



# Best practice recommendations for physiotherapists providing telerehabilitation to First Nations people: a modified Delphi study

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## Abstract

**Objectives** This study aimed to develop best practice recommendations for physiotherapists providing telerehabilitation to First Nations people.

**Design** Modified Delphi study.

**Participants** Eighteen experts from four groups were selected: (a) physiotherapists who provide telerehabilitation to First Nations people, (b) Carrier Sekani Family Services leaders (CSFS, First Nations-led health organization/research partners), (c) telehealth experts from British Columbia (BC), Canada, and (d) First Nations individuals (end users) with experience in telerehabilitation.

**Methods** Panelists rated recommendations on telehealth best practices in two rounds using an online questionnaire. Recommendations were synthesized from a scoping review and two qualitative studies. Each statement was rated on a four-point Likert scale indicating whether it was essential, useful, not useful, or unnecessary for inclusion in the best practices. Statements endorsed by  $\geq 80\%$  of panel members were considered for inclusion in the final document.

**Results** Following the Delphi process, 77 recommendations covering foundational components, information technology utilization, professional expertise, therapeutic relationships, cultural safety, and the telehealth visit were validated for inclusion in the policy document. Participants also validated the methodology.

**Conclusion** The recommendations offer a valuable resource for continuing education and professional development, empowering physiotherapists to enhance their skills and competencies in delivering culturally competent telerehabilitation to the First Nations population. The adoption of these best practices ensures that First Nations people are getting the best standard of care, potentially enhancing uptake and experiences with telehealth. It also enables healthcare organizations and policymakers to monitor adherence to established standards and identify areas for improvement.

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## Contribution of the Paper

- This paper provides best practice recommendations for physiotherapists delivering telerehabilitation to First Nations people, addressing unique cultural aspects and virtual relationship building.
- The study offers physiotherapists expert guidance to enhance the quality and cultural appropriateness of telerehabilitation services for First Nations populations.
- The recommendations serve as a valuable resource for continuing education and professional development, enabling physiotherapists to deliver culturally competent and effective care.
- These best practices facilitate accountability and quality assurance, helping healthcare organizations and policymakers monitor adherence to standards and identify areas for improvement.

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## Introduction

Telerehabilitation, the delivery of rehabilitation services remotely via telecommunications technology, has emerged as a promising avenue to increase rehabilitation access to underserved populations, including Indigenous communities [1,2]. In the context of First Nations people in Canada, access to quality healthcare services, including physiotherapy, has often been hindered by geographical remoteness, scarce availability of professionals, and limited financial resources [3,4]. Physiotherapists can deliver telerehabilitation to bridge these gaps, and there is evidence supporting telehealth as an effective and acceptable way to provide physiotherapy services for some health conditions [5,6].

While available evidence shows that telerehabilitation has the potential to yield outcomes comparable to or even better than those of traditional in-person care [7], its adoption in physiotherapy has been suboptimal [8,9]. One of many reasons for this is a lack of physiotherapist confidence, knowledge, or skills in telehealth [8,10]. To effectively and safely deliver telerehabilitation, physiotherapists must develop distinctive skills tailored for a 'hands-free' environment, relying on modified assessments, digital literacy, and advanced communication skills to accommodate the absence of physical and limited visual cues [11]. Specific training and upskilling clinicians to provide care via telehealth are paramount to ensure a sustainable telerehabilitation delivery [8,10]. In addition, providing telerehabilitation services to First Nations populations requires careful consideration of cultural appropriateness, technological feasibility, and the unique healthcare needs of these communities [12]. Yet, best practices specific to virtually serving First Nations people, particularly in rural and remote settings, are currently lacking.

International telehealth frameworks for physiotherapists have been developed [13,14], however, they do not address the unique cultural aspects or virtual relationship building recognised as the core of Indigenous peoples' identity [15]. Such information would serve as a valuable resource for continuing education and professional development, empowering physiotherapists to enhance their skills and

competencies in delivering culturally competent telerehabilitation to First Nations populations. Moreover, best practice recommendations facilitate accountability and quality assurance, enabling healthcare organizations and policymakers to monitor adherence to established standards and identify areas for improvement [16].

This study aimed to develop best practice recommendations for physiotherapists providing telerehabilitation to First Nations people. Using a modified Delphi method, which builds upon the existing evidence and harnesses the collective expertise of a panel with diverse perspectives, this study sought to establish a consensus on key principles and strategies that can guide physiotherapists in delivering culturally competent and effective telerehabilitation services to First Nations communities.

## Methods

### *Design*

A modified Delphi method was used to obtain consensus on the best practice recommendations. This method is based on the assumption that the cumulative opinion of an expert group outweighs individual opinions, and it is a systematic and reliable approach used to develop clinical guidelines in the absence of a comprehensive evidence base [17]. In this study, participants were presented, via an online questionnaire, with a list of statements regarding best practices for physiotherapists delivering telerehabilitation to First Nations people. Statements were rated by the expert panel over two sequential rounds. A summary of group ratings was fed back to the panel members after both rounds to help experts assess their opinions against those of the group. Endorsed statements were included in the final policy document.

Key advantages of the Delphi method include (a) assimilation of geographically dispersed experts because it is an asynchronous process, (b) mitigation of the effects of power relationships due to the anonymity of the process,

reducing the risk of an individual or group of individuals being overly influential or dominant, (c) possibility to draw on various sources of information to make judgments (e.g. systematic/scoping reviews, qualitative studies, personal experience), and (d) possibility to engage with diverse groups to ensure the process is inclusive [17,18]. Moreover, this approach has been endorsed by Indigenous participants in previous research [19,20].

#### *Development of the recommendations*

Findings from a previous scoping review by current authors [21] and qualitative studies [22,23] informed the initial list of statements provided to the panel in round 1.

#### *Scoping review*

This scoping review mapped and characterized the existing knowledge on telehealth for Indigenous peoples in Australia, Canada, New Zealand, and the United States and explored the key concepts for effective use, cultural safety, and building therapeutic relationships [21]. Based on the scoping review results, an inventory focusing on the key concepts for effective use, cultural safety, and building therapeutic relationships was developed.

#### *Previous qualitative work*

Statements were identified from previously conducted qualitative interviews with physiotherapists and First Nations people regarding telehealth physiotherapy [22,23]. Keeley and colleagues identified several reasons for using qualitative research in a pre-Delphi study, such as identifying key aspects that are important to participants, understanding why they are essential, delimiting the scope of the recommendation, identifying appropriate language for use in a Delphi questionnaire, and comparing with other alternative sources of data (e.g., scoping review) to understand areas of discordance [24].

Information gathered from the scoping review and the interviews were written up as a list of recommendations, transferred to a questionnaire format, and reviewed by the research team to ensure the questionnaire fit the study scope, was comprehensible, had a consistent format, and had no duplicates. The first questionnaire (round 1) encompassed 73 recommendations, thematically organized into six sections: 1) foundational components for the development and delivery of telehealth to First Nations people; 2) information technology in telehealth; 3) professional expertise in telehealth; 4) therapeutic relationships in telehealth; 5) cultural safety in telehealth; and 6) the telehealth visit. Pre-testing of the first questionnaire was conducted with three health professional researchers. The research team that drafted the initial recommendations consisted of three physiotherapists with extensive experience in telerehabilitation research (DPM, KLC, and PGC), the Chief Administrative Officer at CSFS and key research

partner (TH) and a key research partner, and a physician and expert in telehealth (KH).

#### *Participants*

Purposive sampling was used to keep with the tenets of the Delphi method [25]. The Delphi process does not depend on statistical power but on group dynamics to reach a consensus. The targeted sample size was 12 to 20 participants. The panel of experts included a wide variety of perspectives from 4 distinct groups: (a) physiotherapists (PTs) who provide telerehabilitation to First Nations people, (b) research partner Carrier Sekani Family Services (CSFS) leaders (First Nations-led organization that provides health and social services to First Nations communities in North Central BC), (c) telehealth experts from British Columbia, Canada, and (d) First Nations community members (end users). The PTs, CSFS leaders, and telehealth experts from BC were required to have three or more years of experience with telehealth and/or Indigenous health. Self-reported experience could be clinical, academic, or leadership work with telehealth and/or Indigenous people or having published two or more articles on telehealth and/or Indigenous health in peer-reviewed journals. First Nations community members were required to be 19 years or older, belong to one of CSFS member Nations, and have experience with telehealth physiotherapy. In the first round, data on participant demographics was collected, including gender, year of birth, and occupation. Participants were informed that by submitting the completed questionnaire, they were consenting to participate in the study. Additionally, participants were briefed on the confidentiality of their responses.

#### *Data collection*

Study participants were asked a series of online questionnaire questions worded as recommendations in two sequential rounds. Questionnaires were distributed over eight weeks (January to March 2024). Every 4 weeks, participants received an email with a link to the questionnaire as well as weekly reminders to complete the questionnaire. Participants had 3 weeks to respond, and the last week was used to aggregate and share all responses with the panel (counts and proportions of votes in each category for each statement) so that they could see how the group rated each item and change their answers if they wished. The panel's anonymity and confidentiality were ensured during the study by using assigned subject IDs during the electronic rating process. Participants did not know the identities of other panelists during the process to avoid possible bias. All participants met the proposed timeline and participated in each round. The first questionnaire took approximately 30 minutes, and the second questionnaire took approximately 10 minutes. Each person completing the two questionnaire rounds received a \$100 gift card.

Participants were instructed to rate the importance of each item on the list of recommendations for improving telehealth physiotherapy services delivery to First Nations people, using a four-point Likert scale: *essential* (must be included in the recommendations), *useful* (can be included in the recommendations), *not useful* (unsure about this recommendation), and *unnecessary* (must be excluded from the recommendations). Panelists were invited to provide text feedback, suggesting new statements or revisions to existing ones for inclusion in the following round through a free text response field at the end of each section. The questionnaire was constructed and administered online using Qualtrics® ([www.qualtrics.com/](http://www.qualtrics.com/), 2005, Provo, Utah, USA). The subsequent round was used to evaluate additional statements proposed by the expert panel in the first round and to re-evaluate statements without consensus by the panel.

The research team reviewed the endorsed statements to identify any superficial wording, grammatical changes, overlapping statements, and formatting to ensure the resulting policy document was clear and coherent. All expert panelists also had the opportunity to review and approve the final version of the policy document. An audit trail consolidated the study process [26].

After finalizing the development of these best practice recommendations, panel members' satisfaction with the research method was assessed in keeping with Indigenous research principles [27]. Respondents were invited to use a five-point Likert scale (Strongly agree, Agree, Neither Agree nor Disagree, Disagree, and Strongly Disagree) to comment on the appropriateness of the time commitment and the remuneration, whether participating was worthwhile and enjoyable, whether they believed the best practice recommendations would be of benefit to Indigenous people, and whether they recommend the Delphi method for other research projects with Indigenous people. Data was reported using the Guidance on Conducting and Reporting Delphi Studies (CREDES) framework.[28].

### Data analysis

Descriptive statistics (counts, proportions, and frequency distributions) were calculated using Microsoft Excel (Version 16.82). A recommendation was accepted if  $\geq 80\%$  of the panel selected either '*essential*' or '*useful*' on a given item [29]. If 70% to 79% of panel members rated an item as '*essential*' or '*useful*', they were asked to re-rate it in the next round [29]. Items could only be re-rated once. If an item was not endorsed after the second round, it was excluded from the recommendations. Any item that did not meet the above conditions was excluded.

Two independent researchers analyzed comments from the open-ended questions to determine if they contained original ideas that had yet to be included in the round 1 questionnaire. Any statement the research team judged as an original idea was included as a new item to be rated in the round 2 questionnaire. If a statement entered as new in

round 2 had fallen into the re-rate category, it would have been entered into round 3, but that was unnecessary.

## Results

### Participant characteristics

Eighteen individuals agreed to participate. Participants reflected a range of expertise and experience. Eight (8/18, 44%) were physiotherapists, 3 (3/18, 17%) were CSFS leaders, 3 (3/18, 17%) were telehealth experts from BC, and 4 (4/18, 22%) were First Nations people who were patients in the CSFS health care system (end users). Two-thirds of the panel participants identified as women and one-third as men. The mean age was 48 (11) years, and most participants were between 35 and 50 years old (10/18, 56%). Seventeen participants resided in the province of British Columbia, and one in Alberta. Five individuals (5/18, 28%) identified as First Nations people.

### Consensus

All participants completed the first and second rounds. Fig. 1 provides an overview of the modified Delphi data collection process. Most of the statements from the first-round questionnaire were endorsed (69/71, 97%) as *essential* or *useful* for the best practice recommendations. Of these, 15 showed strong agreement ( $> 80\%$  of participants' responses) as *essential* for the policy document. The frequency distribution of responses to the first-round questionnaire is included as File 1 in the Supplementary files. In addition to the 2 statements requiring re-rating, 5 new statements were developed for Round 2 using suggestions provided by the expert panel in Round 1 (see File 2 in the Supplementary files for the frequency distribution of responses to the second-round questionnaire). After

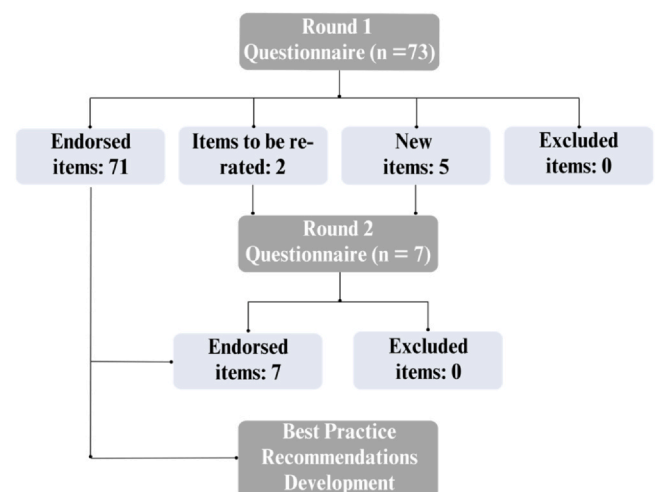


Fig. 1. Outline of the modified Delphi data collection process.

Table 1  
Panel member ( $n = 8$ ) feedback on their level of satisfaction with the research process.

Item	Strongly agree <i>n</i> (%)	Agree <i>n</i> (%)	Neither agree nor disagree <i>n</i> (%)	Disagree <i>n</i> (%)	Strongly disagree <i>n</i> (%)
I thought participating in this research was worthwhile.	5(63)	3(38)	0	0	0
I enjoyed participating in this research.	5(63)	3(38)	0	0	0
I thought the remuneration was appropriate.	5(63)	2(25)	1(13)	0	0
I thought the time commitment was appropriate.	7(88)	1(13)	0	0	0
I would recommend the Delphi method for other research projects with Indigenous people.	5(63)	2(25)	1(13)	0	0

completing the two rounds, all 78 statements were endorsed for inclusion in the policy document.

More than 60 comments were made in the open-ended questions in the first round and 13 in the second-round questionnaire, suggesting a high level of engagement from the participants. Comments that did not indicate new items but instead referred to wording, grammatical changes, formatting (e.g., order or suitability for the pre-established categories), or statements that could be split or merged were addressed in the final version of the policy document and forwarded to the panel at the end of the study. As 2 items were merged, the final best practice recommendations (see [File 3](#) in the [Supplementary files](#)) resulted in 77 recommendations.

#### *Panel member feedback*

At the end of Round 2, expert panelists were asked to give feedback on their experiences as participants and their views on the research methodology (see [Table 1](#) for these results). Only 8 participants (44%, 8/18) completed the questionnaire, but the distribution of participants from each group was proportional to the original sample. Overall, most participants either strongly agreed or agreed with all items from the feedback survey.

## **Discussion**

This study aimed to develop best practice recommendations for physiotherapists providing tele-rehabilitation to First Nations people. Despite recent research overwhelmingly endorsing the need for culturally responsive and safe telehealth services to Indigenous populations [1,30,31], gaps exist in current guidelines. The expert panel reached a consensus on 77 key principles and strategies for delivering culturally competent tele-rehabilitation services to First Nations populations (see [File 3](#) in the [Supplementary files](#)), covering foundational components, information technology utilization, professional expertise, therapeutic relationships, and cultural safety in telehealth. This discussion follows the structure of the key sections outlined in the best practices.

Recent evidence showed that implementing best practice guidelines could amplify physiotherapists' adoption of virtual healthcare services, bolstering their practice in rural and remote regions by facilitating proficient utilization of technology [32]. Building upon this premise, the first section of the present recommendations emphasizes the foundational components of telehealth initiatives aimed at serving First Nations communities. Co-designing the development and implementation of telehealth systems with First Nations communities was unanimously endorsed by the panelists in the first-round questionnaire. Such collaborative approaches have been shown to enhance the cultural appropriateness, acceptability, and effectiveness of telehealth interventions [33–35]. Moreover, building trusting relationships between patients and healthcare providers needs to be a guiding principle of telehealth programs with First Nations people. Telehealth acceptability and its potential to improve healthcare are dependent on these vital relationships [12,21].

Addressing technological limitations through appropriate Information Technology (IT) infrastructure is crucial for equitable and successful telehealth implementation and sustainability [36]. In the IT section of this document, two recommendations failed to reach a consensus in the first-round questionnaire: first, 'Prioritize videoconferencing over other modalities of telehealth (such as telephone, email, and text) to provide physiotherapy treatment'; and second, 'Consider other formats of telehealth such as telephone, email, and text as better options for follow-ups, education, and advice'. In the first-round questionnaire, examples of other modalities of telehealth were not included, and some panelists' comments indicated confusion regarding whether 'other modalities' would also include in-person care, which would then be considered superior to videoconferencing. After adding this information, both recommendations were endorsed in the second-round questionnaire. Individualizing care and considering patients' preferences is essential, but research recommends the use of synchronous clinician-patient communication for physiotherapy assessment and interventions, predominantly video-based telehealth, due to visual feedback advantages [37,38].

Healthcare professionals' competence in delivering telehealth services is paramount to their effectiveness and safety. The recommendations underscored the necessity for

physiotherapists to undergo initial training and continuous professional development in telehealth, supported by existing literature [10,11,39]. Although the recommendations highlighted the need to use best practice frameworks and existing evidence-based research to choose assessment tools and treatments that have equivalence to in-person physiotherapy, there were comments reinforcing that these must be combined with a good understanding of First Nations communities' local context and resources available to the patient, to best inform the suitability of treatment. Moreover, the recommendation to confirm patients' suitability for telehealth visits aligns with research highlighting the importance of assessing patient readiness and health digital literacy before initiating telehealth interventions [40,41].

Establishing and maintaining therapeutic relationships are central to effective telehealth delivery, particularly in the context of First Nations healthcare. The present recommendations emphasized the importance of booking the initial visit as an in-person interaction and prioritizing a hybrid model of care combining telehealth with in-person visits. This approach acknowledges the value of face-to-face interactions in building trust and rapport, which are essential for successful telehealth engagement [42]. Additionally, all panelists endorsed the importance of creating an atmosphere of trust and comfort, encompassing building personable connections and demonstrating empathy [43]. Equalizing power imbalances, developing familiarity with the First Nations group, and working with First Nations telehealth outreach staff (i.e., cultural liaisons) are relevant recommendations to accounting for a history of colonial harms and intergenerational trauma that continues to shape First Nations peoples' health care experiences.

Therapeutic relationships are dynamic and develop over time, and repeated interactions can help build up trust and rapport visit by visit [44]. Thus, the policy document highlights the importance of accommodating the extra time required to build these relationships in telehealth, particularly when culturally sensitive practices are integrated. Additionally, recommendations to explore the timely nature of telehealth as an advantage and welcoming patients to reach out in between visits can foster connections. The therapeutic relationship is not an all-or-none phenomenon, so continuous assessment of its progression over time, particularly in the context of longstanding conditions, can allow clinicians to identify areas of improvement and help individuals achieve better outcomes. High-quality, discipline-specific tools exist and could be used [45], but require cross-cultural validation to ensure relevance and accuracy for Indigenous populations.

Ensuring cultural safety in telehealth is imperative for providing telehealth care to First Nations people. The recommendations emphasized the importance of cultural competency training, adopting trauma-informed care principles, providing holistic telehealth care, and respecting individual autonomy. This aligns with research advocating for culturally safe healthcare practices that recognize and

address the historical trauma and systemic inequalities experienced by Indigenous populations [46]. Moreover, the sections focusing on cultural safety and communication during telehealth visits outline key First Nations cultural norms and provide suggestions on how physiotherapists should engage with First Nations individuals in relationships. These include understanding if and how the patient wants to integrate cultural activities into telehealth visits, being humble and open to learning about healing beliefs and traditional medicine, not insisting on excessive eye contact, toning down the volume and pace of communication, and using humour to keep the visits light and engaging. Some of these aspects have been described previously [47,48], and others may have been described in research for the first time in this policy document.

There were several strengths to this study. The Delphi method's essential characteristics were followed, including confidentiality, iteration, controlled feedback, and group response, to ensure methodological rigour [25,26]. This included establishing a high cut-off (80%) which was necessary given the expert panel's small sample size and diversity. However, there is no universally agreed-upon level of consensus to be employed, as it can vary according to sample size, the aim of the research, and resources. All participants completed both rounds, ensuring opinions were not 'lost' during the Delphi process. A large proportion of participants agreed that the modified Delphi method was appropriate for use in developing recommendations for care involving Indigenous people.

While the Delphi method employed in this study successfully attained its objective of establishing expert consensus on best practice recommendations for physiotherapists providing telerehabilitation to First Nations people, there are limitations worth noting. The number of physiotherapists was relatively bigger than the other groups, but this should not negatively impact the results as the best practices were designed for physiotherapists. Secondly, the vast majority of the Delphi participants were from BC, Canada, and all patients were First Nation individuals from BC, which might limit the generalisability of the recommendations to other Indigenous groups and other provinces or internationally. On the other hand, respecting local geographical and cultural differences is also a positive aspect of the design. This policy document could be used as a foundation for other health professions and adapted to suit their own discipline. These best practices may also be used by the wider public, particularly Indigenous people internationally, to understand what standards they should expect from physiotherapists delivering care via telehealth. Lastly, given the diversity of experts in this study and the nature of the comments provided, the Delphi process may not have provided sufficient opportunities for participants to adequately reflect on feedback as a group. Future revisions to the guidelines may benefit from a modified Delphi process that includes a focus group and/or workshop in which such issues can be addressed.

In conclusion, this study drew on evidence-based research and expert knowledge to inform the development of culturally sensitive best practice recommendations for physiotherapists delivering telerehabilitation for First Nations people. These findings will guide physiotherapists in delivering telerehabilitation to the best standard possible, focusing on the critical aspects of establishing and maintaining positive therapeutic relationships. Physiotherapists, healthcare organizations, and policymakers can use this document to guide the decision-making processes for planning, implementing, and evaluating telehealth physiotherapy for First Nations People. Future research and implementation efforts should focus on translating these recommendations into practice, evaluating their impact on patient outcomes, and further refining telehealth models to optimize responsiveness to specific contexts.

### Ethical approval

The Ethics Committees of the University of British Columbia (H23-02577) and Carrier Sekani Family Services (Oct 23, 2023) approved this study. All participants gave written informed consent.

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### Conflict of interest

The authors have declared that no competing interests exist.

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### Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at [doi:10.1016/j.physio.2025.101464](https://doi.org/10.1016/j.physio.2025.101464).

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## Supplementary Files

**File 1.** Frequency Distribution of Responses to the First-Round Questionnaire.

<b>FOUNDATIONAL COMPONENTS FOR THE DEVELOPMENT AND DELIVERY OF TELEHEALTH TO FIRST NATIONS PEOPLE</b>				
	ESSENTIAL	USEFUL	NOT USEFUL	UNNECESSARY
1. Co-design the development and implementation of telehealth systems with First Nations community members and/or leaders.	100% (18/18)	0%	0%	0%
2. Develop (if not already in place) and maintain a reliable and secure broadband network for telehealth delivery.	83% (15/18)	17% (3/18)	0%	0%
3. Ensure that relationship building with the patient and continuity of care are guiding principles of the telehealth program.	94% (17/18)	6% (1/18)	0%	0%
4. Complete initial training and continuous professional development in telehealth, including but not limited to: communications skills in telehealth, logistic and safety aspects of telehealth, trauma-informed care, and/or cultural safety in telehealth.	83% (15/18)	17% (3/18)	0%	0%
5. Ensure there is enough administrative staff to fully support the telehealth clinical practice, including scheduling appointments and maintaining clinical records.	56% (10/18)	44% (8/18)	0%	0%
6. Ensure there is enough administrative staff to fully support the telehealth clinical practice through equipment maintenance, setup, and troubleshooting.	56% (10/18)	44% (8/18)	0%	0%
7. Understand virtual care payment models and ensure that they account for the extra time required to build relationships, particularly when it involves culturally sensitive practices (e.g., recommendation #40 on having space and time dedicated for prayers and sharing experiences).	78% (14/18)	22% (4/18)	0%	0%
8. Advocate for improving funding for telehealth physiotherapy services from government funders and extended health benefit carriers.	56% (10/18)	44% (8/18)	0%	0%
<b>INFORMATION TECHNOLOGY IN TELEHEALTH</b>				
	ESSENTIAL	USEFUL	NOT USEFUL	UNNECESSARY
9. Implement (if not already in place) and maintain an Electronic Medical Record (EMR) system that enables continuity of care between healthcare professionals.	72% (13/18)	17% (3/18)	6% (1/18)	6% (1/18)

10. Prioritize videoconference over other modalities of telehealth to provide physiotherapy treatment, as it is vital to see the patient during assessment and treatment.	50% (9/18)	22% (4/18)	17% (3/18)	11% (2/18)
11. Consider other formats of telehealth, such as telephone, email, and text as better options for follow-ups, education, and advice.	39% (7/18)	39% (7/18)	17% (3/18)	6% (1/18)
12. Use web-based video platforms that are stable, user-friendly, and compliant with data security requirements.	61% (11/18)	33% (6/18)	0%	6% (1/18)
13. Be competent in web-based video platform functions including, but not limited to: screen sharing and closed captions.	50% (9/18)	39% (7/18)	6% (1/18)	6% (1/18)
<b>PROFESSIONAL EXPERTISE IN TELEHEALTH</b>				
	ESSENTIAL	USEFUL	NOT USEFUL	UNNECESSARY
14. Confirm the patient's suitability for telehealth visits by assessing factors such as overall attitude toward technology, proximity to the clinic, and physical capacity to participate (e.g., visual or auditory challenges).	61% (11/18)	33% (6/18)	6% (1/18)	0%
15. Consider the feasibility of doing virtual home visits versus having the patient come to the nearest health clinic to have assistance with setup and troubleshooting for individuals who do not have access to internet or IT hardware at home, those with low digital health literacy, unstable health conditions, risk of falls, and language barriers.	61% (11/18)	33% (6/18)	6% (1/18)	0%
16. Understand the local context (e.g., topography, weather, wildlife, condition of the roads) and resources available to the patient (e.g., access to a gym, pool, playground, programs/services offered to the community) to inform the suitability of treatment recommendations.	89% (16/18)	11% (2/18)	0%	0%
17. Use best practice frameworks and existing evidence-based research to choose assessment tools and treatments that have equivalence to in-person physiotherapy.	50% (9/18)	39% (7/18)	11% (2/18)	0%
18. Identify opportunities for interprofessional collaboration via technology (e.g., being with the patient and connecting via telehealth with a specialist).	50% (9/18)	44% (8/18)	6% (1/18)	0%
<b>THERAPEUTIC RELATIONSHIPS IN TELEHEALTH</b>				
	ESSENTIAL	USEFUL	NOT USEFUL	UNNECESSARY
19. Book the initial visit as an in-person, face-to-face interaction.	56% (10/18)	28% (5/18)	17% (3/18)	0%

20. Be willing to provide timely consultative services via telehealth, welcoming patients to reach out in-between visits.	61% (11/18)	39% (7/18)	0%	0%
21. Consider referring to another practitioner who has a pre-existing relationship with the patient to oversee their care if an initial in-person visit is not possible and you have no previous relationship with the patient.	50% (9/18)	39% (7/18)	11% (2/18)	0%
22. Prioritize a hybrid model of care with intermittent telehealth and in-person visits (e.g., one week per month on-site service delivery with follow-up telehealth service delivery).	67% (12/18)	28% (5/18)	0%	6% (1/18)
23. Identify First Nations telehealth outreach staff who could work as a cultural liaison and help to establish your credibility in the patient's eyes.	72% (13/18)	22% (4/18)	0%	6% (1/18)
24. Be consistent with the frequency of telehealth visits.	61% (11/18)	22% (4/18)	17% (3/18)	0%
25. Decentralize your inherent power as a healthcare provider through collaborative goal setting, shared-decision making, and an overall strength-based approach that validates people's knowledge and experiences, mitigating the potentially negative connotation that healthcare professions have to First Nations People.	83% (15/18)	17% (3/18)	0%	0%
26. Demonstrate empathy, care, and compassion: show that you are genuinely interested and concerned about patients' situations and that they are important to you.	94% (17/18)	6% (1/18)	0%	0%
27. Develop familiarity and/or knowledge of First Nations People in the area where you are working (e.g., local cultural protocols, language, and kinship structures).	89% (16/18)	11% (2/18)	0%	0%
28. Build personable and familiar relationships with patients who are open and willing to do so while maintaining professional boundaries.	89% (16/18)	11% (2/18)	0%	0%
29. Create an atmosphere of trust and comfort: be respectful, friendly, and warm, have a positive attitude, and make patients feel at ease.	100% (18/18)	0%	0%	0%
<b>CULTURAL SAFETY IN TELEHEALTH</b>				
	ESSENTIAL	USEFUL	NOT USEFUL	UNNECESSARY
30. Complete cultural competency and cultural safety training, as training provides an understanding of local context, Indigenous approaches, and trauma-informed care.	83% (15/18)	17% (3/18)	0%	0%

31. Foster a culturally safe environment, including but not limited to: being open-minded, respectful, vulnerable, non-judgmental, aware of cultural differences, and willing to work on internal biases.	89% (16/18)	11% (2/18)	0%	0%
32. Adopt trauma-informed telehealth care, being aware of and sensitive toward the history of First Nations People.	83% (15/18)	17% (3/18)	0%	0%
33. Provide holistic telehealth care that looks at the whole person, including their mental, physical, emotional, social, and spiritual well-being.	94% (17/18)	0%	6% (1/18)	0%
34. Use First Nations philosophies to structure the treatment plan and ensure it targets physical, mental, emotional, and spiritual health.	67% (12/18)	17% (3/18)	11% (2/18)	6% (1/18)
35. Promote patients' optimistic views regarding telehealth and help them see the value in persisting with telehealth visits, emphasizing its potential to foster empowerment, self-determination, and autonomy.	56% (10/18)	33% (6/18)	6% (1/18)	6% (1/18)
36. Understand that First Nations People may be on different journeys of connecting or reconnecting with their culture, and they may prefer to keep some aspects of their culture private, or they may not wish to integrate culture into their care plan.	72% (13/18)	28% (5/18)	0%	0%
37. Respectfully ask if there is anything that patients would like you to know and consider throughout their rehabilitation, given their culture, experiences, gender, etc., to make it culturally relevant and safe.	67% (12/18)	28% (5/18)	6% (1/18)	0%
38. Outline the potential benefits of telehealth physiotherapy and present cultural practices as therapeutic goals (e.g., having a good range of mobility and strength can help patients hunt and fish better or take care of their Elders better) if relevant and desired by the patient.	56% (10/18)	33% (6/18)	11% (2/18)	0%
39. Allow family members to attend telehealth physiotherapy visits for moral support and assistance with care.	61% (11/18)	39% (7/18)	0%	0%
40. Allow family members to attend telehealth physiotherapy visits for collective decision-making.	61% (11/18)	39% (7/18)	0%	0%
41. Respect individual autonomy, understanding that patients and families are the arbiters of health-related decision-making.	94% (17/18)	6% (1/18)	0%	0%
42. Allow space and time for prayers and sharing experiences if deemed appropriate, particularly in group telehealth physiotherapy sessions.	50% (9/18)	44% (8/18)	6% (1/18)	0%

43. Have a basic understanding of healing beliefs and traditional medicine to understand how physiotherapy practice could align with these practices.	61% (11/18)	39% (7/18)	0%	0%
44. Encourage the use of traditional medicine as an adjunctive treatment and suggest that patients connect with someone in the community who can give appropriate support.	67% (12/18)	28% (5/18)	6% (1/18)	0%
45. Design education materials using First Nations symbols, colours, and language.	50% (9/18)	50% (9/18)	0%	0%
<b>THE THELEHEALTH VISIT</b>				
<b>General Components</b>				
	ESSENTIAL	USEFUL	NOT USEFUL	UNNECESSARY
46. Prepare for the telehealth visit by confirming equipment is available and in good working order and that the internet connections are stable.	72% (13/18)	22% (4/18)	0%	6% (1/18)
47. Plan for the telehealth visit by reviewing the patient's chart, treatment plan, and options for treatment via telehealth.	78% (14/18)	17% (3/18)	0%	6% (1/18)
48. Ensure that both the patient's and the therapist's environments are appropriate for telehealth visits, including but not limited to: adequate lighting, clean quiet and private space, and/or minimal distractions and interruptions.	39% (7/18)	50% (9/18)	0%	11% (2/18)
49. Confirm telehealth visits with the patient, including details regarding space, required equipment for home, patient's attire, and treatment plan.	50% (9/18)	44% (8/18)	0%	6% (1/18)
50. Demonstrate a flexible approach with scheduling, no-shows, internet instability, equipment failure, and priority of the visit for patients.	56% (10/18)	39% (7/18)	0%	6% (1/18)
51. Create an emergency action plan including, but not limited to: personal information, emergency contact information, address, brief medical history, doctor's name, and contact information. In case emergency services need to be contacted, be aware of the closest emergency facility location and contact information.	72% (13/18)	22% (4/18)	6% (1/18)	0%
52. Inform the patient about the benefits and limitations of telehealth, providing information on the distinctive features of telehealth and what will be expected of patients when using technology.	72% (13/18)	28% (5/18)	0%	0%

53. Educate patients about physiotherapy's scope of practice and prepare their expectations for telehealth physiotherapy visits to optimize engagement.	67% (12/18)	33% (6/18)	0%	0%
54. Instruct the patient to assist with remote physical examination, including taking their pulse, sending pictures of their injury, or performing some activities of daily living for neuromuscular assessment.	44% (8/18)	50% (9/18)	0%	6%
<b>Privacy and Confidentiality During the Telehealth Visit</b>				
	ESSENTIAL	USEFUL	NOT USEFUL	UNNECESSARY
55. Confirm with the patients that they are welcome to use artificial backgrounds and keep their microphones muted to increase their privacy.	56% (10/18)	33% (6/18)	6% (1/18)	6% (1/18)
56. Explain to patients how privacy and confidentiality are maintained during telehealth care (e.g., visits will not be recorded without patient consent, physiotherapist will be alone in the room).	72% (13/18)	22% (4/18)	0%	6% (1/18)
57. Identify potential privacy issues (e.g., if there is someone else in the room that makes the patient uncomfortable or unsafe to disclose accurately) and assess the need to switch to in-person care.	78% (14/18)	17% (3/18)	0%	6% (1/18)
<b>Information Technology During the Telehealth Visit</b>				
	ESSENTIAL	USEFUL	NOT USEFUL	UNNECESSARY
58. Establish an individualized contingency plan in case of technology failure, including but not limited to: teaching patients basic troubleshooting procedures, and discussing alternatives to contact them if the connection cannot be re-established.	50% (9/18)	39% (7/18)	6% (1/18)	6% (1/18)
59. Support patients, in their initial and sustained technology use, including but not limited to: facilitating access to digital literacy resources and adapting technology according to digital literacy level.	50% (9/18)	33% (6/18)	6% (1/18)	11% (2/18)
<b>Communication During the Telehealth Visit</b>				
	ESSENTIAL	USEFUL	NOT USEFUL	UNNECESSARY
60. Demonstrate more emotion through your facial expressions and body language, because non-verbal communication can be less evident in telehealth visits.	22% (4/18)	67% (12/18)	6% (1/18)	6% (1/18)

61. Understand that in the initial stages of building relationships, particularly in telehealth due to limited body language expression, it is advisable to strike a balance between not insisting on excessive eye contact and ensuring you appear engaged and committed to the relationship as for many First Nations Peoples, continuous eye contact may not be expected or even accepted as a courtesy of conversation.	44% (8/18)	39% (7/18)	11% (2/18)	6% (1/18)
62. Be cognizant of your positioning in front of the camera, ensuring you are centred on the screen, and patients can see what you are demonstrating.	44% (8/18)	50% (9/18)	0%	6%
63. Use visual aids (e.g., pictures of body anatomy, videos of exercises).	39% (7/18)	50% (9/18)	6% (1/18)	6% (1/18)
64. Adjust your tone of voice, speaking louder if the patient has hearing impairments, but being aware that if you are too loud, some First Nations People may interpret it as if you were shouting at them and be offended.	44% (8/18)	44% (8/18)	6% (1/18)	6% (1/18)
65. Adapt the pace of communication: do not talk fast or aggressively, make pauses to avoid interruptions due to technological delays, anticipate and respect silences.	50% (9/18)	39% (7/18)	6% (1/18)	6% (1/18)
66. Adopt a clean and direct communication style: simplify language, use fewer words, interject less, and enunciate more.	50% (9/18)	39% (7/18)	6% (1/18)	6% (1/18)
67. Be flexible and creative: think about different ways of asking the same question and instructing people on what they need to do, be more descriptive to guide patients through assessments and treatment.	61% (11/18)	28% (5/18)	6% (1/18)	6% (1/18)
68. Use humour when appropriate and try to keep the visits light and fun.	44% (8/18)	39% (7/18)	6% (1/18)	11% (2/18)
69. Give patients time to share their stories: book longer visits if needed, allocate more time for patients to fully express themselves while allowing for technological issues.	72% (13/18)	22% (4/18)	0%	6% (1/18)
70. Show that you are actively listening (repeat back, nod, and move periodically to show you have not frozen).	56% (10/18)	39% (7/18)	0%	6% (1/18)
71. Minimize typing during conversation and inform the patient when you need to type or write.	50% (9/18)	39% (7/18)	6% (1/18)	6% (1/18)
72. Minimize the use of medical jargon and explain things clearly using plain language and examples.	72% (13/18)	22% (4/18)	6% (1/18)	0%
73. Effectively communicate with other healthcare team members using technology (e.g., Electronic Medical Records) to ensure best coordination of care.	61% (11/18)	39% (7/18)	0%	0%

**File 2.** Frequency Distribution of Responses to the Second-Round Questionnaire.

<b>INFORMATION TECHNOLOGY IN TELEHEALTH</b>				
	ESSENTIAL	USEFUL	NOT USEFUL	UNNECESSARY
<b>10.</b> Prioritize videoconference over other modalities of telehealth (such as telephone, email, and text) to provide physiotherapy treatment, as it is vital to see the patient during assessment and treatment.	39% (7/18)	50% (9/18)	6% (1/18)	6% (1/18)
<b>11.</b> Consider other formats of telehealth, such as telephone, email, and text as better options for follow-ups, education, and advice.	44% (8/18)	56% (10/18)	0%	0%
<b>New.</b> Ask for patients' preferred telehealth platforms (e.g., Zoom, WhatsApp, Messenger) while ensuring data security requirements are met, considering that the best technology will be the one that they know, understand, and can navigate seamlessly.	44% (8/18)	56% (10/18)	0%	0%
<b>PROFESSIONAL EXPERTISE IN TELEHEALTH</b>				
	ESSENTIAL	USEFUL	NOT USEFUL	UNNECESSARY
<b>New.</b> Allow people to choose their visit type and place within reasonable decision-making exceptions (e.g., those described in recommendations #14 and #15).	67% (12/18)	28% (5/18)	6% (1/18)	0%
<b>THERAPEUTIC RELATIONSHIPS IN TELEHEALTH</b>				
	ESSENTIAL	USEFUL	NOT USEFUL	UNNECESSARY
<b>New.</b> Invest time and energy in long-term relationship building, acknowledging that fostering connections demand a considerable number of hours (see recommendation #69), skill, and practice, but it is of utmost importance for good service delivery.	72% (13/18)	22% (4/18)	6% (1/18)	0%
<b>New.</b> When home-based virtual visits are possible, consider having a support person within the community for technological and overall appointment assistance, leveraging their skills and relationships to ensure effective engagement with First Nations people.	50% (9/18)	44% (8/18)	6% (1/18)	0%
<b>THE TELEHEALTH VISIT</b>				
<b>General Components</b>				
	ESSENTIAL	USEFUL	NOT USEFUL	UNNECESSARY
<b>New.</b> Educate patients on the technology (e.g., how to connect to the platform, turn the camera on/off, mute/unmute, and troubleshoot common issues).	61% (11/18)	28% (5/18)	6% (1/18)	6% (1/18)

### **File 3. Best Practice Recommendations for Physiotherapists Providing Telerehabilitation for First Nations People**

#### **Purpose of Best Practices Recommendations**

**While in-person care remains the gold standard modality of care delivery for Indigenous and non-Indigenous people, we highlight the value of telerehabilitation as an important component of a successful patient care plan.** This is particularly true for rural and remote communities facing transportation barriers and provider shortages. These best practice recommendations delineate how physiotherapists should engage in telerehabilitation with First Nations people, mindful of their unique needs and contexts. This document offers culturally sensitive guidance to support physiotherapists in delivering high-quality virtual care while maintaining a commitment to in-person engagement whenever possible and appropriate.

#### **Development of Best Practices Recommendations**

The following set of best practice recommendations was developed based on (1.) a scoping review of the literature on telehealth use by Indigenous people<sup>1</sup>, (2.) qualitative data from interviews with physiotherapists and First Nations people from British Columbia (BC)/Canada, and (3.) the opinion of experts from BC/Canada who have extensive knowledge of or experience in telehealth, physiotherapy, and/or Indigenous health.

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#### **How to Apply Best Practices Recommendations**

This document was created to support physiotherapists working in a broad range of settings - both publicly and privately funded – consequently, the relevance of each recommendation may vary accordingly. The focus is mainly on telerehabilitation delivery to First Nations adults, recognizing that pediatric care involves a complex and distinct experience. It is important to acknowledge that First Nations communities and other Indigenous groups are not all the same; they may differ in their understanding, interpretations, approaches, and treatment of physical illness. However, given the shared understanding and values of relationships among many Indigenous cultures, we hope that most recommendations will apply to other Indigenous groups worldwide. Moreover, even though we caution against transferring these findings beyond physiotherapy practice, key lessons may apply to other healthcare practice areas.

1. Moecke DP, Holyk T, Beckett M, et al. Scoping review of telehealth use by Indigenous populations from Australia, Canada, New Zealand, and the United States. *Journal of Telemedicine and Telecare*. 2023;0(0). doi:10.1177/1357633X231158835

This document presents a general set of culturally sensitive recommendations to guide physiotherapists in delivering telerehabilitation for First Nations people to the best standard possible, focusing on the critical aspects of establishing and maintaining positive therapeutic relationships. It is important to remember that each individual is unique, meaning that support must be tailored to their needs. Therefore, these recommendations may not be appropriate for every First Nations person: simply reading them as a checklist will not equip you to be competent in providing virtual care to First Nations people.

This document includes some telehealth competencies for physiotherapists already identified in the literature. Although these general competencies are not specific to working with the First Nations population, they were included to make this document a comprehensive tool. It is imperative for physiotherapists to adhere to the profession's ethical, legal, and regulatory principles and align their practice with organizational procedures and protocols. Moreover, it is important to note that this list is not exhaustive, and other supporting materials may exist outside of this review. Additional helpful information can be found in the following sources:

- [Code of Ethical Conduct for Physiotherapists in Canada](#)
- [Regulation of Physical Therapy in British Columbia \(Legislation & Standards\)](#)
- [CPTBC Telerehabilitation Guide](#)
- [PABC Physiotherapy Virtual Care Toolkit](#)
- [International core capability framework for physiotherapists to deliver quality care via videoconferencing](#)

### **Terminology**

Telehealth is an umbrella term; telerehabilitation is a subfield of telehealth that refers to using information and communication technologies to provide rehabilitation services remotely.

First Nations are one of three distinct groups of Indigenous peoples in Canada (First Nations, Métis, and Inuit). This will be the primary term used in this document, but we also use the term Indigenous when referring to the collective group of Indigenous peoples of Canada.

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# **Best Practice Recommendations for Physiotherapists Providing Telerehabilitation for First Nations People**

The following pages of this document list the Best Practice Recommendations for Physiotherapists Providing Telerehabilitation for First Nations People. There are seventy-seven recommendations in total, grouped under six sections.

## **SECTION 1: FOUNDATIONAL COMPONENTS FOR THE DEVELOPMENT AND DELIVERY OF TELEHEALTH TO FIRST NATIONS PEOPLE**

1. Co-design the development and implementation of telehealth systems with First Nations community members and/or leaders.
2. Develop (if not already in place) and maintain a reliable and secure broadband network for telehealth delivery.
3. Ensure that relationship building with the patient and continuity of care are guiding principles of the telehealth program.
4. Complete initial training and continuous professional development in telehealth, including but not limited to: communications skills in telehealth, logistic and safety aspects of telehealth, trauma-informed care, and/or cultural safety in telehealth.
5. Ensure there is enough administrative staff to fully support a smooth patient journey, recognizing that the practitioner will be offsite (including scheduling appointments, maintaining clinical records, equipment maintenance, setup, and troubleshooting).
6. Understand virtual care payment models and ensure that they account for the extra time required to build relationships, particularly when it involves culturally sensitive practices (e.g., recommendation #46 on having space and time dedicated for prayers and sharing experiences).
7. Advocate for improving funding for telehealth physiotherapy services from government funders and extended health benefit carriers.

## **SECTION 2: INFORMATION TECHNOLOGY IN TELEHEALTH**

8. Implement (if not already in place) and maintain an Electronic Medical Record (EMR) system that enables continuity of care between healthcare professionals.
9. Prioritize videoconference over other modalities of telehealth (such as telephone, email, and text) to provide physiotherapy treatment, as it is vital to see the patient during assessment and treatment.
10. Consider other formats of telehealth, such as telephone, email, and text as better options for follow-ups, education, and advice.
11. Use web-based video platforms that are stable, user-friendly, and compliant with data security requirements.
12. Ask for patients' preferred telehealth platforms (e.g., Zoom, WhatsApp, Messenger) while ensuring data security requirements are met, considering that the best technology will be the one that they know, understand, and can navigate seamlessly.
13. Be competent in web-based video platform functions including, but not limited to: screen sharing and closed captions.

### **SECTION 3: PROFESSIONAL EXPERTISE IN TELEHEALTH**

14. Confirm the patient's suitability for telehealth visits by assessing factors such as overall attitude toward technology, proximity to the clinic, and physical capacity to participate (e.g., visual or auditory challenges).
15. Consider the feasibility of doing virtual home visits versus having the patient come to the nearest health clinic for assistance with setup and troubleshooting for individuals who do not have access to internet or IT hardware at home, those with low digital health literacy, unstable health conditions, risk of falls, language barriers, and no family support.
16. Allow people to choose their visit type and place within reasonable decision-making exceptions (e.g., those described in recommendations #14 and #15).
17. Understand the local context (e.g., topography, weather, wildlife, condition of the roads) and resources available to the patient (e.g., access to a gym, pool, playground, programs/services offered to the community) to inform the suitability of treatment recommendations.
18. Use best practice frameworks and existing evidence-based research, in combination with recommendation #17, to choose assessment tools and treatments that have equivalence to (i.e., are as effective as) in-person physiotherapy.
19. Identify opportunities for interprofessional collaboration via technology (e.g., being with the patient and connecting via telehealth with a specialist and primary care providers).

### **SECTION 4: THERAPEUTIC RELATIONSHIPS IN TELEHEALTH**

20. Book the initial visit as an in-person, face-to-face interaction.
21. Be willing to provide timely consultative services via telehealth, welcoming patients to reach out in-between visits.
22. Consider referring to another practitioner who has a pre-existing relationship with the patient to oversee their care if an initial in-person visit is not possible and you have no previous relationship with the patient.
23. Prioritize a hybrid model of care with intermittent telehealth and in-person visits (e.g., one week per month on-site service delivery with follow-up telehealth service delivery).
24. Identify First Nations telehealth outreach staff who could work as a cultural liaison and help to establish your credibility in the patient's eyes.
25. When home-based virtual visits are possible, consider having a support person within the community for technological and overall appointment assistance, leveraging their skills and relationships to ensure effective engagement with First Nations people.
26. Be consistent with the frequency of telehealth visits.
27. Decentralize your inherent power as a healthcare provider through collaborative goal setting, shared-decision making, and an overall strength-based approach that validates people's knowledge and experiences, mitigating the potentially negative connotation that healthcare professions have to First Nations People.
28. Demonstrate empathy, care, and compassion: show that you are genuinely interested and concerned about patients' situations and that they are important to you.
29. Develop familiarity and/or knowledge of First Nations People in the area where you are working (e.g., local cultural protocols, language, and kinship structures).
30. Build personable and familiar relationships with patients who are open and willing to do so while maintaining professional boundaries.

31. Invest in long-term relationship building, acknowledging that fostering connections could require considerable time (see recommendation #74), energy, skills, and practice, but it is of utmost importance for good service delivery.
32. Create an atmosphere of trust and comfort: be respectful, friendly, and warm, have a positive attitude, and make patients feel at ease.

## **SECTION 5: CULTURAL SAFETY IN TELEHEALTH**

33. Complete cultural competency and cultural safety training, as training provides an understanding of local context, Indigenous approaches, and trauma-informed care.
34. Foster a culturally safe environment, including but not limited to: being open-minded, respectful, vulnerable, non-judgmental, aware of cultural differences, and willing to work on internal biases.
35. Adopt trauma-informed telehealth care, being aware of and sensitive toward the history of First Nations People.
36. Provide holistic telehealth care that looks at the whole person, including their mental, physical, emotional, social, and spiritual well-being.
37. Use First Nations philosophies to structure the treatment plan and ensure it targets physical, mental, emotional, and spiritual health.
38. Promote patients' optimistic views regarding telehealth and help them see the value in persisting with telehealth visits, emphasizing its potential to foster empowerment, self-determination, and autonomy, all the while respecting patients' choice if telehealth is not working for them.
39. Understand that First Nations People may be on different journeys of connecting or reconnecting with their culture, and they may prefer to keep some aspects of their culture private, or they may not wish to integrate culture into their care plan.
40. Respectfully ask if there is anything that patients would like you to know and consider throughout their rehabilitation, given their culture, experiences, gender, etc., to make it culturally relevant and safe.
41. Outline the potential benefits of telehealth physiotherapy and present cultural practices as therapeutic goals (e.g., having a good range of mobility and strength can help patients hunt and fish better or take care of their Elders better) if relevant and desired by the patient.
42. With the patient's explicit consent, allow family members (including extended family) to attend telehealth physiotherapy visits for moral support and assistance with care.
43. With the patient's explicit consent, allow family members (including extended family) to attend telehealth physiotherapy visits for collective decision-making.
44. Respect individual autonomy, understanding that patients and families are the arbiters of health-related decision-making.
45. Allow space and time for prayers and sharing experiences if the patients want to and think it is appropriate, particularly in group telehealth physiotherapy sessions. Be mindful that overuse of prayers, along with land acknowledgements, can be frustrating and may lead to disengagement.
46. Be humble and open to learning about healing beliefs and traditional medicine to understand how physiotherapy practice could align with these practices.
47. Encourage the use of traditional medicine as an adjunctive treatment and suggest that patients connect with someone in the community who can give appropriate support.
48. Design education materials using First Nations symbols, colours, and language.

## **SECTION 6: THE TELEHEALTH VISIT**

### **6.1 General Components**

49. Prepare for the telehealth visit by confirming equipment is available and in good working order and that the internet connections are stable.
50. Plan for the telehealth visit by reviewing the patient's chart, treatment plan, and options for treatment via telehealth.
51. Ensure that both the patient's and the therapist's environments are appropriate for telehealth visits, including but not limited to: adequate lighting, clean quiet and private space, and/or minimal distractions and interruptions.
52. Confirm telehealth visits with the patient, including details regarding space, required equipment for home, patient's attire, and treatment plan.
53. Demonstrate a flexible approach to scheduling, no-shows, internet instability, equipment failure, and priority of the visit for patients.
54. Create an emergency action plan including, but not limited to: personal information, emergency contact information, address, brief medical history, doctor's name, and contact information. In case emergency services need to be contacted, be aware of the closest emergency facility location and contact information.
55. Inform the patient about the benefits and limitations of telehealth, providing information on the distinctive features of telehealth and what will be expected of patients when using technology.
56. Educate patients about physiotherapy's scope of practice and prepare their expectations for telehealth physiotherapy visits to optimize engagement.
57. Instruct the patient to assist with remote physical examination, including taking their pulse, sending pictures of their injury, or performing some activities of daily living for neuromuscular assessment. Alternatively, have someone nearby (e.g., cultural liaison or support staff from recommendations #24 and #25, family or extended family members) who could do this for them.
58. Educate patients on the technology (e.g., how to connect to the platform, turn the camera on/off, mute/unmute, and troubleshoot common issues).

### **6.2 Privacy and Confidentiality During the Telehealth Visit**

59. Confirm with the patients that they are welcome to use artificial backgrounds and keep their microphones muted, and bring their own headphones if the telehealth visit is at the health center (since clinics often cannot offer these due to contamination risk), to increase their privacy.
60. Explain to patients how privacy and confidentiality are maintained during telehealth care (e.g., visits will not be recorded without patient consent, physiotherapist will be alone in the room).
61. Identify potential privacy issues (e.g., if there is someone else in the room that makes the patient uncomfortable or unsafe to disclose accurately) and assess the need to switch to in-person care.

### **6.3 Information Technology During the Telehealth Visit**

62. Establish an individualized contingency plan in case of technology failure if providing home-based care, including but not limited to: teaching patients basic troubleshooting procedures and discussing alternatives to contact them if the connection cannot be re-established. If at the health centre, ensure the administrative support staff is aware of the contingency plan.

63. Support patients, in their initial and sustained technology use, including but not limited to: facilitating access to digital literacy resources and adapting technology according to digital literacy level.

#### **6.4 Communication During the Telehealth Visit**

64. Demonstrate more emotion through your facial expressions and body language, because non-verbal communication can be less evident in telehealth visits.
65. Understand that in the initial stages of building relationships, particularly in telehealth due to limited body language expression, it is advisable to strike a balance between not insisting on excessive eye contact and ensuring you appear engaged and committed to the relationship as for many First Nations Peoples, continuous eye contact may not be expected or even accepted as a courtesy of conversation.
66. Be cognizant of your positioning in front of the camera, ensuring you are centred on the screen, and patients can see what you are demonstrating.
67. Use visual aids (e.g., pictures of body anatomy, videos of exercises).
68. Adjust your tone of voice, speaking louder if the patient has hearing impairments, but being aware that if you are too loud, some First Nations People may interpret it as if you were shouting at them and be offended.
69. Adapt the pace of communication: do not talk fast or aggressively, make pauses to avoid interruptions due to technological delays, do not interrupt, anticipate and respect silences beyond what is typical in non-Indigenous settings, as it allows time for thought.
70. Adopt a clean and direct communication style: simplify language, use fewer words, interject less, and enunciate more.
71. Be flexible and creative: think about different ways of asking the same question and instructing people on what they need to do, be more descriptive to guide patients through assessments and treatment.
72. Use humour when appropriate and try to keep the visits light and fun.
73. Give patients time to share their stories: book longer visits if needed, allocate more time for patients to fully express themselves while allowing for technological issues.
74. Show that you are actively listening (repeat back, nod, move periodically to show you have not frozen, and ask follow-up questions).
75. Minimize typing during conversation and inform the patient when you need to type or write.
76. Minimize the use of medical jargon and explain things clearly using plain language and examples.
77. Effectively communicate with other healthcare team members using technology (e.g., Electronic Medical Records) to ensure best coordination of care.

This document offered culturally sensitive guidance to support physiotherapists in delivering high-quality virtual care visits to First Nations people. It should be used in conjunction with other guidelines for physiotherapists. The importance of an individualized, patient-centred treatment plan cannot be overstated.