the 25 First Nations served by KOTM, most First Nations are excluded from community-based access to the provincial Telehealth/Telemedicine system. Reduced First Nations access to the provincial Telehealth/Telemedicine service widens the gap between mainstream and First Nations health access and further entrenches the health disparities of First Nation people. In an era where technological advances are rapidly occurring in the delivery of health care, having an effective First Nation eHealth strategy that includes Telehealth/Telemedicine is essential for First Nations.

**Provincial Initiatives: HealthForceOntario**

Other provincially funded programs also benefit from investments to Telehealth/Telemedicine. For instance, the Ministry of Health and Long Term Care’s HealthForceOntario program recognizes the importance of retention and recruitment of health professionals in an increasingly competitive health human resource environment. Many of these health human resource recruitment and retention efforts are highlighting local access to education and training as key benefits for the health care workforce. Providing and distributing access to quality health care training and education via Telehealth/Telemedicine technologies is viewed as an important tool for enhancing community capacity to deliver health services. Telehealth/Telemedicine is a mechanism that facilitates the retention of health human resources – particularly in remote and rural communities – that can assist First Nations in achieving the best possible health outcomes for their members.
Provincial Initiatives: eHealth and the Electronic Health Record

Another example of how technology and Telehealth/Telemedicine can assist in the development of a health policy initiative is the linking of electronic health/medical/patient records to the existing provincial networking system. The need for First Nation controlled and linked health records is essential in the assessment of health status and the planning of regional and local health programming. Access to community-based data is the cornerstone to ensure accountability of all levels of government (F/P/FN) in the creation and delivery of health care and to guarantee that the needs of First Nation people are met. Similarly, disease outbreak management systems such as PANORAMA create a practical link between provincial pandemic planning and community-based capacity to respond. Telehealth/Telemedicine is a conduit that ensures that standards, guidelines, quality and safety goals are met by all levels of government who are striving to achieve these essential indicators within new and existing health programming for First Nations. It is also a first generation health information system platform with the capacity to link to 2nd generation – store-forward – and 3rd generation eHR systems.

SUMMARY

Ontario e-Health strategy is based on principles of equal access to health services and improving health outcomes for all Ontarians. It identifies comprehensive Telehealth/Telemedicine as an important element in the transformation and modernization of the provincial health system. Although Telehealth/Telemedicine is readily accessible in almost every provincial hospital and clinic, fewer than 20 percent of all First Nations in Ontario have access to Telehealth/Telemedicine services on-reserve. And while it may not be practical to introduce and support comprehensive Telehealth/Telemedicine services in every Ontario First Nation, adopting a comprehensive service model will ensure that services identified in geographically and culturally diverse communities are available to the degree that First Nations are on par with advances in medicine and health services available to other provincial citizens.

2. Federal Health Access Policies: Historical Policies and Programs (Moving towards Multi-jurisdictional Initiatives)

CANADA HEALTH ACT (GENERAL)

As the enabling legislation that allows for the transfer of federal resources to provincial governments, the Canada Health Act (CHA) outlines principles, objectives and criteria that must be met to secure the transfer of fiscal resources to the provinces for the delivery of insured health services. Through political and financial powers, the federal government is able to exercise considerable influence on health care policies of the provinces. Health is not an enumerated ground identified within the Constitution Act 1984, and is therefore neither identified as an exclusive jurisdiction of the provinces or federal governments. Convention, however, has dictated that the provinces/territories have become the administrators, organization and delivery agents of insured health care services in Canada. The federal government exerts power and influence primarily
through the Canada Health and Social Transfer, which is the legal instrument that transfers fiscal resources to provinces for health services.

There are provincial requirements that must be met and are outlined in the *Canada Health Act* to ensure that the federal government transfers the full contribution to the provinces for health services. These nine requirements include five criteria (public administration, comprehensiveness, universality, portability and accessibility), two specific provisions (which relate to user charges and extra-billing) and two conditions (which pertain to the provision of provincial information and provincial recognition of federal contributions).

Although all jurisdictions delivering health services in Canada are funded through Canada Health and Social Transfers it has been a challenge for provinces and territories to meet the unique health needs of First Nation citizens. First Nations are included in the per capita expenditures for insured health services funded by the federal government through the Canada Health Act, yet there is no mechanism to ensure that First Nations receive services that they, like other provincial residents, are entitled to. In recognition of the gaps in services many initiatives are currently underway to compensate for the jurisdictional quagmire that plagues the delivery of health services to First Nations. Trilateral negotiations to deliver health services are seen as the only practical and progressive manner with which to address disparities in health status.

**FEDERAL PROGRAMS AND INITIATIVES FOR FIRST NATIONS**

Currently the federal government provides health services to First Nations living within their communities that include health promotion, disease prevention and primary care. Health care is also provided to First Nations both on and off reserve through provincial insured services and programming. However, due to factors beyond the control of First Nations, the federal government through the First Nations and Inuit Health Branch provides most health care services that are accessed by First Nations in their communities. There are many difficulties in achieving the same level of services for First Nations people compared to those of other provincial residents in Ontario. Timely access for First Nations to health care is mired by jurisdictional issues, which include debates on whose responsibility it is to deliver health services, geographic location of reserves, higher rates of illness and limited access to health care practitioners. From a health determinants perspective, First Nations have benefited very little from federal increases to funding of provincial health services. First Nations require a solution to their health status that involves their full participation in the policy and program development stage. Attributing benefits to First Nations through mainstream program investments will not produce healthier outcomes and an increase in their health status, but rather further the health disparities that exist between Canadians and First Nations.

**NON-INSURED HEALTH BENEFITS PROGRAM**

Health Canada is the federal department identified to fulfill the constitutional responsibilities for First Nations delivering health services and programs for First Nations. The First Nations and Inuit Branch (FNIHB) is the designated area within Health Canada that is dedicated to delivering health programs and services to First
Nations. FNHIHB manages the Non-Insured Health Benefits Program. The policy directive for the Non-Insured Health Benefits program states that:

The NIHB Program is "to provide non-insured health benefits to First Nations and Inuit people in a manner that is appropriate to their unique health needs; contributes to the achievement of an overall health status for First Nations and Inuit people that is comparable with that of the Canadian population as a whole; is sustainable from a fiscal and benefit management perspective; and facilitates First Nations and Inuit control at a time and pace of their choosing."

Since the introduction of the envelope system in First Nation health, First Nations have been expressing their dissatisfaction with the management of the NIHB Program. With the grave fiscal restraints imparted on management of the NIHB Program since the introduction of the 3% envelope system in 1996/97, access to health services through the NIHB has been greatly reduced.

Financial analyses conducted by the Assembly of First Nations indicates that…

…a trend to increased utilization of health services by First Nations should be expected. In the NIHB Program, this will be felt in diverse areas from dressing changes for diabetes clients (covered under MS&E), to increased pharmaceutical expenditures associated with HIV/AIDS and higher demands on medical transportation. (AFN, p.5 emphasis added)

Experience in First Nations communities suggests that…cost containment measures have had an adverse impact in First Nations communities, for example, on decreased quality of service, longer waits, and denial of service if transportation access is not available. (AFN, p.7) Utilization rates for medical transportation for 2004/05 fiscal year in Ontario region, however, have decreased, as indicated in the 2004/05 NIHB Annual Report. This decrease in costs could be attributable to a number of factors, yet First Nations maintain that medical transportation is harder and harder to access despite the fact that First Nations are the sickest population within Ontario. Despite the anomaly in regional expenditures in medical transportation, the AFN has estimated that total medical transportation expenditures are expected to increase nationally to $525,178,793 by 2013-14.

The articulation of grave increases in medical transportation expenditures is not an exaggeration. In 1997, the Auditor-General for Canada showed NIHB expenditures growing from $85 million in 1990-91 to almost $150 million in 1995-96 - an increase of more than 40 percent. The benefit includes transportation to receive health services that cannot be obtained on-reserve, medical transportation from isolated communities, emergency transport to non-elective care, and community-based transportation to the nearest major centre. First Nation and Inuit Health regional offices administer approximately 60 percent of transportation expenditures with payments made directly to providers by Health Canada. First Nations communities on behalf of the Department administer the other 40% of expenditures, mainly for local medical transportation, under contribution agreements.

As identified in the Blueprint on Aboriginal Health, finding administrative solutions to manage the rise in medical transportation costs involves a number of initiatives that work in tandem. One initiative is better coordination of travel to health services. Another is
seeking innovative ways in which to bring medical services either closer to the community or deliver them within the community. Telehealth/Telemedicine -- as an example of incorporating both of these solutions by providing communities with medically necessary services -- develops the community’s social and technological infrastructure, enhances existing programs and creates opportunities for professional development for community health workers. Telehealth/Telemedicine is a mechanism that guarantees benchmarking services to other Canadians is being met for First Nations. Exhibits 2 and 3 describe the growth and weighting of NIHB expenditures.


AGA Report 2000

![Exhibit 2: Expenditures on Non-Insured Health Benefits](image1)

Source: FIRMS adapted by Program Analysis Division

**Exhibit 3: 2004/05 NIHB Expenditures by Benefit ($ Million)**

Of the total NIHB expenditures in 2004/05 ($767.7 million), pharmacy costs ($343.9 million) represent the largest proportion at 44.8%, followed by transportation costs ($211.5 million) at 27.6% and dental costs ($143.0 million) at 18.6%

Source: FIRMS adapted by Program Analysis Division

**The Current Federal Landscape**

In 2004, the federal government convened a First Ministers Meeting that focused on addressing systemic issues within the Canadian health care system to which First Nations were invited. This was the first time that First Nations were present at this level of political decision-making. The outcome of this meeting secured for the provincial and territorial governments an increase in funding to address wait times and other
administrative/structural concerns with provincial health systems. An agreement between the jurisdictions led to an infusion of $41.3 billion over 10 years for insured health care. Out of that allocation, $5.5 billion was specifically identified for the Wait Times Reduction Fund. At this time it was recognized by the federal government that First Nations would not necessarily benefit in the same manner as other Canadians from the infusion of resources directed at improving health care services. It was then that an agenda focusing on addressing determinants of health for Aboriginal people at the Prime Minister, Premier and Aboriginal leadership level was developed.

A First Ministers Meeting was called to address four key Aboriginal social determinants: health, housing, education and relationships. In preparation for this meeting, federal, provincial/territorial and Aboriginal (F/P/T/A) representatives met to develop solutions to issues and barriers facing First Nations, Inuit and Métis. The F/P/T/A representatives had a year to prepare a jointly developed outcome in the area of health for the FMM. The final product that was produced and endorsed by all political leaders was entitled the Blueprint on Aboriginal Health: A 10-Year Transformative Plan. This document outlined a national agenda for policy and program implementation that would achieve the greatest positive health outcomes for First Nations, Inuit and Métis people in Canada over a ten-year time frame. Unfortunately, the funding committed to implement these changes was not secured in the two most recent federal budgets and very little progress has been made on the plan to increase the health status of First Nations.

The effort and engagement process used to develop the FMM outcomes has not been completely lost however. First Nations had the opportunity to identify common priorities at the national and regional levels that has greatly assisted current political initiatives – of which key areas of services and program enhancements identified through the Patient Wait Times Guarantee Pilots announced by Minister Clement is an example. Another example of a priority identified by all jurisdictions was the enhancement of Telehealth/Telemedicine services to deliver and facilitate improved access to primary and specialty care within First Nation communities.

**PATIENT WAIT TIMES GUARANTEES**

As one of the five priority areas of the Canadian government, federal and provincial jurisdictions have invested in health services that focus on the reduction of wait times. The patient wait time (PWT) service areas measured by the provinces and the federal government include: cancer, vision, diagnostic imaging, joint replacement and cardiac procedures. In Ontario, the measurement of the time frame for evaluative purposes for the PWT is “from when a diagnostic scan order is received by the hospital until the actual exam is completed. This interval is typically referred to as from ‘decision to treat’ to ‘treatment’.” (Senator Kirby Report commissioned by Minister Smitherman, February 2007)

As benchmark indicators for assessing the effectiveness of the PWT initiative, it has been effectively argued by the Assembly of First Nations that the five health service areas identified by the federal government will not address the systemic barriers First Nations face in accessing provincially insured health services, timely or otherwise. A
requirement of assessing data that pertains specifically to First Nations in the area of benchmarking is necessary to evaluate outcomes.

[Gathering] data on the length of time that a First Nation individual waits for specialist care, and [determining] if that time period differs from the general population [will be necessary to outline the distinctive approach needed]. Given the difference in access to health services between First Nations and the majority of Canadians, limiting wait time discussions to after the specialist has placed a person on a wait list will overlook a significant opportunity to potentially lower patient acuity and decrease demand on wait lists before placement on the list. (pg. 2, Road Map to a Patient Wait Times Guarantee for First Nations, AFN 2006)

It is at the first level of care that First Nations typically face barriers. The federal government has been responsive in addressing the need for a distinctive First Nations approach and has worked with the AFN to identify priority areas where FN PWT Guarantees would contribute to positive health outcomes.

Regional First Nation interest, as articulated in the Road Map to a Patient Wait Times Guarantee for First Nations was identified through the First Nation contribution to the Blueprint on Aboriginal Health. The Blueprint has been instrumental in the development of larger policy documents that focus on improvements to First Nations health. For instance, in addressing necessary structural change in the delivery of health care services to First Nations, AFN identifies the need to address “information and technological” changes including...

…telehealth, especially in rural, remote and northern First Nations, and electronic health records to bridge First Nations patient information across all relevant jurisdictions. (pg. 2, Road Map to a Patient Wait Times Guarantee for First Nations, AFN 2006)

In recent months, the federal government has announced two Patient Wait Times (PWT) initiatives that are to be piloted in select First Nation communities testing FN PWT Guarantees. These are prenatal care and diabetes care. To ensure that these guarantees are met, systems will need to be developed that support the health care providers in achieving these goals, as well as demonstrating that the necessary systems are in place to provide the technological infrastructure to meet the evaluative criteria set out including a centralized data registry. Telehealth/Telemedicine can assist in the overall goal of guaranteeing timely access to essential health care services for First Nations people by providing a cost neutral mechanism to bring physician care into a community and provide the necessary services and education for pregnant women.

Telehealth/Telemedicine will also been essential in the diabetes PWTG pilot projects. The national pilot project is expected to decrease diabetic complications by increasing educational health promotion and prevention activities for First Nation people diagnosed with diabetes. A regional First Nations PWTG pilot project was announced at the beginning of the new year in Manitoba. This PWTG focuses on bridging private health care providers with the health needs of First Nations by delivering essential foot care to diabetic First Nations in Manitoba. It is an innovative partnership between First Nations, the federal government and a third party provider.
ABORIGINAL HEALTH TRANSITION FUND

In 2004, the Prime Minister announced investments in Aboriginal health that included the Aboriginal Health Transition Fund (AHTF). Comprised within this Fund are three envelopes designed to integrate and adapt health services for Aboriginal delivered by First Nation, federal and provincial/territorial governments. The AHTF consists of $200 million to be invested in the following areas:

- $80 million for the Integration fund (aimed at ensuring a cohesive health care system that eliminates gaps in services and duplication in services);
- $80 million has been allocated for the Adaptation envelope which is exclusively available to provincial/territorial governments to ensure that health services meet the health care needs of Aboriginal people served within their jurisdiction; and
- $10 million for the Pan-Canadian envelope has been allocated directly for First Nation, Inuit and Métis lead initiatives.

The First Nation allocation for the Pan-Canadian envelope is $5 million over four years and is being distributed to regional First Nation organizations.

In order to adhere to the funding criteria for all levels of the AHTF, all three levels of jurisdictions must coordinate efforts to develop and support integration and adaptation initiatives. Successful outcomes for the AHTF fund must integrate services into sustainable programming that address the health needs of First Nations within a regional boundary.

Considering the new investments in health technology made by the Ontario government and the federal government through Canada Health Infoway, First Nations Telehealth/Telemedicine is positioned to play an important role in meeting the integration and service improvement aims of AHTF. In Ontario, this should mean that First Nations can access the same integration of health care providers from across the province regardless of the geographic, economic or cultural barriers that may exist.

Telehealth/Telemedicine: The Need for Collaboration

Although the last thirty years has seen many policies, programs and services specifically targeting the health status and outcomes of First Nations people, many gaps remain. There are many social and economic determinants that point to why this is the reality for First Nations. For instance, in the 1979 Indian Health policy the federal government recognized the distinct circumstances of First Nations communities, which were characterized as having “a grave disadvantage compared to most other Canadians in terms of health…” Thirty years after the development of the Indian Health Policy, First Nations, federal and provincial governments must continue to work on the goals contained in the following three pillars; community development, relationship building and access to all levels of the Canadian health system. Although there have been strides made in health policy targeting improvements to the health of First Nations, these initiatives have not achieved an improvement to the health status of First Nations. It is clear that technological advancements, community capacity, professional development and networking, as well as bridging the gap in access to health care services are examples of the needs of First Nations citizens and how they can be met through Telehealth/Telemedicine.
First Nations Telehealth/Telemedicine Service Development

Many definitions of Telehealth/Telemedicine exist. Tele like the Ojibway word washa means far away or distant. When it is joined with health it refers to treating and supporting people and communities that are physically distant from care providers. The Canadian Society of Telehealth (http://www.cst-sct.org) adopts a definition of telehealth that highlights both of the ways Telehealth/Telemedicine are used and its capacity to address longstanding gaps in health service access. For the CST, telehealth is the “use of information and communication technology (ICT) to deliver health services, expertise and information over distance, geographic, time, social and cultural barriers” (Reid, 1996). The CST definition also anticipates the important concept of interoperability in Telehealth/Telemedicine. Originally, a term developed in the computing industry, interoperability is a central feature of Telehealth/Telemedicine development in Canada and encompasses “the exchange of information in order to deliver health services and business transactions, without loss of meaning, through a common core of understanding of working processes, policies and regulation, use of the electronic tools, and human skills required.” (Canada, 2003)

Interoperability is usually categorized within three dimensions: a) technical systems need to share standards so that they can talk to each other, b) clinical services have to be managed and delivered within common protocols and practices, and c) organizational structures have to be aligned and compatible. First Nations Telehealth/Telemedicine – borrowing from established notions of cultural competence and safety – has introduced a cultural dimension of interoperability: culturally sensitive health care, such as context appropriate and preventative interventions, development and use of tools to accurately elicit patient preferences and required resource allocation to facilitate access to desired services (e.g., language, community capacity development). (Inter Tribal Health Authority, Telehealth Development Workshop, 2005) This last interoperability theme is the domain of First Nations service providers and the community-based staff who coordinate local service delivery, provide on-site translation services and stimulate community engagement and participation in the service.

Emergence of First Nations Telehealth/Telemedicine Services

Information and communications technologies have been used to address health service access needs of Ontario First Nations communities since the 1930s. The Hudson’s Bay Radio Network regularly used the wireless short wave technology installed in company stores to call for emergency medical advice and to aid transport decisions. Similarly, the Department of Communications introduced high frequency trail or bush radios to link trappers with nursing stations in their home communities to staff at regional hospitals. The introduction of telephony in most First Nations communities between 1975 and 1985 extended the reliability and capacity of telecommunications to support clinical decision-making. Nurses used telephones to confirm treatment and transport decisions with distal physicians. Telephony also enabled transmission of ECGs and slo-scan medical imaging (x-rays) between remote nursing stations and secondary and tertiary health facilities (Carey et al, 1979; Dunn et al, 1980). The application of the latter technologies provided a key evolutionary step towards our current use and understanding of Telehealth/Telemedicine and specifically the clinical protocols, standards and applications that are the exclusive domain of Telemedicine.
EARLY EXPERIMENTAL APPLICATIONS

In the 1990s, federal investments in Telehealth/Telemedicine for First Nations were identified and accelerated. This led to the development of a number of pilot projects being implemented. The MERLIN project (MEDical Remote Link Indian-health Network) used real-time broadband satellite connections to connect the Sioux Lookout Zone Hospital to the Health Canada Regional office in Ottawa and Nursing Stations in the Kitchenuhmaykoosib Innuwug (then known as Big Trout Lake) and Webequie First Nations. MERLIN bypassed telecommunications infrastructure problems through the use of satellites and introduced a prototype version of a Telemedicine workstation. The workstation accommodated medical peripherals – such as the stethoscope – enabled nurse/physician consultations and pushed x-rays and ECGs between sites (HC Data). MERLIN, while technologically advanced, had high operational costs, lack of buy-in from physician and nursing staff and workflow gaps in the clinical service model which resulted in the cancellation of the project.

THE NATIONAL FIRST NATION TELEHEALTH PILOT PROJECT

In 1998, Health Canada secured funds from the Primary Health Care Transition Fund to launch a national First Nations Telehealth pilot project that included sites in Quebec, Manitoba, Saskatchewan, Alberta and British Columbia. Generally, these five projects demonstrated the full scope of barriers that limit implementation, acceptance, use and sustainability of Telehealth/Telemedicine in remote First Nations settings. Evaluation of the five First Nation telehealth pilot projects that ran from 1998 - 2001 revealed that the key to successful Telehealth/Telemedicine implementation in Aboriginal communities is dependent upon human factors (Health Canada – website). For example, Telehealth/Telemedicine acceptance by patients, providers and families necessitated commitment and capacity of individuals involved in the projects, and the presence of stable and committed staff throughout the implementation period. The Health Canada national pilot project identified capacity requirements, particularly at the community level. The Telehealth Site Coordinator role implemented by KOTM was developed to address service and cultural requirements first identified by Health Canada.

ONTARIO’S FIRST NATIONS TELEHEALTH/TELEMEDICINE PARTNERSHIP

In January 2000, Health Canada announced funding to support a regional Telehealth/Telemedicine consultation in northwestern Ontario. Health Canada viewed First Nations in Northwestern Ontario as being highly amenable to Telehealth/Telemedicine access and Keewaytinook Okimakanak was asked to participate in the consultation to represent First Nations in the regional development of telehealth services. Dr. Edward Brown – then Program Director of the legacy NORTH Network and currently OTN CEO - was selected as the lead consultant to oversee the consultation. The consultation engaged regional and community-based health workers and professionals and reflected local needs and priorities across the region and specifically in the Deer Lake, Fort Severn, Keewaywin, North Spirit Lake and Poplar Hill First Nations.
The final report of the regional consultation supported implementation of Telehealth/Telemedicine in the KO First Nations and became the basis for a working partnership between Keewaytinook Okimakanak (Northern Chiefs Council) and the NORTH Network. In April 2001, Keewaytinook Okimakanak entered into a services partnership with NORTH Network. Keewaytinook Okimakanak (KO) was tasked with developing and documenting a telehealth service model that addressed the requirements of rural and remote First Nations. Health Canada funded the partnership for two years as part of the Canada Health Infrastructure Partnership Program (CHIPP). Subsequent project funding has supported the expansion of the project to an additional 19 First Nations sites within the Sioux Lookout Health Zone. KOTM is the most successful and longest running First Nation Telehealth/Telemedicine pilot project in Canadian history. Despite this, current project funding expires in March 2008. In 2006, Keewaytinook Okimakanak (K-Net Services) negotiated a three-year Service Level Agreement with Ontario's Smart Systems for Health Agency (SSHA). The agreement appoints K.O. (K-Net) to be the connectivity provider for all Aboriginal facilities (health centres) that deliver health care services for Aboriginal people across Ontario.

During the past five years, KO Telemedicine has also worked closely with First Nations, Aboriginal health organizations and political territorial organizations such as the Metis Nation of Ontario (MNO), Nishnawbe-Aski Nation (NAN) and the Chiefs of Ontario (COO) to support emergent Telehealth/Telemedicine interests. For instance KO Telemedicine, in partnership with the KO Research Institute, coordinated and delivered COO’s 2005 Telehealth engagement conference with First Nations. In November 2006 the Chiefs of Ontario in assembly resolved to... “support the work that KO Tele[medicine] is delivering in the remote First Nations;” and further resolved that “The Chiefs of Ontario political organization will work with Keewaytinook Okimakanak to identify strategies to make sustainable community-based telehealth for First Nations in Ontario supporting the ongoing operation of these essential health services and programs in our communities acknowledging that it will complement, not compete with future First Nations community and Telehealth activities.”

In 2006, the Chiefs of Ontario and KO Telemedicine submitted separate proposals to develop a tripartite process for supporting existing First Nations Telemedicine services and expanding Telemedicine access throughout Ontario. Although the KOTM process was never initiated, the COO process did engage a consultant to produce a document entitled *Gii-Kaan_Daan: Development of an Ontario First Nations Telehealth/Telemedicine Planning Partnership*. Both processes were terminated by the Associate Regional Director for FNIH Ontario when, in October 2006, he indicated that he would be seeking “direction from Branch senior management regarding telehealth planning in the regions before what has been started goes much further.”

In May 2007, COO re-engaged its telehealth development process and initiated discussions with FNIH and OTN to discuss expansion of First Nations telehealth services. The Ontario Chief indicated that FNIH would be distributing one-time capital to support First Nation Telehealth expansion. Chief Toulouse also indicated that COO would be seeking the support from the Regional Director of FNIH for a Canada Health Infoway proposal to plan and implement expansion activities. A meeting with KO
Telemedicine, Nishnawbe-Aski Nation and the Ontario Chief is planned for mid-June.

**First Nations Telehealth/Telemedicine: Models for Governance**

The growing interest in a First Nations Telehealth/Telemedicine service in Ontario proposes the question of Governance. Telehealth/Telemedicine program Governance is a unique challenge across Canada. Provincial systems vary widely. For instance, the OTN is primarily governed by hospital leadership. In British Columbia, health authority representatives provide leadership. In Manitoba, telehealth/telemedicine is vested in the Winnipeg Regional Health Authority. Variations in governance approaches respect jurisdictional differences and also highlight the distributed nature of the service and the broadly-based interests that are invested in Telehealth/Telemedicine. These same issues are carried over to First Nations programs and are further complicated by the relative newness of Telehealth/Telemedicine services and a highly decentralized model of First Nations health service decision-making that acknowledges the autonomy of each Nation to determine the best course for its members.

**THE CHALLENGE OF DIVERSITY**

Like provincial systems, First Nations telehealth/telemedicine governance assumes many forms. In Alberta, a Health Information Management Committee reports to leadership as part of a Health Canada/First Nations Ministerial Agreement. KOTM is governed by an Advisory Group of member Health Directors and provides yearly accountability updates to regional Chiefs. Manitoba includes a First Nation representative on its Board. Nova Scotia has embedded Telehealth/Telemedicine decision-making within its tri-partite health committee. In British Columbia a similar but less formal tripartite partnership advises on Telehealth/Telemedicine and eHealth (eHR) initiatives. The various Governance models share common elements.

**ELEMENTS FOR SUCCESS**

These common elements acknowledge the special multi-partite character and requirements of Telehealth/Telemedicine services, provide direction and ensure reciprocal accountability between First Nations Telehealth/Telemedicine organizations, and system partners. They also create an interface with the operational entity that operates the service and coordinates community-based access to service providers. Moving forward, First Nations should also anticipate a governance model that respects the inherent jurisdiction, authorities and roles of First Nation governments in the delivery of health services to their membership. Specifically, service partnerships and respect for all levels of government should be based on the following characteristics:

- **Collaboration:** the model respects and balances the jurisdictional authorities of First Nations, the province and the federal government.
- **Interoperability and scalability:** provides the basis for an integrated and comprehensive service, and is able to link with existing and mature networks such as the Ontario Telemedicine Network and MBTelehealth.
- **Effectiveness:** delivers services closer to home based on regional needs and captures efficiencies and economies of scale in the delivery of Telehealth/Telemedicine programming.
- Community-directed: regionally based service delivery that respects geographic and cultural diversity and service requirements of community members

**Observed Benefits of First Nations Telehealth/Telemedicine**

More than 20 years of telehealth pilot project development has demonstrated key benefits of Telehealth/Telemedicine services. Foremost among these benefits is the community acknowledgement of the value that enhanced access to distributed health resources has in rural and remote First Nations. More recently, Telehealth/Telemedicine’s value as a tool for facilitating administrative collaboration and decision-making, staff training and continuous improvement activities has been acknowledged by First Nations. Overall, First Nations that have access to telehealth and Telehealth/Telemedicine services view it as both a tool to enhance the physical wellness of community members and the economic well-being of their community. It is also viewed as a demonstrable step towards First Nations keeping pace with health system modernization measures being introduced within federal and provincial jurisdictions.

In addition to overarching and system-wide benefits, Telehealth/Telemedicine has also demonstrated specific benefits for Ontario First Nations. Exhibit 4 describes documented benefits in rural and remote Ontario First Nations:

<table>
<thead>
<tr>
<th>Exhibit 4: Documented Benefits of First Nations Telehealth Services</th>
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</thead>
<tbody>
<tr>
<td>• Improved access to comprehensive health care for under serviced remote and northern First Nations communities</td>
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<tr>
<td>• Reduced isolation for remote Nursing staff and community health workers through regularly scheduled continuing health education and capacity-building sessions</td>
</tr>
<tr>
<td>• Increased integration and coordination of federal and provincial services on-reserve</td>
</tr>
<tr>
<td>• Enhanced scope of regional health professional retention and recruitment strategies</td>
</tr>
<tr>
<td>• Community-based access to high priority clinical and wellness services available to other First Nations in other parts of Ontario</td>
</tr>
<tr>
<td>• Full integration with the Northern Ontario Medical School community-based learning model, supporting medical student learning and practice needs during community placements</td>
</tr>
<tr>
<td>• Reduced patient travel burden – particularly for the elderly and parents with young children who have to travel long distances for access to medical services</td>
</tr>
<tr>
<td>• Improved community-based health services capacity-building and training for health centre staff and community-based groups</td>
</tr>
<tr>
<td>• Increased capacity for First Nations to collaborate and coordinate planning and decision-making</td>
</tr>
<tr>
<td>• Increased capacity and sustainability of local access to broadband services</td>
</tr>
<tr>
<td>• Creates a new community-based entry point to new health career training and learning</td>
</tr>
<tr>
<td>• Increased participation of family in hospitalized patient care</td>
</tr>
<tr>
<td>• Enables stronger partnerships between health care providers and First Nations</td>
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</tbody>
</table>

**Telehealth Service Applications**

Telehealth/Telemedicine encompasses a wide scope of practice and is often used interchangeably with terms such as eHealth. Canada Health Infoway – a national not-for-profit agency that makes strategic investments in telehealth and Telehealth/Telemedicine development -- has identified four telehealth domains. (Vigneault, 2007) Each domain (see Exhibit 5) enables access to different types of service applications at the community level. This approach recognizes that different Telehealth/Telemedicine applications have different technical, clinical, organizational and cultural requirements and also that each
service represents an evolutionary step in the ways that allied services (e.g. the electronic health record) are develop and used.

For instance, FNIH Regional Office in Alberta has chosen to develop services – such as web portals and educational videoconferencing – that require less bandwidth, less complex service models and fewer points of integration with provincial service providers. As a result, telehealth in Alberta First Nations has focused on services that address issues such as nursing recruitment and retention and the need for community-based educational support and put a lower emphasis on clinical service delivery. In 2004-2005 approximately one percent of all telehealth (24 of 1775 sessions) was classified as a ‘client-centred clinical session’. (Cristescu, 8)

Ontario Region, on the other hand, has adopted a collaborative hybrid model of Telehealth/Telemedicine development. This model addresses community-defined health and wellness needs and provides comprehensive access to Telehealth/Telemedicine services. For example, of the nearly 7,000 sessions that KO Telemedicine coordinated between March 2002 and November 2006, slightly more than 50% were client-centred clinical services, 18 percent were health professional educational events, 17 percent were training sessions for community health staff, 13 percent supported administrative meetings and two percent of all telehealth activity facilitated family visits between community-based family members and persons under care at provincial health facilities.

In addition to the telehealth services described above, First Nations and federal/provincial stakeholders have also participated to varying degrees in the development of home telehealth (known as Telecare) and tele-triage (phone-based nurseline type services such as Telehealth Ontario). Telecare and Tele-triage both make modest connectivity demands. Requiring only phone-line access Telecare provides an opportunity to monitor patient well-being in the home by relaying indicators such as pulse, blood pressure,

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Exhibit 5: Telehealth Domains and Access to Services

<table>
<thead>
<tr>
<th>Telehealth Domains</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telemedicine</td>
<td>Medical applications using <strong>mainly broad bandwidth</strong> ICT (video-conferencing) that allow the delivery of healthcare at distance and the exchange of related medical information.</td>
</tr>
<tr>
<td>Telelearning</td>
<td>A mode of learning using <strong>either broad or low bandwidth</strong> ICT to provide access to interactive and often customized courses (e.g. continuing medical education)</td>
</tr>
<tr>
<td>Telecare (Home Telehealth)</td>
<td>Health applications using <strong>mainly low bandwidth</strong> ICT designed to monitor the state of health of a patient from his/her home including the exchange of related medical information.</td>
</tr>
<tr>
<td>Teletriage</td>
<td>The provision of health information and advice to patients over the telephone (POTS) about preferred courses of action related to level and urgency of care needed. Providers use computerized protocols developed by clinical experts to guide and record the advice provided</td>
</tr>
</tbody>
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3Adapted from *Canada Health Infoway*, February 2007.

John Rowlandson and Saga Williams
Tele-triage largely responds to public health and wellness questions. Often acute in nature, tele-triage staff direct callers to the most appropriate level of service (e.g. self-care to emergency room interventions). Currently, there is no direct First Nations participation in the delivery of either telecare or tele-triage services in Ontario. Accordingly, the telehealth focus in the following sections deals primarily with Telehealth/Telemedicine (a hybrid service that videoconference-enables clinical encounters, delivers health professional education and community health worker training and supports administrative collaboration and decision-making in and among First Nations network members).

TELEHEALTH/TELEMEDICINE SERVICE MODELS

Telehealth/Telemedicine network providers have adopted different approaches to the ways that they deliver Telehealth/Telemedicine service applications. The approach by the provider is called their “service model.” The service model determines which Telehealth/Telemedicine applications will be available and how they will be supported. Some Telehealth/Telemedicine networks adopt a very decentralized approach – for example, they make few knowledge or skill requirements and provide little or no support when problems occur. Others adopt managed service approaches. These networks align local capacity building with highly specialized help and support services. Although each approach enables distribution of Telehealth/Telemedicine services, the managed service approach demonstrates higher success rates, delivers a broader range of services, is more reliable and requires a higher initial investment.

The nature of the managed service is informed by its most complex task. A comprehensive Telehealth/Telemedicine service will require robust and secure network services, fully supported and continuous training opportunities for community staff and easy access to common support services such as videoconferencing, help services, clinical leadership and regional service development. A managed tele-learning videoconference service makes minimal community demands (an administrative person to book the videoconference room) and may out-source programming and other managed services. The main difference between these approaches is that the comprehensive model has the capacity to integrate and utilize other comprehensive Telehealth/Telemedicine services and can support a full range of Telehealth/Telemedicine services – clinical videoconferencing, store-forward, teleradiology, educational videoconferencing, family visits, electronic health records – that the single use service model cannot. For First Nations, a comprehensive service model also proposes an opportunity to influence the development of services. Exhibit 6 compares and contrasts these two service models.

<table>
<thead>
<tr>
<th>Service Model</th>
<th>Infrastructure</th>
<th>Human Resources</th>
<th>Cultural</th>
<th>Business Drivers</th>
<th>Sustainability Issues</th>
</tr>
</thead>
</table>
| **Comprehensive Telehealth/Telemedicine:** The use of secure and private broadband networks to deliver and support clinical services in First Nations. Diagnostic, treatment and wellness service can be delivered in real-time (face-to-face video-conferencing consults) or in store-forward (digital imaging) modes. Standards for comprehensive Telehealth/Telemedicine support development of all other applications (tele-education, health administration, training, telecare, tele-triage) | - Aboriginal, Provincial and Federal health service partnership  
- Health facility on-reserve with a bookable room within the clinical footprint  
- Capacity to deliver and sustain broadband connections to each facility (1.5 million bits/second or faster)  
- Common Services – scheduling, helpdesk, procurement, warranty management, training, policies & procedures.  
- Telehealth/Telemedicine Fee Schedule to remunerate physicians  
- Federal and provincial eHealth strategies emphasize the need to improve access to health and wellness resources to support positive health outcomes.  
- Mature provincial Telehealth/Telemedicine service | - Regional and jurisdictional medical leadership (physician acceptance, clinical standards & safety)  
- Community-based site coordination and promotion (accelerates First Nation uptake, supports cultural safety & competence)  
- Dedicated Telehealth/Telemedicine technical staff (reliability and innovation)  
- Scheduling, community engagement and referral management staff (coordination) | - Interoperable and respectful relationships between FN and non-FN Service Providers  
- Meaningful Aboriginal participation and service ownership  
- Reflecting diversity of Aboriginal culture and practice | - Rural and remote First Nations with low health status, high prevalence of chronic disorders & co-morbid conditions  
- Limited access to primary & specialist health services  
- Limited access to culturally safe health and wellness services and culturally competent providers  
- Economies of scale: the capacity to support a maximum number of sites with a single dedicated network and common services structure  
- System renewal requires that scarce health/human resources be used more effectively.  
- Recruitment/retention  
- Emergent health agendas: health career, wait-times, public health  
- FN health Change Management | - Limited provincial capacity for coordinated delivery of services on-reserve and limited federal capacity for coordinated delivery of health services off-reserve.  
- Cost avoidance not recognized as a system-wide benefit.  
- Fear of technology  
- Inertia |
| **Limited Use Health Videoconferencing:** Use of public and open networks to deliver health education and to support administrative collaboration /decision-making | - Health facility on-reserve with a bookable room  
- Access to high speed internet  
- Federal and/or provincial partner | - Customized or outsourced managed service solution (scheduling, bridging, help desk)  
- One-time or ongoing training resources | - Interoperable and respectful relationships between FN & non-FN Service Providers  
- Reduced cost of contractual training requirements  
- Reduced meeting and collaboration costs  
- FN Health Change Management | - Recruitment/retention  
- Reduced cost of contractual training requirements  
- Reduced meeting and collaboration costs  
- FN Health Change Management | - Addresses limited number of business drivers  
- Little FN incentive to adopt (capacity to improve local health outcomes  
- Inertia/fear of technology |
Conclusion
Telehealth/Telemedicine projects in or in proximity to First Nations and Inuit populations have demonstrated local enthusiasm for Telehealth/Telemedicine initiatives and have highlighted unique service, support and sustainability requirements for the delivery of high quality, secure clinical videoconferencing in isolated and culturally distinct communities. Results of pilot studies and ongoing Telehealth/Telemedicine programs suggest that Telehealth/Telemedicine is being successfully implemented in First Nations communities – particularly when First Nations health organizations are the designated lead agencies and when there is full and seamless integration of Telehealth/Telemedicine as part of the publicly-funded healthcare system. Success is linked to interoperability which includes well-trained community-based human resources.

In First Nation communities, there is a limited pool of available and qualified individuals who can fulfill the requirements of local site coordination. This requires the development of specialized curricula and dedicated common services to reinforce the capacities and limitations incumbent in the site coordinator position and accelerate service interoperability. Specific lessons learned include retaining dedicated training resources on staff, establishing and embedding performance standards as part of the job and working directly with the central KOTM and community health staff to understand how job functions are changing as Telehealth/Telemedicine services expand and system capacities mature.

It will take all levels of government to implement an effective First Nations Telehealth/Telemedicine service. Collaborative action will be needed to inform an policy and program development to determine a functional and flexible Governance regime guide operational leadership and ultimately to guide priorities for expanding First Nations access to Telehealth/Telemedicine and the type(s) of service model that will be supported by the network. Recent internal decisions by FNIH to make capital investments in Ontario First Nations Telehealth/Telemedicine offer up a welcome and challenging opportunity for First Nations to collaborate on a strategy for integrating First Nation Telehealth/Telemedicine with the Ontario Telemedicine Network.
References


