7th Annual General Meeting

Canadian Society of Telehealth

and

5th Annual Symposium

Réseau québécois de télésanté

October 3-5, 2004, Québec

7ème Conférence annuelle

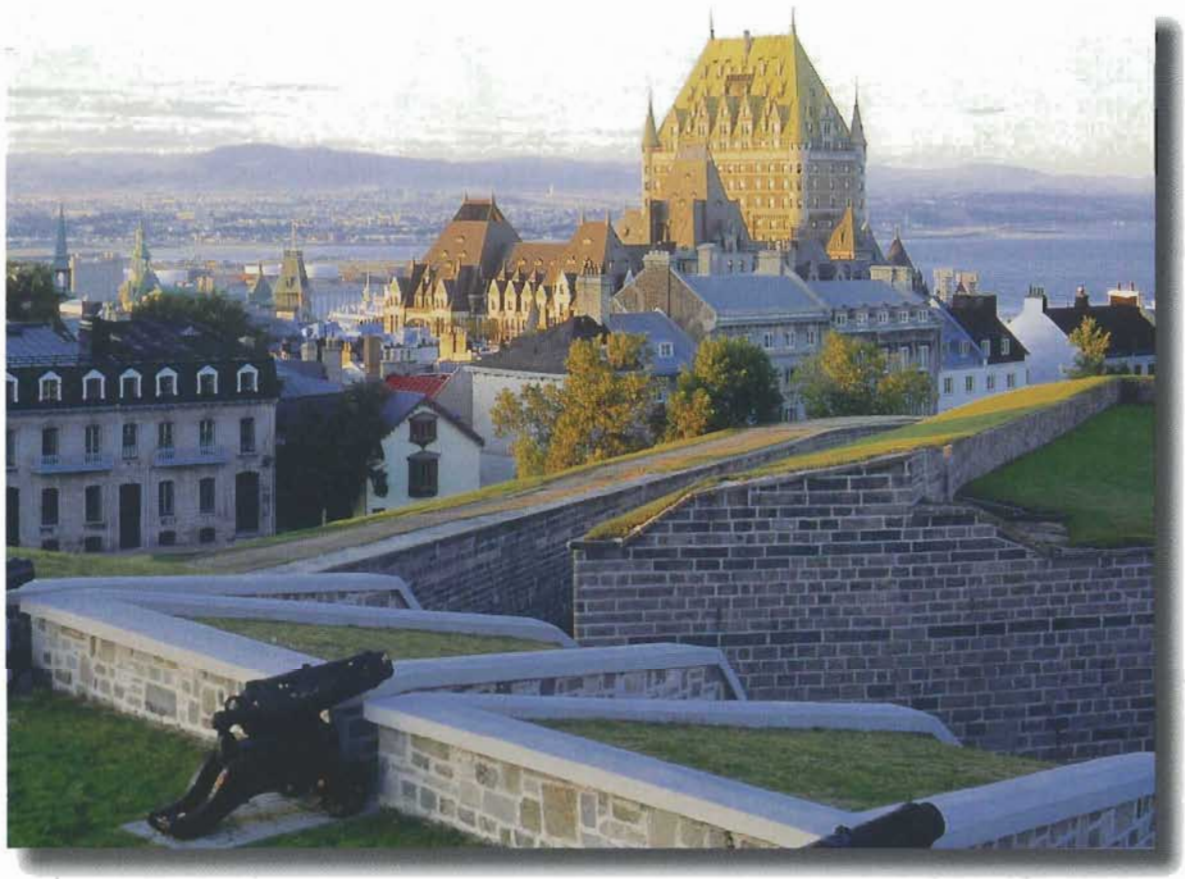
Société canadienne de télésanté

et

5ème Symposium annuel

Réseau québécois de télésanté

3-5 octobre 2004, Québec



Integrating Telehealth: Challenges and Solutions
L'intégration de la télésanté : enjeux et solutions

CONFERENCE PROCEEDINGS

CAHIER DU PARTICIPANT

Bringing healthcare to your doorstep

Telehealth

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Des soins de santé à votre porte

Working closely with healthcare institutions, PHD Medical designs complete Telehealth solutions that increase accessibility to specialized medicine, improve the quality of care, and reduce both the cost of services and the strain on resources.

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Visit our booth at the CST Annual Conference to see how PHD Medical can help bring healthcare to your patient's doorstep.

PHD Medical travaille en étroite collaboration avec les institutions médicales afin de développer des systèmes de télésanté permettant entres autres, une meilleure accessibilité aux services médicaux, une amélioration de la qualité des soins, une réduction des coûts ainsi qu'une meilleure gestion des ressources.

Notre vision unique d'intégrer les appareils de vidéoconférence et les appareils médicaux à divers logiciels de gestion, offre aux institutions de santé une solution clé en main. Flexible, durable et facile à utiliser, notre solution améliore la qualité de vie des patients et facilite le travail des professionnels de la santé.

Visitez notre kiosque lors de la conférence annuelle de la Société Canadienne de Télésanté et découvrez comment PHD Medical peut offrir à vos patients, un accès direct aux soins de santé.

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3-5 octobre 2004, Québec

RQT

CST SCT

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TABLE OF CONTENTS / TABLE DES MATIERES

Message du ministre de la Santé

et des Services sociaux

Le Québec se fait pour la première fois l'hôte de la Conférence annuelle de la Société canadienne de télésanté. C'est avec grand plaisir que je m'associe à cet événement d'intérêt. Je tiens à féliciter le comité local d'organisation qu'a coordonné le Réseau québécois de télésanté, pour la qualité du programme qui sera présenté.

L'organisation des services de santé et des services sociaux que nous mettons en place actuellement se fonde, entre autres, sur un accès égal aux services pour toutes les personnes, sans égard au lieu où elles se trouvent. Les nouvelles technologies, et en particulier la télésanté, contribuent à élargir l'accès à la même qualité de soins et de services partout sur le territoire. De plus, elles favorisent une utilisation optimale des ressources et permettent de mieux répondre aux besoins des populations.

Je vous souhaite, à toutes et à tous, une excellente conférence.

Philippe Couillard

Québec

CANADIAN SOCIETY OF TELEHEALTH

SOCIÉTÉ CANADIENNE DE TÉLÉSANTÉ

From the President

On behalf of the CST Board of Directors, I am pleased to welcome you to the 7th Annual Canadian Society of Telehealth Conference and General Meeting. This year's Conference "Integrating Telehealth: Challenges and Solutions" is being organized in collaboration with the Réseau québécois de télésanté (RQT). We would like to thank our Quebec colleagues for their commitment and support for this exciting event.

The Conference theme, "Integrating Telehealth: Challenges and Solutions", will provide an opportunity for the telehealth/e-health community to engage in discussions and share experiences around the integration of telehealth and telehealth networks into existing healthcare delivery systems. The discussion will address integration related processes and procedures, as well as successes. Such interactions, along with the provision of possible solutions, and an understanding of related challenges, will contribute to more effective and efficient integration.

Conference activities begin on Saturday with the Telehealth Coordinators Special Interest Group 2nd annual meeting, as well as the launch of the Aboriginal Telehealth Knowledge Circle. Four pre-conference workshops, the CST Annual General Meeting, CST Committee Meetings, along with the Welcome Reception will take place on Sunday. Highlights of the Conference include: key note speaker Professor Michael Nerlich (Regensburg University, Germany) focusing on International perspectives of telehealth; three plenary sessions; three focus sessions to cast light on specific topics of interest; an industry breakfast; ten breakfast round table discussions; exhibits; and ~108 peer-reviewed concurrent presentations and poster sessions. The Gala Awards Dinner on Monday evening will provide an opportunity to recognize those that have made exceptional contributions to the telehealth/e-health community, as well as an opportunity to relax amid colleagues and friends across Canada and beyond.

Throughout the Conference, the Local Organizing group has arranged exciting social activities that will provide fantastic opportunities for everyone to enjoy the wonderful landscape and history of Quebec City. Cruise the St. Lawrence River, dine at the famous Le Champlain Restaurant at Château Frontenac, or take a guided tour of the many historical sites Quebec City has to offer. Make sure to make time to visit the exhibit hall to see the e-health state-of-the-art products and services now available.

On behalf of the CST Board of Directors, I would like to acknowledge all of those who have played a role in CST 2004, with special thanks to the Pro Santé group, the Conference Organizing Committees and Scientific Program Committee, as well as our Conference Sponsors and Exhibitors for their support. We welcome you to Quebec City.

Penny Jennett
President, Canadian Society of Telehealth

Bienvenue à Québec.

C'est avec une très grande fierté qu'au nom du Réseau Québécois de Télésanté (RQT) et des comités d'organisation de ce 7ème Congrès annuel de la SCT et 5ème Symposium québécois, je vous souhaite la bienvenue à Québec. C'est également avec beaucoup d'émotion, qu'au nom d'un très grand leader et visionnaire de la télésanté, le Dr Alain Cloutier, je vous souhaite de vivre intensément la concrétisation de son rêve : réunir ces deux grands événements de la télésanté au Canada. Ce rêve a profondément inspiré les extraordinaires réseaux de collaborateurs qui ont investi passion, temps et énergie pour faire de ce Congrès un moment mémorable.

Ce Congrès se veut aussi une étape charnière pour la mobilisation des champions utilisateurs de la télésanté qui sont si essentiels à l'innovation, des décideurs, si nécessaires à son intégration, des chercheurs/évaluateurs, si importants pour apprendre des expériences et, de l'industrie, si au cœur des développements.

La télésanté est beaucoup plus qu'un nouveau service. Elle est une stratégie pour transformer les pratiques et l'organisation des soins, pour en améliorer l'efficacité et l'efficience. Elle est un domaine jeune et en pleine croissance. Son expertise doit se développer et se mailler davantage. La qualité scientifique est impressionnante mais encore perfectible. Ce Congrès vous donnera l'occasion de faire progresser la télésanté et un aperçu des opportunités grandissantes de collaboration que l'on retrouve autant chez soi qu'à travers le monde.

Merci à tous ceux qui ont rendu cet événement possible. Merci à vous d'y participer. Merci à nos généreux commanditaires qui y ont cru.

Bienvenue à Québec et profitez bien de son charme et de son hospitalité.

Jean-Paul Fortin md
RQT et Comités d'organisation

Welcome to Québec City.

It is with great pride that on behalf of the Réseau Québécois de Télésanté (RQT) and the organizing committees of this 7th Annual Meeting of the CST and 5th Symposium Quebecois, I welcome you to Québec. As well, I feel no small emotion when today, on behalf of an exceptional telehealth leader and visionary, Dr. Alain Cloutier, I urge you to live the realization of his dream to the fullest. That dream was to unite the two major telehealth events in Canada. This same dream has proved to be a valuable source of inspiration for the extraordinary network of collaborators who have invested their passion, time and energy into making this Meeting a memorable event.

This Meeting is also intended as a pivotal step in mobilizing the leading-edge users of telehealth that are so crucial to innovation, the decision-makers so necessary to its integration, the researchers/evaluators so important to learn from experiences and the industry members so central to developments.

Telehealth is much more than a new service. It is a strategy for transforming the practices and organization of healthcare in order to improve efficiency and effectiveness. It is a young field in full growth. Telehealth expertise must develop and "connect" further. The quality of the underlying science is impressive, but can still be improved upon. This Meeting will give you the possibility of enhancing telehealth and a glimpse of the growing opportunities for collaboration that can be found both here at home and worldwide.

Thanks to all who have made this event possible. I thank you all for participating, and thanks to our generous sponsors who believed in it.

Welcome to Québec City; enjoy its charm and hospitality to the fullest.

Jean-Paul Fortin M.D.
RQT and Organizing Committees

GENERAL INFORMATION
INFORMATION GÉNÉRALE

GENERAL INFORMATION

Admission Policies
Name badges are required to gain access to the scientific sessions and the exhibit hall. A proper name badge or ticket must be presented to gain access to all social events. **Badges must be worn at all times.**

Registration Desk
The Registration Desk is open the following hours:

Saturday, October 2	1500-1800
Sunday, October 3	0730-1800
Monday, October 4	0700-1700
Tuesday, October 5	0700-1400

Exhibit Hall
The Exhibit Hall is located on the first floor Hilton Hotel in the Foyer and Porte St-Louis-Kent Room.
Exhibits will be open during the following hours:

Monday, October 4	0800-1830
Tuesday, October 5	0800-1400

The Canadian Society of Telehealth is very grateful to our industry partners who have supported this year's conference through exhibiting. Please take time to visit our exhibitors.

Internet Café
Room: Sillery

Sunday, October 3	0700-1700
Monday, October 4	0700-1700
Tuesday, October 5	0700-1400

Enter to Win a Free CST Membership!
Please submit your evaluation form (at the back of this book) to the Registration Desk. All conference participants who submit evaluations forms will be entered into a draw to win a one-year membership (new membership or renewal) with the Canadian Society of Telehealth. Prize value varies with membership status. Not redeemable for cash.

For more information on CST memberships, visit our website at www.cst-sct.org.

Social Activities
It's not too late! If you missed signing up for any social activities, you don't have to miss out on the fun! Please refer to the social program page for a complete list of social activities. Inquire at the registration desk for availability.

CME Credit
The present activity has been credited as a learning activity for the Royal College Maintenance of Certification Program of the Royal College of Physicians and Surgeons of Canada.

INFORMATION GÉNÉRALE

Politique d'admission
Les porte-noms sont obligatoires afin d'avoir accès aux sessions scientifiques et à l'aire d'exposition. Un porte-nom ou un billet doit être présenté afin d'avoir accès à tous les événements sociaux. **Les porte-noms doivent être portés en tout temps.**

Bureau d'inscription
Le bureau d'inscription sera ouvert durant les heures suivantes :

Samedi le 2 octobre	1500-1800
Dimanche le 3 octobre	0730-1800
Lundi le 3 octobre	0700-1700
Mardi le 5 octobre	0700-1400

Aire d'exposition
L'aire d'exposition sera accessible durant les heures suivantes :

Lundi le 4 octobre	0800-1830
Mardi le 5 octobre	0800-1400

Internet Café
Salle : Sillery

Dimanche le 3 octobre	0700-1700
Lundi le 3 octobre	0700-1700
Mardi le 5 octobre	0700-1400

Participer afin de gagner une année d'adhésion gratuite avec la SCT
Veuillez soumettre vos formulaires d'évaluation (au dos de ce livre) au bureau d'inscription. Tous les participants de la conférence qui retourneront le formulaire d'évaluation complété seront éligibles au tirage d'une adhésion pour une année (nouveau membre ou renouvellement) avec l'Association canadienne de télésanté. Le prix peut varier selon le statut d'adhésion. Non échangeable contre argent comptant.

Pour plus d'information concernant l'adhésion avec SCT, visitez notre site internet à www.cst-sct.org

Activités sociales
Il n'est pas trop tard. Si vous n'êtes toujours pas inscrit à certaines activités sociales. Veuillez vous référer à la page des programmes sociaux pour la liste complète des activités. Veuillez vérifier auprès du bureau d'inscription pour la disponibilité des événements.

Programme de Maintien du Certificat
La présente activité est une activité de formation collective agréée aux termes du programme de Maintien du Certificat du Collège royal des médecins et chirurgiens du Canada.

SOCIAL PROGRAM

		Room
Saturday, October 2		
1700-1800	National Telehealth Coordinators Special Interest Group (NTC-SIG) Reception	Panorama : Vieux-Port
	NTC-SIG members only	
Sunday, October 3		
1800-2000	Welcome Reception	Panorama : Vieux-Port
Monday, October 4		
1800-1900	Gala Dinner Reception	Foyer
1900-2300	Gala Dinner and Awards Presentations	Porte du Palais
Tuesday, October 5		
	Post-conference Tours	see registration desk for details

ACTIVITÉS SOCIALES

		Salle
Samedi le 2 octobre		
1700-1800	Cocktail pour le comité « National Telehealth Coordinators Special Interest Group » (NTC-SIG)	Panorama : Vieux-Port
	NTC-SIG membres seulement	
Dimanche, le 3 octobre		
1800-2000	Réception de bienvenue	Panorama : Vieux-Port
Lundi, le 4 octobre		
1800-1900	Réception	Foyer
1900-2300	Banquet	Porte du Palais
Mardi, le 5 octobre		
	Activités post-conférence	voir le bureau d'inscription pour les détails

BUSINESS MEETINGS

		Room
Saturday, October 2		
0900-1200	Aboriginal Telehealth Knowledge Circle	Beauport
1300-1700	National Telehealth Coordinators Special Interest Group (NTC-SIG) Annual General Meeting & Symposium	Beauport
Sunday, October 3		
0800-1000	CST Consent Task Force	Beauport
0800-1000	CST Communications Committee	Beaumont
1000-1130	CST Industry Committee	Beauport
1000-1130	CST Research Committee	Beaumont
1000-1130	CST Membership Committee	Bélair
1130-1300	2004-2005 Conference Planning Committees Joint Meeting	Beauport
1300-1400	CST International Committee	Bélair
1300-1400	CST Education Committee	Beauport
1300-1400	CST Policy and Standards Committee	Beaumont
1400-1600	RQT Committee	Panorama Plaines
1500-1600	CST Old Board of Directors	Portes du Palais
1600-1800	CST Annual General Meeting	Portes du Palais
1800-1830	CST New Board of Directors	Portes du Palais
Tuesday, October 5		
0700-0815	Industry Breakfast	Beaumont-Bélair
1200-1300	Awards Jury	Lauzon

RÉUNIONS DES COMITÉS

		Salle
Samedi 2 octobre		
0900-1200	Aboriginal Telehealth Knowledge Circle	Beauport
1300-1700	National Telehealth Coordinators Special Interest Group (NTC-SIG) Assemblée générale annuelle et symposium	Beauport
Dimanche 3 octobre		
0800-1000	Consent Task Force de la SCT	Beauport
0800-1000	Comité de communication de la SCT	Beaumont
1000-1130	Comité de l'industrie de la SCT	Beauport
1000-1130	Comité de recherche de la SCT	Beaumont
1000-1130	Comité d'adhésion de la SCT	Bélair
1130-1300	Comités de planification des conférences 2004 et 2005	Beauport
1300-1400	Comité international de la SCT	Bélair
1300-1400	Comité d'éducation de la SCT	Beauport
1300-1400	Comité des normes et de règlementation de la SCT	Beaumont
1400-1600	Réunion du RQT	Panorama Plaines
1500-1600	Conseil d'administration de la SCT	Portes du Palais
1600-1800	Assemblée générale annuelle de la SCT	Portes du Palais
1800-1830	Conseil d'administration de la SCT	Portes du Palais
Mardi 5 octobre		
0700-0815	Déjeuner de l'Industrie	Beaumont-Bélair
1200-1300	Jury pour la remise de prix	Lauzon

CST COMMITTEES / COMITÉS DE LA SCT

CST Board of Directors / Conseil d'administration de la SCT	
Penny Jennett, Chair	jennett@ucalgary.ca
Wayne Bell	wbell@digitalgrp.ca
Ed Brown	ebrown@northnetwork.com
Kathy Crone	kcrone@careconnect.org
Robert Filler	robert.filler@sympatico.ca
Chris-Anne Ingram	chrisanne.ingram@iwk.nshealth.ca
Rafiq Khan	rafiq.khan@canarie.ca
Sandra MacDonald-Rencz	Sandra_MacDonald-Rencz@hc-sc.gc.ca
Sarah Muttitt	smuttitt@ms.umanitoba.ca
Ray Postuma	postuma@ms.umanitoba.ca
Carl Robbins	crobbins@mun.ca
Richard Scott	rescott@ucalgary.ca
Shirlee Sharkey	ssharkey@saintelizabeth.com
Roberta Hildebrand, Executive Director, ex officio	director@cst-sct.org
Executive Committee / Comité exécutif	
Penny Jennett, President	jennett@ucalgary.ca
Robert Filler, Past President	robert.filler@sympatico.ca
Chris-Anne Ingram, Secretary	chrisanne.ingram@iwk.nshealth.ca
Richard Scott, Vice President & President-elect	rescott@ucalgary.ca
Roberta Hildebrand, Executive Director, ex officio	director@cst-sct.org
Communications Committee / Comité de communication	
Robert Filler, Chair	robert.filler@sympatico.ca
Amy Lynn Bell, Webmaster	amy@digital-fx.ca
Mathias Fruhwirth	mfruh@rogers.com
Maegan Power	mpower2@gov.nu.ca
Dan Reinbold	dreinbol@mhr.ab.ca
Peter Rossos	peter.rossos@uhn.on.ca
Education Committee / Comité d'éducation	
Carol Flewelling, Chair	cflewelling@northnetwork.com
Paula Archambault	parcha@CareConnect.org
Patricia Dwyer	patricid@mun.ca
Audrey Huziak	huziaka@nwhd.sk.ca
Maureen Leyland	maureenleyland@shaw.ca
Michele McCarthy	michele.mccarthy@calgaryhealthregion.ca
Suzanne Robichaud	suzanner@health.nb.ca
Tammy Troy-Hempey	hempey@cmas.ca
Helen Truran	Helen.Truran@northernhealth.ca
Sybil Young	sybil.young@calgaryhealthregion.ca
Awards Committee / Comité des prix	
Roberta Hildebrand, Acting Chair	director@cst-sct.org
Anne Lawrence	anne.lawrence@hp.com
Trevor Cradduck	trevor.cradduck@keston.com
Sharlene Stayberg	sharlene.stayberg@gov.ab.ca
Glenn Wegner	gwegner@tandberg.ca

Industry Committee / Comité de l'industrie	
Sarah C. Muttitt, Chair	smuttitt@ms.umanitoba.ca
Wolfgang Baun	wolf.baun@eds.com
Wayne Bell	wbell@digitalgrp.ca
Chuck Burt	ceburt@post.bell.ca
Mark Craven	mark.craven@polycom.com
Mark Gallagher	mark.gallagher@xwave.com
Dan Howes	danh@adcom.ca
Abdul Lakhani	a.lakhani@telesat.ca
Pierre Levasseur	Pierre_Levasseur@hc-sc.gc.ca
Rajiv Muradia	rajiv@muradia.com
Dennis Niebergal	niebergal_d@clinicare.com
Mark VanderWerf	mark@AMDtelemedicine.com
Robert Vigneault	robert@siscanada.ca
Glenn Wegner	gwegner@tandberg.ca
International Committee / Comité international	
Richard Scott, Chair	rescott@ucalgary.ca
Michael Allen	michael.allen@dal.ca
Carol Anderson	andearle@telusplanet.net
Robert Aucoin	robert.aucoin@ualberta.ca
Wayne Bell	wbell@telehealth.ca
Marie-Madeleine Bernard	mmb@pace2000.org
Johann Cunningham	jcunning@vanhosp.bc.ca
Robert Filler	robert.filler@sympatico.ca
John P Finley	jfinley@dal.ca
Eugene Igras	eigras@irisinc.ca
Andora Jackson	cst@andora.org
Penny Jennett	jennett@ucalgary.ca
Karen Kennedy	kkennedy@cns.nf.ca
Rafiq Khan	rafiq.khan@canarie.ca
Jay Lynch	jlynch@scohs.on.ca
Jochen Moehr	jmoehr@uvic.ca
John Parboosingh	parboo@telusplanet.net
Andrea Pritchard	ampritch@ucalgary.ca
Suzanne Robichaud	suzanner@health.nb.ca
Peter Rossos	peter.rossos@uhn.on.ca
Joan Sargeant	joan.sargeant@dal.ca
Laura Sato	lsato@cihi.ca
Mary Seshia	mseshia@cc.umanitoba.ca
Shirlee Sharkey	ssharkey@saintelizabeth.com
Karl Stroetmann	karl@empirica.com
Ralph Ulmer	ulmer@arc.ab.ca
Gerbrand Verburg	gverburg@bloorviewmacmillan.on.ca
Membership Committee / Comité d'adhésion	
Sandra MacDonald-Rencz, Chair	Sandra_MacDonald-Rencz@hc-sc.gc.ca
Joseph Gebran	jgebran@cpsi-icsp.ca
Ray Postuma	postuma@ms.umanitoba.ca
Joanne Reid	joanne.reid@sickkids.ca

Nominating Committee / Comité des nominations	
Ed Brown, Chair	ebrown@northnetwork.com
Robert Filler	robert.filler@sympatico.ca
Chris-Anne Ingram	ChrisAnne.Ingram@iwk.nshealth.ca
Penny Jennett	jennett@ucalgary.ca
Shelley Moneta	moneta@hhsc.ca
Lois Scott	lscott@clinidata.com
Richard Scott	rescott@ucalgary.ca
Roberta Hildebrand, Executive Director	director@cst-sct.org
Policy & Standards Committee / Comité des normes et de règlementation	
Wayne Bell, Chair	wbell@telehealth.ca
Debra Allen	drallen@nurses.ab.ca
Deb Bexfield	dbexfield@dthr.ab.ca
Sabrina Hasham	sabrina@hashamconsulting.com
Eugene Igras	eigras@irisinc.ca
Patricia McLean	pmclean@cnps.ca
Gorsev Pristine	gpristine@medisolve.ca
Carl Robbins	crobbins@mun.ca
Richard Scott	rescott@ucalgary.ca
Jayne Smitten	jaynesmitten@shaw.ca
Karl Stroetmann	Karl.Stroetmann@empirica.com
Research Committee / Comité de recherche	
Michael Allen, Chair	michael.allen@dal.ca
Valerie Ashworth	vashworth@phsa.ca
John C. Hogenbirk	jhogenbirk@laurentian.ca
Andora Jackson	cst@andora.org
Barbara Roston	broston@northnetwork.com
Joan Sargeant	joan.sargeant@dal.ca
National Telehealth Coordinators Special Interest Group Council	
Chris-Anne Ingram, Chair	chrisanne.ingram@iwk.nshealth.ca
Liz Adair	ladair@mts.net
Wendy Barker	Wendy.B@pnrha.ca
Johanne Desrochers	Johannec.desrochers@muhc.mcgill.ca
Patricia Dwyer	patricid@mun.ca
Carol Flewelling	cflewelling@northnetwork.com
Stéphanie Froissart	Stephanie_froissart@ssss.gouv.qc.ca
Joseph Gebran	jgebran@cpsi-icsp.ca
Zayna Kunic	telehealth@cw.bc.ca
Mary Beth LeBlanc	leblancmb@cbdha.nshealth.ca
Margarita Loyola	Margarita.loyola@interiorhealth.ca
Angela Nickoloff	anickoloff@northnetwork.com
Krisan Palmer	palkr@reg2.health.nb.ca
Jocelyne Picot	jpicot@infotelmed.ca
Maegan Power	mpower2@gov.nu.ca
Dan Reinbold	dan.reinbold@pchr.ca
Colleen Rogers	colleen_rogers@hc-sc.gc.ca;
Cathy Saunders	cathy.saunders@cdha.nshealth.ca
Helen Truran	Helen.Truran@northernhealth.ca
Donna Williams	donnawilliams@knet.ca

CST-RQT 2004 CONFERENCE COMMITTEES
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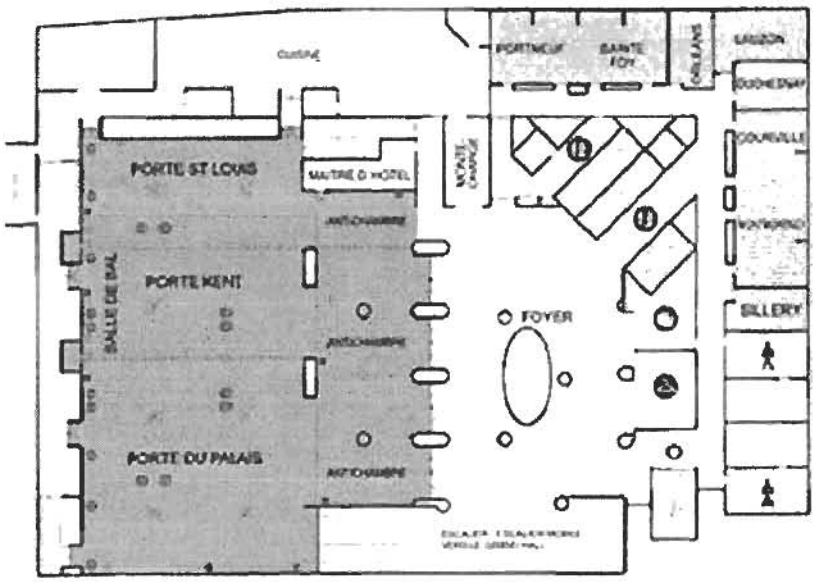
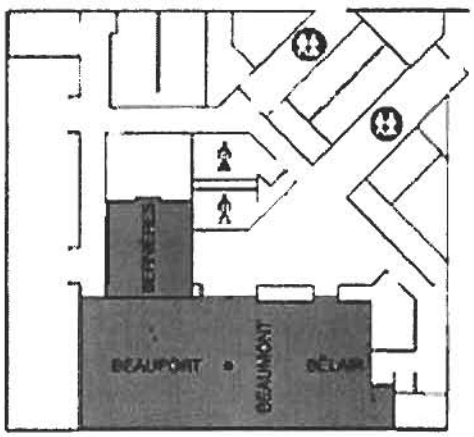
HOTEL FLOOR PLANS
CONFIGURATION DE L'HÔTEL

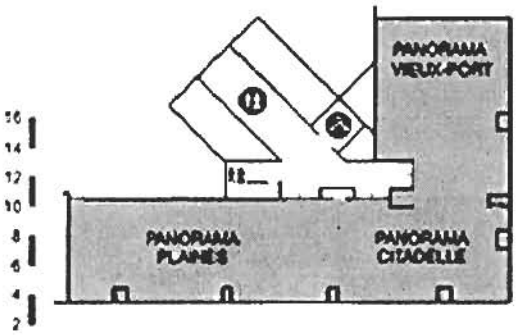
1er étage



2e étage

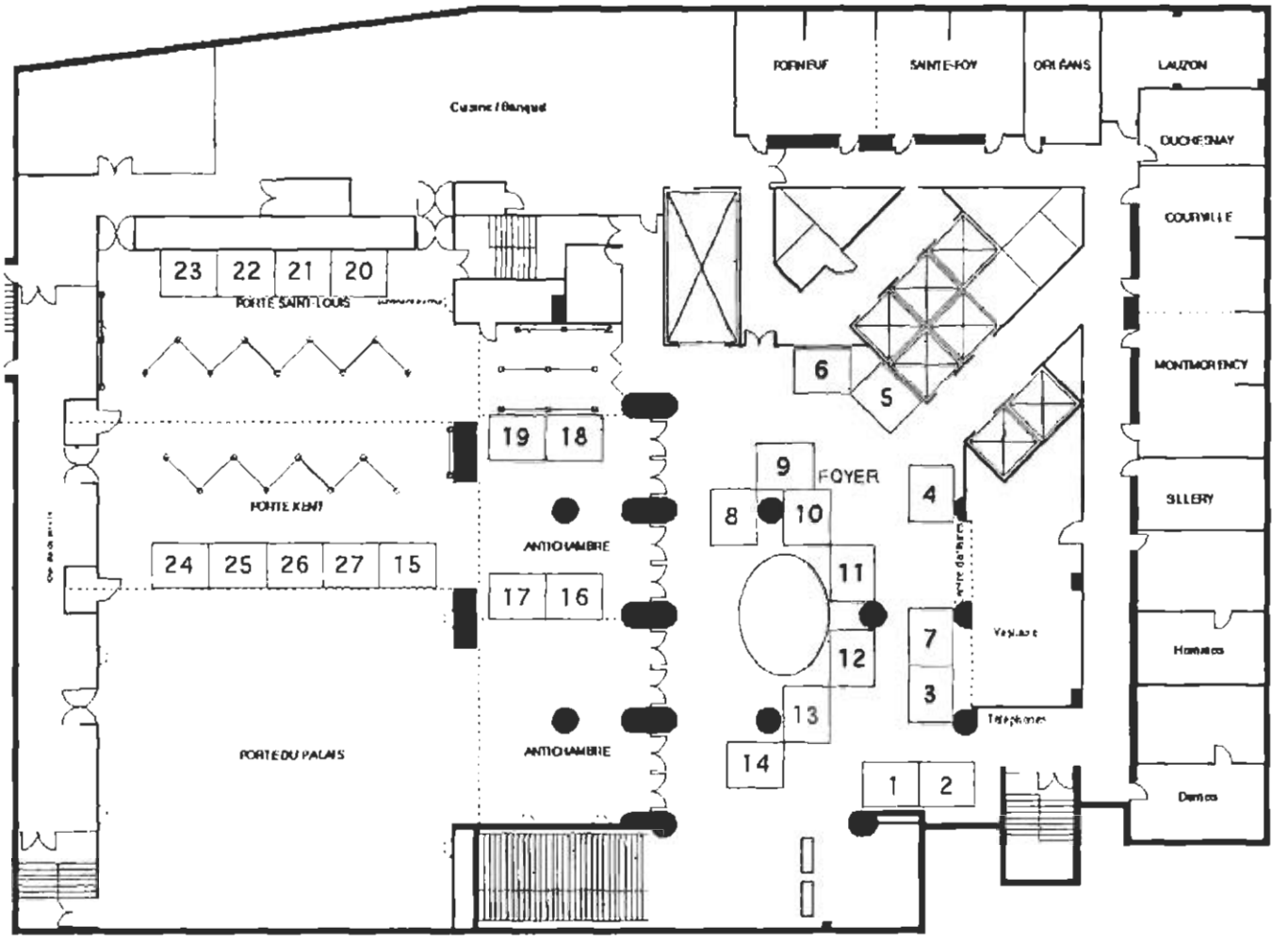


23e étage



Beaumont	2nd floor / 2e étage
Beauport	2nd floor / 2e étage
Bélair	2nd floor / 2e étage
Bernières	2nd floor / 2e étage
Courville	1st floor / 1e étage
Dufferin	Ground Floor / Rez-de-chaussé
Duschesnay	1st floor / 1e étage
Lauzon	1st floor / 1e étage
Montmorency	1st floor / 1e étage
Orléans	1st floor / 1e étage
Panorama	23rd floor / 23e étage
Porte du Palais	1st floor / 1e étage
Porte Kent	1st floor / 1e étage
Porte St Louis	1st floor / 1e étage
Portneuf	1st floor / 1e étage
Sainte-Foy	1st floor / 1e étage
Sillery	1st floor / 1e étage
Villeray	Ground Floor / Rez-de-chaussé

EXHIBITS / EXPOSANTS



Booth / kiosque	
1	American Telecare
2	Medical Computing Group
3 & 7	CBCI
4	Canada Health Infoway / Inforoute Santé Canada
5 & 6	SonoVideo
8	PHD Medical
9	Ministère de la santé et des services sociaux
10	Second Opinion
11	Bell Canada
12	Canadian Communication Products, Inc.
13	Soft Informatique

Booth / kiosque	
14	Technologie New IT
15	Clinidata
16 & 17	AMD Telemedicine
18	Audisoft Technologies
19	ESI Technologies de l'information
20	LMS Medical Systems
21 & 22	Tandberg
23	Télémédic
24	Adcom
25	HomeMed
26	CST-SCT

EXHIBITORS / EXPOSANTS

ADCOM
ADCOM, Canada's premier Real-Time Communication and Collaboration Solutions Provider, provides customers with the tools necessary to unleash the power of their enterprises' intellectual property and creative energy, by maximizing the quality of their collaborative process.
These solutions enable organizations to bring people and information together at the same moment in time with ease, resulting in accelerated decision-making, improved productivity and organizational effectiveness, empowering them to:
COMMUNICATE. COLLABORATE. INNOVATE.

AMD TELEMEDICINE
AMD Telemedicine will exhibit several telemedicine and home telemonitoring products and solutions. The telemedicine products include video scopes and a variety of live and store-and-forward data devices including electronic stethoscopes, 12-lead ECG and a portable ultrasound solution AMD's home telemonitoring solutions feature the Care Companion.

AMERICAN TELECARE INC.
American TeleCare, Inc. provides technology-enabled patient care management solutions, featuring live audio/video/data communication and integrated medical peripherals. ATI's telehealth solutions enable remote, real-time clinical interactions-resulting in increased efficiency in patient care delivery, improved outcomes and increased patient and clinician satisfaction while lowering costs. For more information, visit www.americantelecare.com or call 1-800-323-6667.

AUDISOFT TECHNOLOGIES
Le Frontline Communicator est un système de vidéocommunication sans fil développé pour la télé-assistance et le télé-formation. Grâce au Frontline communicator, vous pourrez discuter à distance avec une autre personne et lui transmettre en continu les images de ce que vous regardez. Le Frontline Comunicator est une solution complète de bout en bout. Le système est composé d'un casque-camera et d'un émetteur ergonomique et léger

BELL CANADA
L'apparition de normes IP ouvertes incite présentement l'industrie des télécommunications à se transformer et entraînera avec elle l'abandon d'une approche centrée réseau au profit d'un environnement où les dispositifs de communication intelligents seront entre les mains du client.
Bell Canada exploite déjà la puissance, la souplesse et la commodité grandissante des communications IP pour permettre aux clients d'être parmi les premiers à accéder aux services émergents d'un univers sans barrières.

CANADA HEALTH INFOWAY
Infoway's mission is to accelerate the development and adoption of compatible electronic health information systems. These systems provide healthcare professionals with rapid access to complete and accurate patient information, enabling better decisions about treatment and diagnosis. The result is a sustainable, more cost-efficient healthcare system offering improved patient safety and better quality of care. *Infoway* invests in Electronic Health Record initiatives and then shares the knowledge and experience gained with jurisdictions across Canada to speed implementation and reduce risk. *Infoway* is an independent, not-for-profit corporation whose members are the federal, provincial and territorial deputy ministers of health.

La mission d'*Inforoute* est d'accélérer l'élaboration et l'adoption de systèmes électroniques d'information sur la santé interopérables. Ces systèmes offrent aux professionnels de la santé d'accéder rapidement à des renseignements complets et exacts sur les patients, permettant ainsi à ceux-ci de prendre de meilleures décisions en ce qui a trait aux traitements et aux diagnostics. Ceci contribue ainsi à créer un système de santé durable et plus rentable, améliorant la sécurité des patients et la qualité des soins. *Inforoute* investit dans des projets en matière de dossier de santé électronique, puis partage les connaissances et l'expérience acquises avec les provinces et les territoires du Canada dans le but d'accélérer la mise en œuvre et réduire le risque. *Inforoute* est une entreprise indépendante à but non lucratif dont les membres sont les sous-ministres de la santé des gouvernements fédéral, provinciaux et territoriaux.

CANADIAN COMMUNICATION PRODUCTS INC.
Canadian Communication Products is a national communications solutions and value-added provider of peripheral telecom and computer products including Loggers &Recorders, Audio & Video Conferencing, Web Conferencing & Bridging, Norstar & M1, Add-ons, UPS and Surge Protectors, Corded and Wireless Headsets and much more

CBCI
Venez nous rencontrer au kiosque CBCI Telecom pour une télé-consultation en direct.

Come and visit us to witness a demonstration of direct Home Teleconsulting.

CLINIDATA CORPORATION
Clinidata is a tele-health services company specializing in 24x7 health information and advice. We provide a variety of services including tele-triage community resource referral, after hours primary care support, benefits information, and disease management to public and private sector organizations.

ESI TECHNOLOGIES
M-Gate implante dans les hôpitaux, aux soins intensifs, a l'observation et a l'urgence. Offre de nombreuses possibilités d'utilisation tant pour les patients que pour les médecins ou le personnel soignant. Il relie les mutimedia, les HIS, le RIS et le PACS. C'est un produit unique au monde a double utilité pour patients et médecins

HOMEMED
The HomMed Home Monitoring system collects and transmits patient vital sign measurements and subjective question responses from a unit located in the patient's home to a Central Station for daily clinical review and assessment. Peripheral devices include digital cameras, microcoagulation systems, spirometers, glucose meters, ECG devices, card readers and videophones. Monitoring is available in French.

LMS MEDICAL SYSTEM
LMS Medical Systems is a leader in the use of advanced mathematical modeling and neural networks. Our CALM™ Suite provides clinicians, risk managers and hospital administrators with clinical information systems and decision support tools designed to improve outcomes and patient care for mothers and their infants during labor and delivery.

MEDICAL COMPUTING GROUP
Medical Computing Group built the first commercial telehealth platform nearing deployment Canada-wide, connecting professionals, knowledge, and technologies. MCG's core business is integrating data, processes and legacy applications to enable telehealth across language and geopolitical boundaries. Handling and archival of multimedia files is one of its specialties. www.medcomp.ca

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Le Medical Computing Group a construit la première plateforme en télésanté étant sur le point d'être déployée à travers le Canada, reliant professionnels, connaissances et technologies. MCG se concentre principalement sur l'intégration des données, processus et applications Legacy afin de permettre à la télésanté de fonctionner au-delà des barrières linguistiques et géographiques. Une de nos spécialités est de gérer et d'archiver les documents multimédia. www.medcomp.ca

PHD MEDICAL
PHD Medical develops complete Telehealth solutions by integrating medical devices, management systems and diagnostic software. Our solutions are rooted in a desire to improve healthcare through research and design. PHD Medical Telehealth systems allow our healthcare customers to increase accessibility to specialized services and improve the quality of care while reducing both costs and strain on healthcare resources.

PHD Medical se consacre au développement de solutions de télésanté en intégrant à la fois, appareils médicaux, systèmes de gestion et logiciels de diagnostiques. Nos solutions sont basées sur le désir d'améliorer les soins de santé par la recherche et le développement. Nos systèmes de télésanté permettent aux patients d'augmenter l'accessibilité aux services spécialisés et d'améliorer la qualité des services médicaux. Ceci permet de réduire à la fois les coûts et la demande en ressources de santé.

SECOND OPINION SOFTWARE
Second Opinion™ is a family of telehealth applications that allow medical practitioners to capture color or grayscale images and data and send them over a TCP/IP Network, a T-120 data channel, or via email to a remote location. Features include integrated security measures, sophisticated annotation tools, fully customizable database plug-ins.

SOFT INFORMATIQUE
Demonstrate PACS, digital dictation.

SONO VIDEO INC.
Equipment, audiovisuals and conference.

TANDBERG
TANDBERG is a leading global provider of visual communication products and services. The Company has dual headquarters in New York and Norway. TANDBERG designs, develops and markets systems and software for video, voice and data. The Company provides sales, support and value-added services in more than 90 countries worldwide. TANDBERG trades publicly on the Oslo Stock Exchange under the ticker TAA.OL. Please visit www.tandberg.ca for more information
TANDBERG is a registered trademark of TANDBERG in the U.S. and select other countries

TELEMEDIC

Un système de suivi à domicile incluant les appareils au domiciles et le système informatique mettant en lien le médecin et la patient. Mission : La mission de TéléMédic consiste à concevoir, produire et livrer des systèmes télémétriques d'acquisition de signes vitaux pour la prestation de services de télésurveillance liés à divers aspects de la santé qui favorisent l'autonomie du patient.

TECHNOLOGIES NEW IT INC.

NewIT conçoit des applications spécialisées, telles le Suivi Clinique intelligent à Distance (SCIAD), permettant aux professionnels de la santé d'assurer un suivi clinique rigoureux pour leurs clientèles vulnérables tout en les maintenant à domicile. Il supporte le objectifs de continuité des soins, habilitation des patients, efficacité et intégration des services par le portage de l'information entre les intervenants.

INVITED SPEAKERS / CONFÉRENCIERS INVITÉS

Richard Alvarez
President and Chief Executive Officer / Président et chef de la direction
Canada Health Infoway / Inforoute Santé Canada

Dr Paul-Émile Barbeau
Abitibi-Témiscamingue

Dr. Edward M. Brown
Sunnybrook Hospital
Director of the NORTH Network

Dr Michel Bureau
Directeur général de la Direction Générale des Services de Santé et Médecine Universitaire (DGSSMU)

Simon Cheesman
Project Developer, NORTH Network

Dr Philippe Couillard
Minister of Health and Social Services, Province of Québec

Dr Véronique Déry
Directeur général et scientifique - AÉTMIS contribution to telehealth

The Honourable Ujjal Dosanjh
Federal Minister of Health

Dr. John Finley
Izaak Walton Killam Hospital, Halifax

Dr Jean-Paul Fortin
Chair, Conference Organizing Committee
Département de médecine sociale et preventive, Université Laval

Sylvie Godbout
Centre hospitalier universitaire de Sherbrooke

Dr. Penny Jennett
President, Canadian Society of Telehealth
Health Telematics Unit, University of Calgary

Dr. Joseph C. Kvedar
President, American Telemedicine Association

Louis Lareng
President, Société Européenne de Télémédecine

Marc Lavallée
Directeur de compte principal, Vertical 7

Jonathan D. Linkous
Executive Director, American Telemedicine Association

Dr. Sarah C. Muttitt
Director, MB Telehealth, Manitoba

Dr. Michael Nerlich
Professor, University Regensburg Medical Center
Germany

Deborah Oong
Assistant Director Community Healthcare and Telehealth, New South Wales Health Department
Australia

Olga Paquin
Centre hospitalier de l'Université Laval

Ron Riesenbach
Director Technical Services, NORTH Network

Dr. Renato Sabbatini
Associate Professor and Chairman of Medical Informatics, State University of Campinas
Brazil

Madeleine St-Geiais
Centre hospitalier universitaire de McGill

John Schneider
Director of Engineering, Neptec Inc.

Sharlene Stayberg
Alberta Health and Wellness

Pierre Traineau
Directeur du CATEL (Club des Acteurs de la Télésanté)
France

Linda Weaver
Chief Technology Officer, Smart Systems for Health Agency

PROGRAM OVERVIEW
SURVOL DU PROGRAMME

PROGRAM OVERVIEW

Registration Desk hours:

Saturday, October 2	1500-1800
Sunday, October 3	0730-1800
Monday, October 4	0700-1700
Tuesday, October 5	0700-1400

	Saturday October 2	Sunday October 3	Monday October 4	Tuesday October 5
Breakfast			Breakfast Roundtables	Industry Breakfast
Morning	Aboriginal Telehealth Knowledge Circle	Pre-Conference Workshops #1 & #2	Opening Remarks and Keynote Address Plenary Session #1	Concurrent Sessions #6-#11 Poster Sessions #1-#4 Focus Sessions #2-#3
Lunch			Lunch in Exhibit Hall	Lunch in Exhibit Hall
Afternoon	National Telehealth Coordinators Special Interest Group (NTC-SIG) Annual General Meeting and Symposium	Pre-Conference Workshops #3 & #4 RQT Committee Meeting CST Annual General Meeting	Concurrent Sessions #1-#5 Focus Session #1 Plenary Session #2	CST President's Address Plenary Session #3 Special Program Infoway Awards for Podium Presentations and Posters Closing Ceremonies
Evening	NTC-SIG Reception	Welcome Reception	Reception and Gala Dinner CST Awards Presentations	

SURVOL DU PROGRAMME

Heures d'ouverture du bureau d'inscription :

Samedi le 2 octobre	1500-1800
Dimanche le 3 octobre	0730-1800
Lundi le 4 octobre	0700-1700
Mardi le 5 octobre	0700-1400

	Samedi le 2 octobre	Dimanche le 3 octobre	Lundi le 4 octobre	Mardi le 5 octobre
Déjeuner			Déjeuners tables-rondes	Déjeuner de l'industrie
Matin	Aboriginal Telehealth Knowledge Circle	Ateliers pre-conférence #1 & #2	Allocution d'ouverture et Introduction Session plénière #1	Sessions parallèles #6-#11 Sessions d'affiches #1-#4 Sessions de mise au point #2-#3
Diner			Dîner dans la salle d'exposition	Dîner dans la salle d'exposition
Après-midi	Assemblée générale annuelle et Symposium du comité « National Telehealth Coordinators Special Interest Group » (NTC-SIG)	Ateliers pre-conference #3 & #4 Réunion du RQT Assemblée générale annuelle de la SCT	Sessions parallèles #1-#5 Session de mise au point #1 Session plénière #2	Discours de la présidente de la SCT Session plénière #3 Programme spécial : Infoway Prix de récompense pour les sessions parallèles et les affiches Cérémonie de clôture
Soirée	Cocktail pour le comité NTC-SIG	Réception de bienvenue	Réception et Banquet Présentation des prix de récompense de la SCT	

SUNDAY WORKSHOPS
ATELIERS DU DIMANCHE

Time	*Session*	*Room*
0730-1800	Registration / Inscription	Foyer
0800-1600	CST Committee Meetings / Réunions des Comités de la SCT	See schedule / consultez l'horaire
0830-1200	Pre-Conference Workshops #1 / Atelier pré-conférence #1	Ste-Foy-Portneuf
	Pre-Conference Workshops #2 / Atelier pré-conférence #2	Courville-Montmorency
1300-1600	Pre-Conference Workshops #3 / Atelier pré-conférence #3	Ste-Foy-Portneuf
	Pre-Conference Workshops #3 / Atelier pré-conférence #3	Courville-Montmorency
1400-1600	Réunion du RQT	Panorama Plaines
1600-1700	CST Annual General Meeting / Assemblée générale annuelle de la SCT	Porte du Palais
1700-1900	Welcome Reception / Réception de Bienvenue	Panorama

Pre-conference Workshop #1 / Atelier pré-conférence #1
Room/Salle : Ste-Foy-Portneuf
0830-1200

Policy
Workshop Leader: **Dr. Richard Scott**, University of Calgary

As telehealth becomes more mainstreamed and integrated into traditional healthcare activities, the need to identify and address policy issues is increasing. At this time there are no firm descriptions or answers to many policy issues, but many perspectives. This workshop will provide an over view of 34 policy issues identified from the literature, and provide participants with the opportunity to describe, discuss, and debate around selected policy issues.

Richard Scott
Dr. Richard Scott is an Associate Professor in the Global e-Health Research and Training Program of the Health Telematics Unit, Department of Community Health Sciences, Faculty of Medicine, University of Calgary, and a Fulbright New Century Scholar alumnus. He has over 16 years healthcare experience as a practicing clinical and forensic toxicologist, Director of Research, and telehealth researcher. His research program is directed towards inter-jurisdictional e-health policy, outcomes evaluation, and environmental e-health. Dr. Scott is a lead co-investigator on a national study designed to investigate the identification and definition of suitable outcome indicators for demonstrating the value of e-health, and to achieve consensus on some suitable outcome indicators. He was a co-investigator for a recent State of the Science study examining socio-economic indicators in relation to the impact of e-health, and co-author of an associated telehealth policy report. He is also pursuing a new area of investigation - the environmental costs and benefits of e-health. As an independent evaluator, Dr. Scott has brought his research expertise to the design and completion of evaluations of e-health applications in home telehealth, web-based tele-triage, tele-cardiology, and extension of hospital care to the home. He is currently examining the role of e-health in the globalization of healthcare, and investigating policy, technology, and evaluation aspects impacting the implementation and integration of e-health globally. Dr. Scott is a Founding member of the Canadian Society of Telehealth (CST) and the current Vice-President. He is also Chairperson for the CST International Committee, and member of several committees and working groups.

Sponsored by / Commandité par : Health Telematics Unit, University of Calgary

Nutrition Break / Pause santé : 1000

Pre-conference Workshop #2 / Atelier pré-conférence #2
Room/Salle : Courville-Montmorency
0830-1200

Cadres légaux et normatifs, responsabilité et sécurité dans la pratique de la télésanté

Workshop Leader: **Me Martin Dubois,** CISSP®

Les usagers des réseaux de santé du Canada et du Québec bénéficient de cadres légaux et normatifs qui exigent une re-formulation de certains paradigmes techniques, éthiques et professionnels pour les praticiens en télésanté. La Loi sur la protection des renseignements personnels et les documents électroniques, la Loi concernant le cadre juridique des technologies de l'information, le Cadre global sur la sécurité du MSSS du Québec, la Loi d'accès et un florilèges de normes et de standards accessoires ont un impacts sur la pratique quotidienne de la télésanté. Cet atelier permettra aux participants de passer en revue les principales problématiques juridiques en télésanté et les ébauches de solutions que nos lois proposent.

Martin Dubois
Me Martin Dubois est titulaire d'un baccalauréat en droit de l'Université Laval (ll.b.). Il est membre du Barreau du Québec depuis 1990 et compte plus de 7 ans d'expérience dans les secteurs émergeant de la sécurité informationnelle et des nouvelles technologies de l'information et des communications.
Il a été le premier et est le seul avocat en cabinet privé au Canada à détenir la certification internationale CISSP® (*Certified Information Systems Security Professional*). La certification CISSP® est un standard *de facto* de l'industrie de la sécurité informationnelle. La spécialisation de Me Dubois lui permet d'offrir une expertise unique au Canada, intégrant à la fois une maîtrise des encadrements juridiques aux aspects logiques et technologiques propres à ces domaines.

Nutrition Break / Pause santé : 1000

Pre-conference Workshop #3 / Atelier pré-conférence #3
Room/Salle : Ste-Foy-Portneuf
1300-1600

Tips and Techniques for Successful Submissions

Workshop Leader: **Dr. Michael Allen**, *Dalhousie University CME*

One responsibility of the CST Research Committee is to peer review abstract submissions for the Annual Conference. Many abstracts show great promise, but could be presented in a much stronger manner that shows off an author's work to best advantage. Experienced authors will provide you with 'hands-on' exercises plus practical tips and techniques on how to write an abstract, give a clear oral presentation, and an informative poster. Participants will be able to use these skills not just for CST, but for submissions anywhere.

Michael Allen

Michael Allen graduated from Dalhousie Medical School in 1976. He worked as a family physician in rural and urban areas of Nova Scotia for 17 years before joining Dalhousie Continuing Medical Education in 1994. Since joining Dalhousie CME he has had an interest in the use of information technology for continuing education. He has designed and presented workshops to help physicians use computers in medicine, been involved in presenting CME programs on the Internet, and has helped develop a province-wide videoconferenced CME network. He and his colleague Joan Sargeant were co-recipients of the John Ruedy award for innovation in medical education for their work in distance education.

Presented by / Presenté par : CST Research Committee

Nutrition Break / Pause santé : 1430

Pre-conference Workshop #4 / Atelier pré-conférence #4
Room/Salle : Courville-Montmorency
1300-1600

Business Process Re-engineering

Workshop Leader: **Robert Vigneault, MA, PMP; Director - Business Development**

BPR can be viewed as the systematic analysis and re-design of core business processes to achieve improvement in critical-to-quality (CTQ) performance. Many of the methods and skills related to BPR are applicable to healthcare organizations as they complement the integration of telehealth into their operations. This workshop will provide participants with an overview, strategies, and tools with which to approach Business Process Reengineering.

Robert Vigneault

Mr. Vigneault is currently the Director, Business Development for SIS Business Alliance. He is a graduate of the Masters of History Program at Carleton University where he researched both the development of Child Health Programs in Canada and the impact of Social Change on the Medical Profession.

Robert has worked in both private and public healthcare with Health Canada (First Nations and Inuit Health Branch), IBM, TecKnowledge Healthcare Systems and Atlantic Blue Cross Care. Robert has led projects in Document Management, Business Process Re-engineering, Systems Development, TeleHealth and e-Health – most recently as the National Implementation Services Manager for the e-Health Solutions Unit of the First Nations and Inuit Health Branch. He is a Certified Project Management Professional (PMP).

Robert has a strong interest in the application of information technology and telecommunications to health service delivery, as well as the management of cultural change inherent in implementing technical solutions. With extensive experience in Project Management, Business Process Re-Engineering, as well as Simulation and Activity Based Costing techniques, he brings a unique perspective to the analysis and remodelling of key business or clinical processes.

Sponsored by / Commandité par : SIS Business Alliance

Nutrition Break / Pause santé : 1430

MONDAY MORNING
LUNDI A.M.

MONDAY MORNING, OCTOBER 4

Time	*Session*	*Room*
0700-1700	Registration	Foyer
0800-1900	Exhibits and posters displays	Foyer/Porte St-Louis-Kent
0700-0815	Breakfast roundtables #1, #2, #3	Villeray
	Breakfast roundtables #4, #5, #6	Courville-Montmorency
	Breakfast roundtables #7, #8	Ste-Foy-Portneuf
	Breakfast roundtable #9	Beaumont
	Breakfast roundtable #10	Beauport
0830-0920	Opening Remarks and Keynote Address	Porte du Palais
0920-1200	Plenary session #1 – International Models and Applications	Porte du Palais
1020-1050	Nutrition Break	Foyer/Porte St-Louis-Kent
1050-1200	Plenary Session #1 continues	Porte du Palais
1200-1320	Lunch, Exhibits and Poster Viewing	Foyer/Porte St-Louis-Kent

LUNDI A.M., LE 4 OCTOBRE

Heure	*Session*	*Salle*
0700-1700	Inscription	Foyer
0800-1900	Exposants et affiches	Foyer/Porte St-Louis-Kent
0700-0815	Déjeuners tables-rondes #1, #2, #3	Villeray
	Déjeuners tables-rondes #4, #5, #6	Courville-Montmorency
	Déjeuners tables-rondes #7, #8	Ste-Foy-Portneuf
	Déjeuner table-ronde #9	Beaumont
	Déjeuner table-ronde #10	Beauport
0830-0920	Allocution d'ouverture et Introduction	Porte du Palais
0920-1200	Session plénière #1 - Modèles internationaux et applications	Porte du Palais
1020-1050	Pause santé	Foyer/Porte St-Louis-Kent
1050-1200	Session plénière #1 suite	Porte du Palais
1200-1320	Dîner, exposants et affiches	Foyer/Porte St-Louis-Kent

BREAKFAST ROUNDTABLES
DÉJEUNERS TABLES-RONDES

Monday Morning / Lundi matin : 0700-0815

No.	Breakfast Roundtables / Déjeuners tables-rondes	Room/Salle
1	**Integrating Telehealth into Medical Schools – Issues and Considerations** *Expert Facilitator:* Kendall Ho, MD FRCPC, Associate Dean & Director, Division of Continuing Education, University of British Columbia *Scribe:* Karl Stroetmann, PhD, empirica GmbH, Bonn, Germany Telehealth is emerging as a major clinical direction in health services delivery, yet telehealth is far from being mainstream in medical school curricula in Canada and aboard. How can we influence the educational system so that telehealth will become part of what future medical and health professional trainees learn? What are some of the key factors and messages, including issues in research and education, that we need to develop and implement? Case studies in education and research in telehealth will be discussed, and strategies of integrating telehealth into medical curriculum will be tabled for brainstorming and input.	Villeray
2	**Standards for Sustainability-Enabling Scope and Practice for First Nations Telehealth from Policy to Provider: Building a Community of Practice for First Nations Telehealth** *Expert Facilitator:* John Rowlandson, Coordinator, Policy and Standards, Aboriginal Telehealth Knowledge Circle *Scribe:* Donna Williams, Regional Telehealth Coordinator, KO Telehealth Effective First Nations telehealth programming, while sharing many common practices and protocols with non-native hospital- and urban-based initiatives, is characterized by community capacity to influence service modeling and by practitioner capacity to adapt telehealth systems to address distinctive local conditions and support regional needs. Our breakfast roundtable will consider the First Nations innovation dynamic both as a change agent in the on-going development of provincial telehealth systems and as an opportunity to engage an emerging national community of Indigenous practice.	Villeray
3	**Centralized Scheduling Model for Telehealth: How Does it Impact Integration?** *Expert Facilitator:* Carol Fenton, RN, Clinical Services Manager, NORTH Network *Scribe:* Paula Archambault, Eastern Ontario Telehealth Network Centralized scheduling offers a fast, efficient, and reliable, 'one stop shopping' approach for healthcare providers who wish to access telehealth services. Using a centralized model, all requests can be channeled to directly to a scheduling hub, where staff knowledgeable can effectively manage each request on behalf of the requester. Our breakfast roundtable will discuss why the centralized scheduling contributes to integration of telehealth into the healthcare delivery system.	Villeray
4	**Telehealth Policy: How Does Policy Affect Integration and What Can We Do to Influence It?** *Expert Facilitator:* Robert Filler, M.D. FRCSC, Consultant in Telehealth *Scribe:* Sandra Dalziel, Cinical Project Manager, NORTH Network Despite some progress in the development of public policies for licensing, fee for service, and credentialing for health care providers engaged in Telehealth, important issues remain unsettled. In this session we will discuss where we are at present, and what can and should be done to put these remaining items to rest.	Courville-Montmorency

BREAKFAST ROUNDTABLES
DÉJEUNERS TABLES-RONDES

Monday Morning / Lundi matin : 0700-0815

No.	Breakfast Roundtables / Déjeuners tables-rondes	Room/Salle
5	**Integrating Home Telehealth into Routine Chronic Illness Care: Moving Forward** *Expert Facilitator:* Marilynne Hebert, BScN, PhD, University of Calgary, Health Telematics Unit *Scribe:* Jay Lynch, University of Ottawa - Palliative Care Home care provides health services to individuals in their place of residence in order to promote, maintain or restore health, and to maximize independence, while minimizing the effects of disability or illness. Home telehealth is an innovative service delivery alternative which holds considerable potential for the care of people with chronic illnesses. Given the complexities of both the potential types of home telehealth services and home care requirements, the challenge remains to integrate the two into routine practice. We will discuss ways to move this field forward, beginning with the following considerations: • How do we ensure each implementation contributes to the body of evidence around effectiveness in supporting positive patient outcomes i.e. the role of evaluation, sharing results and tools? • Would it be beneficial to incorporate these results and tools into a "home telehealth business case template"? • How could we present evidence to policy and decision makers more effectively?	Courville-Montmorency
6	**Integrating Telehealth Networks: The Technical Perspective** *Expert Facilitator:* Ron Riesenbach, Director of Technical Services, NORTH Network *Scribe:* Peter Danyliuk, Manager of Network Engineering NORTH Network Provincial governments across the country are struggling to provide rural and remote citizens with cost-effective access to urban clinicians. Telehealth offers an effective solution to this problem, but, because referral patterns know few boundaries, pan-provincial connectivity is essential. Impeding this requirement to provide ubiquitous access at reasonable cost is the fact that telehealth networks typically are founded as regional initiatives or discipline-specific services (such as mental health networks, or paediatric services). Evolving and growing without standards or guidelines, these regional networks are now faced with the mandate to interconnect with one another, but are saddled with frustrating technical interoperability issues. This round-table will explore the problems, challenges and successes of telehealth networks across the country as they struggle to rationalize their technical infrastructure to support the pan-provincial service mandate.	Courville-Montmorency

BREAKFAST ROUNDTABLES
DÉJEUNERS TABLES-RONDES

Monday Morning / Lundi matin : 0700-0815

No.	Breakfast Roundtables / Déjeuners tables-rondes	Room/Salle
7	**Integration with Health Care Service Delivery** *Expert Facilitator:* Ms. Heather Garden, Telehealth Director Provincial Health Services Authority Vancouver, British Columbia *Scribe:* Peter Youell, Regional Tele-Mental Health Coordinator, Education Technology Services CareConnect and Royal Ottawa Health Care Group Telehealth is a relatively new method of delivering clinical services within the health system. Until recently in Canada, many of the telehealth clinical services that have been implemented have been done so on a pilot study or research trial basis. To achieve sustainability and growth in telehealth as a consistently available form of service delivery routinely funded through provincial health budget allocations, telehealth clinical activity needs to be integrated into the range of service options provided through public healthcare institutions. During this session the group will discuss what processes can be utilized to move telehealth from its current more informal structure to a model that is further integrated with the rest of the health system.	Ste-Foy-Portneuf
8	**Blending Telehealth and Health Care Networks - Meeting the Mandate** *Expert Facilitator:* Sarah Muttitt, MD, FRCPC, FAAP, MBA, Director, MBTelehealth *Scribe:* Michele McCarthy, TeleHealth Operations Manager, Calgary Health Region "Care Closer to Home" is a theme shared by telehealth networks and many clinical programs that are being charged with providing services to clients regardless of residence. Telehealth is a natural enabler, efficiently and effectively linking patients and providers across geographic and institutional boundaries. However, to date, few clinical networks have strategically engaged telehealth as a means to extend their reach and support integrated service delivery across the spectrum of care. This roundtable will explore opportunities, challenges, and strategies for building successful partnerships between telehealth and established health care networks to support enhanced access to disease management and prevention programs.	Ste-Foy-Portneuf
9	**Indicateurs de résultats en télésanté : rapports d'activités** *Expert Facilitateur:* Johanne Desrochers, McGill University Health Centre / Centre Universitaire de Santé McGill *Scribe:* Jean-François Talbot, Montreal University Health Centre / Centre hospitalier Universitaire de Montréal Un des défis actuels en télésanté est celui relié au processus de production de rapports d'activités pour ce secteur. Ces rapport sont des outils utilisés par différents acteurs dans des contextes variés : le clinicien, l'administrateur, le chercheur ou l'enseignant. Étant donné l'absence d'harmonisation quant aux façons de faire, cet atelier offrira aux participants l'occasion d'échanger sur les approches utilisées, fournira des exemples et souhaite mettre à contribution les participants afin d'émettre des recommandations qui nous l'espérons permettront l'élaboration de lignes directrices qui précéderont l'élaboration de normes et standards (SVP, acheminer un exemplaire du rapport d'activités utilisé chez vous lors de l'inscription à cette activité).	Beaumont

BREAKFAST ROUNDTABLES
DÉJEUNERS TABLES-RONDES

Monday Morning / Lundi matin : 0700-0815

No.	Breakfast Roundtables / Déjeuners tables-rondes	Room/Salle
10	**Télésoins à domicile : comment le CLSC du Futur intègre t-il les télésoins à l'approche traditionnelle de prestation de soins et de services de première ligne ?** *Expert Facilitateur :* Linda Gorman, CLSC Orléans *Scribe :* Suzanne Robichaud, Corporation hospitalière Beausejour Le Centre de Santé Orléans en banlieue de Québec innove dans sa façon de suivre la clientèle à domicile en bonifiant son programme d'organisation de services de santé par l'apport des technologies de l'information : télésoins- dossier clinique informatisé-référentiels. Via une approche interactive les participants seront invités à partager avec les autres les conditions de succès et les défis reliés à l'intégration de ces nouvelles pratiques dans l'organisation du travail.	Beauport

MONDAY MORNING PLENARY SESSION

Time	Session	Room
0830-0920	**Opening Remarks and Keynote Address** Moderator: Madeleine Poulin ***Dr. Philippe Couillard***, Minister of Health and Social Services, Québec ***The Honourable Ujjal Dosanjh***, Federal Minister of Health	Porte du Palais
0850-0920	**Keynote Address - Telehealth: International Perspectives** ***The Potential of Telehealth and its Use*** ***Dr. Michael Nerlich***, Professor, University Regensburg Medical Center, Germany	Porte du Palais
0920-1200	**Plenary Session #1 - International Models and Applications** Moderator: Madeleine Poulin	Porte du Palais
0920-0940	Presentation #1 - ***Perspective from Australia*** **Telehealth to e-Health: Choices in Healthcare Delivery, a Case Study from Sydney** ***Deborah Oong***, Assistant Director Community Healthcare and Telehealth, New South Wales Health Department, Australia	
0940-10:00	Presentation #2 - ***Perspective from Europe*** **Focus sur la France : des expériences d'accompagnement des acteurs multidisciplinaires de la télésanté** ***Pierre Traineau,*** Directeur du CATEL (Club des Acteurs de la Télésanté), France	
1000-1020	**Panel discussion period**	
1020-1050	Nutrition Break	Foyer/Porte St-Louis-Kent
1050-1110	Presentation #3 - ***Perspective from the U.S.A.*** **The U.S. Perspective from the ATA** ***Dr. Joseph C. Kvedar***, President, American Telemedicine Association ***Jonathan D. Linkous***, Executive Director, American Telemedicine Association	Porte du Palais
1110-1130	Presentation #4 - ***Perspective from Brazil and Latin America*** **Telehealth in Brazil : Current Status and Perspectives for International Collaboration** ***Dr. Renato Sabbatini,*** Associate Professor and Chairman of Medical Informatics, State University of Campinas, Brazil	
1130-1150	**Panel discussion period**	
1150-1200	**Summary and Wrap-Up of the International Perspectives** ***Dr. Penny Jennett***, President, Canadian Society of Telehealth	
1200-1320	**Lunch, Exhibits and Poster Viewing**	Foyer/Porte St-Louis-Kent

SESSION PLÉNIÈRE LUNDI A.M.

Heure	Session	Salle
0830-0920	**Allocution d'ouverture et Introduction** Modératrice : Madeleine Poulin ***Dr Philippe Couillard***, ministre provincial de la santé et des services sociaux ***L'honorable Ujjal Dosanjh***, ministre fédéral de la santé	Porte du Palais
0850-0920	**Introduction - Télésanté : perspectives internationales** ***The potential of Telehealth and its use*** ***Dr Michael Nerlich,*** Professeur, University Regensburg Medical Center, Germany	Porte du Palais
0920-1200	**Session plénière #1 - Modèles internationaux et applications** Modératrice : Madeleine Poulin	Porte du Palais
0920-0940	Présentation #1 - ***Perspectives de l'Australie*** **Telehealth to E-Health : Choices in Healthcare Delivery, a Case Study from Sydney** ***Deborah Oong***, Assistant Director Community Healthcare and Telehealth, New South Wales Health Department, Australia	
0940-10:00	Présentation #2 - ***Perspective de l'Europe*** **Focus sur la France : des expériences d'accompagnement des acteurs multidisciplinaires de la télésanté** ***Pierre Traineau,*** Directeur du CATEL (Club des Acteurs de la Télésanté), France	
1000-1020	**Discussion en plénière**	
1020-1050	Pause santé	Foyer/Porte St-Louis-Kent
1050-1110	Présentation #3 - ***Perspectives des États-Unis*** **La perspective des Etats-Unis selon l'AAT** ***Dr Joseph C. Kvedar***, Président, Association américaine de télémédecine ***Jonathan D. Linkous***, Directeur général, Association américaine de télémédecine	Porte du Palais
1110-1130	Présentation #4 - ***Perspectives du Brésil et de l'Amérique Latine*** **Telehealth in Brazil : current status and perspectives for international collaboration** ***Dr Renato Sabbatini,*** Associate Professor and Chairman of Medical Informatics, State University of Campinas, Brazil	
1130-1150	**Discussion en plénière**	
1150-1200	**Résumé de la plénière : Perspectives Internationales** ***Dr Penny Jennett***, Présidente de la Société canadienne de télésanté	
1200-1320	**Dîner, exposants et affiche**	Foyer/Porte St-Louis-Kent

MONDAY AFTERNOON
LUNDI P.M.

MONDAY AFTERNOON, OCTOBER 4

Time	*Session*	*Room*
0700-1700	Registration	Foyer
0800-1900	Exhibits and posters displays	Foyer/Porte St-Louis-Kent
1320-1450	Concurrent Podium Session #1 – Présentations en français	Ste-Foy-Portneuf
	Concurrent Podium Session #2 – Clinical Care/Integration	Courville-Montmorency
	Concurrent Podium Session #3 – Homecare/Technology	Villeray
	Concurrent Podium Session #4 – Evaluation/Telehealth Tools	Dufferin
	Concurrent Podium Session #5 – Sustainability/Integration	Beauport
	Focus Session #1 – Implementation and Scheduling	Porte du Palais
1500-1750	Plenary Session #2 – Canadian Models and Applications	Porte du Palais
1545-1615	Nutrition Break	Foyer/Porte St-Louis-Kent
1615-172	Plenary Session #2 continues	Porte du Palais
1800-1900	Gala Dinner Reception	Foyer
1900	Gala Dinner and CST Awards Presentations	Porte du Palais

LUNDI P.M., LE 4 OCTOBRE

Heure	*Session*	*Salle*
0700-1700	Inscription	Foyer
0800-1900	Exposants et affiches	Foyer/Porte St-Louis-Kent
1320-1450	Session parallèlle #1 – Présentations en français	Ste-Foy-Portneuf
	Session parallèlle #2 – Clinical Care/Integration	Courville-Montmorency
	Session parallèlle #3 – Homecare/Technology	Villeray
	Session parallèlle #4 – Evaluation/Telehealth Tools	Dufferin
	Session parallèlle #5 – Sustainability/Integration	Beauport
	Session de mise au point #1 – Mise en œuvre et planification	Porte du Palais
1500-1750	Session plénière #2 – Modèles canadiens et applications	Porte du Palais
1545-1615	Pause santé	Foyer/Porte St-Louis-Kent
1615-172	Session plénière #2 suite	Porte du Palais
1800-1900	Réception	Foyer
1900	Banquet et Présentation des prix de récompense de la SCT	Porte du Palais

CONCURRENT PODIUM SESSION #1
SESSION PARALLÈLE #1
MONDAY / LUNDI : 1320-1450

Présentations en français

Room/Salle : Ste-Foy-Portneuf
Moderator / Modératrice : Johanne Desroschers

No.	*Abstract Title & Authors / Titre du résumé et auteurs*
1	**LA TÉLÉSURVEILLANCE POUR LE SOUTIEN À DOMICILE DES AÎNÉS: ÉVALUATION DES IMPACTS D'UN NOUVEAU SERVICE PUBLIC** Vincent C[1,2], Reinharz D[1], Deaudelin I[2], Garceau M[2], Talbot L[3]. [1]Faculté de médecine, Université Laval, Québec, QC. [2]Centre interdisciplinaire de recherche en réadaptation et intégration sociale, Québec, QC. [3]Dép. sciences infirmières, Université de Sherbrooke, QC.
2	**LA TÉLÉSANTÉ UNE STRATÉGIE POUR SOUTENIR LA PRATIQUE EN RÉGIONS ÉLOIGNÉES : ENTREVUES AUPRÈS DE MÉDECINS DE L'EST DU QUÉBEC** Duplantie J[1], Gagnon MP[1,2], Fortin JP[1,3], Landry R[3]. [1]Unité de recherche en santé publique, Québec, QC. [2]AATRM, Barcelone, Espagne. [3]Université Laval, Sainte-Foy, QC.
3	**TÉLÉSOINS À DOMICILE : SYSTÈME 24-7 POUR SUPPORT AUX CLSC, FAMILLES ET ÉTABLISSEMENT EN RÉGION** Bélanger G, Dougherty G, Rodd C. Soins Intensifs Ambulatoires à domicile et clinique de diabète, Hôpital de Montréal pour enfants du Centre Universitaire de Santé McGill, Montréal, QC. Presented by Aubin N.
4	**A PARTNERSHIP APPROACH TOWARD THE DEVELOPMENT OF COMMUNITY MINORITY LANGUAGE SERVICES IN ONTARIO** Côté A[1], Soucie P[2]. [1]Northern Ontario Francophone Psychiatry Program, Ottawa, ON. [2]CareConnect, Ottawa, ON.
5	**WHAT DO WE NEED FOR TELEHEALTH SUCCESS? PERCEPTIONS AMONG PHYSICIANS AND MANAGERS OF EASTERN QUEBEC HOSPITALS.** Gagnon MP[1,2], Duplantie J[1], Fortin JP[1,3], Landry R[3]. [1]Unité de recherche en santé publique, Québec, QC. [2]AATRM, Barcelona, Spain. [3]Université Laval, Sainte-Foy, QC.
6	**TELE-OTOSCOPY FOR THE QUÉBEC INUIT COMMUNITIES OF NUNAVIK** Ayukawa H[1], Billard, I[2], Ferguson R[3]. [1]Audiology, Montreal Children's Hospital of the McGill University Health Centre and Tulattavik Health Centre. [2]Inuulitsivik Health Centre. [3]Nunavik Regional Health Board.

1

LA TÉLÉSURVEILLANCE POUR LE SOUTIEN À DOMICILE DES AÎNÉS: ÉVALUATION DES IMPACTS D'UN NOUVEAU SERVICE PUBLIC

Vincent C[1,2], Reinharz D[1], Deaudelin I[2], Garceau M[2], Talbot L[3]. [1]Faculté de médecine, Université Laval, Québec, QC. [2]Centre interdisciplinaire de recherche en réadaptation et intégration sociale, Québec, QC. [3]Dép. sciences infirmières, Université de Sherbrooke, QC.

OBJECTIFS : Pour une première fois dans les services à domicile, une étude documente l'impact d'un service public de télésurveillance soutenu par une centrale téléphonique employant du personnel infirmier et une technologie améliorée (système d'appel d'urgence 24h/7j avec possibilités de rappels vocaux). L'étude poursuivait quatre objectifs : 1) Mesurer les effets de la télésurveillance sur la qualité de vie des aînés, sur ses habitudes de vie, sur les hospitalisations et sur les services à domicile; 2) Mesurer l'impact de la télésurveillance sur le fardeau des proches aidants; 3) Documenter l'utilisation de la télésurveillance par les aînés et le taux de satisfaction, et 4) Mesurer l'évolution des coûts de l'utilisation de la télésurveillance.
MÉTHODES : Les intervenants de CLSC ont inscrit 38 aînés (et 38 aidants) à la télésurveillance. L'évaluation a consisté en des prise de mesures répétées (-3 mois, -1 sem., + 3 et + 6 mois) lors de visites à domicile avec des instruments standardisés.
RÉSULTATS : Il y a maintien de la qualité de vie et des habitudes de vie, une diminution du fardeau chez l'aidant et une satisfaction élevée. Il y a une plus grande utilisation du service concernant les questions de santé que dans la littérature. Une diminution importante des hospitalisations et des visites à domicile après 3 et 6 mois a été constatée ainsi qu'une diminution des coûts de santé. Plus de formation continue aux intervenants est nécessaire (méconnaissance des nouvelles fonctions) et l'accès à la télésurveillance pour les aînés dont le maintien à domicile est précaire devrait être gratuit.

2

LA TÉLÉSANTÉ UNE STRATÉGIE POUR SOUTENIR LA PRATIQUE EN RÉGIONS ÉLOIGNÉES : ENTREVUES AUPRÈS DE MÉDECINS DE L'EST DU QUÉBEC

Duplantie J[1], Gagnon MP[1,2], Fortin JP[1,3], Landry R[3]. [1]Unité de recherche en santé publique, Québec, QC. [2]AATRM, Barcelone, Espagne [1]Université Laval, Sainte-Foy, QC

BUT : Identifier les effets potentiels de la télésanté sur les facteurs de recrutement et de maintien des médecins spécialistes et omnipraticiens de l'Est du Québec.
MÉTHODES : 50 entrevues de groupe et individuelles ont été menées auprès de médecins spécialistes, d'omnipraticiens et de gestionnaires de 4 régions de l'Est du Québec (Bas-St-Laurent, Côte-Nord, Saguenay-Lac-St-Jean et Gaspésie-Îles-de-la-Madeleine).
RÉSULTATS : Selon les médecins et gestionnaires rencontrés, la télésanté permettrait la mise en place de gardes régionales et offre aux médecins en régions le soutien des collègues des grands centres. Par conséquent, la télésanté s'avérait un outil efficace pour contrer la surcharge de travail qui constitue l'un des facteurs nuisant au recrutement de médecins en régions éloignées. De plus, plusieurs médecins tant spécialistes qu'omnipraticiens ont mentionné qu'en favorisant l'organisation de programmes de formation bidirectionnels, la télésanté permettrait aux médecins en régions non seulement d'augmenter leur accès à de la formation continue, mais aussi de faire de l'enseignement. Cette téléformation aurait donc pour avantage de faire connaître les équipes médicales en régions (facteur de recrutement) et de donner aux recrues une formation plus adaptée aux besoins de celles-ci (facteur de rétention). Toutefois, selon certains gestionnaires, il ne serait pas souhaitable de recruter une personne insécure qui accepte de travailler en région éloignée grâce à la télésanté car elle risque de quitter plus rapidement la région.
CONCLUSIONS : Bien que la télésanté soit un outil dont le potentiel demeure méconnu, il est possible d'imaginer qu'elle devienne l'un des facteurs influençant le recrutement et la rétention des médecins en régions éloignées.

3

TÉLÉSOINS À DOMICILE : SYSTÈME 24-7 POUR SUPPORT AUX CLSC, FAMILLES ET ÉTABLISSEMENT EN RÉGION
Bélanger G, Dougherty G, Rodd C. Soins Intensifs Ambulatoires à domicile et clinique de diabète, Hôpital de Montréal pour enfants du Centre Universitaire de Santé McGill, Montréal, QC. Presented by Aubin N.

BUT : Présenter les bénéfices aux patients et cliniciens faces à l'utilisation d'une technologie simple et conviviale : ordinateur de poche et téléphone cellulaire, afin de soutenir la réintégration et le maintien à domicile de 982 enfants : 532 enfants inscrits dans 12 programmes de l'unité des soins ambulatoires intensifs, 450 enfants de la clinique de diabète.
MÉTHODE : Un suivi systématique de clientèle, incluant une garde 24-7, est déployé afin d'améliorer les trois indicateurs suivants :

- éviter l'hospitalisation
- éviter la visite à l'urgence,
- réduire la durée de séjour,

des enfants qui bénéficient à domicile de soins complexes, chroniques et continus. Les technologies actuellement utilisées sont le « Palm Pilot iPaq pocket PC » et le téléphone cellulaire.
RÉSULTATS : Déployée depuis plus de cinq ans, cette technologie rend accessible au clinicien de garde :

- les plans des soins,
- profils pharmacologiques,
- sommaire du dossier médical,
- protocoles de soins,
- alertes,
- guides de pratiques individualisés.

On note une diminution significative d'au moins 1 des trois indicateurs pré-cités. Cette approche est intégrée dans la gestion des épisodes de soins et assiste l'équipe de soins spécialisés du centre tertiaire dans sa mission de soutien aux intervenants de première ligne : CLSC, médecins traitant, écoles, garderies.
CONCLUSION :

- Technologie peut coûteuse et conviviale.
- Nécessite peut de formation du personnel
- Améliore la qualité du suivi de clientèles
- Réduit les déplacements : familles et cliniciens
- Utilisation plus appropriée des services de santé

4

A PARTNERSHIP APPROACH TOWARD THE DEVELOPMENT OF COMMUNITY MINORITY LANGUAGE SERVICES IN ONTARIO

Côté A[1], Soucie P[2]. [1]Northern Ontario Francophone Psychiatry Program, Ottawa, ON. [2]CareConnect, Ottawa, ON.

INTRODUCTION: The historical legacy of several rural communities in Northern Ontario has provided them with a rich francophone culture, however these communities were under-serviced by mental health services in the french language. The Northern Ontario Francophone Psychiatry Program (NOFPP), a division of the Ontario Psychiatric Outreach Program, and partner in the CareConnect network of Eastern Ontario, addressed this service gap through the coordination of clinical visits by psychiatrists. In 2002, services were enhanced through the successful integration of tele-psychiatry.
DESCRIPTION: The NOFPP and CareConnect enable the delivery of french language mental health services to community-based providers in select northern and eastern Ontario communities, rich in francophone culture. These efforts toward continuously customizing every component of telehealth service for francophone clients, while maintaining a commitment of establishing a physical presence in their chosen communities is a model for a regional network establishing minority language services for telehealth.
RESULTS: Several NOFPP psychiatrists adjusted their practices to incorporate telehealth, rapidly adding over 200 clinical tele-psychiatry consultations over 24 months. Evaluations by clients and rural, community-based mental health care providers indicated massive appreciation of services accessible in their language of choice, and in their clinical setting of choice. Momentum continues to grow as new clinical champions within the network conceive and implement minority language services.
CONCLUSIONS: Telehealth can be leveraged to support two predominant trends in mental health; greater emphasis on the development of community-based services, and the advancement of a client's right to quality service in their language of choice.

5

WHAT DO WE NEED FOR TELEHEALTH SUCCESS? PERCEPTIONS AMONG PHYSICIANS AND MANAGERS OF EASTERN QUEBEC HOSPITALS.

Gagnon MP[1,2], Duplantie J[*], Fortin JP[1,3], Landry R[3]. [1]Unité de recherche en santé publique, Québec, QC. [2]AATRM, Barcelona, Spain. [3]Université Laval, Sainte-Foy, QC.

PURPOSE: To explore general practitioners (GP), specialists, and hospital managers' view about telehealth and their perceptions of factors that could increase its integration.
METHODS: A multiple case study was conducted in 14 healthcare centres of Eastern Quebec. Group as well as individual interviews involved a total of 40 physicians and 24 managers. Data codification was performed independently by two researchers who reached consensus on classification categories. Content of all interviews was analysed according to these categories.
RESULTS: In general, GPs and specialists have positive perceptions concerning telehealth. Tele-education is the most valued aspect for many clinicians. However, many respondents were not aware of the various clinical applications of this technology. Users were more likely to mention clinical benefits in their practice and to foresee further applications. Managers were mostly enthusiastic towards telehealth although some perceived a threat for medical workforce allocation in remote areas. According to physicians and managers, telehealth success is likely to depend on five factors: 1) Focus on local needs; 2) Peer networking 3) Physicians' involvement: 4) Ease of use; and 5) Remuneration. These findings highlight the need for a planned telehealth development which respects particularities of healthcare organisations and clinical work in remote regions.
CONCLUSIONS: Our understanding of factors influencing telehealth integration in medical practice is now deeper. However, we need to acknowledge the specific context of each hospital and region since it directly influences needs and resources related to telehealth. A unique telehealth solution for everyone is therefore unlikely to succeed.

6

TELE-OTOSCOPY FOR THE QUÉBEC INUIT COMMUNITIES OF NUNAVIK

Ayukawa H[1], Billard, I[2], Ferguson R[3]. [1]Audiology, Montreal Children's Hospital of the McGill University Health Centre and Tulattavik Health Centre. [2]Inuulitsivik Health Centre. [3]Nunavik Regional Health Board.

PURPOSE: The technology provides significant benefits to 14 Inuit communities of Northern Quebec by improving services in audiology and ENT.
METHODS: A first generation of video-otoscope was introduced 6 years ago, together with analog technology. . This set-up involved carrying a TV with integrated VHS, as well as the video-otoscope which was shared between two audiologists. Images were stored on VHS videotapes making retrieval of images difficult, and it was also impossible to easily compare images taken at different points in time. In February 2004, two new-generation digital otoscopes where acquired, including a software application that allows the clinician to view, store and retrieve images.
RESULTS: This technology is used for various purposes. .Pictures are used for counselling of patients and for training of nurses, doctors and residents, and Inuit health workers. The quality of images is greatly enhanced, storage and retrieval is user friendly which allows comparison with the previous condition to be made. The audiologists travelling by plane between communities find the equipment much easier to transport Patients benefit from better timeliness in ENT consultations both on an urgent or elective basis.
CONCLUSION: Real-time consultations are currently available in two communities and differed time consultations are possible from all fourteen communities. Real time services will be possible, as soon as adequate infrastructure to permit live transmission with an acceptable quality of image is made available. In the future, this technology will be easy to integrate into the patient's electronic health record.

CONCURRENT PODIUM SESSION #2
SESSION PARALLÈLE #2
MONDAY / LUNDI : 1320-1450

Clinical Care/Integration

Room/Salle : Courville-Montmorency
Moderator / Modérateur : John Rowlandson

No.	*Abstract Title & Authors / Titre du résumé et auteurs*
7	**NURSE TELE-TRIAGE AND THE PRIMARY CARE PHYSICIAN: AN OVERVIEW OF THE ONTARIO EXPERIENCE** Poole L. Clinidata Corporation, Toronto, ON.
8	**YO CHAPLEAU: A SCHOOL BASED EARLY INTERVENTION TELEHEALTH PROGRAM FOR YOUTH IN RURAL AND REMOTE COMMUNITIES** Youell P[1], White M[2]. [1]Mental Health Services Coordinator, CareConnect, Ottawa, ON. [2]Early Intervention Program, Royal Ottawa Hospital, Ottawa, ON.
9	**INNOVATIVE DELIVERY OF SPECIALIZED PHYSIOTHERAPY SERVICES FOR PATIENTS WITH FACIAL NERVE AND VESTIBULAR DYSFUNCTIONS** Sutherland V[1], Dorion J[2], Toland J[2]. [1]NORTH Network Telemedicine at the Sunnybrook Site, [2]Ambulatory Rehabilitation at the Sunnybrook Site, Sunnybrook and Women's College Health Sciences Centre, Toronto, ON.
10	**PUSHING THE BOUNDARIES OF TELEMEDICINE. CHRONIC PAIN CLASSES, AN INTRIGUING NEW APPLICATION OF THE TECHNOLOGY** Sutherland V[1], Gardner-Nix J[2], Hall L. [1]NORTH Network Telemedicine at the Sunnybrook Site, [2]Department of Anaesthesia at the Sunnybrook Site, Sunnybrook and Women's College Health Sciences Centre, Toronto, ON.
11	**EXPLOITING SYNERGIES FROM A PHARMACIST DRUG INFORMATION SERVICE AND A PUBLIC MEDICATION INFORMATION SERVICE TO ENHANCE EVIDENCE-BASED CARE** Gavura S, Wichman K, Cheung T. Drug Information and Research Centre, Ontario Pharmacists' Association.
12	**TELEMEDICINE IN THE PROVISION OF AUGMENTATIVE/ALTERNATIVE COMMUNICATION FOR AMYOTROPHIC LATERAL SCLEROSIS (ALS, LOU GEHRIG'S DISEASE) PATIENTS IN NORTHERN ONTARIO** Vibe M[5], Dharas T[2], Ezerzer F[2], Gryfe P[2], Janson J[2], Naughton S[3], Sutherland V[1], Thomson L[4]. [1]NORTH Network Telemedicine at the Sunnybrook Site, [2]Assistive Technology Clinic at Sunnybrook Centre for Independent Living, Sunnybrook and Women's College Health Sciences Centre, Toronto, ON. [3]NORTH Network Telemedicine, Orillia Soldier's Memorial Hospital, Orillia, ON. [4]NORTH Network Telemedicine, Sensenbrenner Hospital, Kapuskasing, ON. [5]NORTH Network Telemedicine, North Bay General Hospital, North Bay, ON.

7

NURSE TELE-TRIAGE AND THE PRIMARY CARE PHYSICIAN: AN OVERVIEW OF THE ONTARIO EXPERIENCE

Poole L. Clinidata Corporation, Toronto. ON.

INTRODUCTION: In September 2003, Clinidata Corporation launched the Telehealth Health Advisory Service (THAS) for the Ontario Family Health Networks in Ontario. Funded by the Ontario Ministry of Health and Long-Term Care, THAS is a nurse tele-triage service that is available to enrolled patients after hours.
DESCRIPTION: The benefits to enrolled patients include symptom triage by a registered nurse, access to an on-call primary care physician and with the callers' consent, a copy of the clinical record can be transmitted to their physician. Physicians that are participating in one of the primary care groups be it a primary care network, family health network, family health group etc., are required to provide after hour coverage as well as extended hour clinics for their enrolled patients.
RESULTS: The outcomes to date indicate that both patients and physicians are benefiting from the THAS service. While several of the primary care physicians are initially reluctant or have strong opinions about the nurse tele-triage service, most believe that the service is of value to their patients. Another comment from the physician groups is that they expected to be paged more frequently by THAS after hours. For the most part, there is a high degree of patient satisfaction with the THAS service.
CONCLUSION: The link with the primary care physician, the enrolled patient and the tele-triage service is intended to improve accessibility to care 24/7. This presentation will outline how this is being achieved, along with a description of some of the challenges and potential opportunities.

8

YO CHAPLEAU: A SCHOOL BASED EARLY INTERVENTION TELEHEALTH PROGRAM FOR YOUTH IN RURAL AND REMOTE COMMUNITIES

Youell P[1], White M[2]. [1]Mental Health Services Coordinator, CareConnect, Ottawa. ON. [2]Early Intervention Program, Royal Ottawa Hospital, Ottawa. ON.

INTRODUCTION: YOChapleau (Youth Online Chapleau) was developed to leverage telehealth to challenge the risks of substance abuse and related issues that social isolation can impose on youth living in rural and under-serviced communities. The foundation of this initiative is the Early Intervention Program (EIP) of the Royal Ottawa Hospital, a unique and successful school-based service operating under the hospital's Substance Abuse and Concurrent Disorders Program. The Royal Ottawa Hospital is CareConnect's innovation leader for specialized tele-mental health services.
DESCRIPTION: YO Chapleau is a convergence of telehealth and distance education methodologies and technologies applied to the traditional EIP classroom program. This has enabled two schools in this community, located 1,200 kilometers north of Ottawa to participate in the program. The project takes a proven program curriculum and re-invents it for the videoconference medium, infusing it with creativity and interactivity to engage kids 11-14 years of age.
RESULTS: Over the course of 18 months and nearly 100 class sessions, this project has witnessed positive indications that it is succeeding in influencing youth in making positive lifestyle decisions. Evaluations by students, school co-facilitators, school administrators, and EIP staff have validated the continuation of this pilot project, and encouraged the exploration of strategies to expand access to other schools in northern Ontario communities.
CONCLUSIONS: An effective health care prevention program, delivered utilizing telehealth technologies in a creative and engaging format, can have a positive and significant impact on crucial lifestyle decisions for youth in rural and under-serviced communities.

9

INNOVATIVE DELIVERY OF SPECIALIZED PHYSIOTHERAPY SERVICES FOR PATIENTS WITH FACIAL NERVE AND VESTIBULAR DYSFUNCTIONS

Sutherland V[1], Dorion J[2], Toland J[2]. [1]NORTH Network Telemedicine at the Sunnybrook Site, [2]Ambulatory Rehabilitation at the Sunnybrook Site, Sunnybrook and Women's College Health Sciences Centre, Toronto, ON.

INTRODUCTION: Telemedicine has provided access to rehabilitation services for patients with facial nerve and vestibular dysfunctions who live in remote communities from the Physiotherapists administering the treatment.
DESCRIPTION: Patients with ENT related disorders are referred to the Ambulatory Rehabilitation Services at Sunnybrook and Women's College Health Sciences Centre for rehabilitation of facial nerve and vestibular dysfunctions. Vestibular Rehabilitation is an individual exercise program designed to improve problems with balance, dizziness, or visual control due to inner ear disorders. Facial Movement Retraining aims to improve weakness and involuntary muscle contractions associated with facial nerve conditions via a personalized exercise program. These specialized programs provide clinical care within the Sunnybrook & Women's physicial setting as well as providing assessment and treatment for patients in northern communities via the NORTH Network Telemedicine Technology. A shortage of clinical expertise means there is not ready access for this ongoing care in their home communities. Using videoconferencing, the Physiotherapists support individualized rehabilitation programs for their patients with regular follow-up sessions every four-to-six weeks for a period of 12 to 18 months. Prior to integrating the rehabilitation services with the telemedicine technology, many patients were not able to access these unique rehabilitation services due to geographic barriers such as transportation issues, travel costs and time restrictions. With over 80 NORTH Network Telemedicine Studios within the provinces of Ontario and Manitoba, accessibility barriers are now minimized for these clients.
CONCLUSION: Without the telemedicine medium, many of the patients would not have access to ongoing rehabilitation resulting in limited final recovery.

10

PUSHING THE BOUNDARIES OF TELEMEDICINE. CHRONIC PAIN CLASSES, AN INTRIGUING NEW APPLICATION OF THE TECHNOLOGY

Sutherland V*, Gardner-Nix J[2], Hall L. [1]NORTH Network Telemedicine at the Sunnybrook Site, [2]Department of Anaesthesia at the Sunnybrook Site, Sunnybrook and Women's College Health Sciences Centre, Toronto, ON.

INTRODUCTION: Sunnybrook and Women's College Health Sciences Centre, with the NORTH Network is pioneering the use of the telemedicine technology by delivering Mindfulness-based Chronic Pain Management (MBCPM) Classes to multiple northern Ontario communities, connecting them with a host group and a Chronic Pain Consultant from the department of Anaesthesia.
DESCRIPTION: Mindfulness-based Chronic Pain Management (MBCPM)Classes are a western form of eastern meditation techniques, based on the Mindfulness-based Stress Reduction Classes founded by Jon Kabat-Zinn in Massachusetts Medical School in 1979. This intriguing application has enabled a number of northern Ontario communities to connect with a chronic pain consultant leading a class for chronic pain patients from the host telemedicine site at Sunnybrook & Women's. The weekly two-hour sessions incorporate meditation, readings from Kabat-Zinn's book "Full Catasrophe Living" and discussions and exercises around learning to live "mindfully" in the moment allowing for greater stress resilience, greater enjoyment of life and often, reduced disability. Most of the patients would not have been able to attend weekly chronic pain management classes if they had had to travel to the host hospital in Toronto for reasons such as transportation problems,travel expenses,time limitations,and pain exacerbated by travel. Measures are being used to assess outcomes. Currently, participants complete quality of life, degree of suffering (PRISM/test) and catastrophizing questionnaires and results are being analyzed and trends defined.
CONCLUSIONS: Telemedicine is pioneering province-wide access to pain management classes. Many observations are being made and lessons learnt about the delivery of these classes.

11

EXPLOITING SYNERGIES FROM A PHARMACIST DRUG INFORMATION SERVICE AND A PUBLIC MEDICATION INFORMATION SERVICE TO ENHANCE EVIDENCE-BASED CARE

Gavura S, Wichman K, Cheung T. Drug Information and Research Centre, Ontario Pharmacists' Association.

INTRODUCTION: The Ontario Pharmacists' Association (OPA) operates the Drug Information and Research Centre (DIRC), one of the largest drug information centres in Canada, answering over 40,000 inquiries per year from health professionals. DIRC also provides pharmacist consultation to the public through the Telehealth Ontario service, answering an additional 24,000 calls per year.

DESCRIPTION: A series of internal databases and references are maintained by DIRC to assist with answering drug information questions from both health professionals and Telehealth recipients. A number of external software resources complement these databases. Resources are shared between both services. Drug information pharmacists rotate between services. The centralized knowledge base allow DIRC pharmacists to provide detailed, standardized responses on drug availability, drug safety, drug utilization and evidence-based care to Telehealth recipients.

RESULTS: Providing the Telehealth service allows DIRC to identify issues of broad public interest, which can influence DIRC's communication to pharmacists. At the same time, information compiled by DIRC for pharmacists is also immediately available to Telehealth callers.

DIRC's existing links to experts in other specialties and services ensure that Telehealth information is consistent and reflects best practices.

Through the integration of these two services, Telehealth information is more thorough and complete than is available from a community-based pharmacist.

CONCLUSIONS: A centralized drug information centre is able to ensure consistency and thoroughness in telehealth responses and gives recipients of the service access to enhanced information on medications.

12

TELEMEDICINE IN THE PROVISION OF AUGMENTATIVE/ALTERNATIVE COMMUNICATION FOR AMYOTROPHIC LATERAL SCLEROSIS (ALS, LOU GEHRIG'S DISEASE) PATIENTS IN NORTHERN ONTARIO

Vibe M[5], Dharas T[2], Ezerzer F[2], Gryfe P[2], Janson J[2], Naughton S[3], Sutherland V[1], Thomson L[4]. [1]NORTH Network Telemedicine at the Sunnybrook Site, [2]Assistive Technology Clinic at Sunnybrook Centre for Independent Living, Sunnybrook and Women's College Health Sciences Centre, Toronto, ON. [3]NORTH Network Telemedicine, Orillia Soldier's Memorial Hospital, Orillia, ON. [4]NORTH Network Telemedicine, Sensenbrenner Hospital, Kapuskasing, ON. [5]NORTH Network Telemedicine, North Bay General Hospital, North Bay, ON.

INTRODUCTION: The rationale for this project was to provide Augmentative/Alternative Communication aids to Amyotrophic Lateral Sclerosis (ALS) patients, with communication disorders, in northern Ontario, where the appropriate level of prescriptive authority is unavailable.

DESCRIPTION: The project was carried out by allied health care professionals with complimentary professional designations being available at both sites, in order to achieve assessment, dispense, training and follow-up requirements related to meeting the patient's communication needs. Occupational Therapists collaborated in determining physical status, needs and methods of access. Speech Language Pathologists collaborated in determining speech status, cognitive status and language abilities. Communication devices required for proper assessment were couriered to the northern assessment site, in order to make clinical observations by the team of caregivers via the telemedicine technology regarding the appropriateness of the devices for each patient. Training was provided at subsequent sessions, after the delivery of the patient's individually customized devices.

RESULTS: The project provided services for five patients, at different sites, and resulted in the presciption of Voice Output Communication Aids (VOCAs) with concomitant benefit of allowing for wheelchair modifications, as well as, the mounting of each device onto the wheelchair.

CONCLUSIONS: This project prevented the physical exhaustion of already phyically compromised individuals; resulted in financial savings related to both the air ambulance process and professional travel time; and provided education of the patient's local professionals and onsite training and ongoing support to the patients.

CONCURRENT PODIUM SESSION #3
SESSION PARALLÈLE #3
MONDAY / LUNDI : 1320-1450

Homecare/Technology

Room/Salle : Villeray
Moderator / Modératrice : Mary Beth Leblanc

No.	*Abstract Title & Authors / Titre du résumé et auteurs*
13	**INTERNET-BASED SUPPORT GROUPS FOR FAMILY CAREGIVERS OF PERSONS WITH DEMENTIA, STROKE OR PARKINSON: RESULTS OF A FEASIBILITY STUDY** Marziali, E[1], Donahue P[2]. [1]Baycrest Centre for Geriatric Care & University of Toronto, Toronto, ON. [2]University of Calgary, Calgary, AB.
14	**PREPARING A BUSINESS CASE FOR HOME TELEHEALTH** Gebran J[1], Stayberg S[1], Brockway P[2]. [1]Telehealth Unit, Alberta Health and Wellness, Edmonton, AB. [2]Calgary Health Region, Calgary, AB.
15	**CHALLENGES IN GENERATING EVIDENCE FOR HOME TELEHEALTH** Hebert MA[1], Jansen JJ[1], Brandt R[2], Hailey D[1], van der Pol M[2]. [1]Health Telematics Unit, Faculty of Medicine, University of Calgary. [2]Department of Community Health Sciences, Faculty of Medicine, University of Calgary.
16	**EVALUATION OF HOME TELEHEALTH SERVICES IN RURAL NORTHERN MAINE: COST IMPACT OF SAVINGS ON IN-PERSON NURSE VISITS FOR CHF CLIENTS** Edwards MA[1], Dubois T[1], Farren-Tibbetts J[1], Codrey J[2], Berry D[2], Carew C[1]. [1]Sunrise County Home Care Services, HealthWays/Regional Medical Center at Lubec, Lubec, ME. [2]Visiting Nurses of Aroostook,The Aroostook Medical Center, Presque Isle, ME.
17	**LEVERAGING DSL TECHNOLOGIES TO SECURELY DELIVER INTERNET TELE-HEALTH TO THE HOME AND SMALL CLINIC** Danyliuk P, Goncharenko D. North Network, Computer Services, Toronto, ON.
18	**HOW BIG SHOULD THE HELP-DESK BE?: AN ANALYSIS OF HOW HELP-DESK USAGE CHANGES WITH INCREASING NETWORK ACTIVITY** Pal I, Riesenbach R. NORTH Network, Toronto, ON.

13

INTERNET-BASED SUPPORT GROUPS FOR FAMILY CAREGIVERS OF PERSONS WITH DEMENTIA, STROKE OR PARKINSON: RESULTS OF A FEASIBILITY STUDY

Marziali, E[1], Donahue P[2]. [1]Baycrest Centre for Geriatric Care & University of Toronto, Toronto, ON. [2]University of Calgary, Calgary, AB.

INTRODUCTION: The aim of the project was to develop and evaluate the effects of an innovative internet-based support group on caregiver stress and coping.
DESCRIPTION: An easy to use web site was built to support video conferencing links for disease-specific groups of caregivers. Caregivers in each disease group, located in two remote areas (Timmins and Lethbridge) were recruited. Equipment (computers, webcams and audio headsets) and high speed internet access were installed in their homes. We developed an easy to use computer information manual to train caregivers who had no previous experience with computers. Two professional health care providers (nurse and social worker) were trained to deliver the online group intervention. Following ten weekly sessions of professionally facilitated sessions, a group member assumed the facilitator task with the aim of supporting caregiver group meetings for the duration of their caregiving careers.
RESULTS: Pre intervention and at five month follow up long interviews were held with all participants. The feedback was extremely positive. Group members had bonded and provided support for each other in developing and implementing strategies for managing stress more effectively. All participants found the web site links easy to use and the video-based virtual group process was rated as effective as face-to-face interactions.
CONCLUSIONS: The results of the project show that caregivers of persons with long-term disabilities benefit from a telehomecare program that addresses the stresses and strains associated with the enormous challenges of providing care for a dependent family member.

14

PREPARING A BUSINESS CASE FOR HOME TELEHEALTH

Gebran J[1], Stayberg S[1], Brockway P[2]. [1]Telehealth Unit, Alberta Health and Wellness, Edmonton, AB. [2]Calgary Health Region, Calgary, AB.

INTRODUCTION: Home Telehealth is an emerging and important field that has the potential to increase access to Homecare services in rural and urban centres. A methodology and template will be presented to assist health regions and other Homecare organizations in developing a business case for Home Telehealth applications, including a tool to measure the return on investment. A major challenge in preparing business cases is selecting an appropriate framework to articulate the desired future state, the current state, an environmental scan, and a proposal to move forward. For Home Telehealth, this challenge is amplified as a result of the relative paucity of Home Telehealth applications.
DESCRIPTION: A group of homecare leaders and others with an interest in delivering home telehealth applications were established. The group selected a business case framework, identified a potential scenario, and developed a full business case for the scenario.
RESULTS: A template was prepared for home telehealth applications that included an environmental scan, a current and future state description, a return on investment calculation, and a proposal for proceeding including an implementation plan and a program evaluation framework. These could be customized as required as new home telehealth applications are being proposed.
CONCLUSIONS: The methodology and template will enable organizations unfamiliar with the technological requirements of Telehealth to address implementation issues and facilitate integration into their delivery strategy. Program leaders can determine how performance will be measured, and therefore monitor the projects' progress and outcomes.

15

CHALLENGES IN GENERATING EVIDENCE FOR HOME TELEHEALTH

Hebert MA[1], Jansen JJ[1], Brandt R[2], Hailey D[1], van der Pol M[2]. [1]Health Telematics Unit, Faculty of Medicine, University of Calgary. [2]Department of Community Health Sciences, Faculty of Medicine, University of Calgary.

PURPOSE: The literature suggests more rigorous evidence is needed to support investments in home telehealth. This presentation discusses challenges in implementing such a study to compare traditional palliative home care visits and "video-visits" in combination with traditional visits.
METHODS: 320 palliative home care clients recruited in 4 Alberta health regions are randomly assigned to either control or treatment groups. Changes in symptom management and quality of life, as well as cost-effectiveness measures, are compared between the groups. Interviews with selected clients who have had a range of experiences using the technology are conducted. Fifty home care nurses in 11 rural communities are trained to participate in the study, both in using the videophone as well as completing the data collection. A research assistant in each region is responsible to install and remove the videophones.
RESULTS: The home care nurses and managers have demonstrated a tremendous willingness to participate in the study, in spite of competing interests for their time. One of the most striking results, but least quantifiable, is the fact that clients want to keep their video-phones at the end of their study participation. Economic assessment is the most challenging due to minimal data recorded on a routine basis, e.g. distance and fuel costs are not recorded if nurses use fleet cars for their home visits.
CONCLUSIONS: While a focus on economic outcomes is essential for a sustainable health care system, other "valuable" outcomes from both the client's and nurse's perspectives perhaps should be considered to carry equal weight.

16

EVALUATION OF HOME TELEHEALTH SERVICES IN RURAL NORTHERN MAINE: COST IMPACT OF SAVINGS ON IN-PERSON NURSE VISITS FOR CHF CLIENTS

Edwards MA[1], Dubois T[1], Farren-Tibbetts J[1], Codrey J[2], Berry D[2], Carew C[1]. [1]Sunrise County Home Care Services, HealthWays/Regional Medical Center at Lubec, Lubec, ME. [2]Visiting Nurses of Aroostook,The Aroostook Medical Center, Presque Isle, ME.

PURPOSE: Evaluate clinical utility, quality, and cost impact of interactive home telehealth services in a rural area.
METHODS: Evaluation surveys assessed clinical content, satisfaction, problem frequency, and session lengths. For 15 telehealth clients with a diagnosis of congestive heart failure (CHF), data was gathered on both in-person and telehealth visits. A retrospective comparison was made on visits per week for 18 non-telehealth CHF clients. A simple cost model was developed to reveal potential cost savings.
RESULTS: For 2,740 telehealth visits with 144 clients from 1999-2002, high satisfaction ratings were provided by clients and nurses. Problem levels declined to 5% of sessions by the third year. Many common nursing tasks were achieved through televisits. The CHF patients in telehealth care received similar frequencies of telehealth and in-person visits (1.56 and 1.37 per week), which were 20 min. and 45 min. in average duration, respectively. In-person visits were significantly less frequent than in the non-telehealth comparison group, 1.82 per week ($p<.04$, t-test). On a monthly basis, providing 7 telehealth visits was associated with a reduction of 2 in-person visits from control group levels. Mean monthly nurse contact time was 6.8 hrs. for telehealth vs. 5.8 hr. for standard care clients. Factoring in mileage costs and staff time to travel 50 mi. round-trip, savings about $50 per client per month were projected using $100/hr. for RN time.
CONCLUSION: Data on real world operations of two rural home health agencies support the view that home telehealth services can be clinically effective and cost effective.

17

LEVERAGING DSL TECHNOLOGIES TO SECURELY DELIVER INTERNET TELE-HEALTH TO THE HOME AND SMALL CLINIC

Danyliuk P, Goncharenko D. North Network, Computer Services, Toronto, ON.

INTRODUCTION: DSL offerings have now evolved to the point that viable low cost video technologies can be implemented within the home or small medical clinic. Ordering premium or ultra DSL is the first step towards leveraging the Internet for your Tele-Health requirements. However, what about security and quality of service? What video platforms and modes of operations work best? What are the benefits and risks? How do you seamlessly integrate this service offering into your present mode of operations?
DESCRIPTION: This presentation will overview and focus on various DSL options and associated costs, performance, and reliability. Also we will overview related Inter-networking technologies & platforms.
RESULTS: This session will provide attendees with pragmatic results related to DSL based mode of operations that utilizes high speed, low cost, and secure Internet based communications. Various internetworking platforms and implementation methodologies will be covered. Operational concepts related to costs, benefits and risks will be demonstrated.
CONCLUSIONS: DSL has a significant role to play in Tele-Health deployments.

18

HOW BIG SHOULD THE HELP-DESK BE?: AN ANALYSIS OF HOW HELP-DESK USAGE CHANGES WITH INCREASING NETWORK ACTIVITY

Pal I, Riesenbach R. NORTH Network, Toronto, ON.

INTRODUCTION: It is often difficult to predict how many technical staff will be needed to support a telehealth help-desk. To better understand and predict help-desk usage, it may instructive to examine the experience of larger telehealth networks that have several years of experience and support large volumes of activity.
DESCRIPTION: NORTH Network is one of Canada's busiest telehealth networks supporting over 150 videoconference systems spanning 100+ member sites. With over 1,500 clinical and educational events every month, NORTH's Technical Services and Support Desk (TSSC) performs many of the 1st-level support tasks necessary to keep the service operating and growing. TSSC uses a number of automatic and semi-automated tools to track incidents and responses. These data were analyzed to better understand usage trends in light of the growth of the number of sites and events.
RESULTS: NORTH's five-person TSSC provides 1st & 2nd level support and is backed up by an additional seven application and network specialists which provide 3rd level support. This team responds to approximately 500 phone calls and opening and dealing with over 100 trouble tickets. In addition to scheduled tertiary care, NORTH's help-desk can also support a number of 7*24 emergency services and can manage approximately 75 bridged/gateway sessions per month.
CONCLUSIONS: The intensity of activity of the TSSC correlates to both the number of sites supported and the volume of activity on the network. The details of the trends are instructive, especially when examined on a categorical level as well as on the type of incidents being reported.

CONCURRENT PODIUM SESSION #4
SESSION PARALLÈLE #4
MONDAY / LUNDI : 1320-1450

Evaluation/Telehealth Tools

Room/Salle : Dufferin
Moderator / Modératrice : Karen Waite

No.	*Abstract Title & Authors / Titre du résumé et auteurs*
19	**MEASURING WHAT WE DO: THE DESIGN AND APPLICATION OF A WORKLOAD MEASUREMENT TOOL** Loewen L, Adair L. MBTelehealth, Winnipeg Regional Health Authority, Winnipeg, MB.
20	**TELEHEALTH READINESS FOR CONDUCTING ELECTIVE CONSULTATIONS IN ONTARIO: DEVELOPMENT OF A SELF-ASSESSMENT TOOL** Nickoloff A[1], Archambault P[2], Fenton C[3], Feltz L[4], Kroeker A[4], Robinson D[4]. [1]NORTH Network, Toronto, ON. [2]CareConnect, Ottawa, ON. [3]NORTH Network, Timmins, ON. [4]VideoCare, London, ON.
21	**A STRUCTURED APPROACH TO THE DEVELOPMENT OF USER FEEDBACK TOOLS FOR TELEMEDICINE** Gopal VM[1,2], Lindsay MP[1,3], Pal I[2], and the TNO Evaluation Working Group. [1]Department of Health Policy, Management & Evaluation, University of Toronto, Toronto, ON. [2]NORTH Network, Toronto, ON. [3]Institute for Clinical Evaluative Sciences, Toronto, ON.
22	**ALBERTA CANCER BOARD / CAPITAL HEALTH JOINT TELEHEALTH LUNG CANCER TRIAGE & FOLLOW-UP CLINIC "TOOLKIT"** Allen D[1], Butts C[1], Cummings G[1], Delorme T[2], Gebran J[4], Hoeber M[1], Janzen H[1], King C[2], Reinbold D[3], Winton T[1,2]. [1]Alberta Cancer Board (ACB), AB. [2]Capital Health (CH), Edmonton, AB. [3]Peace Country Health (PCH), Grande Prairie, AB. [4]Alberta Health & Wellness (AHW), Edmonton, AB.
23	**SUCCESSFUL UTILIZATION OF A WWW BASED SCHEDULING SYSTEM TO COORDINATE TELEHEALTH ACTIVITY** Bulger T [1], Neal D [2]. [1]Telemental Health Service, Alberta Mental Health Board, Ponoka AB. [2]Olantra Inc. Calgary, AB.
24	**OPEN SYSTEMS SCHEDULING: A HOLISTIC APPROACH TO FIRST NATIONS TELEHEALTH INTEGRATION** Stevens A. Telehealth Scheduler, Keewaytinook Okimakanak, Balmertown, ON.

19

MEASURING WHAT WE DO: THE DESIGN AND APPLICATION OF A WORKLOAD MEASUREMENT TOOL

Loewen L, Adair L. MBTelehealth, Winnipeg Regional Health Authority, Winnipeg, MB.

PURPOSE: Integration requires a new approach to the telehealth coordinator role however the exact nature of this multifaceted position has not yet been quantified. To support integration, the MBTelehealth Network identified a need to begin the systematic measurement of coordinator workload to accurately reflect the role and capture the proportion of time spent on key activities.
METHODS: The nursing workload measurement system used by the Canadian Institute for Health Information was modified to reflect the telehealth coordinator role in Manitoba. Following pilot testing, the measurement tool was implemented with all telehealth coordinators reporting their activities during May 2004.
RESULTS: This presentation will provide an overview of the development process and key findings. Workload reports were received from 21 staff representing 20 sites and 1,724 paid hours. The majority of coordinator time (56.8%) was spent on functional centre activities, which included clerical, scheduling, employee meetings and travel within and between facilities. The second most frequent activities (29.4%) were interventions, which included clinical and non-clinical session assistance, participant orientation, treatment procedures and clinical documentation. Variations in proportion of activities were seen between full-time/part-time status, urban/non-urban sites and clinician/non-clinician sites. There was little variation seen between Registered Nurse and non Registered Nurse Coordinators.
CONCLUSIONS: Use of this tool provides needed insight into the current telehealth coordinator role and will support planning, budgeting, and identification of staff education needs. Future administration of the tool will track changes in coordinator activities as integration of telehealth services in Manitoba progresses.

20

TELEHEALTH READINESS FOR CONDUCTING ELECTIVE CONSULTATIONS IN ONTARIO: DEVELOPMENT OF A SELF-ASSESSMENT TOOL

Nickoloff A[1], Archambault P[2], Fenton C[3], Feltz L[4], Kroeker A[4], Robinson D[4]. [1]NORTH Network, Toronto, ON. [2]CareConnect, Ottawa, ON. [3]NORTH Network, Timmins, ON. [4]VideoCare, London, ON.

INTRODUCTION: There are currently 3 telemedicine networks in Ontario, each serving a geographically distinct region of the province and each having their own set of technologies, processes, standards & policies. Each network recognizes the importance of ensuring that appropriate telehealth services for patient care can be delivered in a seamless fashion throughout the province.
DESCRIPTION: Clinical leaders from each network determined that variation existed in the state of readiness and ability of many individual network sites to enable quality telehealth consultations. Consensus was obtained on a comprehensive set of minimum requirements for any Ontario network site to participate in clinical telehealth activity. Additionally, it was believed that the requirements would serve as a guide to facilitate the implementation and expansion of elective clinical telehealth services at network sites.
RESULTS: A 5-page self-assessment telehealth readiness tool was developed using the NIFTE dimensional framework of telehealth readiness including infrastructure and planning readiness, workplace environment readiness and technical readiness components. Sites that either host patients or provide consulting services or both can use the tool. Questions are grouped to help identify where strengths or gaps may exist and so that resources can be applied using a systematic approach.
CONCLUSIONS: It is possible for 3 distinct telehealth networks to agree on a minimum set of readiness requirements to enable safe and effective inter-network patient consultations. The next step is to investigate whether incorporating a grading system that outlines different levels or states of readiness would enhance the tool and provide better information for users.

21

A STRUCTURED APPROACH TO THE DEVELOPMENT OF USER FEEDBACK TOOLS FOR TELEMEDICINE

Gopal VM[1,2], Lindsay MP[1,3], Pal I[2], and the TNO Evaluation Working Group. [1]Department of Health Policy, Management & Evaluation, University of Toronto, Toronto, ON. [2]NORTH Network, Toronto, ON. [3]Institute for Clinical Evaluative Sciences, Toronto, ON.

INTRODUCTION: Introduction: Accountability for the quality of clinical and technical telemedicine services provided to end users of telemedicine is an imperative. Survey methods can result in valuable feedback from a range of users, including front line staff and patients, when using systematically developed and validated survey tools. This presentation will discuss activities taking place in Ontario to develop common feedback tools to measure feedback from patients and a range of providers. The final results from one such survey process –a client feedback tool for a Technical Support Service Centre (TSSC) – will be presented.
METHODS: The systematic approach to designing telemedicine feedback tools in Ontario includes: a thorough literature review, identification of key dimensions for measurement, identification of key survey items and validation of the tools. The TSSC survey consisted of 35 questions addressing accessibility, helpfulness and efficiency. The survey was administered in web-based format over six weeks to Telehealth coordinators (THCs) responsible for initiating and managing patient telemedicine appointments, education and training events.
RESULTS: Fifty-six THCs completed the TSSC survey (63% response rate). Strong areas of service included: problem resolution and access. Communication was one area where improvements were recommended.
CONCLUSIONS: Feedback questionnaires are essential tools to identify the successes and gaps in clinical and technical services, and identify improvement opportunities. Standardized questionnaires are being developed through a collaborative effort across Ontario that will provide opportunities for benchmarking and best practice identification. The TSSC survey results provide valuable information on telemedicine help-desk services that could be generalized across all telemedicine providers.

22

ALBERTA CANCER BOARD / CAPITAL HEALTH JOINT TELEHEALTH LUNG CANCER TRIAGE & FOLLOW-UP CLINIC "TOOLKIT"

Allen D[1], Butts C[1], Cummings G[1], Delorme T[2], Gebran J[4], Hoeber M[1], Janzen H[1], King C[2], Reinbold D[3], Winton T[1,2]. [1]Alberta Cancer Board (ACB), AB. [2]Capital Health (CH), Edmonton, AB. [3]Peace Country Health (PCH), Grande Prairie, AB. [4]Alberta Health & Wellness (AHW), Edmonton, AB.

INTRODUCTION: An AHW funded Clinical Telehealth Grant enables patients and families in their home communities to be seen by a multidisciplinary team of Edmonton based specialists in thoracic surgery, medical and radiation oncology. This unique project required the development of instruments to ensure appropriate communication, scheduling, and documentation.
DESCRIPTION: A potentially transferable referral, scheduling and clinical activity documentation and follow-up "Toolkit" has been developed. A single "Patient Record" form, available in both paper and digital (electronic health record) format follows the client from referral through scheduling, evaluation, diagnostic and therapeutic recommendations, definitive therapeutic treatment and follow-up. The "Patient Record" is part of the client's permanent record. The "Clinic Schedule" details the order patients will be seen and is designed to allow partnering telehealth departments to work together efficiently. The "Patient and Provider Satisfaction Survey" comprise proven evaluation questionnaires. The final component is a Memorandum of Understanding that details each partner's roles and responsibilities.
RESULTS: The "Toolkit" has successfully facilitated the care of over 120 patients in a busy bi-weekly lung cancer telehealth clinic. The efforts of multidisciplinary care providers from several organizations working within four distinct organizations in multiple geographically separate sites have been coordinated and the quality and safety of the care provided has been enhanced by the "Toolkit".
CONCLUSIONS: The "Toolkit" developed as part of this telehealth lung cancer clinic has proven to be an important tool which has facilitated the provision of comprehensive, well coordinated quality clinical care to rural patients.

23

SUCCESSFUL UTILIZATION OF A WWW BASED SCHEDULING SYSTEM TO COORDINATE TELEHEALTH ACTIVITY
Bulger T [1], Neal D [2]. [1]Telemental Health Service, Alberta Mental Health Board, Ponoka AB. [2]Olantra Inc. Calgary, AB.

INTRODUCTION: The distributed nature of delivering clinical, learning, and other services via telehealth technology is best coordinated using a shared electronic system. Such a system is a critical means of enabling communication between parties separated by great distances and jurisdictional boundaries.
Partnering jurisdictions in Western Canada utilize a World Wide Web based Telehealth Program Coordination and Scheduling System. This presentation will outline how the system enables the integration of telehealth programs and provides real time utilization data. In addition results of a recent user feedback survey and highlights regarding future growth of the system will be provided.
DESCRIPTION: Designed to meet the unique needs of scheduling telehealth events the Scheduling System is used by 31 agencies in three provinces and one territory to coordinate all telehealth activity. System users are able to determine technology availability throughout participating provinces/territories and schedule events according to a hierarchy of permissions.
RESULTS: Since the system was made available in September 2001 over 22,000 events have been scheduled. Interactive real time reporting allows continuous monitoring by program administrators. A feedback questionnaire has been distributed to system users; results will be presented at the CST conference. Future growth of the system will include working with partnering jurisdictions to integrate with provincial client and patient registry systems.
CONCLUSIONS: A distributed scheduling system allows partnering telehealth programs to coordinate the delivery of clinical, learning, and other telehealth services. Comprehensive, customizable, reporting allows local, regional, and provincial/territorial program administrators to easily obtain utilization data.

24

OPEN SYSTEMS SCHEDULING: A HOLISTIC APPROACH TO FIRST NATIONS TELEHEALTH INTEGRATION
Stevens A. Telehealth Scheduler, Keewaytinook Okimakanak, Balmertown, ON.

INTRODUCTION: Patients living in Northwestern Ontario's remote First Nations communities face many challenges when it comes to attending medical appointments. Keewaytinook Okimakanak (KO) Telehealth is using an open systems approach to scheduling to provide the flexibility necessary to meet the needs of First Nations patients.
DESCRIPTION: Since 2002 the KO Telehealth Scheduler has been working with North Network's Central Scheduling Office and Noninsured Health Benefits Branch to set up clinical appointments for patients from remote First Nations communities. Often clinical appointments have to be rescheduled due to traditional land-based harvesting. For example, the KO Telehealth Scheduler will not schedule appointments during goose hunting season. KO Telehealth Scheduling's success depends on its recognition of existing traditional community networks.
RESULTS: If a family member is the only caregiver in the home and if their partner gets ill on the day he or she has to fly out, they must cancel their appointment. In doing so, he or she jeopardizes subsequent appointments due to the inflexibility of the current system. The checks and balances that currently exist between the First Nations network and other health care systems need to undergo a review towards more flexibility.
CONCLUSIONS: Regulatory systems must be as diverse as the environment it hopes to direct. KO Telehealth plays a key role in supporting First Nations communities by successfully integrating telehealth for First Nations health care into the existing health care system.

CONCURRENT PODIUM SESSION #5
SESSION PARALLÈLE #5
MONDAY / LUNDI : 1320-1450

Sustainability/Integration

Room/Salle : Beauport
Moderator / Modératrice : Helen Novak Lauscher

No.	*Abstract Title & Authors / Titre du résumé et auteurs*
25	**CHALLENGES OF IMPLEMENTING TELEHEALTH IN SMALL NON-PROFIT AGENCIES** Garden H. Telehealth, Provincial Health Services Authority, BC.
26	**PEDIATRIC SURGERY TELEHEALTH: ROOM TO GROW** Postuma R. Section of Pediatric General Surgery, Winnipeg Children's Hospital, Winnipeg, MB and MBTelehealth, MB.
27	**WORKING AT A DISTANCE – SUPPORTING TELEHEALTH COORDINATORS THROUGH PEER MENTORING GROUPS** Adair L. MBTelehealth, Winnipeg Regional Health Authority, Winnipeg, MB.
28	**BROADBAND CONNECTIVITY CAPACITIES TO RURAL REMOTE AREA VALUE-ADD – VIEWS FROM THE HEALTH-CARE FIELD** Jennett P, Yeo M, Scott R, Teo W. Health Telematics Unit, Faculty of Medicine, University of Calgary, Calgary, AB.
29	**THE PERCEIVED ROLE OF TELEMEDICINE IN HEALTHCARE DELIVERY FOR REMOTE AND RURAL COMMUNITIES: THE PHYSICIANS' PERSPECTIVE** Lindsay MP[1,2], Keleher S[2]; Williams R[3], Tepper J[1]. Ferraro L[3]. [1]Institute for Clinical Evaluative Sciences, Toronto. [2] Faculty of Medicine, University of Toronto. NORTH Network[3].
30	**CONTEXT COUNTS: A CRITICAL EXAMINATION OF TELEHEALTH IN LABRADOR** Peddle KM. Department of Communication Studies, Concordia University, Montreal, QC

25

CHALLENGES OF IMPLEMENTING TELEHEALTH IN SMALL NON-PROFIT AGENCIES

Garden H. Telehealth, Provincial Health Services Authority, BC.

PURPOSE: To discuss the lessons learned, considerations and future potential for successfully implementing telehealth in small non-profit organizations.
METHODS: Select child development centres participated in a large scale telehealth project with limited success related to future sustainability. A post-project needs assessment was undertaken to identify opportunities for local and shared telehealth services. Fit of technology to resources and needs was also addressed as an aspect of the post-project review.
RESULTS: The child development centres (CDCs) that participated in the project were left with the burden of paying large operational costs to access technology that in most cases was of limited use to their organizations. Currently, sustainability of the technology varies considerably between CDCs. These organizations are community based and differ substantially from one another in their configuration of services and funding base. The potential of replacing large video conferencing units with internet based technology has been identified as an opportunity for CDCs that service large geographically remote locations. This application is in the process of being implemented between a northern CDC site in Terrace and the Queen Charlotte Islands, where video conferencing is currently not an option.
CONCLUSION: It is essential to do a thorough needs assessment that focuses on the commitment and ability to allocate ongoing operational funding. Match of the technology to both the service and fiscal requirements of the organizations involved needs to be addressed as a component of telehealth service planning.

26

PEDIATRIC SURGERY TELEHEALTH: ROOM TO GROW

Postuma R. Section of Pediatric General Surgery, Winnipeg Children's Hospital, Winnipeg, MB and MBTelehealth, MB.

PURPOSE: To review the use of telehealth in an academic, tertiary-based pediatric general surgery practice and evaluate the potential for growth.
METHODS: The concurrent electronic patient database of one pediatric surgery consultant for the province of Manitoba, North Western Ontario and Nunavut was reviewed with respect to the utilization of telehealth over the MBTelehealth network for the period 2001 to June 28, 2004. The potential for growth in telehealth was also examined.
RESULTS: During the 3.5 years, 234 (12%) children received 325 (11%) services by telehealth in the consultant's Pediatric Surgery Ambulatory Clinic: 36% and 32% respectively when urban (Winnipeg) patients were excluded. The utilization increased over time. Of the services provided by telehealth, 67% were consultations for a range of common pediatric surgery problems, and 23% of the sessions were follow ups. In only a few situations did the child need subsequent in-person evaluation. Not all children living in or near the 20 telehealth-capable communities received pediatric surgery services by telehealth for a variety of interesting reasons.
An evaluation of all in person ambulatory visits found that over 70% could have seen by telehealth. Thus, over the study period, an additional 375 pediatric ambulatory surgical visits could have been provided by telehealth if it had been available in all 80 non-urban health centers.
CONCLUSIONS: Telehealth was used in an increasing proportion of non-urban children, but there is a very significant potential for growth if all rural patients had access to telehealth.

27

WORKING AT A DISTANCE – SUPPORTING TELEHEALTH COORDINATORS THROUGH PEER MENTORING GROUPS

Adair L. MBTelehealth, Winnipeg Regional Health Authority, Winnipeg, MB.

INTRODUCTION: This presentation will provide an overview of the implementation of peer support groups within the MBTelehealth network. Peer support groups enhance communication within the network, improve work life, support peer mentorship and provide ongoing continuing education for Site Coordinators who often work in isolation.
DESCRIPTION: MBTelehealth has coordinators at 24 sites throughout the province of Manitoba who work on a full or part-time basis. Communication, education and ongoing support are instrumental in reducing feelings of isolation and maintaining coordinator competency and high skill levels. This presentation will review the structure and ongoing utilization of peer support groups within the telehealth network, integration of new staff into these groups and identify some of the challenges and successes to date.
RESULTS: There have been four Peer Support Groups created within the MBTelehealth Network. Successes and challenges will be shared regarding the groups and their functions in the areas of education, communication and peer support.
CONCLUSIONS: Peer support groups within a network assist with the integration of new and diverse telehealth staff, promotes program communication, and provides coordinators with access to ongoing education and competency. They also set the groundwork for other initiatives where a team concept is beneficial such as process improvement initiatives and marketing plan development. The peer support groups will be the foundation for the future development of a network for key participants as we move toward integration of the telehealth program into current health care practices.

28

BROADBAND CONNECTIVITY CAPACITIES TO RURAL REMOTE AREA VALUE-ADD – VIEWS FROM THE HEALTH-CARE FIELD

Jennett P, Yeo M, Scott R, Teo W. Health Telematics Unit, Faculty of Medicine, University of Calgary, Calgary, AB.

PURPOSE: The advent of the SuperNet, a broadband capacity with 4700 links to 422 rural remote Alberta communities, provides new Internet-based capacities and options to an already established provincial ISDN telehealth system with 239 live sites. The purpose of this presentation is to present views from the field as to the anticipated value and impact of this new infrastructure.
METHODS: Survey methodology, i.e. questionnaire, was adopted. A representative sample by health region (n=9) and type of end-user (n=35, 5 groups – Government, Health Regions, Providers/Practitioners, Organizations, and Private Sector) was recruited using snowball and purposive sampling. All (100%) of those approached agreed to participate. Seven areas were investigated: Value, Limitations, Impact on Usual and Current Telehealth Care, Required Infrastructure, Policy, Evaluation, and Readiness.
RESULTS: Similar issues were identified by end-user groups within each area; however ranking of priority areas varied by region and group. Key findings suggest that clarification around privacy and security, costs, public awareness and acceptance, along with required policy changes, and timeline for migration is required.
CONCLUSIONS: Feedback from the health care field and its grass roots, along with recognition of its diversity, is essential to enable the migration of telehealth capacities onto a broadband IP architecture. Findings are being shared with the Provincial Telehealth Committee, Alberta Health and Wellness, and associated private sector carriers to assist with buy-in and the implementation of change.

29

THE PERCEIVED ROLE OF TELEMEDICINE IN HEALTHCARE DELIVERY FOR REMOTE AND RURAL COMMUNITIES: THE PHYSICIANS' PERSPECTIVE

Lindsay MP[1, 2], Keleher S[2]; Williams R[3], Tepper J[1], Ferraro L[3]. [1]Institute for Clinical Evaluative Sciences, Toronto. [2] Faculty of Medicine, University of Toronto. NORTH Network[3].

INTRODUCTION: Shortages of primary care and specialist practitioners in Northern Ontario are endemic, due to both professional and personal factors. Telemedicine offers one solution to the challenges of providing care in settings where patients and the needed providers are not available in the same community. The purpose of this study is to determine to the extent telemedicine assists physicians working in Northern Ontario.
METHODS: Focus groups and structured interviews were conducted with several physicians practicing in Northern Ontario. Participants were stratified into two groups: physicians practicing where telemedicine capability has been operational for two years or more, and physicians practicing in areas that are soon to adopt the technology. Two investigators participated in each interview. The data was analyzed using qualitative framework analysis.
RESULTS: Experienced telemedicine physicians identified several enablers and challenges telemedicine poses to their practice. Those physicians new to telemedicine had expectations for benefits that were similar to those realized by the experienced physicians. The results also identified examples of local innovation that could be applied on a larger scale, and identified opportunities, limitations and potential threats that telemedicine providers must address as they continue to build and implement a comprehensive telemedicine network.
CONCLUSIONS: Telemedicine is seen as an opportunity for physicians who are either experienced telemedicine users or soon to be engaged with the technology. There is still room to enhance the nature and quality of the service delivery, and several examples of how to offer these enhancements exist at the local level.

30

CONTEXT COUNTS: A CRITICAL EXAMINATION OF TELEHEALTH IN LABRADOR

Peddle KM. Department of Communication Studies, Concordia University, Montreal, QC

INTRODUCTION: Currently telehealth is being offered as an innovative solution to austerity, staffing issues and problems accessing care in Canada's rural communities. Despite the current enthusiasm for telehealth in provincial and federal policy documents, many of these promises have not been realized.
DESCRIPTION: The Labrador region is a large and sparsely populated area that was awarded a federal "Smart Community' project to increase the region's technological capacity. While telehealth was key in the SmartLabrador plan, there has been limited uptake of newly available technologies for this purpose. I address this problem with the research question, What are the socio-technical barriers to telehealth use in Labrador?
RESULTS: The qualitative study reveals that the context in which telehealth is situated figures largely into its success or failure. Analysis of the Labrador telehealth context reveals how attempts to bridge distance are limited by organizational factors, technical problems, staff turnover and a lack of provincial telehealth policy. The barriers to telehealth use are not simply technical, but relate to issues of privacy, liability and inter-agency coordination.
CONCLUSION: The user context must be considered as the centre of program design. Telehealth in Labrador has been impeded by a variety of factors, such as the malfunction and inflexibility of technology, chronic shortage of staff and the fiscally restrained health system. Most importantly, there is a need to implement telehealth policy at the provincial level, and to address the lack of user involvement in health services planning.

FOCUS SESSION #1

Monday Afternoon: 1320-1450

Implementation and Scheduling

Room

Introduction to Telehealth: Requirements for Applications
Madeleine St-Gelais, Centre hospitalier universitaire de McGill
Olga Paquin, Centre hospitalier de l'Université Laval
Sylvie Godbout, Centre hospitalier universitaire de Sherbrooke

Porte du Palais

NORTH Network's Telehealth Scheduling Tool: an Overview and Demonstration of a Custom Software Application
Presentation and live demonstration from North Network (patient scheduler)
Ron Riesenbach, Director Technical Services, NORTH Network
Simon Cheesman, Project Developer, NORTH Network

Web Scheduling Tool for Telehealth Activities at McGill University
Presentation and live demonstration from Vertical 7
Marc Lavallée, Directeur de compte principal, Vertical 7

SESSION DE MISE AU POINT #1

Lundi après-midi: 1320-1450

Mise en oeuvre et planification

Salle

Introduction to Telehealth: Requirements for Applications
Madeleine St-Gelais, Centre hospitalier universitaire de McGill
Olga Paquin, Centre hospitalier de l'Université Laval
Sylvie Godbout, Centre hospitalier universitaire de Sherbrooke

Porte du Palais

NORTH Network's Telehealth Scheduling Tool: an Overview and Demonstration of a Custom Software Application
Presentation et demonstration en direct de North Network (horaire du patient)
Ron Riesenbach, Director Technical Services, NORTH Network
Simon Cheesman, Project Developer, NORTH Network

Web Scheduling Tool for Telehealth Activities at McGill University
Presentation et démonstration en direct de Vertical 7
Marc Lavallée, Directeur de compte principal, Vertical 7

MONDAY AFTERNOON PLENARY SESSION

Time	Session	Room
1500-1730	**Plenary session #2** **Canadian Models and Applications** Moderator: Madeleine Poulin	Porte du Palais
1500-1515	Presentation #1 **The Alberta Experience: Integrating Telehealth into Clinical Service Delivery** ***Sharlene Stayberg,*** Alberta Health and Wellness	
1515-1530	Presentation #2 **Integrating Telemedicine into Clinical Practice of Paediatric Cardiology in Eastern Canada** ***Dr. John Finley***, Izaak Walton Killam Hospital, Halifax	
1530-1545	**Panel discussion period**	
1545-1615	Nutrition Break	Foyer/Porte St-Louis-Kent
1615-1630	Presentation #3 **Telehealth Integration: Evolution or Revolution?** ***Dr. Sarah C. Muttitt***, Director, MB Telehealth, Manitoba	Porte du Palais
1630-1645	Presentation #4 **Telemedicine Applied to First Line Healthcare Delivery in Rural Areas** ***Dr. Paul-Émile Barbeau***, Abitibi-Témiscamingue	
1645-1705	**Panel discussion period**	
1705-1715	**Summary and Wrap-up of Canadian Perspectives** ***Dr. Edward M. Brown***, Sunnybrook Hospital, Director of the NORTH Network, Ontario	
1715-1720	**Closing Statement** ***Dr. Jean-Paul Fortin***, Chair, Conference Organizing Committee	Porte du Palais
1800-1900	Gala Dinner Reception	Foyer
1900	Gala Dinner and CST Awards Presentations	Porte du Palais

SESSION PLÉNIÈRE LUNDI P.M.

Heure	Session	Salle
1500-1730	**Session plénière #2** **Modèles canadiens et applications** Animation : Madeleine Poulin	Porte du Palais
1500-1515	Présentation #1 **The Alberta experience : integrating telehealth into clinical service delivery** ***Sharlene Stayberg***, Alberta Health and Wellness	
1515-1530	Présentation #2 **Integrating telemedicine into clinical practice of paediatric cardiology in Eastern Canada** ***Dr John Finley***, Izaak Walton Killam Hospital, Halifax	
1530-1545	**Discussion en plénière**	
1545-1615	Pause santé	Foyer/Porte St-Louis-Kent
1615-1630	Présentation #3 **Telehealth Integration : evolution or revolution ?** ***Dr Sarah C. Muttitt***, Director, MB Telehealth, Manitoba	Porte du Palais
1630-1645	Présentation #4 **Telemedicine applied to first line healthcare delivery in rural areas** ***Dr Paul-Émile Barbeau***, Abitibi-Témiscamingue	
1645-1705	**Discussion en plénière**	
1705-1715	**Résumé de la plénière : Perspectives canadienne** ***Dr Edward M. Brown***, Sunnybrook Hospital, Director of the NORTH Network, Ontario	
1715-1720	**Allocution de fermeture** ***Dr Jean-Paul Fortin***, Président, Comité local de planification	Porte du Palais
1800-1900	Réception	Foyer
1900	Banquet et Présentation des prix de récompense de la SCT	Porte du Palais

TUESDAY MORNING
MARDI A.M.

TUESDAY MORNING, OCTOBER 5

Time	*Session*	*Room*
0700-1400	Registration	Foyer
0800-1500	Exhibits and posters displays	Foyer/Porte St-Louis-Kent
0700-0815	Industry Breakfast - Canada – Promoting Our e-Health Expertise Internationally	Beaumont-Bélair
0830-1000	Concurrent Podium Session #6 – Clinical Care/Integration	Beauport
	Concurrent Podium Session #7 – Outcomes/Evaluation	Villeray
	Concurrent Podium Session #8 – e-Learning	Ste-Foy-Portneuf
	Concurrent Podium Session #9 – Integration	Dufferin
	Concurrent Podium Session #10 – Global eHealth/Policy	Courville-Montmorency
	Focus Session #2 – Télémédecine - Panorama de la Télémédecine en Europe	Porte du Palais
1000-1030	Nutrition Break	Foyer/Porte St-Louis-Kent
1030-1200	Concurrent Podium Session #11 – Clinical Care/Integration	Dufferin
	Poster Session #1 – Clinical Care	Villeray
	Poster Session #2 – Clinical Care	Ste-Foy-Portneuf
	Poster Session #3 – e-Learning/Benefits for Healthcare Workers	Courville-Montmorency
	Poster Session #4 – Homecare/Technology/Policy Integration	Beauport
	Focus Session #3 – Telehealth in Developing Countries	Porte du Palais
1200-1330	Lunch, Exhibits and Poster Viewing	Foyer/Porte St-Louis-Kent

MARDI A.M., LE 5 OCTOBRE

Heure	*Session*	*Salle*
0700-1400	Inscription	Foyer
0800-1500	Exposants et affiches	Foyer/Porte St-Louis-Kent
0700-0815	Déjeuner de l'Industrie - Canada – Promoting Our e-Health Expertise Internationally	Beaumont-Bélair
0830-1000	Session parallèlle #6 – Clinical Care/Integration	Beauport
	Session parallèlle #7 – Outcomes/Evaluation	Villeray
	Session parallèlle #8 – e-Learning	Ste-Foy-Portneuf
	Session parallèlle #9 – Integration	Dufferin
	Session parallèlle #10 – Global eHealth/Policy	Courville-Montmorency
	Session de mise au point #2 – Télémédecine - Panorama de la Télémédecine en Europe	Porte du Palais
1000-1030	Pause santé	Foyer/Porte St-Louis-Kent
1030-1200	Session parallèlle #11 – Clinical Care/Integration	Dufferin
	Session d'affiches #1 – Clinical Care	Villeray
	Session d'affiches #2 – Clinical Care	Ste-Foy-Portneuf
	Session d'affiches #3 – e-Learning/Benefits for Healthcare Workers	Courville-Montmorency
	Session d'affiches #4 – Homecare/Technology/Policy Integration	Beauport
	Session de mise au point #3 – Telehealth in Developing Countries	Porte du Palais
1200-1330	Dîner, exposants et affiches	Foyer/Porte St-Louis-Kent

CONCURRENT PODIUM SESSION #6
SESSION PARALLÈLE #6
TUESDAY / MARDI : 0830-1000

Clinical Care/Integration

Room/Salle : Beauport
Moderator / Modérateur : Bill Pascal

No.	*Abstract Title & Authors / Titre du résumé et auteurs*
31	**USING INTERNET VIDEO TECHNOLOGY TO IMPROVE HEALTH CARE DELIVERY TO PEOPLE WHO ARE DEAF – PROJECT RESULTS** Hughes G[1], Hudgins B[1], MacDougall J[2]. [1]Institute of Biomedical Engineering, University of New Brunswick, Fredericton, NB. [2]Canadian Deafness Research and Training Institute, Montreal, QC.
32	**A MODEL FOR SPEECH AND LANGUAGE SERVICES TO FIRST NATIONS COMMUNITIES UTILIZING A FIRST NATIONS TELEHEALTH NETWORK** Williams D. Regional Telehealth Coordinator, Keewaytinook Okimakanak, Balmertown, ON.
33	**EVALUATION OF VIDEO RELAY INTERPRETING SERVICES FOR THE DEAF AND HARD OF HEARING ON THE MAINE TELEHEALTH NETWORK** Dubois T[1], Morin L[2], Newton D[2], Edwards MA[1], Emerson R[1]. [1]Maine Telemedicine Services, Regional Medical Center at Lubec/HealthWays, Lubec, ME, USA. [2]Pine Tree Society for Handicapped Children and Adults, Scarborough, Maine, USA.
34	**MOBILE TELEASSISTANCE - A SERVICE FOR BETTER INTEGRATING CHRONICALLY ILL BUT STILL MOBILE CITIZENS** Stroetmann K, Stroetmann V, Wickel R. empirica Institute for Communications and Technology Research, Bonn, Germany
35	**INTERACTIVE VOICE RESPONSE SYSTEMS: LEVERAGING TECHNOLOGY TO IMPROVE OUTCOMES FOR CARDIAC PATIENTS** Sherrard H, Kearns SA, Struthers C. University of Ottawa Heart Institute, Ottawa, ON.
36	**SEE YOU ON THE VIDEOPHONE – OPENING THE LINES OF COMMUNICATION FOR FAMILIES AT THE HOSPITAL FOR SICK CHILDREN** Cheng A, Fontana Chow K. Telehealth Program, The Hospital For Sick Children, Toronto, ON.

31

USING INTERNET VIDEO TECHNOLOGY TO IMPROVE HEALTH CARE DELIVERY TO PEOPLE WHO ARE DEAF – PROJECT RESULTS

Hughes G[1], Hudgins B[1], MacDougall J[2]. [1]Institute of Biomedical Engineering, University of New Brunswick, Fredericton, NB. [2]Canadian Deafness Research and Training Institute, Montreal, QC.

INTRODUCTION: A technological solution was investigated as a way of accessing sign language interpretation services from a remote location by people who are Deaf when accessing health care services.
DESCRIPTION: Participants including people who are Deaf (24), health professionals and Information Providers (14), and sign language interpreters (4) were involved in communication simulations. 40 health and employment related simulations that mimicked what occurs in health professional offices, medical clinics, emergency rooms, and office situations were executed by the participants. The sign language interpreter participated in these sessions using internet based video technology while being located in another city, or province. Data was collected using questionnaires that were completed by all participants involved in the simulations.
RESULTS: The technological solution allowed for effective communication between the participants using both visual and vocal communication. The Deaf participants and health professionals/information providers were confident they understood each other when communicating. The sign language interpreters indicated the Deaf participants and health professionals/information providers understood each other. The sign language interpreters rated various aspects of the system performance lower than the other participants involved in the simulated sessions.
CONCLUSIONS: The provision of sign language interpretation services from a remote site using telehealth technology with high bandwidth internet connectivity is possible.

32

A MODEL FOR SPEECH AND LANGUAGE SERVICES TO FIRST NATIONS COMMUNITIES UTILIZING A FIRST NATIONS TELEHEALTH NETWORK

Williams D. Regional Telehealth Coordinator, Keewaytinook Okimakanak, Balmertown, ON.

INTRODUCTION: Speech and Language services within the Sioux Lookout Health Zone have been largely inaccessible due to large geographical distances and the huge costs of obtaining these services. In addition, jurisdictional issues have left First Nations with little access to provincial programs. Through a partnership with the George Jeffrey Treatment Centre in Thunder Bay, KO Telehealth has developed a model for delivering services via KO Telehealth, a First Nations Telehealth network.
DESCRIPTION: The model for delivering speech and language services currently involves an initial "face-to-face" assessment. Follow-up sessions are scheduled every 2 weeks for 1 hour. Prior to the session, an equipment list is sent to the Community Telehealth Coordinator at the community site. In order to facilitate learning, a "Communication Coordinator" is identified who can attend telehealth sessions with the child and ensure that homework is completed and that the child has progressed enough to attend additional sessions. As there is no one person that can fulfil the role of communication coordinator, the Community Telehealth Coordinator's role is to assist in the procurement of a person suitable for this role.
RESULTS: By partnering with George Jeffrey Treatment Centre, KO Telehealth has been able to provide speech and language services to children in remote communities in an economically viable manner. Evaluations done by the Speech and Language Pathologist have indicated a positive response for both service provider and client.
CONCLUSIONS: Telehealth is an economically viable and effective way to provide speech and language services to children in remote First Nations communities.

33

EVALUATION OF VIDEO RELAY INTERPRETING SERVICES FOR THE DEAF AND HARD OF HEARING ON THE MAINE TELEHEALTH NETWORK

Dubois T[1], Morin L[2], Newton D[2], Edwards MA[1], Emerson R[1]. [1]Maine Telemedicine Services, Regional Medical Center at Lubec/HealthWays, Lubec, ME, USA. [2]Pine Tree Society for Handicapped Children and Adults, Scarborough, Maine, USA.

INTRODUCTION: For many rural areas, the provision of American Sign Language (ASL) interpreting services between Deaf and hard-of-hearing (D/HOH) patients and their providers is challenged by major travel distances and long waiting times. In Maine, 26% of Deaf consumers do without professional interpreting when receiving care at local hospitals.
DESCRIPTION: The two agencies worked collaboratively to develop ASL interpreting services via videoconferencing over 384kbs ISDN lines. Intensive preparatory work was done on protocols, pilot testing, and hospital staff training. Evaluation elements included patient questionnaires and consumer focus groups, as well as surveys of providers and interpreters. For input from clients with low literacy, a videotape was produced in ASL to explain the VRI process, to gather informed consent, and to pose evaluation questions.
RESULTS: By May 2004, 76 uses have occurred at 12 hospitals and one community health center, growing at a rate of approximately 1 per week. Data from trainings of staff revealed a 27% improvement in the percent of correct answers about Deaf culture and the rights of Deaf individuals to communication assistance. Interpreters felt that their preparation for VRI was adequate and that hospital staff usually knew how to work well with them and followed the VRI protocols. Providers, patients, and interpreters expressed high levels of satisfaction with the service and provided answers consistent with an improvement in patient access to services.
CONCLUSIONS: Access to quality ASL interpreting services in rural Maine has been substantially enhanced through VRI.

34

MOBILE TELEASSISTANCE - A SERVICE FOR BETTER INTEGRATING CHRONICALLY ILL BUT STILL MOBILE CITIZENS

Stroetmann K, Stroetmann V, Wickel R. empirica Institute for Communications and Technology Research, Bonn, Germany

INTRODUCTION: Many chronically ill could still be geographically mobile and even travel interna-tionally if teleassistance were available. Our research tests and evaluates the technical, organ-isational and economic characteristics and supports the rapid implementation of an innovative, mobile, trans-European emergency and assistance service.
DESCRIPTION: Combining GSM cellular telephony and satellite-based GPS in one innovative unit allows users initiate alarm calls whenever and wherever they need or want to do so.
Qualified teleassistance centre personnel responds to the user's specific situation. If required the exact location is transmitted immediately so that appropriate help can be dispatched - Europe-wide if necessary.
Basic services provide a voice connection to the centre and dispatch of emergency services. Value added services provide connections to GP or specialist, pharmacy, relatives. Tests are underway in Germany, Spain and UK involving industry, response centres, patient groups, citi-zens.
RESULTS: Specific target groups are patients suffering from Alzheimer, Parkinson, MS; and dis-abled and frail but still mobile citizens. Depending on their specific conditions, the service allows them considerably more freedom, QoL, security, even international travel. Service concepts, work flow organisation and value chain implementation experience will be presented.
CONCLUSIONS: Integrating advanced location and mapping tools with mobile communications allows new service concepts and provides a clear business case both for industry and for care service providers. Some chronically ill patients and specific at-risk groups can greatly benefit from appropriately designed service delivery.

35

INTERACTIVE VOICE RESPONSE SYSTEMS: LEVERAGING TECHNOLOGY TO IMPROVE OUTCOMES FOR CARDIAC PATIENTS

Sherrard H, Kearns SA, Struthers C. University of Ottawa Heart Institute, Ottawa, ON.

PURPOSE: To determine the feasibility of using Interactive Voice Response (IVR) technology to enhance an existing 24/7 call-back system, for post discharge follow-up of cardiac surgical patients.
METHODS: For the period of December 2003 to March 2004, we pilot tested the IVR system in 110 post operative cardiac surgical patients to determine the robustness of the technology and its acceptability to patients.
RESULTS: The technology was sufficiently robust to establish contact 100% of the time. Sixty-six percent of patients responded. The system determined the remaining 34% of patients chose not to answer the call, disconnect the call or had cellphones as their only telephone. The algorithm successfully identified patients with problems and sorted responses to one of three streams: patients requiring immediate attention; patients requiring call back; and patients not experiencing any problems. The health care professional found the system easy to use. Fifty percent of 110 patients responded to a survey regarding satisfaction with the IVR system. Eighty nine percent of this group thought the IVR system was a good way to follow-up on patients post discharge.
CONCLUSIONS: IVR is a reliable, cost effective and acceptable tool for the follow-up of post-operative patients. The success of this pilot suggests its usefulness in selected groups.

36

SEE YOU ON THE VIDEOPHONE – OPENING THE LINES OF COMMUNICATION FOR FAMILIES AT THE HOSPITAL FOR SICK CHILDREN

Cheng A, Fontana Chow K. Telehealth Program. The Hospital For Sick Children, Toronto, ON.

INTRODUCTION: The videophone project explores how the use of visual images helps to ease the loneliness for a hospitalised child and allows them to remain connected to and supported by their community. It also promotes the family centred care approach, which is fundamental to the concepts and philosophies of care at Sick Kids.
DESCRIPTION: When a child is hospitalised and isolated from their familiar environment and peer support groups, it can be a time of high anxiety filled with concerns regarding their illness and their ability to achieve wellness and go home. The inability to participate in an important event, such as a sibling birthday party or classroom presentation, can exacerbate these feelings of anxiety and negatively impact their psycho/social determinants of health. The visual component of the Videophones provides a higher level of connectiveness.
RESULTS: The mobility of these phones enables children to communicate with siblings, friends from school, teachers in the classroom and extended family. This functionality is truly in keeping with the hospitals mission to be 'The Hospital Without Walls'.
CONCLUSIONS: In keeping with our outcome projections, the videophones have positively contributed to the psycho /social well being of children at Sick Kids. The collaborative approach of the Child Life and Telehealth Programs, in conjunction with the Research Team, has given the necessary resources and evaluative depth to this project.

CONCURRENT PODIUM SESSION #7
SESSION PARALLÈLE #7
TUESDAY / MARDI : 0830-1000

Outcomes/Evaluation

Room/Salle : Villeray
Moderator / Modératrice : Doris McLean

No.	*Abstract Title & Authors / Titre du résumé et auteurs*
37	**RANDOMIZED CONTROLLED TRIAL OF THE EFFECT OF NURSE TELETRIAGE ON DEFERRABLE MEDICAL VISITS** Hogenbirk JC[1], Pong RW[1], Lee HN[2], Lemieux S[1], Liboiron-Grenier L[1]. [1]Centre for Rural and Northern Health Research, Laurentian University, Sudbury, ON. [2]Group Health Centre, Sault Ste. Marie, ON.
38	**THE SIGNIFICANCE OF QUALITATIVE METHODS IN EVALUATING SMALL TELEHEALTH PROJECTS OR PILOT PROJECTS** Heaton L[1], Picot J[2]. [1]Department of Communication, University of Montreal, Montreal, QC. [2]Infotelmed Communications, Montreal, QC.
39	**TELEHEALTH EVALUATION IN MANITOBA: AN INTEGRATED APPROACH** Loewen L. MBTelehealth, Winnipeg Regional Health Authority, Winnipeg, MB.
40	**A REGIONAL APPROACH TO EVALUATION OF CLINICAL TELEHEALTH PROJECTS** Hebert M[1], Yeo M[1], Nijssen-Jordan C[2], Keenan C[2]. [1]Health Telematics Unit, University of Calgary, Calgary, AB. [2]Calgary Health Region, Calgary, AB.
41	**NATIONAL TELEHEALTH OUTCOME INDICATOR PROJECT (NTOIP) - APPROVED INDICATORS** Scott RE[1], McCarthy GF[2], Jennett PA[1]. [1]Health Telematics Unit, University of Calgary, Calgary, AB. [2]Atlantic Health Sciences Corporation, Saint John, NB.
42	**CONSISTENT TERMINOLOGY FOR TELEHEALTH - WHY WE NEED IT, HOW WE CAN ACHIEVE IT, AND EXAMPLES** Scott RE. Health Telematics Unit, University of Calgary, Calgary, AB.

37

RANDOMIZED CONTROLLED TRIAL OF THE EFFECT OF NURSE TELETRIAGE ON DEFERRABLE MEDICAL VISITS

Hogenbirk JC[1], Pong RW[1], Lee HN[2], Lemieux S[1], Liboiron-Grenier L[1]. [1]Centre for Rural and Northern Health Research, Laurentian University, Sudbury, ON. [2]Group Health Centre, Sault Ste. Marie, ON.

PURPOSE: To assess the effect of nurse teletriage on deferrable medical visits to a membership-based health care organization in Ontario.
METHODS: 1057 consenting volunteers were stratified into three patient groups and then randomly assigned to the Care-As-Usual Group (CAUG) or the Teletriage Group (TG). TG patients were given promotional material and encouraged to call the teletriage service before initiating any medical visit. CAUG patients were asked to behave as usual. The number of visits were analyzed as a single-blind RCT for diagnosis codes identified a priori as potentially deferrable visits (e.g., common cold).
RESULTS: The strength of the intervention (teletriage promotion) declined over time, though statistically significant differences existed at the end of the 14 month study. Mean call rate for TG patients was 50% higher than CAUG patients ($p=0.02$) and 30% more TG patients called than did CAUG patients ($p=0.04$). Overall, teletriage promotion did not have a significant effect on the mean number of visits to the community health centre for all visits ($p=0.14$); for common cold visits ($p=0.99$) or for other potentially deferrable visits ($p=0.07$). Subgroup analyses suggest that visits for common cold plus acute bronchitis and bronchiolitis were significantly reduced for patients identified a priori as "frequent visitors", but not for "families" or "other patients".
CONCLUSIONS: The effect of teletriage promotion was significant only for a subgroup of patients and only for one of three categories of potentially deferrable visits. Regular promotion aimed at frequent visitors may further reduce deferrable medical visits.

38

THE SIGNIFICANCE OF QUALITATIVE METHODS IN EVALUATING SMALL TELEHEALTH PROJECTS OR PILOT PROJECTS

Heaton L[1], Picot J[2]. [1]Department of Communication, University of Montreal, Montreal, QC. [2]Infotelmed Communications, Montreal, QC.

PURPOSE: To describe the significance or qualitative methods in assessing organizational and systemic impacts of telehealth initiatives
METHOD: A meta-analysis based on the results of several evaluations of telehealth pilot projects for remote or rural Canadian populations.
RESULTS: In addition to the traditionally cited advantages of qualitative methods in providing a pool of rich, detailed information, there are sound theoretical bases for employing qualitative methods in evaluating small or pilot projects. Over the past twenty years, technology usages theory (Vedel, Vitalis, Flichy) has demonstrated that technology use is extremely fluid in early stages of implementation and stabilizes only after several years. Theories of organizational change (Brannen & Salk, Orlikowski) regularly highlight the importance of context and of individuals' perceptions in influencing the course of events, particularly when the change has a strong technological component. In the context of small projects featuring particular circumstances, short time lines and small numbers, qualitative data often provide the only way of understanding the ensemble of factors at play. Consequently, they may provide invaluable help in assessing organizational impacts, possibilities for integration with regular aspects of health care and healthcare systems, and ultimately policy development. While improved health outcomes and lower costs may be the ultimate goal, they cannot be measured adequately in a highly fluid situation without an indepth consideration of various stakeholders' perspectives.
CONCLUSIONS: Qualitative evaluations are a valuable complement to other, quantitative outcome measures particularly in projects in their early stages or where numbers are insufficient to ensure statistical representativity and validity.

39

TELEHEALTH EVALUATION IN MANITOBA: AN INTEGRATED APPROACH

Loewen L. MBTelehealth, Winnipeg Regional Health Authority, Winnipeg, MB.

INTRODUCTION: As telehealth networks integrate within the health care system, evaluation approaches must also evolve. Telehealth program evaluation tends to be time limited or project focused and telehealth data are notably absent or incomplete in most provincial administrative health databases such as those tracking physician billing and ambulatory services. MBTelehealth is working towards an integrated continuous improvement approach to evaluation both internally and at a system level.
DESCRIPTION: The MBTelehealth program has seen considerable growth with a 98.5% increase in overall utilization and 137% growth in clinical utilization during the last fiscal year. Utilization data, while important, provides only one perspective on network operations. The network is now using a multi-perspective framework based on Kaplan and Norton's Balanced Scorecard for ongoing evaluation of network operations. The scorecard is used to translate organizational goals into performance measures and supports ongoing quality improvement.
RESULTS: Evaluation indicators that target system competency, client focus, responsiveness, and work life have been identified. Data sources include utilization, user surveys and occurrence reports. In addition to internal data, current efforts are targeted at improving the integration of telehealth activity into administrative health databases at a provincial level.
CONCLUSION: Reports on indicators and targets are now included in ongoing internal and external communications and are utilized to review network operations overall and at a regional level. This presentation will provide an overview of the process for ongoing scorecard development and will include indicators and benchmarks identified to date as well as adjustments made to reflect evolving network priorities.

40

A REGIONAL APPROACH TO EVALUATION OF CLINICAL TELEHEALTH PROJECTS

Hebert M[1], Yeo M[1], Nijssen-Jordan C[2], Keenan C[2]. [1]Health Telematics Unit, University of Calgary, Calgary, AB. [2]Calgary Health Region, Calgary, AB.

PURPOSE: The presentation illustrates an approach for evaluating development and implementation of clinical telehealth projects in a health region.
METHODS: A number of programs and departments within the Calgary Health Region received funding to implement telehealth projects in their areas. A team at the Health Telematics Unit was enlisted to develop an evaluation framework for each project, and resulting in a generic framework that all future projects could use. Each project's evaluation framework was developed iteratively with input from the Regional Telehealth Manager, Medical Director and Project Boards. Existing program evaluation completed by the Southern Alberta Child and Youth Health Network and the Institute of Medicine Evaluation Framework provided the foundation. Each framework built on project descriptions and stated goals outlined in the funding proposals. Specific indicators, measures, and data collection strategies were determined by each Project Board.
RESULTS: As much as possible each evaluation framework attempted to use existing data and reports (e.g., The Provincial Scheduling System) to identify the number of video conferencing sessions, as well as number of participants. While evaluation is an integral requirement for each of these pilot projects, building data collection into routines requires a longer-term strategy to automate much of these processes.
CONCLUSIONS: Despite diversity in project focus, a generic evaluation plan tailored to project-specific goals and objectives can provide an effective regional approach to application for funds and evaluation of clinical telehealth projects/programs. Incorporating additional data collection requirements into busy clinicians, managers, and support staff's days remains a challenge.

41

NATIONAL TELEHEALTH OUTCOME INDICATOR PROJECT (NTOIP) - APPROVED INDICATORS

Scott RE[1], McCarthy GF[2], Jennett PA[1]. [1]Health Telematics Unit, University of Calgary, Calgary, AB. [2]Atlantic Health Sciences Corporation, Saint John, NB.

INTRODUCTION: NTOIP sought to identify, define, and seek consensus on outcome indicators for evaluation of telehealth, and to describe a core set of indicators that could be used by the broader telehealth community. NTOIP has completed its mandate and published Approved Telehealth Outcome Indicator Guidelines.
DESCRIPTION: Building on the information, perspective, and input gathered throughout the NTOIP process, proposed Candidate Outcome Indicators (COI's) were reviewed and a list of Proposed Outcome Indicators developed. These were thoroughly described using a standard format, published on the NTOIP web site, and opened for a novel web-based consensus building process. Feedback from this process was used to produce Tentative Outcome Indicators (TOI's). Each TOI was again critiqued through the web-based consensus building process. This final feedback was used to refine each indicator to produce the final Approved Outcome Indicators.
RESULTS: The Approved Telehealth Outcome Indicator Guidelines consist of 34 indicators in one or more of the four themes of Quality (9 indicators), Access (8 indicators), Acceptability (7 indicators), and Cost (10 indicators). From these a core set of 12 indicators (three for each theme) were selected through NTOIP and web-based feedback, and are recommended for adoption and consistent use.
CONCLUSION: The process and outputs of NTOIP collectively raise awareness of outcome indicators; describe a process for systematic development of outcome indicators; present definitions for e-health outcomes, indicators, measures, and tools; and set the stage for continued reflection and refinement of these and future indicators that others may propose.

42

CONSISTENT TERMINOLOGY FOR TELEHEALTH - WHY WE NEED IT, HOW WE CAN ACHIEVE IT, AND EXAMPLES

Scott RE. Health Telematics Unit, University of Calgary, Calgary, AB.

INTRODUCTION: Precise communication is critical for meaningful and constructive exchange in any field. Yet evidence exists for inconsistency in, and unfamiliarity with, terminology used in the telehealth arena. How can we expect to engage the public and key decision and policy-makers if we - as proponents of telehealth - are not consistent ourselves in the use of telehealth related terms? A program was initiated to investigate and advance use of consistent and evidence-based telehealth terminology
DESCRIPTION: a) Evidence of inconsistent use in telehealth terminology was sought from the literature, and through a 'definitions exercise' that was undertaken by participants at two national pre-conference workshops. Content analysis of keywords in responses was compared to that for 'gold standard' definitions. b) Tools for construction of evidence-based definitions were developed. c) Definitions were constructed using these guidelines.
RESULTS: a) Evidence of inconsistency and uncertainty in the use of telehealth terms was found in the literature. Content analysis of the definitions from workshop participants clearly demonstrated inconsistency in their understanding of common terms, with no individual able to match the 'gold standard' definitions. b) The tools developed for construction of definitions were reformulated as guidelines. c) Using these guidelines, eight definitions were constructed: telehealth unit, telehealth facility, telehealth site, telehealth activity, telehealth application, telehealth service, telehealth program, and telehealth network.
CONCLUSION: To encourage adoption of consistent telehealth terminology, this program provides: national leadership; guidelines for and examples of evidence-based definition of terms; and, an opportunity for Canada to take an international lead.

CONCURRENT PODIUM SESSION #8
SESSION PARALLÈLE #8
TUESDAY / MARDI : 0830-1000

e-Learning

Room/Salle : Ste-Foy-Portneuf
Moderator / Modératrice: Patricia Huntly

No.	*Abstract Title & Authors / Titre du résumé et auteurs*
43	**DEVELOPMENT AND EVALUATION OF A MODULE FOR TRAINING READERS IN SCREENING FOR DIABETIC RETINOPATHY USING DIGITAL IMAGING.** Boucher MC[1], Bélair ML[1], Martin J[2]. [1]University of Montréal, Montréal, QC. [2]Université du Québec, Montréal, QC.
44	**OUR MEMBERS TALK TO US: THE WINNING PARTNERSHIP OF TECHNOLOGY, HEALTH, AND EDUCATION AT NORTH NETWORK** Carter L. Education, NORTH Network, Sudbury/Toronto, ON.
45	**CASE STUDY OF VIRTUAL COLLABORATION IN HEALTH INFORMATICS TRAINING** Palacios M, Hebert M. Health Telematics Unit, Faculty of Medicine, University of Calgary, AB.
46	**RESULTS OF A SURVEY OF TELEHEALTH COORDINATORS' TRAINING AND EDUCATIONAL NEEDS** Picot J[1], Grant-Fraser E[2], Nickoloff A[3]. [1]Infotelmed Communications Inc, Montreal, QC. [2]Concordia University, Montreal, QC [3]NORTHnetwork, Toronto, ON.
47	**DESIGN OF A LEARNING OBJECT TO FACILITATE PROVIDER TRAINING IN THE MEASUREMENT OF DERMAL PERFUSION** Evans AW, Larouche J, Spero L. Faculty of Medicine, University of Toronto, Toronto, ON.
48	**VIDEOCONFERENCING MAKES VIRTUAL LEARNING POSSIBLE: AN INTEGRATED MODEL** Lundstrom T, Berry S, Chimenti B. Health Sciences North, Thunder Bay, ON.

43

DEVELOPMENT AND EVALUATION OF A MODULE FOR TRAINING READERS IN SCREENING FOR DIABETIC RETINOPATHY USING DIGITAL IMAGING.

Boucher MC[1], Bélair ML[1], Martin J[2]. [1]University of Montréal, Montréal, QC. [2]Université du Québec, Montréal, QC.

PURPOSE : to develop educational software for preparing a first-level "trained reader" to detect abnormalities related to diabetic retinopathy (DR) and to validate this software by measuring agreement between the trained readers and ophthalmologists.
METHODS: We developed software illustrating the normal retina and abnormalities related to diabetic retinopathy. Five non ophthalmologists were independently trained with the educational module and asked to analyse a group of images from 100 eyes with various degrees of severity of diabetic retinopathy. The trained readers had to decide for presence or absence of abnormality and judge the image quality as sufficient or insufficient. Two ophthalmologists had previously analysed the images. Agreement between the readers and the ophthalmologists was then measured.
RESULTS: The mean percent agreement between the trained readers and the ophthalmologists was 86.2% (98% confidence interval 80.5-91.9%). The k coefficient varied from 0.610 to 0.800 (mean 0.709); k values for the five readers were all in the range of good agreement.
CONCLUSION: This training module could eventually be used to formally train first level readers for DR screening with digitized images of the fundus and contribute to the establishment of mass screening programs for DR.

44

OUR MEMBERS TALK TO US: THE WINNING PARTNERSHIP OF TECHNOLOGY, HEALTH, AND DISTANCE EDUCATION AT NORTH NETWORK

Carter L. Education, NORTH Network, Sudbury/Toronto, ON.

PURPOSE: The purpose of this undertaking was to learn about the educational and professional development needs of NORTH Network members through a strategic needs assessment. This was the first large educational needs assessment undertaken by NORTH Network since its inception.
METHODS: Using a blended methodology of quantitative (two surveys) and qualitative (interviews) measures, NORTH Network's Education Team gathered data regarding members' educational needs and preferred distance learning formats within technology-enabled learning settings.
FINDINGS: A members-focused survey revealed interests in:
- exploring webcasting as an educational technology
- participating in educational sessions outside the parameters of the "typical" workday
- participating as presenters for educational sessions
- taking part in rounds in an array of specialty areas

The survey also generated an extensive statement of educational topics, speakers, and related resources. Through a second survey and interviews with NORTH's Telehealth Co-ordinators and Regional Telehealth Co-ordinators, NORTH has been made aware of the membership's interest in exploring the web as a support for educational activities and resources; the idea of offering educationally-focused series over time; and the option of regional champions for education.
CONCLUSION: As the utilization of the NORTH Network increases in the continuing professional development field, it is vital that the Network enable sessions and activities that respond to its members' needs. Additionally, given the promising future of education in the health sector, NORTH Network must carefully consider other human and technological means of supporting education.

45

CASE STUDY OF VIRTUAL COLLABORATION IN HEALTH INFORMATICS TRAINING

Palacios M, Hebert M. Health Telematics Unit, Faculty of Medicine, University of Calgary, AB.

INTRODUCTION: The CIHR Health Informatics PhD-Postdoc Strategic Training Program (CHPSTP) is funded for 6 years to establish a collaborative graduate training program. Eight university partners across Canada participate and provide Research Learning Experiences (RLEs) and mentoring relationships not available from local programs.
PURPOSE: Study objectives are to:
• Explore the development and outcomes of RLE #1, the Virtual Community, using a Community of Practice approach
• Examine technology mediated interactions between trainees and mentors
A better understanding of the factors influencing virtual collaboration in HI research and training is expected to inform similar initiatives that increase access to training with experts, facilitating a significant advance of the HI discipline.
METHODS: A qualitative approach using a single case study design was used to address the study objectives. Data were collected through semi-structured telephone interviews with trainees and mentors that participated in the Virtual Community. These were supplemented by documentary data that included online discussion in Blackboard System (asynchronous online communication and collaboration software) and participation in virtual lectures using CENTRA® (synchronous online communications software).
RESULTS: After two years, the Program has been considered a growing success by the trainees and mentors. Through the use of technology, trainees are receiving high quality training in HI, and along with their mentors, are collaborating in a way that wouldn't have been possible otherwise.
CONCLUSIONS: Preliminary analysis suggests the Virtual Community is achieving its purpose of bringing trainees and mentors together to collaborate. However, there are still areas to strengthen for a sustainable system.

46

RESULTS OF A SURVEY OF TELEHEALTH COORDINATORS' TRAINING AND EDUCATIONAL NEEDS

Picot J[1], Grant-Fraser E[2], Nickoloff A[3]. [1]Infotelmed Communications Inc, Montreal, QC. [2]Concordia University, Montreal, QC. [3]NORTHnetwork, Toronto, ON.

PURPOSE: The NIFTE guidelines recommend that "health professionals providing telehealth services have the necessary education, training/orientation and ongoing continuing education/professional development to ensure they possess the necessary competencies for the safe provision of quality health services".
METHODS: A survey was designed to assess the educational and training needs of telehealth coordinators across Canada, principally those working in remote, rural and non-urban areas. A first group completed the survey in the summer of 2003 (of 45 who received the survey, 26 completed it). At the request of the NORTHnetwork the same survey was distributed in November 2003 to an equal number of coordinators, of which an equal number of responses was received (26).
RESULTS: The results demonstrate the majority of respondents think they would benefit from courses/training in two or three areas related to their work. The presentation will provide the combined results of the survey (n=52), and where appropriate, compare the results obtained from the two groups.
CONCLUSIONS: Telehealth coordinators in non-urban areas would benefit from additional training. Based on the combined results of the survey, the presentation will conclude with suggestions regarding the strategies which are more likely to be successful in offering training and educational courses to coordinators working in remote and rural areas.

47

DESIGN OF A LEARNING OBJECT TO FACILITATE PROVIDER TRAINING IN THE MEASUREMENT OF DERMAL PERFUSION

Evans AW, Larouche J, Spero L. Faculty of Medicine, University of Toronto, Toronto, ON.

INTRODUCTION: The rationale behind the project is to build an interactive and web-based learning module for the transcutaneous oximetry tool. This tool is a non-invasive, accurate, and cost effective method of measuring a patient's circulation at the skin surface level, which has applications in various medical and surgical specialties, as well as allied health providers. Currently, there is a lack of familiarity with its use and results interpretation due to the logistical difficulties in assembling teacher, student, and clinical subjects together for lengthy assessments.
DESCRIPTION: The project is funded by McGraw-Hill Ryerson and is a collaboration between UHN Hyperbaric Medicine Unit (content) and Bell University Health Communication Lab (BUL) who used Macromedia Flash MX Professional to build the module.
RESULTS: The programming aspects are in its preliminary stages which helps students to become familiar with background theory and identify key principles. (Visual animations were created to show how oxygen is delivered to the skin and its relationship to the routine graphical output of the tissue oxygen measurement tool.) The completed module will permit the student to apply these principles by observing the factors, which critically affect the relationship between several variables. The module facilitates learning through simulated experimentation and rehearsal. The module features the transcutaneous oximetry tool being used on normally perfused skin juxtaposed with skin suffering pathological [abnormal] oxygen delivery.
CONCLUSION: Guided by interval feedback our storyboard and initial animations the interactive e-learning module's apparent advantage in engaging the student will be further developed and evaluated regarding its impact on learning retention.

48

VIDEOCONFERENCING MAKES VIRTUAL LEARNING POSSIBLE: AN INTEGRATED MODEL

Lundstrom T, Berry S, Chimenti B. Health Sciences North, Thunder Bay, ON.

INTRODUCTION: Geography and financial resources to access health care education in Northwestern Ontario have necessitated the development of a learning model different from the traditional didactic, face-to-face education session. With the advent of videoconferencing, virtual learning is now possible.
In this rural and remote region, health care educators are working together sharing technology, resources and learning models to help health practitioners find the most effective way to learn over distance and incorporate new knowledge and skill into their clinical practice. This model is shifting the delivery of education from the classroom to virtual learning anytime, anywhere, anyone.
DESCRIPTION: The learner-centred learning process includes identifying learning needs, posing clinical questions, facilitating literature searches, organizing practice based learning activities, encouraging reflective practice and evaluating the impact of education on clinical practice. Videoconferencing and computer based technology are the key resources in the delivery of these activities.
RESULTS: Based on the collected data of a regional education needs survey, and accumulated experiences of over 200 videoconferences, this presentation will provide quantitative and descriptive data of educational outcomes.
CONCLUSION: This model describes the integration of people, processes and technology which ensures that health care education is accessible and effective for practitioners in Northwestern Ontario. Health care educators, responsible for education in a large geographical region, may find this model useful to work collaboratively to develop a consistent structure of continuing professional development using videoconferencing for an array of education activities.

CONCURRENT PODIUM SESSION #9
SESSION PARALLÈLE #9
TUESDAY / MARDI : 0830-1000

Integration

Room/Salle : Dufferin
Moderator / Modératrice : Debora Robinson

No.	*Abstract Title & Authors / Titre du résumé et auteurs*
49	**THE NEW BRUNSWICK TELE-CARE EXPERIENCE: MULTIPLE SERVICES, ONE PROVIDER, THE EFFICIENCIES AND THE CHALLENGES** Savoie L[1], Newton T[2]. [1]Call Centre Operations, Clinidata Corporation, Moncton NB. [2]Hospital Services, Department of Health and Wellness, Fredericton NB.
50	**PHYSICIAN LEADERSHIP: EXPANDING TELEHEALTH SERVICES THROUGH COMMUNITIES OF PRACTICE** Soucie P[1], Archambault P[2]. [1]Medical Director, CareConnect, Ottawa, ON. [2]Clinical Coordinator, CareConnect, Ottawa, ON.
51	**NEW BRUNSWICK'S PROVINCIAL TELEHOMECARE DEMONSTRATOR PROJECT-EMPCARE@HOME** Hagerman V[1], Seymour, A[2]. Regional Director, Telehealth River Valley Health (Regional Health Authority 3), NB. [2]Vice President Health Information/CIO, River Valley Health (Regional Health Authority 3), NB.
52	**ABORIGINAL TELEHEALTH KNOWLEDGE CIRCLE, A LEADER IN TELEHEALTH KNOWLEDGE TRANSFER AND COMMUNITY BASED PRACTICE** Fox-Radulovich S[1], Maar M[2]. [1]Ojibwe Cultural Foundation, M'Chigeeng First Nation, ON. [2]Noojmowin Teg Health Centre, Sucker Creek First Nation, ON.
53	**INTEGRATING CLINICAL TELEHEALTH APPLICATIONS WITH TRADITIONAL MEDICINE - THE VIDEOCARE EXPERIENCE** Hastings D, MacLean N, Ridgewell J, Robinson D, Feltz L, Kroeker A, King S, Spracklin E.
54	**TELE-"HEALTH REFORM": HOW TELEHEALTH IS CONGRUENT WITH THE PRINCIPLES OF HEALTH REFORM IN ALBERTA** O'Neill SK, Reinbold DR. Peace Country Health, Grand Prairie, AB.

49

THE NEW BRUNSWICK TELE-CARE EXPERIENCE: MULTIPLE SERVICES, ONE PROVIDER, THE EFFICIENCIES AND THE CHALLENGES

Savoie L[1], Newton T[2]. [1]Call Centre Operations, Clinidata Corporation, Moncton NB. [2]Hospital Services, Department of Health and Wellness, Fredericton NB.

INTRODUCTION: New Brunswick's Tele-Care is respected as a Canadian pioneer of 24/7 tele health services that support and integrate patient access and referral for primary care, public health and emergency services.
DESCRIPTION: In 1995, Tele-Care's Services were limited to Symptom Triage, Health Information and Poison Information. Since then, five other programs have been added: Rabies Information, West Nile Virus Information, Prenatal Benefits Information, Gambling Help Line and Organ and Tissue Donor Screening Line.
Grouping health services, which are the responsibility of different sectors of the Department of Health, has many advantages in terms of cost, standardization of care and accessibility. Contracting out to a private sector company to operate the service has also resulted in many positive outcomes.
The SARS situation and other public health issues demonstrated how well the model works. The population had quick and easy access to the public health information. On the other hand, offering multiple services with the same staff represents some technological challenges and some clinical complexities for the nurses providing the services. Gradual orientation, cross training, coaching, documented call processes and on-going refreshers have proven to produce good outcomes.
RESULTS: A well-established, flexible, model that allows cost efficiencies by building on already existing infrastructure and expertise. The NB model also promotes integration and breaks down silos
CONCLUSION: The advantages of having a private sector partner provide a broad range of tele-health services using the same infrastructure and staffing far out-weigh the challenges. This model enables a small province like New Brunswick to provide a comprehensive array of tele-health services at an affordable cost.

50

PHYSICIAN LEADERSHIP: EXPANDING TELEHEALTH SERVICES THROUGH COMMUNITIES OF PRACTICE

Soucie P[1], Archambault P[2]. [1]Medical Director, CareConnect, Ottawa, ON. [2]Clinical Coordinator, CareConnect, Ottawa, ON.

INTRODUCTION: The role of CareConnect's Professional Advisory Committee (PAC) is:

- To champion the CareConnect service delivery channel and recruit additional clinicians,
- To identify and solicit support from CareConnect for clinicians transforming their practice to include telehealth,
- To review and approve CareConnect clinical protocols,
- To provide input into the prioritization of CareConnect clinical initiatives.

DESCRIPTION: The Professional Advisory Committee (PAC) evolved from a group of Physician Leaders whose interest in promoting telehealth services served as the foundation for the success of CareConnect's initial federal CHIPP pilot project. The PAC meets quarterly through the medium of video-conferencing. The PAC members collaborate on professional practice issues and share best practice knowledge and lessons learned. In addition, this body identifies regional clinical needs, physician recruitment needs and approves any physician-related policies and guidelines.
RESULTS: Over the course of the last six months, the PAC has had five video-conference sessions. It has succeeded in developing and approving six policies, and facilitated access for eight new and expanded clinical services throughout the region. Most Network sites have realized the value of having access to this highly skilled leadership resource group, and have come forward with a delegate to participate as a member of the CareConnect Physician Leader group.
CONCLUSIONS: The PAC offers a community of practice model for integrating telehealth into clinical practice. Members of this committee benefit from a communication structure that is informal and promotes networking throughout the region. Clinical services have been expanded and new services offered as a result of the work of the PAC.

51

NEW BRUNSWICK'S PROVINCIAL TELEHOMECARE DEMONSTRATOR PROJECT-EMPCARE@HOME

Hagerman V[1], Seymour, A[2]. Regional Director, Telehealth River Valley Health (Regional Health Authority 3), NB. [2]Vice President Health Information/CIO, River Valley Health (Regional Health Authority 3), NB.

INTRODUCTION (RATIONALE): River Valley Health (Regional Health Authority 3), Province of New Brunswick has been designated as the provincial demonstrator site for a major telehomecare initiative called EMPcare@home.
DESCRIPTION: With a focus on chronic care disease management, this $ 0.5 Million project represents an exciting and innovative approach to the provision of home care services offered by New Brunswick's renowned Extra Mural Program (EMP). Conference attendees that want to focus their telehomecare efforts on Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary (COPD) Disease, Wound Care and Palliative Care will be particularly interested in attending this session.
RESULTS: This session will profile the critical path River Valley Health has taken over the last year to acquire the designation of a provincial demonstrator. Particular focus will be placed on the process taken to bring together the necessary financial, clinical, technical, project management, research and evaluation project requirements.
CONCLUSION: Participants who attend this session will be asked to "think out of the box" when it comes to gaining the required support, knowledge, expertise and funding to dramatically shift the Canadian home care service delivery model with telehomecare as an enabler.

52

ABORIGINAL TELEHEALTH KNOWLEDGE CIRCLE, A LEADER IN TELEHEALTH KNOWLEDGE TRANSFER AND COMMUNITY BASED PRACTICE

Fox-Radulovich S[1], Maar M[2]. [1]Ojibwe Cultural Foundation, M'Chigeeng First Nation, ON. [2]Noojmowin Teg Health Centre, Sucker Creek First Nation, ON

INTRODUCTION: Aboriginal Telehealth Knowledge Circle (ATKC) was formed as a community based group with expertise in Aboriginal Telehealth initiatives from across Canada. Prior to the formation of ATKC, many small Aboriginal initiatives were working in isolation, often unaware that other Aboriginal initiatives were facing similar issues relating to clinical practice, sustainable funding and technological barriers. ATKC vision is to exchange technological tools and share templates for transference of information to Aboriginal communities to improve the health of Aboriginal People.
DESCRIPTION: ATKC is in the process of establishing a national network of Aboriginal expertise to enable the exchange of Telehealth experience and best practices. A data base as it relates to technology, clinical practice, education opportunities and funding strategies for Aboriginal communities is currently being compiled. This database can offer support for Aboriginal communities looking for guidance in bringing Telehealth to their communities. In addition, ATKC has a role in advocating for Aboriginal representation within organizations involved in telehealth policy and to work with Aboriginal organizations to advocate telehealth as an effective tool for accessing health care within Aboriginal communities.
RESULTS: ATKC has submitted a proposal to fund website and database development for Aboriginal community telehealth initiatives. In addition, ATKC has established a liaison with the Canadian Society of Telehealth. Partnerships with the National Aboriginal Health Organization and the Assembly of First Nations have also been formed.
CONCLUSIONS: ATKC has initiated its objectives of providing support and advocacy for Aboriginal Telehealth initiatives within Canada.

53

INTEGRATING CLINICAL TELEHEALTH APPLICATIONS WITH TRADITIONAL MEDICINE - THE VIDEOCARE EXPERIENCE

Hastings D, MacLean N, Ridgewell J, Robinson D, Feltz L, Kroeker A, King S, Spracklin E.

INTRODUCTION: This presentation reviews the business plan VideoCare has developed to integrate the clinical applications of telehealth into mainstream health care in Southwestern Ontario.
DESCRIPTION: We required an efficient process to respond to the demand for clinical activity in our network. We began by forming the Clinical Integration Team; its membership was based on experience in traditional medicine. In collaboration with our partners in Ontario, namely Care Connect and North Network, we developed The Site Readiness Tool, and the Operational Processes Manual which would help guide our providers in establishing Best Clinical Practices. Once the foundation for clinical activity was built, we turned our attention to educating health care providers about the possibilities in telehealth. Our communication strategies concentrated on stakeholders in health care that we felt would become champions and would help us "spread the word". Finally an efficient intake process that could easily turn requests and ideas into reality was established.
RESULT: We are prepared to nurture the anticipated growth of clinical applications at VideoCare. Our next project will be to evaluate how well we are able to integrate clinical applications in telehealth with traditional medicine.
CONCLUSION: The easiest way to integrate two things is to make them the same. The process that we have developed to integrate clinical telehealth applications into traditional medicine is based on duplicating the processes involved in both. Successful integration will be possible.

54

TELE-"HEALTH REFORM": HOW TELEHEALTH IS CONGRUENT WITH THE PRINCIPLES OF HEALTH REFORM IN ALBERTA

O'Neill SK, Reinbold DR. Peace Country Health, Grand Prairie, AB.

INTRODUCTION: In January 2002, the Alberta Provincial government accepted all ten recommendations of the Mazankowski report on Health care reform in Alberta and appointed a Health Reform Implementation team to chart a new course for Health Care Reform in Alberta.
DESCRIPTION: The authors analyzed the Mazankowski report recommendations from a telehealth perspective and explored how the integration of telehealth technology is strategically aligned with the 10 specific recommendations and four overall directions of reform in Alberta.
These directions are:
1. Patient / Customer Focus
2. Accountability: Policy, programs, Delivery and Education.
3. Sustainability: Finances and People
4. Infrastructure support: Information Technology and Management.

RESULTS: From January 01st 2003 to June 28th 2004 Peace Country health conducted 3,466 hours of educational and clinical telehealth involving 3,831 professionals and 470 patients.
The majority of this telehealth activity was congruent with the recommendations and directions of reform.
For example; diabetic education, nutrition education (which also involved schools), tobacco use reduction and lung cancer triage telehealth sessions increased access to services and moved health care upstream closer to the patient / customer.
CONCLUSION: The authors conclude that specific existing clinical and educational telehealth services, which were implemented by Peace Country Health, are strategically aligned with the Alberta government's plan to reform healthcare in Alberta.

CONCURRENT PODIUM SESSION #10
SESSION PARALLÈLE #10
TUESDAY / MARDI : 0830-1000

Global eHealth/Policy

Room/Salle : Courville-Montmorency
Moderator / Modératrice: Colleen Rogers

No.	*Abstract Title & Authors / Titre du résumé et auteurs*
55	**THE U21 TELEHEALTH COMMITTEE – STRATEGIC ANALYSIS OF GLOBAL TELEHEALTH** Ho K[1], Scott RE[2] on behalf of U21 Telehealth Committee. [1]Division of Continuing Medical Education, Faculty of Medicine, University of British Columbia. [2]Health Telematics Unit, University of Calgary, Calgary, AB.
56	**ONLINE TELE E-HEALTH RESEARCH TACTICS CUBA-NORTH AMERICA TO IMPROVE PRIMARY CARE AND FAMILY MEDICINE RESEARCH COLLABORATION STRATEGY** Stusser RJ[1], Kriel RL[2], Dickey RA[3], Krach LA[2]. [1]Primary Care Vedado Education Polyclinic, Havana, Cuba. [2]University of Minnesota, Minneapolis, MN. USA. [3]Wake Forest University School of Medicine, Winston-Salem, NC, USA.
57	**STRENGTHENING THE RELATIONSHIP: CARECONNECT'S MASTER COLLABORATION AGREEMENT FOR NETWORK PARTICIPANTS** McCarron P[1], Crone K[2]. [1]Planning Consultant, CareConnect, Ottawa, ON. [2]Executive Director, CareConnect, Ottawa, ON.
58	**TELEHEALTH CONSENT: THE NOVA SCOTIA TELEHEALTH NETWORK PROVIDES A PROVINCE WIDE TELEHEALTH CONSENT FOR CLINICAL APPLICATIONS.** LeBlanc MB[1]. Nova Scotia TeleHealth Network, Halifax, NS.
59	**ENCOURAGING PRIVACY SAVVY IN A NETWORKED ENVIRONMENT** Waite K, Wainberg D. NORTH Network, Sunnybrook and Women's College Health Sciences Centre, Toronto, ON.
60	**THE HEALTH ON THE NET FOUNDATION: AN NGO PROVIDING WEB HEALTH INFORMATION TOOLS AND SERVICES TO CITIZENS AROUND THE WORLD** Boyer C[1], Provost M[1,2]. [1]Health On the Net Foundation, Geneva, Switzerland. [2]College of Pharmacy, The University of Georgia, Athens, GA, USA

55

THE U21 TELEHEALTH COMMITTEE – STRATEGIC ANALYSIS OF GLOBAL TELEHEALTH

Ho K[1], Scott RE[2] on behalf of U21 Telehealth Committee. [1]Division of Continuing Medical Education, Faculty of Medicine, University of British Columbia. [2]Health Telematics Unit, University of Calgary, Calgary, AB.

INTRODUCTION: Universitas 21, an international network of research-intense and teaching universities, formed a Telehealth Committee to identify areas in global telehealth within which strategic actions would be beneficial. Three priority areas were identified: Underserved Populations, Global e-Health Policy, and Professional Portability.
DESCRIPTION: Using a traditional SWOT analysis, distinct strengths, weaknesses, opportunities, and threats have been described in each area, and a White Paper submitted to U21.
RESULTS: Telehealth is seen as offering an excellent opportunity to enhance access, equity, and convenience for underserved populations, and to augment local health providers' skills through virtual consultation. In supporting this and other telehealth applications, the need for professional portability to facilitate beneficial exchange of provider practice and promotion of global education was identified as critical. Establishment of common principles and complementary policy will facilitate inter-jurisdictional integration of telehealth into practice and education, and to the benefit of all populations. An ongoing weakness in the quality and quantity of research demonstrating cost effectiveness and sustainability is a major challenge. In addition, threats related to inappropriate use of existing healthcare resources and priority for adoption of telehealth solutions, ad hoc policy development, resistance to change, and a lack of global coordination must be addressed.
CONCLUSION: This major international initiative holds promise for advancing global application and integration of telehealth. Canada would benefit from development of a national strategy to ensure awareness of, and direct involvement in, all such activities.
ACKNOWLEDGEMENT: The telehealth committee would like to acknowledge funding support by the Universitas 21 organization.

56

ONLINE TELE E-HEALTH RESEARCH TACTICS CUBA-NORTH AMERICA TO IMPROVE PRIMARY CARE AND FAMILY MEDICINE RESEARCH COLLABORATION STRATEGY

Stusser RJ[1], Kriel RL[2], Dickey RA[3], Krach LA[2]. [1]Primary Care Vedado Education Polyclinic, Havana, Cuba. [2]University of Minnesota, Minneapolis, MN, USA. [3]Wake Forest University School of Medicine, Winston-Salem, NC, USA.

INTRODUCTION: Implementation of online tele e-health research tactics as a way to strengthen the primary care and family medicine (PM/FM) research collaboration strategies between North America and Cuba, and help reduce talent emigration, are proposed.
DESCRIPTION: Cuban PC/FM researchers could assimilate and develop US and Canadian advanced internet and other information and telecommunication technologies, methodology, and environments, which are in development since 1994, to perform secure and ethical e-health research collaboration web-based through virtual netclinics with US and Canadian researchers.
EXPECTED RESULTS: Active participation of Cubans in North American top research with economic assistance could help encourage and improve Cuban researchers working and living conditions, and allow Cubans to participate in simultaneous highest level PC/FM research of the northern and southern countries, strengthening Cubans scientific capacity. This Tele e-Health Research Program, offers an important venue to re-establish the active support of the North American scientific staff in the biomedical/public health progress in Cuba, while the tense political debate, specifically with USA, moves toward mutually advantageous resolution. Even afterwards, this concept offers to strengthen research collaboration between both neighbours, while discouraging the talent emigration, which has been one factors hampering a major advancement of health care, education, and research in Cuba, since the 1960s. A PC/FM research collaboration program, the "Vedado Tele e-Health Project", could be a starting point on unquestionable scientific and humanitarian bases, to improve the difficult research collaboration between North America and Cuba.
CONCLUSIONS: This model of project could be expandable to other developing and developed countries.

57

STRENGTHENING THE RELATIONSHIP: CARECONNECT'S MASTER COLLABORATION AGREEMENT FOR NETWORK PARTICIPANTS

McCarron P[1], Crone K[2]. [1]Planning Consultant. CareConnect, Ottawa, ON. [2]Executive Director, CareConnect, Ottawa, ON.

INTRODUCTION: CareConnect was created in March 2003 following a successful federal CHIPP-funded project. With the creation of a new telehealth Network, came the need for formal agreements with current and incoming participating hospitals. To ensure this, CareConnect worked closely with the hospitals and legal counsel to develop a unique document appropriate for all parties involved.
DESCRIPTION: The Master Collaboration Agreement (MCA) outlines the parameters of the relationship between CareConnect and its Participants, including the obligations of the Participants and CareConnect itself. It ties the transfer of assets and equipment directly to a performance matrix and measurable targets. In June and July, individual meetings were held with the CEO of each Participant hospital to review the document and sign off on the agreement.
RESULTS: Twenty-six partners (on 40 sites) have signed individual MCAs. This has resulted in the deployment of $1.4 million in capital equipment to assist in the growth of clinical services. The agreements have formalized the new Network and assisted in its expansion in both Eastern and Southeastern Ontario. As a result, we are projecting an increase of 284% in activity this year.
CONCLUSIONS: The MCA is an innovative and comprehensive tool that strengthens and formalizes the relationship between the Network and its Participants. It ensures senior management buy-in at each site and kick-starts telehealth programs across the region.

58

TELEHEALTH CONSENT: THE NOVA SCOTIA TELEHEALTH NETWORK PROVIDES A PROVINCE WIDE TELEHEALTH CONSENT FOR CLINICAL APPLICATIONS.

LeBlanc MB[1]. Nova Scotia TeleHealth Network, Halifax, NS.

PURPOSE: To share the experience of the Nova Scotia TeleHealth Networks' journey to implementing written, informed telehealth consent.
METHOD: The presentation will review the process utilized to decide if a written telehealth consent was necessary and the development of the policy and procedure. What should telehealth consent include? As well, must we have a separate telehealth consent form as we move towards an integrated telehealth system?
RESULTS: This past year, the NSTHN has utilized a consultated process to develop a formal telehealth consent. This presentation will address the pros and cons of a provincial versus district consent, the components of the consent and the provincial process which occurred to formalized the consent. What should a policy and procedure on telehealth include? How should the policy be implemented?
CONCLUSION: Consent for Telehealth has its pros and cons. The Nova Scotia experience will highlight the postion of the province on telehealth consent and address the challenges and successes from a provincial perspective.

59

ENCOURAGING PRIVACY SAVVY IN A NETWORKED ENVIRONMENT

Waite K, Wainberg D. NORTH Network. Sunnybrook and Women's College Health Sciences Centre, Toronto, ON

INTRODUCTION: The telehealth industry presents unique challenges in complying with privacy legislation. A telehealth network is, by definition, a shared resource. While each party participating is part of their own unique environment and is bound by data protection requirements of that situation, the shared infrastructure requires that strategies be developed to ensure that data protection obligations are met across the network.
DESCRIPTION: NORTH Network, one of Canada's most active telehealth networks, recognized that the demands of this unique mode of care delivery required a privacy strategy distinct from that undertaken by a more traditional health care organization. Ontario's pending Personal Health Information Protection Act provided the impetus for the development of a shared responsibility model as well as a collaborative approach to ensure that the initiative would provide NORTH Network users with confidence that personal health information is protected through all network activities.
A privacy impact assessment provided direction for the privacy initiative. A privacy team representativing a cross section of the organization, external privacy advisor and internal staff crafted a privacy initiative with an implementation plan intended to encourage privacy awareness and data protection across the network.
RESULTS: An overarching privacy policy; supporting policies, procedures and guidelines; data sharing agreements; and a comprehensive privacy training and communications strategy have been created to work in tandem to ensure that NORTH fulfills its data protection obligations.
CONCLUSION: A shared responsibility model and a collaborative approach are essential to the successful deployment of a privacy initiative in a telehealth environment.

60

THE HEALTH ON THE NET FOUNDATION: AN NGO PROVIDING WEB HEALTH INFORMATION TOOLS AND SERVICES TO CITIZENS AROUND THE WORLD

Boyer C[1], Provost M[1,2]. [1]Health On the Net Foundation, Geneva, Switzerland. [2]College of Pharmacy, The University of Georgia, Athens, GA, USA.

INTRODUCTION: As early as 1995, a team was composed of the directors of the Geneva University Hospital, the U.S. National Library of Medicine, and the European Commission, and the Minister of the Geneva Health Ministry. They foresaw that consumers, newly empowered to research their own medical conditions, can easily fall prey to misleading advice. Multiple information sources needed to be considered, weighed and analyzed. With no international legal framework, consumers urgently needed means to check the reliability and the relevance of health information, and enhanced access to information of the highest quality.
DESCRIPTION: This team created the Health On the Net Foundation. HON has been developing solutions to increase accessibility of health information and to protect Internet citizens through a third party accreditation program.
RESULTS: Over ten years, HON took several actions. HON introduced the first Code of Conduct for online health information providers, the HONcode, which has over 3,600 participating web sites. HON has recently expanded the HONcode accreditation and enforcement activities to include collaborators in diverse linguistic and cultural areas. HON monitors trends in consumer health Internet use to provide appropriate solutions, including a multilingual medical search engine and directory, and self-help tools such as Stop-Tabac, an interactive smoking cessation program. All HON services are free of commercial influence. HON has a NGO special consultative status to the U.N.
CONCLUSION: HON fulfills its mission to guide the growing online community to sound, reliable medical information and expertise. HON welcomes international collaborations to continue integrating Telehealth technologies to the service of citizens.

FOCUS SESSION #2

Tuesday Morning: 0830-1000

Panorama de la Télémédecine en Europe

Room

Moderator: Dr Jean-Paul Fortin

Porte du Palais

CATEL, France
Louis Lareng, President, Société Européenne de Télémédecine

SESSION DE MISE AU POINT #2

Mardi matin: 0830-1000

Panorama de la Télémédecine en Europe

Room

Modérateur : Dr Jean-Paul Fortin

Porte du Palais

CATEL, France
Louis Lareng, Président de la Société Européenne de Télémédecine

CONCURRENT PODIUM SESSION #11
SESSION PARALLÈLE #11
TUESDAY / MARDI : 1030-1200

Clinical Care/Integration

Room/Salle : Dufferin
Moderator / Modératrice : Trish Lundstrom

No.	*Abstract Title & Authors / Titre du résumé et auteurs*
61	**TELEPSYCHIATRY IMPROVES ABILITY OF GENERAL PRACTITIONERS TO PROVIDE MENTAL HEALTH SERVICES IN UNDERSERVED COMMUNITIES** Urness D, Tian E, Wass M. Telemental Health Service, Alberta Mental Health Board, Ponoka, AB.
62	**TELEHEALTH TECHNOLOGY EXTENDS FORENSIC MENTAL HEALTH CLINICAL SERVICES TO RURAL COMMUNITIES** Allen D[1], Halpin P[2], Walsh B[3], Bulger T[1], Konrad M[1]. [1]Telemental Health Service, Alberta Mental Health Board, Ponoka, AB. [2]Forensic Assessment & Outpatient Services, Calgary Health Region. [3]Forensic Adult Community Services, Capital Health.
63	**USING TELEHEALTH TO CONNECT FAMILIES AND HEALTH CARE TEAMS ACROSS SOUTHERN ALBERTA** Young S, Staveley R, Nijssen-Jordan C. Alberta Children's Hospital, Calgary Health Region, Calgary, AB.
64	**TELETPN: PROVIDING AND SUPPORTING LIFE SUSTAINING CARE** Rossos P[1], Saqui O[2], Fairholm L[2], Baun M[2], Allard J[2]. [1]University Health Network Telehealth Program, Center for Global eHealth Innovation, University of Toronto, Toronto, ON. [2]Home TPN Program, Toronto General Hospital, University Health Network, Toronto, ON.
65	**HOW TO CREATE A THERAPEUTIC BOND IN TELEHEALTH: THE CONTRIBUTION OF TELEPRESENCE AND EMOTIONS** Bouchard, S. Laboratoire de Cyberpsychologie, Université du Québec en Outaouais, Gatineau, QC.
66	**SMOOTH SAILING IN SEASONED SHIPS: NEED, READINESS, RESPONSIVENESS IN INTER-PROVINCIAL TELEHEALTH** Salenieks ME[1], Muir L[2], Forsyth L[3], Davis G[3], Pal I[4], Denis C[4]. [1]University Health Network, Toronto, ON. [2]Pictou County Health Authority, NS. [3]Nova Scotia Telehealth Network, NS. [4]North Network, ON.

61

TELEPSYCHIATRY IMPROVES ABILITY OF GENERAL PRACTITIONERS TO PROVIDE MENTAL HEALTH SERVICES IN UNDERSERVED COMMUNITIES

Urness D, Tian E, Wass M. Telemental Health Service, Alberta Mental Health Board, Ponoka, AB.

PURPOSE: The objective of this study was to confirm that a telepsychiatry service available in Alberta supports mental health services provided by rural general practitioners and enables the delivery of effective care to clients in their home community.
METHODS: The present study was designed as a one-time survey of referring physicians. One hundred and fifty four (154) general practitioners (GPs) were invited to participate. These physicians had referred one or more clients for a telepsychiatry consultation between August 2001 and August 2003.
RESULTS: Seventy one (71) referring GPs returned completed questionnaires, for a response rate of 46% (no incentives or follow-up). Eighty six percent of responding physicians state that telepsychiatry improves their ability to manage psychiatric patients locally. Overall, 92% of responding physicians were very satisfied or satisfied (48% very satisfied, 44% satisfied) with the telepsychiatry service
CONCLUSIONS: Rural GPs provide extensive mental health services with limited access to specialized psychiatric services. The present evaluation demonstrates that a telepsychiatry service improves the ability of referring GPs to provide care to their psychiatric clients. This service is well accepted and has become the established means for providing psychiatric consultations in many communities. There is tremendous potential for implementing this model of service in other jurisdictions.

62

TELEHEALTH TECHNOLOGY EXTENDS FORENSIC MENTAL HEALTH CLINICAL SERVICES TO RURAL COMMUNITIES

Allen D[1], Halpin P[2], Walsh B[3], Bulger T[1], Konrad M[1]. [1]Telemental Health Service, Alberta Mental Health Board, Ponoka, AB. [2]Forensic Assessment & Outpatient Services, Calgary Health Region [3]Forensic Adult Community Services, Capital Health.

INTRODUCTION: In Alberta core forensic mental health services are based in Edmonton and Calgary and limited forensic psychiatric expertise is available in rural communities. Historically clients have had little option but to travel to receive services. Providing forensic mental health services via telehealth technology extends the reach of forensic mental health clinicians.
DESCRIPTION: In August of 2000 the Provincial Forensic Psychiatry Program began a province wide needs assessment that led to the establishment of Community Geographic Teams (CGTs). CGTs are resources dedicated to providing forensic services to outlying rural areas. Videoconferencing technology has been used as an integral part of the delivery of CGT clinical services since 2002. In November 2003, grant funding secured through Alberta Health and Wellness provided opportunity to augment existing forensic services delivered via telehealth. Partnering organizations identified opportunities to extend direct consultation services, initiate multi-disciplinary case conferencing and increase forensic expertise available in rural communities through capacity building in-services.
RESULTS: Telehealth technology has improved access to specialized forensic mental health services for rural Albertans. Since 2002, forensic clinicians have provided 237 direct consultations. Multi-disciplinary case conference sessions with rural CGT resources are now conducted weekly.
CONCLUSIONS: The use of telehealth technology to provide clinical services has been integrated into the Provincial Forensic Psychiatry Program in Alberta. Combining telehealth services with traditional outreach enables the delivery of specialized forensic mental health services to clients in their home community, making efficient use of scarce forensic mental health resources.

63

USING TELEHEALTH TO CONNECT FAMILIES AND HEALTH CARE TEAMS ACROSS SOUTHERN ALBERTA
Young S, Staveley R, Nijssen-Jordan C. Alberta Children's Hospital, Calgary Health Region, Calgary, AB.

INTRODUCTION: The Southern Alberta Child & Youth Health Network (SACYHN) provides paediatric care "closer to home" for children across southern Alberta.
DESCRIPTION: To provide seamless healthcare SACYHN uses videoconferencing or telehealth to integrate healthcare for families in their community. If a child is hospitalized, parents can discuss treatment changes with the physician or visit with family members separated by distance using telehealth. In planning for discharge families, healthcare professionals in the home community and the Alberta Children's Hospital (ACH) team connect by telehealth to ensure a seamless transfer of care. After discharge, follow-up care is often completed by telehealth meeting the needs of the child without travel. Finally, telehealth allows a parent to become a "virtual" member of a support group, even if they are the only family in their community with a child living with a certain condition.
RESULTS: In six months, this paediatric program doubled the number of clinical sessions completed using telehealth. Parents and providers reported extremely high satisfaction. "Key learnings" included building on the preexisting telehealth usage by responding to the needs of the families and providers. Funding by Alberta Wellnet provided a dedicated project coordinator who created a "culture of possibility".
CONCLUSION: Healthcare teams were supported in developing new applications to address gaps in healthcare delivery for those who live outside of Calgary and require the services of ACH. Success is breeding success as more teams are requesting assistance in learning to use telehealth as a way to connect.

64

TELETPN: PROVIDING AND SUPPORTING LIFE SUSTAINING CARE
Rossos P[1], Saqui O[2], Fairholm L[2], Baun M[2], Allard J[2]. [1]University Health Network Telehealth Program, Center for Global eHealth Innovation, University of Toronto, Toronto, ON. [2]Home TPN Program, Toronto General Hospital, University Health Network, Toronto, ON.

INTRODUCTION: Home total parenteral nutrition (HTPN) has permitted adults and children with intestinal failure to sustain life at home.
HTPN patients require multi-disciplinary care and intensive monitoring. Complications may result in prolonged hospitalizations and death. Remote patients frequently have physical and financial barriers to travel.
TeleTPN integration was considered to cost effectively improve patient care, remote provider support, and stakeholder education. To date there is no published literature on the use of telehealth in HTPN.
DESCRIPTION: The UHN HTPN program started in November 1970 at the Toronto General Hospital with enrollment of the first Canadian and second international patient to receive this therapy. It is the only provincially funded program in Ontario. The UHN Telehealth Program was initiated in March 2002 in partnership with the NORTH Network (http://www.northnetwork.com). Clinic-based portable telehealth units were introduced in February 2003; early adopters included the HTPN team.
RESULTS: There are 59 active patients in the program, and 14 (24%) are followed by telehealth. A recent survey of these patients revealed the following:
Travel distance to UHN (km): 611 +/- 213
Travel cost per trip C$: 724 +/- 224
Satisfaction with remote consultation, education, and follow-up: 100%
CONCLUSIONS: Home TPN is an example of advanced supportive care that can benefit from telehealth integration. We are in the process of more extensive analysis to quantify the health and economic benefits of this intervention and incorporate telehealth in a strategic plan for the HTPN program.

65

HOW TO CREATE A THERAPEUTIC BOND IN TELEHEALTH: THE CONTRIBUTION OF TELEPRESENCE AND EMOTIONS

Bouchard, S. Laboratoire de Cyberpsychologie, Université du Québec en Outaouais, Gatineau, QC.

CONTEXT: Previous studies in telemedicine have reported that patients can form a strong bond with medical staff through remote telecommunications. This bond is a core element in the creation of a therapeutic alliance in psychiatry and psychotherapy and is also important for case management in other specialties in medicine. Bouchard et al. (2004) proposed that such a bond is possible because of the sense of telepresence, or the illusion of «being with» with the other person during communications in telehealth.
AIM: Following a brief presentation on the construction and validation of a measure of telepresence (N = 90), a study assessing the contribution of emotional content on the sense of telepresence is presented. The hypothesis was that highly emotionally charged discussions would lead to a stronger sense of telepresence, and thus to a stronger bond.
METHOD: A sample of 18 adults discussed in videoconference on two emotionally charged situations (strong or weak emotional content) in a randomized counterbalanced repeated measure design (half of the participants began with the strong emotional content, the other half with the weak emotional content).
RESULTS: The statistically significant interaction ($p < .001$) between the order of the discussions and the strengths of the emotional content confirmed that emotionally charged situation lead to a stronger sense of «being there with the other person». Facilitating variables such as attitudes toward different means of communications were significantly related to telepresence.
DISCUSSION: The implications for the case management and the bond between patients and telehealth professionals will be discussed.

66

SMOOTH SAILING IN SEASONED SHIPS: NEED, READINESS, RESPONSIVENESS IN INTER-PROVINCIAL TELEHEALTH

Salenieks ME[1], Muir L[2], Forsyth L[3], Davis G[3], Pal I[4], Denis C[4]. [1]University Health Network, Toronto, ON. [2]Pictou County Health Authority, NS. [3]Nova Scotia Telehealth Network, NS. [4]North Network, ON.

INTRODUCTION: Need drives development but readiness to respond in a timely manner requires mature technical systems and human intervention.
DESCRIPTION: The Nova Scotia – Ontario initiative that facilitates consultations between people from Nova Scotia referred by their physicians to the Lung Transplant program in Toronto at the University Health Network was put together relatively quickly and smoothly. Nova Scotia has a robust telehealth network with videoconference installations in 46 health care facilities throughout the province, centralized scheduling and a provincial technical support desk. The University Health Network is the largest teaching hospital in Canada and offers the only lung transplant program in English speaking eastern Canada. UHN is also a partner in the NORTH Network and supported by the technical support desk and central booking of the network, which supports over one hundred videoconferencing units at eighty six sites within its telehealth network.
RESULTS: Inter-provincial consultations have been supported by the joint effort of 3 domains of telehealth activity: clinical coordinators, schedulers and technical support individuals. Since May of 2003 over twenty people from Nova Scotia have consulted by videoconference with physicians of the UHN Lung Transplant Program.
CONCLUSION: The communication between the technical support, scheduling and clinical coordinators has unfolded with little fanfare to connect very ill people and their families in Nova Scotia to physicians at the UHN in Ontario.
This presentation will document the experiences of the collaboration in the areas of clinical coordination, scheduling and technical support.

POSTER PRESENTATIONS SESSION #1
SESSION D'AFFICHES #1
TUESDAY / MARDI : 1030-1200

Clinical Care

Room/Salle : Villeray
Moderator / Modératrice : Mary Beth Leblanc

No.	*Abstract Title & Authors / Titre du résumé et auteurs*
P01	**TELE-PHARMACY AT INTERIOR HEALTH** Loyola M, Southby R. Interior Health, BC.
P02	**TELE-THORACIC SURGERY CONSULTATION AT INTERIOR HEALTH** Loyola M, Southby R. Interior Health, BC.
P03	**RESULTS OF A NEW HEALTH SERVICE MODEL UTILIZING TELEMEDICINE IN SCREENING FOR DIABETIC RETINOPATHY** Boucher MC. University of Montreal, Montreal, QC.
P04	**TELEHEALTH VISITATION IN A SECURE PSYCHIATRIC FACILITY - CHALLENGES AND OPPORTUNITIES** Bruce L. Staff Education and Telehealth Coordinator, Mental Health Centre Penetanguishene, Penetanguishene, ON.
P05	**IMPLEMENTATION OF TELEPHARMACY IN NUNAVIK** Guévin JF, Lefebvre P, Mallet L, Papillon-Ferland L. McGill University Health Center (MUHC), Montreal, QC.
P06	**MAWI WOLAKOMIKSULTINE: TOGETHER LET'S HAVE GOOD HEALTHY MINDS** Sappier R[1], Hagerman V[2]. [1]Director of Health, Tobique First Nation Community, NB. [2]Regional Director, Telehealth, River Valley Health, NB.
P07	**FRAMEWORK FOR ACTION: IMPLEMENTING NEXT STEPS IN A PHASED-IN TELEOPHTHAMOLOGY PROGRAM FOR DIABETICS IN FIRST NATIONS COMMUNITIES** Cleary M. Special Projects Coordinator, Keewaytinook Okimakanak Telehealth, Balmertown, ON.
P08	**DEVELOPMENT AND IMPLEMENTATION OF AN URGENT TELEPSYCHIATRY CONSULTATION SERVICE** Bulger T, Urness D., Allen D. Telemental Health Service, Alberta Mental Health Board, Ponoka, AB.
P09	**TELEHEALTH CAN REDUCE THE TRANSFERT TO TERTIARY CENTRES OF NEWBORNS WITH CARDIORESPIRATORY RHYTM PROBLEMS** Côté A. Respiratory Medicine, Montreal Children's Hospital, Montreal, QC.
P10	**INTEGRATING TELEHEALTH WITH AN ITINERANT DIAGNOSTIC ENDOSCOPY SERVICE IN NORTHERN MANITOBA: A CASE STUDY** Spencer T. MB Telehealth, Flin Flon, MB.
P11	**TELEHEALTH WHEELCHAIR SEATING CONSULTATION AND MENTORING** Bryce J, Whitney B, Gorin D, McCarthy M, Gao M. Calgary Health Region, Calgary, AB.

P01

TELE-PHARMACY AT INTERIOR HEALTH
Loyola M, Southby R. Interior Health, BC.

INTRODUCTION: Interior Health is one of the Health Authorities in British Columbia. It covers the middle section of the Province - incorporating approximately 690,000 people, 35 acute care sites and 1200 physicians. Interior Health is using telehealth in innovative ways to help improve the ways our staff, physicians and patients access one another. One of these initiatives is Tele Pharmacy.
DESCRIPTION: Tele-pharmacy is the use of videoconferencing equipment to monitor and supervise pharmacy services from a distance. The shortage of pharmacy professionals in B.C. has made telehealth initiatives such as tele-pharmacy even more important to Interior Health.
RESULTS: Interior Health tele-pharmacy operates between the following communities: 100 Mile House to Williams Lake; and Cranbrook to Fernie, Creston and Invermere. This enables the pharmacist at the regional site to supervise the provision of prescriptions to patients at smaller, rural or remote sites. Not only does this save the pharmacist frequent travel between locations but it also offers a respite to solo pharmacists. When a pharmacist is not available, other pharmacists within Interior Health can provide professional services to these locations. "Wonderful equipment; you can read the labels on frozen syringes, and marks on the pills can be identified. That works really well. It helps us to be there when we are not physically there," says Diane Semenchuk – East Kootenay Regional Hospital pharmacist.
CONCLUSIONS: Tele-pharmacy is widely used at Interior Health and it is an example of how Telehealth is improving access to services in rural/small urban communities.

P02

TELE-THORACIC SURGERY CONSULTATION AT INTERIOR HEALTH
Loyola M, Southby R. Interior Health, BC.

INTRODUCTION: Interior Health is one of the Health Authorities in British Columbia. It covers the middle section of the Province - incorporating approximately 690,000 people, 35 acute care sites and 1200 physicians. Thoracic surgery is a highly specialized field for which Kelowna General Hospital has been recognized as one of the centres of excellence in the Province. As such, patients requiring treatment in this field either need to travel to Kelowna, or have a specialist travel out to them for initial assessments and post operative follow up consultation. The travel for the surgeons takes considerable time and energy and often creates further delays for patients trying to access the specialists at the Kelowna site.
DESCRIPTION: A video-consultation room was implemented in each of the four health service areas. The telehealth connection allows the thoracic surgeons to provide patient assessments and post operative follow ups as appropriate for thoracic surgery patients who reside in areas outside of the Central Okanagan - without requiring the patient to travel from their most immediate area or have the surgeon travel to the remote site.
RESULTS: Using the videoconferencing facilities means that both the physicians and the patients get to stay in their home community. That leads to quicker diagnoses, less stress for the patient and their family, and better health outcomes.
CONCLUSION: This telehealth initiative supports the region's goal for telehealth as it maximizes the practical use of telehealth technologies within the provision of health care to the residents of Interior Health.

P03

RESULTS OF A NEW HEALTH SERVICE MODEL UTILIZING TELEMEDICINE IN SCREENING FOR DIABETIC RETINOPATHY

Boucher MC. University of Montreal, Montreal, QC.

INTRODUCTION: The difficulty of implementing efficient regular eye screening strategies for diabetic retinopathy (DR) as recommended by the Canadian Diabetic Guidelines is responsible for most cases of blindness caused by diabetes. We present the results of a new health model for screening for DR for known diabetics through telemedicine in four urban settings.
DESCRIPTION: Through a central appointment centre, patients are referred to an imaging centre where fundus imaging is performed within defined standards. With encryption and through a safe transmission protocol the data is transmitted to a Data Centre. Ophthalmologists having a secure access tot the data make their diagnosis and recommendations . A report is generated and sent to all involved physicians in the patient's care. All patients are notified of their results and recalled yearly if no disease is detected and, in the presence of disease, a timely appointment with the ophthalmologist is already set up when the patient is contacted.
RESULTS: 38% of the screened patients had never had any eye examination for DR while 81% had not been examined for over 2 years. 34% of the screened patients had some degree of DR with 11% of them requiring urgent follow-up or treatment. Ophthalmologists were relieved of 79 % of screening examinations for DR while screening was offered to all.
CONCLUSION: This model for mass screening for DR with telemedicine in diabetic patients has proved to be not only feasible but practical and reliable while saving medical resources and reaching to previously unscreened diabetic patients.

P04

TELEHEALTH VISITATION IN A SECURE PSYCHIATRIC FACILITY - CHALLENGES AND OPPORTUNITIES

Bruce L. Staff Education and Telehealth Coordinator, Mental Health Centre Penetanguishene, Penetanguishene, ON.

INTRODUCTION: The maximum-security Oak Ridge facility the Mental Health Centre Penetanguishene serves male patients from across Ontario who cannot be properly managed in lesser secure mental health facilities in the province. When space is available, patients are also admitted from other provinces and territories on the basis of inter-provincial transfer agreements, meaning that some patients are thousands of miles from family. Telehealth provides an opportunity for patients to enjoy the therapeutic benefit of family visits. Technology is a manageable challenge, but there are other factors impacting on the implementation of a Telehealth visiting program.
DESCRIPTION: Working with the Social Workers in the 140 bed, Oak Ridge Division, the author will examine the barriers and opportunities for using Telehealth as a vehicle for maintaining and supporting family relationships during patient stay. Social workers develop and maintain liaisons between family members and patients of the facility in order to improve client's well being and where feasible support transition into a less restrictive setting. This project will look at organizational and institutional constraints, as well as individual clinician, patient and family reactions to Telehealth visitations, which may impact on the successful implementation of this program. Surveys, interviews and focus groups will be used to collect participant feedback.
RESULTS: This project will take place during August and September 2004, with results to be reported by September 30, 2004.
CONCLUSIONS: Conclusions, when the project is complete in September 2004, will address challenges and opportunities along with recommendations developed by participants.

P05

IMPLEMENTATION OF TELEPHARMACY IN NUNAVIK

Guévin JF, Lefebvre P, Mallet L, Papillon-Ferland L. McGill University Health Center (MUHC), Montreal, QC.

INTRODUCTION: Inuit people of Nunavik receive pharmaceutical services from two local hospitals located at each extremity of Quebec's arctic region where pharmacist's presence is insured on a voluntary basis only. Telepharmacy is seen as a possible alternative to provide continuous expertise in pharmaceutical care.
DESCRIPTION: The projected telepharmacy service would be offered from one pediatric and one adult hospital within the MUHC. A consultant type relationship with health professionals and the pharmacists located in Nunavik would address a range of questions: disease state management, acute pharmacotherapy problems, pharmaceutical care in targeted populations and collaboration in education programs. Because of legal barriers, telepharmacy will not take responsibility for the distribution and control of drugs in Nunavik. The feasibility of integrating the MUHC pharmacy computer software with local networks will be evaluated during the first visit in July 2004. During that visit, outcomes will be more clearly defined. During the second visit in September 2004 the actual collaboration will begin with assessment of pharmaceutical care needs. Regular follow-ups will be scheduled according to demand. Further developments in technology use, notably with Palm-type personal digital assistants will also be evaluated to provide complete access to electronic patient files and eventual electronic prescribing.
RESULTS: Description of initial steps and barriers to implementation, number of consultation requests, number of patients followed and prescriptions analyzed will be made in October 2004.

P06

MAWI WOLAKOMIKSULTINE: TOGETHER LET'S HAVE GOOD HEALTHY MINDS

Sappier R[1], Hagerman V[2]. [1]Director of Health, Tobique First Nation Community, NB. [2]Regional Director,Telehealth, River Valley Health, NB.

INTRODUCTION: The name of the Telehealth Partnership Project to be profiled in this session is Mawi Wolakomiksultine, which is a Maliseet name adopted by telehealth project partners from Health Region 3, New Brunswick, meaning 'Together, let us have good healthy minds.'
DESCRIPTION: Roxanne Sappier, Health Director, Tobique Wellness Center, Tobique First Nation Community, will focus on the value this telehealth partnership has already had in her community at the project's mid-point.
RESULTS: She will provide a high level summary of the three tactical initiatives that will be used to bring telemental health, teleaddictions and tele-education services into her community; the focus on privacy and security education and information systems standardization; as well as the steps that have been taken to provide her community's Health Center with access to the RHA (region health authority) electronic patient record.
CONCLUSION: Collectively, Roxanne will describe how her community is positioning this demonstrator project to be expanded to the other four Maliseet First Nation communities in her health region.

P07

FRAMEWORK FOR ACTION: IMPLEMENTING NEXT STEPS IN A PHASED-IN TELEOPHTHAMOLOGY PROGRAM FOR DIABETICS IN FIRST NATIONS COMMUNITIES

Cleary M. Special Projects Coordinator, Keewaytinook Okimakanak Telehealth, Balmertown, ON.

INTRODUCTION: An initial Teleophthalmology pilot project, pioneered by North Network and Keewaytinook Okimakanak, showcased the use of a portable retinal camera for retinal screening to diabetics in their respective first nations communities. Various logistical and technical problems were identified and forwarded for application of an improved Phased-in diabetic retinopathy screening and community-based laser treatment pilot program to 2 first nations communities via teleophthalmology.
DESCRIPTION: KO is in the process of incorporating lessons learned from the initial pilot project into Phase 1 application of a combined retinal screening and community-based laser treatment program.
In attempt to enhance the phased-in retinal screening and treatment program , progress to date includes; only one trained operator for retinal photography, inception meeting in the community to further enhance communication between primary stakeholders: family physicians, nursing station, KO and community residents; streamlined administrative workflow in scheduling community clinics and incorporating the CTC's into delivery of the program ,identifying technical support team contacts available to the operator prior to travel to the communities, formalizing the referral process and reporting of results to key stakeholders, physician, resident, nursing station.
RESULTS: The application of lessons learned from the original pilot project will enhance the overall delivery of a combined screening and treatment project in first nations communities.
CONCLUSIONS: The proposed combination of retinal screening and on site treatment program will provide pivotal information to the Ophthalmic Health Care communities and to the momentum of Primary Health Care Initiatives, both regionally and nationally.

P08

DEVELOPMENT AND MPLEMENTATION OF AN URGENT TELEPSYCHIATRY CONSULTATION SERVICE

Bulger T, Urness D., Allen D. Telemental Health Service, Alberta Mental Health Board, Ponoka, AB.

INTRODUCTION: Telehealth technology is widely used to provide psychiatric consultations to Albertans in rural/underserved communities. To date few specialist services have been available on an urgent or emergent basis, a limiting factor being psychiatrist availability. This initiative brings together clinicians from partnering organizations to establish a roster of consulting psychiatrists who can respond to referrals within one to four business days.
DESCRIPTION: Few options exist in rural communities when urgent mental health services are required. Telehealth facilitates timely access to a psychiatric consultation without travel to a major urban centre. Referrals for an urgent consultation include individuals with suicidal ideation, acute psychosis, or the need for an immediate medication assessment.
Partnering with three regional health authorities, a roster of 10 consulting psychiatrists has been established. At least one psychiatrist is available Monday to Friday to respond to an urgent referral.
This rapid response and an emphasis on working collaboratively with practitioners and local mental health resources emphasizes a shared care model of service.
RESULTS: From November 2003 to June 2004, 127 urgent consultations have been completed. The average wait time for an urgent consultation is 3 days.
CONCLUSIONS: Through this initiative clients and their mental health care providers have timely access to consulting psychiatrists. This initiative supports integration and the local delivery of mental health care services.

P09

TELEHEALTH CAN REDUCE THE TRANSFERT TO TERTIARY CENTRES OF NEWBORNS WITH CARDIORESPIRATORY RHYTM PROBLEMS

Côté A. Respiratory Medicine, Montreal Children's Hospital, Montreal, Canada

INTRODUCTION: Newborns are prone to cardiorespiratory rhythm anomalies (apnea, bradycardia) leading potentially to serious decrease in blood oxygen levels. The evaluation of these problems, when persistent, is usually done in tertiary pediatric centres, which implies the transfer of newborns from regional centres.
DESCRIPTION: Since 2002, we have developed a telehealth service with regional centres that consists of local acquisition of physiological data (respiration, ECG and hemoglobin-oxygen saturation levels) and transfer of electronic data to tertiary centres for immediate interpretation. Personnel from regional centres have been trained to performed the studies and continuous telehealth education is provided for both physicians and health professionals through conferences and a website.
RESULTS: 245 transmissions of cardiorespiratory and oxygenation data have occurred (97 newborns). The results of the tests have lead to change in therapy, further investigation, or have reassured the local medical team of the benignity of the condition. Infants had 1 to 7 additional recording studies to monitor progress over the course of their illness, all performed in the regional centres. Only three newborns were transferred to a tertiary centre, two due to rapid deterioration of their respiratory status documented with the recording system, and one due to equipment failure.
CONCLUSION: Telehealth has the potential to significantly decrease the transfer to tertiary centres of newborns with cardiorespiratory rhythm problems. In addition, the education program provides expertise in regional centres.

P10

INTEGRATING TELEHEALTH WITH AN ITINERANT DIAGNOSTIC ENDOSCOPY SERVICE IN NORTHERN MANITOBA: A CASE STUDY

Spencer T. MB Telehealth, Flin Flon, MB.

INTRODUCTION: While gastroscopy and colonoscopy are relatively common diagnostic procedures, they are often unavailable in rural and northern centres. With pre-surgical consultation and follow-up, rural and northern patients often make two or three trips to the city for this routine procedure.
DESCRIPTION: To reduce patient travel costs, one Northern Manitoba Regional Health Authority established an itinerant diagnostic endoscopy service supported by telehealth. A Winnipeg-based general surgeon now makes monthly visits to the region to perform endoscopy procedures and uses a telehealth link for all related pre-surgical consultations and follow-up care. Without the integration of telehealth into this service model, the time commitment required from the surgeon for patient consultations would make this service unfeasible.
This presentation will describe the model for integrating telehealth into itinerant endoscopy services and it will show how this particular service has provided benefits beyond the anticipated travel savings including reduced waiting times and efficiencies in the use of operating room resources. It will also suggest that improved access to diagnostic endoscopy services may be leading to an increase in preventative screening examinations in this northern patient population.
RESULTS: After seven months of operation this service has resulted in: improved access to care, significantly reduced waiting times, cost savings through reduced travel, and better utilization of operating room resources by transferring routine procedures from a busy urban centre to underutilized rural operating rooms.
CONCLUSION: Telehealth-supported diagnostic endoscopy is efficient and effective and is a particularly good fit as an itinerant service to rural and northern regions.

P11

TELEHEALTH WHEELCHAIR SEATING CONSULTATION AND MENTORING

Bryce J, Whitney B, Gorin D, McCarthy M, Gao M. Calgary Health Region, Calgary, AB.

INTRODUCTION: This rehabilitation project is unique in that it provides seating services to underserved communities, involves critical participation from private vendors and utilizes rural therapists' expertise to serve other rural communities within the Calgary Health Region. The goals of the project are to improve access and to enhance learning and skills among practitioners, thereby building system capacity to better manage complex seating needs.

DESCRIPTION: Referring sites were surveyed to determine caseload and resources required. Vendors were invited to act as the technical resource for both wheelchair components and videoconferencing/camera operators. Considerable attention was paid to the development of both clinical and technical processes as it was recognized that errors might have significant financial implications as well as possibly risk patient health/comfort. The University of Calgary provides evaluation services.

RESULTS:

- 10 consultations for 7 patients as of June 28, 2004
- 11 staff and 3 seating technicians trained
- Less travel means patients are less fatigued; therapists obtain a better seating assessment
- Skills and knowledge are transferred from the consulting therapists to the referring therapists
- Telehealth is a viable method of delivering seating services

CONCLUSIONS:

Factors that contributed to success:

- Including the vendor in the clinic process allows therapists to focus on patient
- "Buy-in" by rehabilitation staff at all levels
- Documentation and training around processes
- Earlier involvement of key stakeholder, Alberta Assistance for Daily Living, advisable

NEXT STEPS:

- Consider project sustainability
- Begin liaison with regional rehabilitation services to develop additional services

POSTER PRESENTATIONS SESSION #2
SESSION D'AFFICHES #2
TUESDAY / MARDI : 1030-1200

Clinical Care

Room/Salle : Ste-Foy-Portneuf
Moderator / Modératrice : Marilynne Hebert

No.	*Abstract Title & Authors / Titre du résumé et auteurs*
P12	**PRIMARY CARE VIDEO TELE E-HEALTH PROJECT IN DEVELOPMENT: OUTLINE OF THE DESIGN, RATIONALE AND PRELIMINARY RESULTS** Albert MJ[1], Stusser RJ[1], Enriquez JA[2], Quintana E[2], Gonzalez R[3]. [1]PC Research & Telecommunication Unit, Vedado Education Polyclinic, Havana Cuba. [2]Center for Health Informatics and Tele Health Development, Havana Cuba. [3]Center for Digital Research, Havana Cuba.
P13	**KO TELEHEALTH FIRST NATION EXPANSION FOR LONG TERM HEALTH CARE EQUITABILITY** Houghton K. CA. Keewaytinook Okimakanak Telehealth, Balmertown, Ontario
P14	**INTERFACING HOSPITAL ADMITTING SYSTEMS TO THE CRITICALL RESOURCE REGISTRY** Moneta S, MacKay W. Ontario CritiCall Program, Hamilton, ON.
P15	**PAEDIATRIC CARDIOLOGY – THE TELEHEALTH APPROACH** Reid J[1], Fontana Chow K[1]. Ouellet S[2]. [1]The Hospital for Sick Children, Telehealth Program, Toronto, ON. [2]London Health Sciences Centre, London, ON.
P16	**AKWESASNE TELEHEALTH PROJECT – OVERCOMING INFRASTRUCTURE ISSUES AND SUSTAINABILITY ISSUES** Seymour AT. Mohawk Council of Akwesasne, Cornwall ON.
P17	**INTEGRATING TELEHEALTH INTO GERIATRIC SERVICES IN NORTH WESTERN ALBERTA - THE CARE PROGRAM** Reinbold D, Curle L, O'Neill S. Peace Country Health, Grande Prairie, AB.
P18	**TELEREHABILITATION AND TELEGERIATRICS AT THE GLENROSE REHABILITATION HOSPITAL** Henderson, I. Capital Health, Glenrose Rehabilitation Hospital, Edmonton, AB.
P19	**DEPARTMENT OF MEDICINE: CLINICAL TELEHEALTH INTEGRATION THROUGHOUT A DEPARTMENT** McCulloch K[1], Silvius J[1], Nijssen-Jordan C[1], McCarthy M[1], Gao M[1], Adams S[1], Bowen T[1], Flemons W[1], Mackay E[1], Poole B[1], Read R[1], Taub K[1], Watanabe M[2], Yeo M[2], Hebert M[2]. [1]Calgary Health Region, Calgary, AB. [2]University of Calgary, Calgary, AB.
P20	**PROGRAM DELIVERY AND TELEHEALTH: CRITICAL SUCCESS FACTORS** Stuart M, Iskiw B. Telehealth Department, Capital Health Authority, Edmonton, AB.
P21	**COMMUNICATIONS, COMMUNITY, CONSISTENCY AND CUSTOMIZATION: THE MAGIC BEHIND RAPID EXPANSION** Stein S, Allard D, Danyliuk P, Fenton C, Nickoloff A[1]. [1]NORTH Network, Toronto, ON. [2]NORTH Network, Timmins, ON.
P22	**SAVETIME: SUCCESSFUL EMERGENCY SERVICES** Nijssen-Jordan C, Curry G, Watson T, Traboulsi D, MacLead B, Conroy S, McCulloch K, Gao M, McCarthy M. Calgary Health Region, Calgary, AB.

P12

PRIMARY CARE VIDEO TELE E-HEALTH PROJECT IN DEVELOPMENT: OUTLINE OF THE DESIGN, RATIONALE AND PRELIMINARY RESULTS

Albert MJ[1], Stusser RJ[1], Enriquez JA[2], Quintana E[2], Gonzalez R[3]. [1]PC Research & Telecommunication Unit, Vedado Education Polyclinic, Havana Cuba. [2]Center for Health Informatics and Tele Health Development, Havana Cuba. [3]Center for Digital Research, Havana Cuba.

PURPOSE: To evaluate critically the assimilation of modern digital and virtual systems in a primary care polyclinic and its family medicine practices in a Havanan health area.
METHODS: Clinical trials of health informatics, tele health, internet health systems, and other ICTs, with collaboration of national institutes and foreign universities. If the tele ehealth systems improve the quality of the health care indicators, then it would be extended to 443 NHS polyclinics.
RESULTS: Utilizing the information and dispensarization systems of the health area, the situation and activities, in our polyclinic and its practices have been improved. The technological improvement of tele ECG equipment in three practices and the polyclinic have allowed a better handling of myocardial infarction and arrhythmias, conceived its use in the NHS emergency system from the practices to the hospital, and designed other low-cost tele health care systems. The first web site of a Cuban polyclinic in the AAFP has been established at: http://familydoctor.org/myhavananpolyclinic/, and another site is being built covering the health care situation and programs. There is access from the polyclinic library through the NHS Intranet to the virtual library and university for tele learning /education. The design and coordination with national and foreign centers of sub projects on online tele e-health research collaboration web-based, PDA, and HMR with smart card health passport are in development as well.
CONCLUSIONS: We show the design and initial results of the components of the Vedado Tele e-Health Project, which is locally improving the efficiency of our family medicine.

P13

KO TELEHEALTH FIRST NATION EXPANSION FOR LONG TERM HEALTH CARE EQUITABILITY

Houghton K. CA, Keewaytinook Okimakanak Telehealth, Balmertown, Ontario

PURPOSE: To review methodology incorporated into a remote First Nation Telehealth Expansion from 5 communities to 24 communities.
METHODS: A successful pilot project 2001/2003 has led to expansion funding from 2003/2006 in which long term sustainability will be sought in the form of expanding into the Health Canada funding model.
RESULTS: Four distinct relationships and proposals were required to obtain funding dollars in the following areas: Operational; Capital; Connectivity. The integration of funding partners is instrumental in the governance structure being implemented in order to build the relationships directly required to integrate provincial with federal funding.
CONCLUSION: Partnerships and relationship building at the community level to the highest levels of government will allow long term sustainability.

P14

INTERFACING HOSPITAL ADMITTING SYSTEMS TO THE CRITICALL RESOURCE REGISTRY

Moneta S, MacKay W. Ontario CritiCall Program, Hamilton, ON.

INTRODUCTION: The Ontario CritiCall Program is a provincially-funded program that serves as the 'medical 911' for physicians caring for seriously ill patients. An objective of CritiCall is to obtain accurate, timely and uniform information regarding resource availability throughout the province. In emergency situations, and particularly during periods when resources are at, or near capacity, accurate resource information is crucial.
To obtain this information, CritiCall uses it's secure, Internet-based Central Bed and Resource Registry. The Registry processes about 2 million updates annually by hospitals. It's the responsibility of each participating hospital to ensure that information recorded is accurate and updated regularly. In most hospitals, this information is updated by hospital staff.
DESCRIPTION: Increasing challenges with respect to critical care resource availability reinforce the need for resource information to be highly accurate and communicated in a timely manner. To enhance the reliability of information, the CritiCall Program is piloting the development and implementation of automated interfaces to hospital Admit/Discharge/Transfer (ADT) systems. This automated process would improve the real-time identification of available system resources. In some cases, communicating resource availability before hospital department staff might otherwise have a chance to update the system. Real-time data will also enhance CritiCall's availability to communicate resource challenges when they occur. The Registry can generate an automated e-mail or paged message to appropriate hospital leaders or to the Ministry of Health, to advise when all hospitals in a particular area are at or nearing capacity.
RESULTS/CONCLUSIONS: The first interfaces will go-live mid-October 2004.

P15

PAEDIATRIC CARDIOLOGY – THE TELEHEALTH APPROACH

Reid J[1], Fontana Chow K[1], Ouellet S[2]. [1]The Hospital for Sick Children, Telehealth Program, Toronto, ON. [2]London Health Sciences Centre, London, ON.

INTRODUCTION: The Hospital for Sick Children (Sick Kids) has embarked upon a collaborative initiative with other paediatric academic health sciences centres to provide cardiovascular surgical services to children residing in Ontario. The outcomes of this cutting edge initiative facilitate and expediate the treatment of children with complex cardiac conditions.
DESCRIPTION: This initiative encompasses the mission statement of Sick Kids, to be the "Hospital Without Walls". We believe that all children residing in Ontario are entitled to equal access to specialty services regardless of their geographical location. Traditionally, families of children requiring complex care have had the added burden of traveling to centres of excellence, for treatment. Telehealth has provided a viable option for these families and assists in the provision of specialized, timely health care within their own communities. The cardiology team at Sick Kids interacts via Telehealth with the cardiology team at the Children's Hospital of Western Ontario twice weekly. Clinical assessments and treatment options for complex paediatric cases are presented and discussed. Telehealth technology enables the transmission and exchange of diagnostic quality images. These images include, but are not limited to, echocardiography, digital angiography, computed tomography and magnetic resonance imaging.
RESULTS: This exchange of clinical expertise and diagnostic information provides a seamless continuity of care between the cardiac teams at both facilities.
CONCLUSION: Sick Kids is in partnership with the Ontario Children's Health Network, collaborating to build an accessible, family-centered, high-quality provincial health system for paediatric and youth services. Paediatric cardiology will play an integral role in this network by providing cardiovascular surgical services.

P16

AKWESASNE TELEHEALTH PROJECT – OVERCOMING INFRASTRUCTURE ISSUES AND SUSTAINABILITY ISSUES
Seymour AT. Mohawk Council of Akwesasne, Comwall ON.

INTRODUCTION: The Mohawk Council of Akwesasne (MCA) is the local government for a large First Nation with a population of 10,000. The organization employs over 1000 employees in all areas of public service. Parts of Akwesasne are in Ontario, Quebec and New York State. In March 2004, MCA completed a pilot telehealth project in partnership with Canarie. The presentation to CST by MCA will describe the pilot project, focusing on some of the infrastructure issues that were resolved. In addition, we will discuss some of the sustainability issues that we currently face.
DESCRIPTION: The implementation of a telehealth pilot project in Akwesasne was challenging because of the geographical layout of the community. For example, the St.Lawrence River flows through our territory. At the onset of the pilot project the technical requirements needed to implement telehealth were not clearly understood. There was a lack of communication between the technical staff of MCA and the project staff (who were non-technical).
RESULTS: In May 2003, a new project coordinator was hired for MCA's telehealth project. The new coordinator worked closely with MCA technical staff to resolve all technical problems, including the tender for telehealth equipment. In November 2003, the telehealth equipment became fully operational.
CONCLUSIONS: Effective project leadership and good technical input are critical to successful implementation. The challenges that MCA now faces include maintaining its external network of contacts as well as promoting the use of telehealth and teletechnology to other departments within MCA. This will support long term sustainability.

P17

INTEGRATING TELEHEALTH INTO GERIATRIC SERVICES IN NORTH WESTERN ALBERTA - THE CARE PROGRAM
Reinbold D, Curle L, O'Neill S. Peace Country Health, Grande Prairie, AB.

INTRODUCTION: Peace Country Health (PCH) operates the Consultation and Assessment Resource for the Elderly (CARE) Program. In 2004, Telehealth services became an integral component of this valuable clinical program. The CARE team is composed of Registered Nurses, a Psychiatric Nurse and a Social Worker. Consultation and assessment is also available from other disciplines such as Occupational Therapy, Physiotherapy, Speech/Language Pathology, geriatric psychiatry, and geriatric services. Funding for this program was secured through two sources; The Alberta Health and Wellness Telehealth Clinical Grant Fund provided funding for nursing and support staffing. Peace Country Health provided funding through the PCH Renovations Grant which was used to customize a dedicated clinical/educational room for the program.
DESCRIPTION: The integration of telehealth enhanced the existing CARE program by adding 2 days/week of clinical and educational telehealth sessions by a Registered Geriatric Nurse Specialist, to reach the large geographical area of Peace Country Health for assessment, consultation and education to rural providers in facility and community settings.
RESULTS: To date the CARE program has provided clinical assessments and educational sessions to 16 communities in Peace Country Health. Over 70 telehealth transactions totalling 92.5 hours of services have been conducted and this activity is expected to continue to increase.
CONCLUSIONS: This presentation will examine the successes and challenges of this project, how the integration of telehealth into this program has enhanced care for the elderly in Peace Country Health as well as the future direction of CARE services that will be delivered via telehealth.

P18

TELEREHABILITATION AND TELEGERIATRICS AT THE GLENROSE REHABILITATION HOSPITAL
Henderson, I. Capital Health, Glenrose Rehabilitation Hospital, Edmonton, AB.

PURPOSE: To showcase how Telehealth is being integrated into clinical care for rehabilitation and geriatrics patients to improve management of their chronic disease/illness.
INTRODUCTION: The Glenrose Rehabilitation Hospital (GRH) is a 244-bed facility in Edmonton, Alberta with a catchment area including central and northern Alberta, eastern BC, Saskatchewan and the Arctic; currently, 30-50% of GRH patients live in regions outside Edmonton. The facility admits patients of all ages and has an extensive outpatient and day patient component (~170,000 attendances/year). The majority of the 20,000 active cases have a chronic condition. In an effort to improve service access, the GRH has expanded its use of clinical Telehealth in Rehabilitation and Geriatrics over the past 4 years. In November/03, the GRH was awarded two Alberta Health Grants to support expansion of these clinical applications.
DESCRIPTION: The two projects utilize existing Telehealth equipment at GRH and partnering RHA's. GRH specialists hold clinical visits with patients in remote regions. Telehealth is also used to facilitate a transfer of learning to remote providers. Several marketing strategies have been utilized to encourage clinician and physician buy-in including: display boards; focus groups; rounds sessions; department meeting presentations; open houses; and circulation of utilization statistics and targets.
RESULTS: From April/03–March/04, Teleclinical utilization increased by 42.2% compared to the previous fiscal year.
CONCLUSION: Expansion of Telehealth has improved access to services for remote patients and has enabled GRH to enhance its level of patient care.

P19

DEPARTMENT OF MEDICINE: CLINICAL TELEHEALTH INTEGRATION THROUGHOUT A DEPARTMENT
McCulloch K[1], Silvius J[1], Nijssen-Jordan C[1], McCarthy M[1], Gao M[1], Adams S[1], Bowen T[1], Flemons W[1], Mackay E[1], Poole B[1], Read R[1], Taub K[1], Watanabe M[2], Yeo M[2], Hebert M[2]. [1]Calgary Health Region, Calgary, AB. [2]University of Calgary, Calgary, AB.

INTRODUCTION: Introduction and integration of telehealth throughout a Department of Medicine that has multiple divisions within a tertiary care system.
DESCRIPTION: Within the Department of Medicine, 5 divisions were initially selected based upon expressed interest and identified need. These divisions included Allergy / Immunology, Dermatology, Geriatrics, Infectious Disease and Nephrology. Internal Medicine was later added. A needs assessment was performed with each division. Priorities were established in partnership. Processes were reviewed and adapted in consultation. Training was delivered. Trial clinical sessions were executed and evaluated. All clinical initiatives were designed to be fully integrated and sustainable.
RESULTS:

Geriatrics	-Three virtual Tele-geriatric clinics every month
	-35 consults complete in first 6 months
Nephrology	-Two virtual multi-disciplinary clinics every month
	-8 consults in first 6 months
Internal Medicine	-Two new initiatives
	-Diabetic Education team
	-Discharge planning to rural facilities
	-2 trial consults – commencement September 2004
Allergy/Immunology, Dermatology and Infectious Disease	
	-Completed 1 clinical session each
	-Presently, ad hoc utilization

CONCLUSIONS:
-Project Coordinator with a clinical background is key.
-Physician lead important to physician participation.
-Both Physician and Nurse champions are required.
-Initial priorities may not work out and flexibility is crucial.
-Some divisions utilize scheduled clinical sessions, others require ad hoc.
-Technical needs of certain divisions are difficult to meet.
-Positive exposure encourages development in other areas.

P20

PROGRAM DELIVERY AND TELEHEALTH: CRITICAL SUCCESS FACTORS
Stuart M, Iskiw B. Telehealth Department, Capital Health Authority, Edmonton, AB.

INTRODUCTION: Traditional clinical program delivery models are well developed but not necessarily readily adaptable to integrating remote and distance technologies. Serving a broad geographical base, Capital Health currently delivers clinical services using telehealth in a range of disciplines.
DESCRIPTION: Through clinical grant fund projects (via AHW) and existing telehealth programs, CH has learned key success factors in achieving program delivery excellence. The factors that will be identified and discussed address access, quality and efficiency.
RESULTS: Understanding the existing program delivery structure (providing and receiving), goals and objectives of the care delivery team(s), physical and technological capacities and human resources capabilities are key elements in establishing an environment for success. In addition, establishing realistic performance measures and developing sound evaluation frameworks provide added value necessary for sustainability and integration.
An excellent example is the CH led Northern Alberta Renal Program (NARP). With 13 satellite units located within Central and Northern Alberta, the NARP program has evolved in its capabilities and outreach capacity to serve rural and remote renal insufficiency patients using applied telehealth technology. The application of these learning's regarding critical success factors for program delivery and sustainability will be outlined.
CONCLUSIONS: Through the use of the key learning's (i.e. understanding of critical success factors) derived from targeted clinical telehealth applications, CH has demonstrated a leadership role in advancing the integration of telehealth into enhanced program delivery models.

P21

COMMUNICATIONS, COMMUNITY, CONSISTENCY AND CUSTOMIZATION: THE MAGIC BEHIND RAPID EXPANSION
Stein S, Allard D, Danyliuk P, Fenton C, Nickoloff A[1]. [1]NORTH Network, Toronto, ON. [2]NORTH Network, Timmins, ON.

INTRODUCTION: A high degree of complexity accompanies the task of integrating multiple sites into an existing telemedicine network. NORTH Network, one of Canada's most active telemedicine networks, has developed a coordinated process to manage the multi-faceted challenges leading to the successful integration of new end-points.
DESCRIPTION: The New Site Implementation Team uses a 4-stage methodology to implement each new end point. In the first stage, NORTH determines the proposed applications of the new sites and maps them to existing services as well as assists in identification of local champions who advance the program in the community. In stage two, NORTH conducts a roll-out meeting to impart the who-what-when-where-why and how of NORTH "culture". Stage three involves the deployment of the technology including network connectivity and configuration and equipment installation. Training on the technology and clinical processes rounds out the third stage. In the final stage, the end-points are in control of their local program and NORTH assists in the promotion and activation of technology uptake.
RESULTS TO DATE: Approximately 100 sites and 150 end-points have been implemented. An additional 90 end-points are scheduled for implementation in 2004.
CONCLUSIONS: An innovative, team based, collaborative approach combined with a detailed implementation plan as well as timely communication and engagement of the community is critical to the implementation process. While the methodology forms the basis for the implementation process, each new end-point requires the thoughtful consideration of the team in order to customize the process for the unique requirements that the setting demands.

P22

SAVETIME: SUCCESSFUL EMERGENCY SERVICES

Nijssen-Jordan C, Curry G, Watson T, Traboulsi D, MacLead B, Conroy S, McCulloch K, Gao M, McCarthy M. Calgary Health Region, Calgary, AB.

OBJECTIVE: The Southern Alberta Access to Vital E-Services Telehealth Initiative for Medical Emergencies (**SAVETIME**) provides emergent and urgent advice and support between emergency physicians and rural physicians. Phase I of the project is to serve rural sites within the Calgary Health Region.

METHODS INCLUDED:

- Presentations to executive leaders and physicians at both rural and urban sites. STARS Air Ambulance became a partner, becoming first point of contact for rural site referrals.
- Work flow, clinical and technical processes were created to ensure timely, efficient referrals.
- Training methods were developed

RESULTS:

- Training completed for 65 physicians, 65 nurses, 10 STARS staff, 8 health records staff
- 21 consultations (radiology, acute rashes, MI, orthopedics, pediatrics) completed within in first 5 months of project

CRITICAL SUCCESS FACTORS:

- A process and workflow that integrates new technology with current workflow and referral patterns
- Funding for an emergency physician champion
- Support from the Department of Emergency Services executive level
- Communication of successes from one referring site to another
- Technology that is easy to use, visible and accessible
- A change in focus to urgent patients rather than resuscitation patients was required to build skill and confidence in the service
- 24/7 technical support is ideal

NEXT STEPS:

- Explore methods of providing 24/7 technical support
- Continue to develop service to other CHR rural sites
- Move forward with Phase II: interregional consults and stroke services

POSTER PRESENTATIONS SESSION #3
SESSION D'AFFICHES #3
TUESDAY / MARDI : 1030-1200

e-Learning/Benefits for Health Care Workers

Room/Salle : Courville-Montmorency
Moderator / Modératrice : Patricia Huntly

No.	*Abstract Title & Authors / Titre du résumé et auteurs*
P23	**INTEGRATING EDUCATION AND TRAINING FOR COMMUNITY HEALTH SERVICE PROVIDERS VIA A FIRST NATIONS TELEHEALTH NETWORK** Williams D. Regional Telehealth Coordinator, Keewaytinook Okimakanak, Balmertown, ON.
P24	**ONTARIO MEDICAL EDUCATION NETWORK (OMEN) - THE EFFECT OF TECHNOLOGY ON SATISFACTION WITH MULTISITE ROUNDS** Sadovy B[1], Regehr G[2], Byrne N[2]. [1]University Health Network, [2]Wilson Centre for Research in Education, University of Toronto.
P25	**CAN A WEB PORTAL BE AN EFFECTIVE COMMUNICATION TOOL FOR TELEHEALTH COORDINATORS ACROSS CANADA?** Nickoloff A. NORTH Network, Toronto, ON.
P26	**APPLYING EXPERIENTIAL LEARNING TO TELEHEALTH COORDINATOR TRAINING PROGRAMS** Breslow L[1], Nickoloff A[1], Fenton C[2]. [1]NORTH Network, Toronto, ON. [2]NORTH Network, Timmins, ON.
P27	**THE IMPACT OF EHEALTH INFORMATION ON PATIENTS' MEDICATION ADHERENCE, KNOWLEDGE AND ATTITUDES: A RANDOMIZED CONTROLLED TRIAL** Provost M[1], Galen RS[1], DiPiro JT[1,2], Watson R[3], Zinkhan G[4], Martin B[1], Perri III M[1]. [1]Clinical and Administrative Pharmacy, College of Pharmacy. [2]Management Information System, Terry College of Business. [3]Medical College of Georgia. [4]Marketing, Terry College of Business, The University of Georgia, Athens, GA, USA.
P28	**VIRTUAL MEDICAL EDUCATION: AN EXAMINATION OF THE NORTHERN ONTARIO SCHOOL OF MEDICINE'S DISTRIBUTED CLINICAL LEARNING SITE MODEL** Barnett R, Mussico M, McKenzie O, Pashuk K, Rupert H, Zmijowskyj, T. Northern Ontario Medical School, Thunder Bay & Sudbury, ON.
P29	**STRATEGIC ALLIANCES TO PROVIDE CANCER INFORMATION THROUGH WEB-ENABLED KIOSKS IN PHARMACIES AND THE WORKPLACE** Galen RS[1], Springston J[2], Hill M[4], Sandmann L[3], Kiley R[3], Provost M[1]. [1]College of Pharmacy, [2]Grady College of Journalism (Advertising and Public Relations), [3]College of Education, The University of Georgia, Athens, GA, USA. [4]East Georgia Cancer Network, Atlanta, GA, USA.
P30	**REMOTE ACCESS TO EDUCATION AND SUPPORTS FOR HEALTH CARE PROVIDERS: A MANITOBA FIRST NATIONS DEMONSTRATION** Larsen L[1], Stevens E[2]. [1]Saint Elizabeth Health Care, Markham, ON. [2]First Nations and Inuit Health Branch, Manitoba Region, Winnipeg, MB.
P31	**TRANS-ATLANTIC TECHNOLOGY-ENABLED CONTINUING MEDICAL EDUCATION FOR GERMAN AND CANADIAN PHYSICIANS: COMPARING AND CONTRASTING LEARNING STYLES AND KNOWLEDGE UPTAKE** Ho K[1], Griebenow R, Jarvis-Selinger S[1], Lehmacher W, Stosch C, Novak Lauscher H[1], Fedeles M[1], Bluman R[1]. [1]Continuing Medical Education, University of British Columbia, Vancouver, BC. [2]University of Cologne, Cologne, Germany
P32	**INTEGRATING THREE LEVELS OF EDUCATION SERVICES: TECHNOLOGY, PEOPLE AND PROGRAMS ACTIVITIES** Chimenti B, Lundstrom T, Berry S. Health Sciences North, Thunder Bay, ON.

P23

INTEGRATING EDUCATION AND TRAINING FOR COMMUNITY HEALTH SERVICE PROVIDERS VIA A FIRST NATIONS TELEHEALTH NETWORK

Williams D. Regional Telehealth Coordinator, Keewaytinook Okimakanak, Balmertown, ON.

INTRODUCTION: Distance, time, costs and lack of relevant professional development workshops are currently obstacles to capacity building for healthcare workers living in Northwestern Ontario's remote First Nation communities. These health care workers are often the front line health support within the communities and are responsible for providing both primary health care and illness prevention strategies within the communities. One of the roles of Keewaytinook Okimakanak (KO) Telehealth has been to facilitate the training and professional development of First Nations health care workers via Telehealth to increase access to health information and peer support.
DESCRIPTION: KO Telehealth has offered education specific for First Nations health workers by partnering with Aboriginal organizations mandated to provide education and support. Some of these organizations include the Sioux Lookout Diabetes Program, the Northern Education Centre for Aging and Health, Alzheimer's society, and Nodin Mental Health Services. These organizations host education sessions specific for FN health care providers within the Sioux Lookout Health Zone of Health Canada.
RESULTS: KO Telehealth has been able to provide education specific to Health care workers such as Diabetes workers, Home and Community Care Coordinators, Personal Support Workers, Crisis Team Coordinators, Mental Health Workers, and Drug and Alcohol workers. Education targeting health care workers is well received, well attended and well evaluated. KO Telehealth is currently in the process of evaluating impacts on the health status of the target population.
CONCLUSIONS: Telehealth is an economically viable and effective way to support health care workers in First Nations communities.

P24

ONTARIO MEDICAL EDUCATION NETWORK (OMEN) - THE EFFECT OF TECHNOLOGY ON SATISFACTION WITH MULTISITE ROUNDS

Sadovy B[1], Regehr G[2], Byrne N[2]. [1]University Health Network, [2]Wilson Centre for Research in Education, University of Toronto.

PURPOSE: Analysis of a three-year participant evaluation of the OMEN Education Grand Rounds was done to determine whether the potential technological barriers associated with the videoconferencing technology are disappearing and what factors of the multipoint rounds affect participants' satisfaction. OMEN consists of six (6) Ontario Medical Schools. Education Grand Rounds are conducted on a monthly basis from September until June and discuss issues and developments in the area of medical education.
METHODS: We performed statistical analysis of 423 evaluations of the OMEN Education Grand Rounds for the period 2001-2004 and examined factors that affect participants' satisfaction with the rounds.
RESULTS: Ratings of the overall quality of the rounds were highly correlated with the content issues (r=.74) but not with the technology issues (r=.24) suggesting that the quality of technology was not affecting overall participants satisfaction with the rounds.
However, the quality of the presentation itself was rated more highly by face-to-face audience (e.g. content and presenter quality means=4.6 and discussion mean=4.3) than the remote audience (e.g. content and presenter quality means=4.1 and discussion mean=3.8) although ratings of the interest in the topic itself were not (face-to-face and remote audience means=4.4). This suggests that technology may in fact be playing some role in the overall satisfaction with the videoconferencing.
CONCLUSIONS: While there were no explicit complaints about the technology, it may nonetheless be having subtle effect on the satisfaction with the rounds and this possibility requires further exploration.

P25

CAN A WEB PORTAL BE AN EFFECTIVE COMMUNICATION TOOL FOR TELEHEALTH COORDINATORS ACROSS CANADA?

Nickoloff A. NORTH Network, Toronto, ON.

INTRODUCTION: Over the past few years, telehealth coordinators across Canada have identified a desire to collaborate with each other about operational and clinical issues. However, an inability to exchange information in a timely fashion and a lack of opportunity to network on a regular basis were identified barriers to collaboration. NORTH Network, in conjunction with the Telemedicine Networks of Ontario, recently developed a web site portal to facilitate communication among Ontario telemedicine sites. Recognizing the value gained from sharing national experiences, NORTH Network offered to provide the Canadian coordinators with a similar 'virtual' place to work together.
DESCRIPTION: A portal was developed to allow information to be shared among Leadership Council and General members of the Canadian Society of Telehealth National Telehealth Coordinator Special Interest Group (NTC-SIG). The portal hosts both a document repository that allows users to share documents and a discussion forum to facilitate discussions.
RESULTS: This presentation will provide a detailed analysis of portal usage over the first year. Preliminary results from October 2003 to June 2004 show Leadership members started 21 discussion threads which generated 39 replies in total. Twenty-nine documents were posted, 70% which were for administrative purposes such as meeting minutes and workshop reports. General members started 2 discussions and posted 1 document.
CONCLUSION: The portal has not yet been utilized by General membership. Repeated marketing, promotion and education about the features and functionality are required. Feedback from users and recommendations for increasing utilization by the general membership in the future will be presented.

P26

APPLYING EXPERIENTIAL LEARNING TO TELEHEALTH COORDINATOR TRAINING PROGRAMS

Breslow L[1], Nickoloff A[1], Fenton C[2]. [1]NORTH Network, Toronto, ON. [2]NORTH Network, Timmins, ON.

INTRODUCTION: One of the key success factors of NORTH Network is the presence of Telehealth Coordinators at each member site who are well trained with the knowledge and skills required to facilitate effective patient consultations. Until recently, much of the training consisted of a few experienced Coordinators sharing lessons learned in a didactic manner followed by a short practicum component. While the participants expressed gratefulness for the information learned, the trainers wanted to change teaching methods to increase learner participation by engaging different learning styles.
DESCRIPTION: A mind mapping exercise was conducted to answer the specific question "What is the role of a Telehealth Coordinator in a clinical consultation?" This exercise discerned common themes in their responsibilities before, during and after consultations such as network policies, participant orientation, paperwork requirements, and patient facilitation. By grouping concepts and ideas, 7 learning objectives were identified.
RESULTS: A 3-hour training module employing various learning methods was designed. Methods of learning include round robin discussions, fill in the blank questionnaires, video exercises, and consultation role-play. Collection of participant feedback and observation checklists was incorporated into the evaluation process for the training. Current plans are to deploy the module in summer of 2004.
CONCLUSION: Applying adult learning concepts organized NORTH Network's Telehealth Coordinator training program into a learner centered module that will be sustainable for years to come. Blending current adult education techniques with experienced Coordinators allows training to be innovative, interactive and enjoyable while never overlooking the reason behind it: Facilitating effective patient consultations.

P27

THE IMPACT OF EHEALTH INFORMATION ON PATIENTS' MEDICATION ADHERENCE, KNOWLEDGE AND ATTITUDES: A RANDOMIZED CONTROLLED TRIAL

Provost M[1], Galen RS[1], DiPiro JT[1,2], Watson R[3], Zinkhan G[4], Martin B [1], Perri III M[1]. [1]Clinical and Administrative Pharmacy, College of Pharmacy. [2]Management Information System, Terry College of Business. [3]Medical College of Georgia. [4]Marketing, Terry College of Business, The University of Georgia, Athens, GA, USA.

PURPOSE: To evaluate the impact of Web health information (WHI) on medication adherence, disease knowledge and the patient-pharmacist relationship.
METHODS: A randomized controlled trial was conducted with patients recruited from pharmacies, a cardian rehabilitation and adult Fitness Center, a senior group and a large multinational corporate headquarters. Eligible participants had Internet access and were taking prescribed medications for the treatment of high cholesterol, hypertension and/or diabetes. The intervention group was encouraged to visit the WHI portal 4 times. The portal linked to health information sources and tracked usage by participants over 2-month period. Internet-based surveys assessed several measures including medication adherence, disease knowledge, self-efficacy, and WHI use.
RESULTS: 81 patients (38 Intervention; 43 Control) aged 32-87 years (Mean 56 yrs, SD 14.1) consented and returned the baseline questionnaire. At baseline, 70% of patients had used the Web to seek health information. The majority (57%) did not seek WHI often, prior to the study. Participants in the intervention group made a total of 184 web visits including trips to 353 linked pages. Each participant spent on average 3.0 min (SD 5.0) per page. Results indicate that web-based information may serve as a useful complement to other information sources. Specifically, we predict that the intervention group has more knowledge and greater levels of medication adherence (as compared to the control group).
CONCLUSION: Integrating the use of WHI in clinical practice may benefit patients taking chronic prescribed medications. Nonetheless, there exist great challenges as to convince patients to self-educate using reliable WHI.

P28

VIRTUAL MEDICAL EDUCATION: AN EXAMINATION OF THE NORTHERN ONTARIO SCHOOL OF MEDICINE'S DISTRIBUTED CLINICAL LEARNING SITE MODEL

Barnett R, Mussico M, McKenzie O, Pashuk K, Rupert H, Zmijowskyj, T. Northern Ontario Medical School, Thunder Bay & Sudbury, ON.

INTRODUCTION: The mission and values of the Northern Ontario School of Medicine include the improvement of health across the entirety of Northern Ontario. This will be accomplished through an innovative distributed education model incorporating a *minimum* of seventy (70) distributed sites throughout rural, remote, and urban communities connected via virtual learning technology.
DESCRIPTION: This distributed learning model will facilitate both the responsiveness of the undergraduate curriculum to the changing health needs of communities, and the education of students in the processes of assessing and addressing health issues specific to individual communities.
RESULTS: This project is in its early stages. Preliminary findings and challenges will be shared.
CONCLUSIONS: This proposed distributed learning site model will provide an experience of immersion for medical students in a multiplicity of environments as defined by geography, rurality, cultural diversity, and determinant of health status; while maintaining a standard curriculum delivery vehicle via telecommunications technology and portable information products. The process of developing the learning site network is described, including the methods used to create educational partnerships within communities, and the technology and applications to be used in the provision of the curriculum.

P29

STRATEGIC ALLIANCES TO PROVIDE CANCER INFORMATION THROUGH WEB-ENABLED KIOSKS IN PHARMACIES AND THE WORKPLACE

Galen RS [1], Springston J [2], Hill M [4], Sandmann L [3], Kiley R [3], Provost M [1]. [1]College of Pharmacy, [2]Grady College of Journalism (Advertising and Public Relations), [3]College of Education, The University of Georgia, Athens, GA, USA. [4]East Georgia Cancer Network, Atlanta, GA, USA.

INTRODUCTION: The number of patients developing cancer will double in the next 50 years (North American Association of Central Cancer Registries). The Georgia Cancer Coalition has funded intervention programs aimed at providing the community pharmacists with the knowledge and skills to establish active cancer prevention in pharmacy. Despite the large amount of health information available on the Internet, patients may not know where to go when diagnosed with cancer. Cancer awareness and information can increase early cancer detection and increase adoption of preventive measures.
DESCRIPTION: Partnerships between groups of researchers and clinicians allowed development of a cancer information portal and integration of web-kiosks in the community to increase cancer awareness, cancer education and prevention among patients and pharmacists.
RESULTS: A multidisciplinary team was created to increase the chance of success and sustainability of the project. The College of Journalism developed the kiosk attract-sequences, the advertising campaign, and designed the Web portal. The College of Pharmacy developed a Community Pharmacist Certification course, developed content for the portal and the evaluation. The College of Education developed the evaluation program to study the kiosk effectiveness and other outcomes. Critical challenges exist in engaging clinical community partners and academicians. Community pharmacists are often not involved in outcomes evaluation studies while academicians may not translate research into practice. The launch of the program in pharmacies is targeted for November 2004.
CONCLUSION: Collaborations between national cancer associations, academic researchers from several departments as well as community pharmacists helped the provision of Web cancer information via web-enabled kiosks.

P30

REMOTE ACCESS TO EDUCATION AND SUPPORTS FOR HEALTH CARE PROVIDERS: A MANITOBA FIRST NATIONS DEMONSTRATION

Larsen L [1], Stevens E [2]. [1]Saint Elizabeth Health Care, Markham, ON. [2]First Nations and Inuit Health Branch, Manitoba Region, Winnipeg, MB.

INTRODUCTION: A project involving approximately 35 Manitoba First Nations communities and Tribal Councils; First Nations and Inuit Health Branch, Manitoba Region; and Saint Elizabeth Health Care is demonstrating the value of remote, dynamic access to knowledge and health human resources.
DESCRIPTION: This project uses a web-based learning, collaboration and communication application to promote local capacity building and support health providers and program management. A train-the-trainer concept, designed to create local 'champions', and self-training tools are combined with implementation meetings to tailor the uptake to specific needs, readiness and structures of each participating organization.
Dr. Lynda Atack is leading a comprehensive evaluation process which includes a range of indicators: knowledge uptake, including computer skills and comfort as well as educational content; costs; user satisfaction; changes in practice; access to specialists; and barriers and enablers affecting use and access of remote education and support. Data collection concludes July 9. A separate business case forms part of the final report.
RESULTS: The evaluation is not yet complete; however, it is evident that the value of the application during this demonstration appears clear. Innovative solutions are creatively overcoming various barriers. The focus now is on sustainability and achieving greater benefit from the application through links to prior learning assessments and certification.
CONCLUSION: Lessons learned and the best practices that emerge will serve as a tool for future e-learning and remote access initiatives, and support these communities as they move forward with more fully integrating e-learning and e-collaboration into their operations and practice.

P31

TRANS-ATLANTIC TECHNOLOGY-ENABLED CONTINUING MEDICAL EDUCATION FOR GERMAN AND CANADIAN PHYSICIANS: COMPARING AND CONTRASTING LEARNING STYLES AND KNOWLEDGE UPTAKE

Ho K[1], Griebenow R, Jarvis-Selinger S[1], Lehmacher W, Stosch C, Novak Lauscher H[1], Fedeles M[1], Bluman R[1]. [1]Continuing Medical Education, University of British Columbia, Vancouver, BC. [2]University of Cologne, Cologne, Germany

PURPOSE: This project investigated knowledge translation for Canadian and German physicians based on collaboration in the design, delivery, and evaluation of a continuing medical education strategy combining videoconferencing, Internet, and media-rich CD-ROM applications.
METHODS: German and Canadian physicians attended a three-hour case-based videoconference workshop to discuss with cardiologists the latest treatments in hypertension and cardio protection in diabetics. They completed a needs assessment prior to the workshop and a reflection survey following CD-ROM/Internet interactions. Participating physicians had two weeks to use CD-ROM/Internet medical resources and interact on-line to discuss patient management issues. Focus group sessions were held to obtain "live feedback" on issues of change in practice and to compare clinical and cultural contexts.
RESULTS: Videoconferencing was effective at bridging distance, allowing for immediate discussion, and permitting good group interactions; however, a lack of informal one-on-one exchange (i.e., after the formal workshop) with international colleagues was noted. Combining face-to-face and technology-enabled interaction fostered reflection and learning related to different health care systems. Despite consensus to medicate, implementation varied because of differing medical practice patterns and responsibilities of drug costs.
CONCLUSIONS: By exploring distinct groups, this study identified socio-cultural, political, practical, and health system differences that influence knowledge uptake and translation. Identification of these differences contributed to physician self-reflection on practice patterns and potential adaptations. Results indicate that a coupling of videoconferencing, web resources, and asynchronous interaction can be effective in creating an intimate environment of learning and exchange between two groups of geographically separated physicians.

P32

INTEGRATING THREE LEVELS OF EDUCATION SERVICES: TECHNOLOGY, PEOPLE AND PROGRAMS ACTIVITIES

Chimenti B, Lundstrom T, Berry S. Health Sciences North, Thunder Bay, ON.

INTRODUCTION: Conditions of great distance and costs have restricted access to continuing professional development for health care practitioners in Northwestern Ontario.
Now that each community has videoconference technology and are connected through a common network, health care professional education has become more convenient and less restricted.
DESCRIPTION: With videoconference connectivity in place across the region, health care educators are now working together to develop a virtual learning model that is assisting practitioners to learn both interdependently and independently while sharing the regional resources and technology
The three levels to this model consist of identifying learning activities that aid health care practitioners to guide their personal learning journey; roles and services that facilitate learner participation; and the most appropriate technology to effectively deliver specific learning requirements of the model.
RESULTS: Using this proposed educational model, staff educators can deliberately plan specific learning activities and share resources that will benefit practitioners throughout the region. Administrators can compare the impact of education on clinical practice. Learners can effectively plan their continuing professional development for expected clinical outcomes.
CONCLUSION: The virtual learning process being implemented in Northwestern Ontario is one example of a successful collaborative educational project that is providing a variety of learning activities to health care practitioners in this region.

POSTER PRESENTATIONS SESSION #4
SESSION D'AFFICHES #4
TUESDAY / MARDI : 1030-1200

Home Care/Technology/Policy/Integration

Room/Salle : Beauport
Moderator / Modérateur : Rénald Lemieux

No.	*Abstract Title & Authors / Titre du résumé et auteurs*
P33	**EXPÉRIENCE DE SUIVI CLINIQUE INTELLIGENT À DISTANCE EN GROSSESSE À RISQUE AU CENTRE HOSPITALIER ANNA-LABERGE** Denis S, Collette S. Centre hospitalier Anna-Laberge, Châteauguay, QC.
P34	**TELEHEALTH SOLUTIONS: IMPROVED CONTINUUM OF CARE AND QUALITY OF LIFE FOR PATIENTS REQUIRING VENTILATORY ASSISTANCE IN THE HOME.** Troini R. National Program for Home Venilatory Assistance, McGill University Health Centre, Montreal, QC.
P35	**TELEHOME CARE: A NEW MODEL FOR DELIVERY OF CARE** Sherrard H, Struthers C. University of Ottawa Heart Institute, Ottawa, ON.
P36	**L'ÉTAT DE LA SITUATION EN COMPRESSION D'IMAGES VIDÉO POUR LA TÉLÉSANTÉ** Beaudoin JJ[1], Tardif PM[2]. [1]Université Laval, Québec, QC. [2]Logibec Groupe Informatique Ltée, Montréal, QC.
P37	**POLICY AND RESEARCH IMPLICATIONS FOR TELEHEALTH: RESULTS OF CHIPP** Chatterton S. Office of Health and the Information Highway, Health Canada.
P38	**PHASE II REPORT TELE-ONCOLOGY PROGRAM: BRIDGING DISTANCE IN THE DELIVERY OF CANCER SERVICES WITHIN NEWFOUNDLAND AND LABRADOR** House AM[1], Dwyer P[2], Pippy S[3]. [1]Professor Emeritus and Honorary Research Professor, Memorial University of Newfoundland. [2]Telehealth and Educational Technology Resource Agency, Faculty of Medicine, Memorial University of Newfoundland. [3]Research Associate, Newfoundland Cancer Treatment Research Foundation, Dr. H. Bliss Murphy Cancer Centre.
P39	**THE IMPORTANCE OF COMMUNITY BASED NEEDS ASSESSMENT: LESSONS LEARNED IN THE DEVELOPMENT OF A SUSTAINABLE TELEHEALTH SYSTEM** Garden H[1], Truran H[2]. [1]Telehealth, Provincial Health Services Authority, BC. [2]Telehealth, Northern Health Services Authority, BC.
P40	**INTEGRATING TELEHEALTH INTO CLINICAL PROGRAMS – A PROGRAM EVALUATION FROM ALBERTA** Gebran J. Alberta Health & Wellness, Edmonton, AB.
P41	**LA TELEREADAPTATION, UN SUPPORT UTILE ET EFFICACE POUR LA PRESTATION DE SERVICES D'AIDES TECHNIQUES AUPRES DE LA CLIENTELE EN DEFICIENCE PHYSIQUE.** Corbeil J. Centre de réadaptation Lucie-Bruneau, Montréal, QC.

P33

EXPÉRIENCE DE SUIVI CLINIQUE INTELLIGENT À DISTANCE EN GROSSESSE À RISQUE AU CENTRE HOSPITALIER ANNA-LABERGE

Denis S, Collette S. Centre hospitalier Anna-Laberge, Châteauguay, QC.

INTRODUCTION : Avant l'émergence de la technologie SCIAD, l'infirmière de la clinique de périnatalité du CHAL assurait le suivi de sa clientèle diabétique et hypertendue en prenant les résultats de glycémies et de pression lors d'appels téléphoniques hebdomadaires. Le temps consacré à ces appels ainsi qu'à la gestion de ces pathologies occupaient une place importante du temps infirmier devenu nécessaire pour d'autres types de services à dispenser à de nouvelles clientèles.
DESCRIPTION : Le programme SCIAD proposé au cours de l'hivers 2000, offrait la possibilité de créer un lien direct et constant entre l'infirmière du centre hospitalier et la patiente à son domicile en plus de gérer l'information clinique transmise de façon intelligente et automatisée. Dans ce nouveau mode de suivi, la collecte des données est plus régulière et complète car le système questionne la patiente au moment opportun et s'adapte aux résultats obtenus pour requérir des renseignements supplémentaires au besoin. L'infirmière bénéficie ainsi de plus de données pour réagir rapidement en ciblant l'intervention la plus adéquate pour sa cliente.
RESULTATS : Après quatre années de fonctionnement, 420 patientes ont bénéficiées de ce type de suivi à la clinique de périnatalité. De plus, les données électroniques de ces patientes sont maintenant partagées entre l'infirmière de la clinique, 3 médecins et une diététiste où chacun intervient selon son expertise.
CONCLUSION : La technologie SCIAD est un outil complémentaire crucial à la pratique professionnelle actuelle. Elle permet la détection rapide des écarts et l'intervention précoce pour le bien-être des patientes et de leur bébé.

P34

TELEHEALTH SOLUTIONS: IMPROVED CONTINUUM OF CARE AND QUALITY OF LIFE FOR PATIENTS REQUIRING VENTILATORY ASSISTANCE IN THE HOME.

Troini R. National Program for Home Venilatory Assistance, McGill University Health Centre, Montreal, QC.

INTRODUCTION: To present the results of an organizational analysis and the impact of telehealth solutions.
DESCRIPTION: Patient/family satisfaction surveys and other quality indicators were analyzed for the key organizational elements contributing to the success of a program providing homecare services to patients in both urban and rural regions of Quebec. Costs of these services were also analyzed.
RESULTS: Three key elements were identified: 1) Teaching/training provided to the patient/family and community care workers; 2) Regular home visits; 3) Regular exchange of information between the program's clinical specialists and the community health care workers providing care to the patient in their region. The cost of these services was higher for patients in outlying regions.
Research of existing and potential telehealth technology applications rendered the following possible solutions for the 3 elements identified above. 1) Videoconferencing; 2) Televisits; 3) Teleconsultations by clinical specialists directly into the patients home through the use of an architectural platform developed specifically for this program. These potential telehealth solutions would reduce the cost of these services for patients in outlying regions.
CONCLUSIONS: The integration of telehealth solutions to the existing service delivery model of this McGill University Health Centre based program would greatly improve the overall organizational costs as well as continuity of care and the quality of life of this patient population.

P35

TELEHOME CARE: A NEW MODEL FOR DELIVERY OF CARE

Sherrard H, Struthers C. University of Ottawa Heart Institute, Ottawa, ON.

INTRODUCTION: Telehome care is a new delivery model featuring a home monitoring system that uses regular POTS lines to transmit data from peripheral devices such as ECG, weight, and vital signs based on patient need.
DESCRIPTION: Results from a randomized control trial completed in 2003 provided valuable information on integrating this technology into usual patient care. Based on this study, referral criteria have been established for groups of patients to ensure efficient use of the technology. Protocols and medical directives have been validated for patients with angina and heart failure. The development of an electronic health record (EHR) with clinical parameter flags for each patient have been developed. A home monitoring education program has been completed.
RESULTS: This new model for delivery of care has been fully integrated into clinical services to improve cardiac patient care by providing access to specialized care after discharge. The staffing ratio depending on the case mix is 1 RN/30 patients and the cost of the monitoring units is ~10,000. A fully deployed model for telehome care can include health applications, patient information services and management applications such as EHR.
CONCLUSION: Telehome care is a cost effective delivery model. It promotes the integration of primary and specialist care, improves access to remote areas and ultimately improves patient care.

P36

L'ÉTAT DE LA SITUATION EN COMPRESSION D'IMAGES VIDÉO POUR LA TÉLÉSANTÉ

Beaudoin JJ[1], Tardif PM[2]. [1]Université Laval, Québec, QC. [2]Logibec Groupe Informatique Ltée, Montréal, QC.

BUT : Étudier l'applicabilité des principales normes de compression vidéo aux différents besoins de la télésanté.
METHODES : Nous présentons un résumé des principales normes de compression vidéo (MPEG-1, MPEG-2, MPEG-4, H.261, H.263 et H.264) et les différents critères qui peuvent être utilisés pour juger de la qualité de l'image, ainsi que leur importance relative.
RESULTAT : La quantité de données que représente une séquence vidéo numérique brute est telle que sa transmission directe, sans autre forme de traitement, serait très peu efficace et extrêmement exigeante en terme de largeur de bande. L'utilisation d'une compression d'image vidéo adéquate permet d'éliminer la redondance et d'obtenir une représentation plus compacte. Les besoins de la télésanté sont nombreux et varient d'une application à une autre. Lorsque la qualité est primordiale, la compression sans perte permet de reconstituer parfaitement l'image originale. Elle est cependant peu efficace et il est préférable d'utiliser les techniques de compression avec perte, qui suppriment les informations les moins significatives de l'image. Ces informations deviennent alors irrécupérables et la compression est accompagnée d'une diminution plus ou moins importante de la qualité de l'image reconstruite. La compression avec perte peut être réalisée par une variété de méthodes, en combinant plusieurs techniques exploitant les caractéristiques spatiales et temporelles de la séquence vidéo. Par ailleurs, l'utilisation de la vidéo sur des réseaux sans fil amène des contraintes sur les algorithmes qui doivent être utilisés.
CONCLUSION : Les derniers développements au niveau de la recherche en compression vidéo promettent un support de qualité aux efforts déployés en télémédecine.

P37

POLICY AND RESEARCH IMPLICATIONS FOR TELEHEALTH: RESULTS OF CHIPP

Chatterton S. Office of Health and the Information Highway, Health Canada.

PURPOSE: From the viewpoint of CHIPP funded projects, present what has been identified as policy and research implications for telehealth.
METHODOLOGY: The Canada Health Infostructure Partnerships Program (CHIPP) was implemented in the Spring of 2000 as a one time only, cost-shared program in support of large implementation model projects in strategic areas of telehealth and electronic health records. Among CHIPP's objectives was to accelerate ICT-enabled health care delivery renewal across Canada, and ultimately improve the accessibility and quality of health care for Canadians. All 29 projects were required to provide final reports in evaluation, and project objectives met. In preparing their final reports, projects were asked to consider both the policy and the research implications of their work, and identify next steps.
RESULTS: This presentation focuses on the main recommendations made by the telehealth projects. Subjects include education and training, community readiness, integration, and licensure and reimbursement.

P38

PHASE II REPORT TELE-ONCOLOGY PROGRAM: BRIDGING DISTANCE IN THE DELIVERY OF CANCER SERVICES WITHIN NEWFOUNDLAND AND LABRADOR

House AM[1], Dwyer P[2], Pippy S[3]. [1]Professor Emeritus and Honorary Research Professor, Memorial University of Newfoundland. [2]Telehealth and Educational Technology Resource Agency, Faculty of Medicine, Memorial University of Newfoundland. [3]Research Associate, Newfoundland Cancer Treatment Research Foundation, Dr. H. Bliss Murphy Cancer Centre.

PURPOSE: NCTRF and TETRA propose a Tele-oncology Program to diffuse and enhance province-wide cancer treatment, support, management and educational services.
Phase II Needs Assessment Report: involved those with knowledge of cancer services and supports, to understand the opinions and interests of those potentially affected by the proposal, and to identify the potential direct and indirect effects of the program.
METHODOLOGY: Literature Review; Review of other cancer centres and programs; regional assessments; Key Information Interviews (KII); Focus Groups
April to December 2003 regional assessments were conducted with 130 participants culminating in the Phase II Final Report.
FINDINGS: Gaps in the provision of cancer services to people in rural areas of the province were identified. Policies and guidelines are required to facilitate telehealth integration. The perception that more could and should be done to support people with cancer, families and the health care professionals who deliver support, were issues urban and regional groups emphasized.
Major recommendations for Tele-Oncology are to: Enhance access to clinical and support services; reduce travel costs; enhance education and knowledge for cancer care teams in the regions; validate a model that could be utilized in other primary health care areas.
CONCLUSION: The Tele-Oncology program would address patient and provider need for: consultation, education and peer support; professional development; coordination and integration of new services with existing services; the transmission of information across traditional and regional boundaries; and assist the NCTRF in its provincial efforts to deliver services and support healthcare providers, people with cancer, and their families "closer to home".

P39

THE IMPORTANCE OF COMMUNITY BASED NEEDS ASSESSMENT: LESSONS LEARNED IN THE DEVELOPMENT OF A SUSTAINABLE TELEHEALTH SYSTEM

Garden H[1], Truran H[2]. [1]Telehealth, Provincial Health Services Authority, BC. [2]Telehealth, Northern Health Services Authority, BC.

PURPOSE: To discuss the process developed and utilized to integrate and create sustainable telehealth services in northern British Columbia from a system that was initially implemented through a central project model.
METHODS: The Northern Health Services Authority (NHA) engaged the Provincial Health Services Authority in a partnership to support development of a clinical needs assessment framework that is being applied to identify and prioritize the clinical needs of communities and regional programs that can be met through use of telehealth technology.
RESULTS: The post-project needs assessment uncovered a significant variation in requirements and potential for utilizing telehealth between communities due to differences in population demographics, local configuration of services, geography and local leadership. Many of these differences were not recognized in the earlier implementation of project based applications, thus some services were not integrated or sustained. Use of the technology continues to vary substantially between communities that received equipment through project funding. The needs assessment has demonstrated the requirements for aligning future telehealth development with clinical service redesign and planning within the NHA.
CONCLUSION: A comprehensive community based needs assessment should be accomplished prior to the start of any telehealth service implementation. Identification of sufficient service volume/acuity, local champion and telehealth provider capacity is the foundation for identifying sustainable telehealth requirements. Alignment of telehealth service within the continuum of care and clinical service options is also required.

P40

INTEGRATING TELEHEALTH INTO CLINICAL PROGRAMS – A PROGRAM EVALUATION FROM ALBERTA

Gebran J. Alberta Health & Wellness, Edmonton, AB.

INTRODUCTION: In 2003 Alberta Health and Wellness introduced the Clinical Grant Fund to assist health regions integrate telehealth into clinical programs. Objectives of the Fund include:

- Ensuring that clinical services under development are sustained beyond early phases of implementation;
- Increasing access to clinical telehealth services throughout the province;
- Demonstrating the viability of telehealth in clinical program delivery.

DESCRIPTION: Alberta health regions were invited to submit proposals outlining how telehealth could be incorporated into their clinical programs. Specific emphasis was made on the volume of clinical activity that would be delivered through the proposals.
An expert panel reviewed all proposals with $2.3M allocated to 21 projects. Most of the projects will be have reached substantial completion in fall 2004.
To receive funding, the successful projects were required to deliver the telehealth activity outputs and processes outlined in the proposals. In addition, each project is required to provide plans for integrating and sustaining the telehealth services in the clinical services and completing project evaluation to demonstrate the impact of the project on the clients, care providers, and organizations involved.
RESULTS: In addition to the project evaluations, Alberta Health and Wellness has initiated a program evaluation of the Fund. Preliminary data has shown the program to be successful in establishing sustainable telehealth programs, demonstrating the viability of clinical telehealth applications, and improving access to clinical telehealth services in Alberta.
CONCLUSION: The Fund has been an effective mechanism for encouraging health regions to integrate telehealth as a delivery mechanism for 21 clinical programs. Updated data and analyses will presented.

P41

LA TELEREADAPTATION, UN SUPPORT UTILE ET EFFICACE POUR LA PRESTATION DE SERVICES D'AIDES TECHNIQUES AUPRES DE LA CLIENTELE EN DEFICIENCE PHYSIQUE.

Corbeil J. Centre de réadaptation Lucie-Bruneau, Montréal, QC.

L'expérimentation de cliniques de mobilité en visioconférence (CMV) a permis d'introduire cette nouvelle technologie pour la prestation de services auprès des personnes ayant une déficience physique. Les CMV évitent les nombreux déplacements des intervenants du programme des aides techniques dans les CHSLD de la région de Montréal et ceux de l'Abitibi-Témiscamingue pour évaluer la condition des usagers et recommander les équipements répondant à leurs besoins.

Le projet a permis de confirmer que les résultats des CMV équivalent à ceux obtenus en cliniques de mobilité traditionnelle. Il a révélé qu'elle accélère largement l'accès aux services, facilite le travail des équipes d'intervenants-experts qui n'ont plus à parcourir des centaines de kilomètres pour attribuer une aide technique. Éliminant ainsi les déplacements et les frais qui y sont associés, l'utilisation de la visioconférence représente des avantages économiques et pratiques d'autant plus évidents lorsque l'établissement d'hébergement à desservir est situé à une grande distance du programme des aides techniques.

L'expérimentation a permis de mettre en valeur l'ouverture des intervenants, facteur qui a pris une place centrale dans le succès de l'introduction de la visioconférence. Dans un tel contexte d'innovation où la pratique professionnelle et l'organisation du travail connaissent d'importantes transformations, on observe effectivement que le développement et le maintien de cette nouvelle approche reposent grandement sur leur capacité d'adaptation et sur leurs initiatives personnelles.

FOCUS SESSION #3

Tuesday Morning: 1030-1200

Telehealth in Developing Countries

Room

Moderator: Dr. Richard E. Scott, Associate Professor, Health Telematics Unit, University of Calgary

Porte du Palais

Dr. Richard Scott for ***Dr. Richard Wootton***, Centre for Online Health
Dr. Oryema Johnson, Director, Africa Telehealth Project
Dr. Maurice Mars, Deputy Dean, Professor and Head of Telehealth, Nelson R Mandela School of Medicine, South Africa
Mengistu Kifle, Graduate Student, Sweden

SESSION DE MISE AU POINT #3

Mardi matin: 1030-1200

Telehealth in developing countries

Room

Modérateur : Dr. Richard E. Scott, Associate Professor, Health Telematics Unit, University of Calgary

Porte du Palais

Dr Richard Scott pour ***Dr Richard Wootton***, Centre for Online Health
Dr Oryema Johnson, Director, Africa Telehealth Project
Dr Maurice Mars, Deputy Dean, Professor and Head of Telehealth, Nelson R Mandela School of Medicine, South Africa
Mengistu Kifle, Graduate Student, Sweden

TUESDAY AFTERNOON
MARDI P.M.

TUESDAY AFTERNOON PLENARY SESSION

Time	Session	Room
1330-1345	**CST President's Address**	Porte du Palais
1345-1500	**Plenary session #3** **Deciders/Organization/Industry Perspectives** Moderator: Madeleine Poulin	Porte du Palais
1345-1400	Presentation #1 **Les orientations ministérielles en télésanté** ***Dr. Michel Bureau***, directeur général de la Direction Générale des Services de Santé et Médecine Universitaire (DGSSMU)	
1400-1415	Presentation #2 **Benefits of Technology Assessment as a Guidance Tool for Telehealth Implementation** ***Dr. Véronique Déry***, directeur général et scientifique - AÉTMIS contribution to telehealth	
1415-1430	Présentation #3 **Implementation of Telehealth on the Ontario Smart Systems for Health Agency Infrastructure** ***Linda Weaver***, Chief Technology Officer, Smart Systems for Health Agency	
1430-1445	Presentation #4 **Participation of the Private Sector in the Implementation of Telehomecare Networking** ***John Schneider***, Director of Engineering, Neptec Inc.	
1445-1500	**Panel discussion period**	
1500-1515	Nutrition Break	Foyer/Porte St-Louis-Kent
1515-1630	**Special Program: Infoway Orientations** **Canadian Vision of Telehealth** Moderator: Madeleine Poulin ***Richard Alvarez***, President and Chief Executive Officer, Canada Health Infoway	Porte du Palais
1630-1700	**Closing Ceremonies** Moderator: Madeleine Poulin **Presentation of Awards for Podium and Poster Presentations** **Closing Address** ***Dr. Jean-Paul Fortin***, Chair, Conference Organizing Committee	Porte du Palais

SESSION PLÉNIÈRE MARDI P.M.

Heure	Session	Salle
1330-1345	**CST President's Address**	Porte du Palais
1345-1500	**Session plénière #3** **Décideurs/Organisation/Perspectives de l'industrie** Animation : Madeleine Poulin	Porte du Palais
1345-1400	Présentation #1 **Les orientations ministérielles en télésanté** ***Dr Michel Bureau***, directeur general de la Direction Générale des Services de Santé et Médecine Universitaire (DGSSMU)	
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1430-1445	Présentation #4 **Participation of the Private Sector in the Implementation of Telehomecare Networking** ***John Schneider***, Director of Engineering, Neptec Inc.	
1445-1500	**Discussion en plénière**	
1500-1515	Pause santé	Foyer/Porte St-Louis-Kent
1515-1630	**Programme spécial : Infoway Orientations** **Canadian Vision of Telehealth** Animation: Madeleine Poulin ***Richard Alvarez***, Président et chef de la direction, Inforoute Santé Canada	Porte du Palais
1630-1700	**Cérémonie de clôture** Animation : Madeleine Poulin **Prix de récompense pour les sessions parallèles et les affiches** **Allocution de fermeture du colloque** ***Dr Jean-Paul Fortin***, Président, Comité local de planification	Porte du Palais

Integrating Telehealth: Challenges and Solutions
L'intégration de la télésanté: enjeux et solutions
Hilton Hotel Québec,
October 3-5, 2004

RQT

CONFERENCE EVALUATION FORM

☐ Government ☐ Physician ☐ Private Consultant ☐ Graduate Student

☐ Academic ☐ Nurse ☐ Industry ☐ Clinician

☐ Telehealth Coordinator ☐ Other (Please specify) _____

Are you a member of the Canadian Society of Telehealth? ☐ **YES** ☐ **NO**

Please circle the number that best reflects your assessment of each of the following aspects:

	1 = Poor	2 = Fair	3 = Good	4 = Very Good	5 = Excellent
1. **CONTENT:** Relevance to my job, compatibility with my expectations	1	2	3	4	5
2. **FORMAT:** Mix of plenary, panel, concurrent, poster, breakfast roundtable sessions, audience size	1	2	3	4	5
3. **WEBSITE:** usefulness, navigation	1	2	3	4	5
4. **PERCEIVED LEARNING:** How would you rate the amount you have learned in this conference compared to similar conferences?	1	2	3	4	5
5. **ORGANIZATION:** Scheduling, registration, flow of events	1	2	3	4	5
6. **OVERALL RATING OF THIS CONFERENCE**	1	2	3	4	5

Comments:

_____

_____

7. **PLEASE RATE THE FOLLOWING CONFERENCE COMPONENTS**

	1 = Poor	2 = Fair	3 = Good	4 = Very Good	5 = Excellent
Pre-Conference Workshops	1	2	3	4	5
Keynote Speaker	1	2	3	4	5
Plenary Sessions – Panel Discussions	1	2	3	4	5
Concurrent Sessions	1	2	3	4	5
Breakfast Roundtable Discussions	1	2	3	4	5
Posters	1	2	3	4	5
Exhibits	1	2	3	4	5
ime for Networking and Informal Discussions	1	2	3	4	5

8. What was the *most effective* part of the conference? Indicate why.

9. What was the *least effective* part of this conference? Indicate why.

10. How could this conference have been improved?

11. Please list *Topics* for future conferences as well as possible *Speakers*:

12. Comments on the exhibitors, their displays, product knowledge, samples, etc. and/or suggestions

13. Additional comments or suggestions:

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Please return this to the registration desk at the end of the conference.

The Canadian Society of Telehealth (CST) is the first Canadian non-profit health association devoted to Telehealth. The organization promotes all aspects of telehealth, which is the use of information and communications technologies to deliver health care over large and small distances. The CST is proud to be the acknowledged Canadian leader in multi-disciplinary and inter-sectoral education and discourse in telehealth. Launched in 1998, annual CST conferences have attracted more than 350 delegates each year. Please visit the CST website at www.cst-sct.org for information about the next annual conference.

Membership in the Canadian Society of Telehealth is open to individuals and organizations interested in telehealth. CST members come from a wide variety of backgrounds including clinical providers, program managers, healthcare researchers, students, institutional administrators, health informatics professionals, telehealth service consultants, government, and technology providers. For a list of membership benefits, costs and application forms please visit the CST Website at www.cst-sct.org or contact the CST Secretariat at E-mail: cst@eventsmgt.com.

Vision

Optimal health and healthcare – anyone, anytime, anywhere - enabled by information and communication technology.

Mission

The Canadian Society of Telehealth leads the transformation of health care through information and communication technology by providing a forum for advocacy, communication and sharing of resources among our communities of interest.

Core Values

As we fulfill our Mission and pursue our Vision, we will:

- above all, focus on improvement of the health and health care of individuals and communities
- be respectful of the diverse cultures and environments
- embrace innovation, rigorous evaluation and dissemination of new knowledge
- collaborate in building capacity for utilization of information and communication technology in health care

Benefits of CST Membership

- Networking opportunities to make contact with members from across Canada
- Members' Only website resource materials
- Support to members from a recognized organization
- Access to Special Interest Groups and their educational sessions
- Specialty workshops
- International initiatives and linkages
- Annual conferences
- Enhanced relationships with related organizations
- Access to telehealth standards and references

Contact Us

Canadian Society of Telehealth
www.cst-sct.org
cst@eventsmgt.com
Phone: 613-531-9476
Fax: 613-531-0626

Mailing Address:
4 Cataraqui Street, Suite 310
Kingston Ontario K7K 1Z7
Canada

Société canadienne de télésanté

La Société canadienne de télésanté (SCT) est la première association canadienne de santé à but non lucratif dédiée à la télésanté. Cette organisation fait la promotion de tous les aspects de la télésanté et elle consiste en fait à l'utilisation des technologies de l'information et des communications pour offrir des soins de santé sur de petites ou de grandes distances. La SCT est fière d'être reconnue comme un leader canadien au niveau de l'éducation et du discours multi-disciplinaires et inter-sectoriels en télésanté. Inaugurées en 1998, les conférences annuelles de la SCT attirent plus de 350 délégués. Veuillez visiter le site internet de la SCT à www.cst-sct.org pour plus d'information sur notre prochaine conférence annuelle.

Tout individu ou toute organisation intéressé par la télésanté peut devenir membre de la Société canadienne de télésanté. Les membres de la SCT sont issus d'un large éventail de carrières, y compris des fournisseurs de soins, des gestionnaires de programmes, des chercheurs en santé, des étudiants, des administrateurs d'institutions, des professionnels en informatique de la santé, des consultants en services de télésanté, des fonctionnaires ainsi que des fournisseurs de produits technologiques. Pour obtenir une liste des bénéfices réservés aux membres, des coûts et des formulaires d'inscription, veuillez visiter le site internet de la SCT au www.cst-sct.org ou contacter le Secrétariat de la SCT (courriel : cst@eventsmgt.com)

Vision

Santé et soins de santé optimaux – pour tous, en tout temps, partout – rendus possibles au moyen de la technologie en information et en communication.

Mission

La Société canadienne de télésanté est à l'avant-garde du changement dans le domaine de la santé grâce à la technologie de l'information et des communications en offrant un forum pour la promotion, la communication et le partage des ressources parmi nos communautés d'intérêt.

Valeurs fondamentales

Tout en accomplissant notre mission et notre vision nous mettrons par-dessus tout l'emphase sur l'amélioration de la santé et des soins de santé des individus et des communautés, le respect des divers milieux et cultures, la promotion de l'innovation, une évaluation rigoureuse, la dissémination des nouvelles connaissances ainsi que la collaboration dans le développement de la capacité d'utilisation des technologies d'information et de communication dans le domaine de la santé

Bénéfices pour les membres de la SCT

- Occasions de réseautage avec les membres partout au Canada
- Site internet de ressources réservé aux membres
- Soutien aux membres d'un organisme reconnu
- Accès aux groupes d'intérêts spéciaux et à leurs sessions éducatives
- Ateliers spécialisés
- Initiatives et liaisons internationales
- Congrès annuels
- Amélioration des relations avec des organismes reliés
- Accès aux normes et renvois de la télésanté

Pour nous contacter

Société canadienne de télésanté
www.cst-sct.org
cst@eventsmgt.com
Téléphone : 613-531-9476
Télécopieur : 613-531-0626

Adresse postale :
4 rue Cataraqui, bureau 310
Kingston (Ontario) K7K 1Z7
Canada