HEART HEALTH IN NORTHERN BC

COMMUNITY CONSULTATION 2018

DRAFT

northern health
the northern way of caring

ACKNOWLEDGMENTS

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PHOTO OF SKEENA RIVER BY SJ KERR

FROM NORTHERN HEALTH'S STRATEGIC PLAN TO 2021

(Excerpts related to this project)

Vision

Northern Health leads the way in promoting health and providing health services for Northern and rural populations.

Mission Statement

Through the efforts of dedicated staff and physicians, in partnership with communities and organizations, we provide exceptional health services for Northerners.

Values

Value statements guide decisions and actions.

We will succeed in our work through:

- **Empathy** – Seeking to understand each individual's experience.
- **Respect** – Accepting each person as a unique individual.
- **Collaboration** – Working together to build partnerships.
- **Innovation** – Seeking creative and practical solutions.

Priority 1: Healthy people in healthy communities

Northern Health will partner with communities to support people to live well and to prevent disease and injury.

Priority 2: Coordinated and accessible services

Northern Health will provide health services based in a Primary Care Home and linked to a range of specialized services which support each person and their family over the course of their lives, from staying healthy, to addressing disease and injury, to end-of-life care.

Priority 3: Quality

Northern Health will ensure a culture of continuous quality improvement in all areas.

CONTENTS

EXECUTIVE SUMMARY

About this report

The Board of Northern Health consults Northern BC residents regularly on important health issues. In 2018 another public consultation process was launched, and the topic was Heart Health in Northern BC. The results will complement the 2017 Northern Health (NH) Cardiac Strategy, which provides direction for bringing access to appropriate, seamless, quality cardiac care across Northern BC.

Cardiovascular disease is the most common cause of death globally. In Northern BC, as in the rest of the province, it is the second most significant contributor to the burden of disease, just behind cancer. This alone makes heart health an important topic to review, understand, and act on. Added to this, risk factors that have a direct bearing on chronic disease are seen at higher rates in Northern BC. These include physical inactivity, poor diet, smoking, obesity, and substance use. Access to health care is a challenge in mostly rural and often remote Northern communities, adding yet another reason to address heart health.

From September to December 2018, residents of Northern BC provided their ideas, stories and advice to Northern Health on heart health and cardiac care services. Thirty-four meetings were hosted, including focus groups with cardiac patients and family members; public meetings; sessions with Indigenous communities and health leaders; and meetings with service providers and local stakeholders. These meetings, along with ideas submitted through an online forum called Thoughtexchange, engaged more than 700 Northern residents.

Participants provided honest, heartfelt, and clear comments. They expressed appreciation for what is working well to prevent heart disease, and to treat those who live with it. There were also critical comments on what needs to improve.

This report summarizes what was learned. It describes common themes heard across the North, as well as what was learned in each separate meeting and through online engagement.

The report includes recommendations for the Board and senior management of Northern Health to use in their planning. These recommendations are not prescriptive, but are presented as strategies to consider. Some can be acted on more easily than others. The recommendations are not listed in order of importance. Each includes a rationale and strategies to consider when acting on it.

PHOTO OF QUEEN CHARLOTTE SUNRISE BY SJ KERR

Recommendation 1: Prevent heart disease

Work with local governments, Indigenous groups, community organizations, and Northern Health primary care teams to increase education and screening, and to contribute to improving access to recreation, healthy food, adequate housing, and inclusion.

Rationale

The best approach to dealing with heart disease is to prevent it in the first place. It's useful that the same approaches to preventing other chronic diseases also help prevent cardiac conditions from worsening or reccurring.

Prevention of heart disease (and other chronic illnesses) is supported through healthy personal behaviours that reduce the risk of illness. These include having a healthy diet, being physically active, monitoring body weight, and not using tobacco.

Disease prevention is also supported through a person's living situation, which is not necessarily dependent on personal behaviour or choices. This means access to the necessities of a healthy life: adequate and healthy food, safe and appropriate housing, access to community facilities and transportation, not being stigmatized for differences, and having a sense of belonging to a family, community, and culture.

Providing useful and accessible information and education on heart disease and providing screening for risk factors are also key elements in prevention.

Northern Health is only one partner in providing services and supports that can help individuals and communities prevent heart disease. This is why a collaborative effort is needed.

Strategies to consider

BUILD ON EXISTING NORTHERN HEALTH PREVENTION EFFORTS

Northern Health's Population Health programs and efforts to embed promotion and prevention in primary care interprofessional teams (IPTs), already contribute to this work. During the current transition of public health staff and resources into local interprofessional teams there are challenges in maintaining some activities. This can be addressed by:

- Re-emphasizing the importance of school and community health promotion work as roles evolve in IPTs;
- Systematically integrating more screening and prevention education into individual patient visits;
- Ensuring services that provide nutrition and diet education and smoking cessation are more widely available, and well-communicated;
- Continuing to offer IMAGINE Grants for community health promotion (with an emphasis on preventing heart disease upon release of this report); and
- Ensuring the regional Population Health team's resources and expertise are understood and used, and that they have a good understanding of the operations of IPTs.

REINVIGORATE COMMUNITY AND INDIGENOUS PARTNERSHIPS

Community leadership in creating indoor and outdoor recreation opportunities, addressing community issues like access to food, affordable housing, economic development, transportation, safety, and education, all impact the prevention of heart disease. Northern Health's vision is to lead the way in promoting health and providing health services for Northern and rural populations. Much of its work in promoting health, beyond providing direct health care services, is as a partner. Efforts to further support prevention of heart disease include:

- Ensuring Northern Health community leaders (Health Service Administrators, Community Service Managers, IPT Leads) contribute to First Nations Health Authority – Northern Region, community health, local Indigenous community and social service tables and gatherings. This engagement allows Northern Health to bring expertise, evidence-based practice, resources and moral support to efforts to address community issues which affect the prevention of disease. This includes ongoing efforts to work with Indigenous community efforts;
- Advocating for local, provincial and federal policies that address the determinants of health, using evidence-based approaches, and building on current work with the University of Northern British Columbia (UNBC) and other research partners.

Recommendation 2: Improve access to quality cardiac care services

Develop a more integrated system of cardiac care in Northern BC, with a network that includes the smallest communities and links to services outside the region.

Rationale

Residents of Northern BC understand that not every health care service can be provided in every health facility. They do, however, believe that as residents of British Columbia, services should be fully available to them in an effective, coordinated way, and available as close to home as possible.

While appreciative of care provided for screening, diagnosis, treatment and rehabilitation for heart disease, residents find the current system is fragmented, has gaps and is not well understood or easy to navigate. Some health care providers share these feelings.

Many pieces of an integrated service are in place now or are being developed. A concerted effort, building on the 2017 Northern Health Cardiac Strategy, is needed to pull those pieces together, build capacity in services, improve coordination and use a closer-to-home lens in meeting patient and family needs.

The strategies below are aimed at improving both access to services, and services themselves, both locally and when patients must leave the North for care.

Strategies to consider

BRING CARDIAC SERVICES CLOSER TO PATIENTS

Almost every time a patient has a consult or meeting via videoconference or with a visiting specialist or technician, a trip out of town is avoided.

This is a benefit to people in Northern BC, where travel is often over long distances, and roads can often be dangerous due to animals and weather. The cost in time, dollars, stress, risk, and transportation can be significant.

EXPAND THE USE (1) TELEHEALTH AND (2) SPECIALISTS WHO VISIT NORTHERN COMMUNITIES

Northern Health and physicians can expand this service further by using existing technologies for videoconferencing, such as computers, iPads and smartphones. Any room can then be turned into a videoconferencing room; patients can be at a different location than their primary service provider; and all can participate in a conversation with the specialist.

Primary care teams can make sure patients know about the videoconference option, and physicians, nurse practitioners and IPTs can systematically request telehealth/videoconferencing from specialists when referring patients.

Similarly, Northern Health can increase efforts and systems that support an increase in services from visiting specialists, whether it be the cardiologists who visit Haida Gwaii, the internist who visits Fort Nelson, travelling pacemaker clinics, or other services. These include recruitment, incentives such as housing (or recreation), support for scheduling, and local space and equipment.

IMPROVE ACCESS TO SERVICES

WORK WITH CARDIAC SERVICES BC ON ITS CARDIAC SERVICES MODEL

Northern Health and Cardiac Services BC could collaborate to contribute to finalizing and then using the tiers of cardiac services model currently being developed, which should provide guidance about the types of service a community might expect to find locally (and elsewhere).

EXPAND THE REACH OF SOME SERVICES IN NORTHERN HEALTH

Sometimes there are constraints caused by staffing, equipment and low levels of local use (for example, echocardiogram equipment is available, but no technician). However, we can test innovative approaches to recruiting and scheduling staff, sharing resources, and providing access to services like stress tests, echocardiograms and patient education.

IMPROVE COORDINATION OF CARE

Northern cardiac patients and their families feel considerable anxiety because of the following:

- Gaps in information
- Uncertainty about how to ask questions
- Poor communication between specialists and local health care providers
- Not knowing about next steps or referrals
- Unexplained wait times
- Not feeling their concerns were properly heard, understood or believed.

SUGGESTED SOLUTIONS:

- Develop an established, documented community cardiac care pathway, including
  - Community awareness and information
  - Integrated care locally (through primary care)
  - Defined and well-coordinated community followup and supports when returning from out-of-region care
- Work with St. Paul's, Kelowna General and the other three cardiac centres to develop a more consistent and coordinated approach to social supports (travel, accommodation etc.) and information provided upon discharge.
- Expand Northern Health's online cardiac care links with detailed information on local support for cardiac patients, including information on rehabilitation services, peer support networks and NORTH (Network of Regional to Tertiary Healthcare) heart function clinics.

Recommendation 3: A regional cardiac centre in Northern BC

Take steps toward creating a regional cardiac centre based in Prince George.

RATIONALE

The geographic, environmental, social and economic challenges of living in Northern BC impact health. People living in the North exhibit more risk factors that have a direct bearing on chronic disease than seen elsewhere in BC, and travel challenges can be daunting. In all regions of BC, the proportion of seniors in the population is increasing, leading to an increased need to address chronic disease, including cardiac disease.

While some procedures would still require travel south, a cardiac centre in Prince George would offer some specialized diagnostics and treatment for Northern BC residents, and other BC regions would also benefit through referrals. Such a centre would enable Northern Health, Cardiac Services BC, UNBC, the Divisions of Family Practice, and other partners to develop a more fully integrated system for

Northern cardiac care. This would provide support for a fuller continuum of services; improved patient coordination; recruitment of health care staff; education; and research relevant to the population.

The consultation showed that support for this direction is strongest in communities nearer Prince George, moderate as the distance increases, and weaker at extreme distances. It is important to understand that all cardiac patients in Northern BC could benefit from a more comprehensive approach to needed services, but many patients and referring physicians would continue to use specialized services in Southern BC.

Strategies to consider

- Develop plans that ensure people with cardiac disease have access to cardiac programs and services across all regions in the North, with a regional centre integrated into a network of care, complementing and expanding specialized services in the North.
- Complete the analysis and feasibility work needed to determine whether a regional cardiac centre in Northern BC will fill unmet needs and will be successful (usage, effectiveness, impact, quality).
- Review the Cancer Centre for Northern BC for lessons learned: history, staff recruitment, usage, travel patterns, and other relevant information.

Work with institutional and government partners to establish steps toward implementation.

Recommendation 4: Rehabilitation services

Ensure cardiac rehabilitation services are consistently offered, are understood by health care providers and patients, and are coordinated with out-of-region specialized care.

Rationale

People living with cardiac disease must often change their lives in order to remain as healthy as possible, enjoy day-to-day life, and reduce the risk of serious cardiac events. This means learning about appropriate ways to exercise; eating an appropriate diet; monitoring their own state of health; using prescribed medications properly; and more. Patients also often need advice and encouragement to make lifestyle choices and to help family, friends, and co-workers understand their needs. This may need professional and structured services.

The consultation revealed a significant lack of knowledge about what rehabilitation supports and services are available, and a perception that there are not enough available in many communities.

Strategies to consider

INCREASE AVAILABLE REHABILITATION PROGRAMMING

- Clarify what good cardiac rehabilitation practice looks like in each size of community, and work with health care providers and community partners to put visible and scheduled rehabilitation services in place.
- Develop models of cardiac patient peer support that are widespread, structured and well-promoted. These could be based on the Chronic Disease Self-Management Program at the University of Victoria, or other existing models.
- Use telehealth facilities or community video meeting spaces, such as libraries, to provide education and group appointments from better resourced centres to those that are more remote.

REFERRALS AND INFORMATION

- Ensure existing NORTH heart function clinics are adequately staffed and well promoted to primary care practices and patients. This will help provide heart failure patients with advice, medication adjustments, monitoring, education and care. The clinics also support education for health care workers.

- Give specialized centres, such as St. Paul's Hospital, written and online information to support Northern BC patients on discharge. Strive to put accurate information and contacts directly in the hands of patients and their families.

Recommendation 5: Support for patients and families

Improve support for cardiac patients and families through enhanced coordination of their health care journey and finding ways to reduce the burden of travel.

Rationale

Some of the strongest sentiments, stories and suggestions in the consultation were about

- Struggles patients and families have around getting timely information
- Difficulties in getting answers to their questions
- A lack of coordination and communication between their care providers
- Struggles with travel
- Feeling left alone to deal with their anxieties and fears

Where these concerns seemed less intense, there was helpful primary care being provided by doctors, nurse practitioners and other team members; thoughtful care providers along the way; and access to needed information. Those who already are, or became, effective self-advocates also felt less frustration.

Some patients actually choose not to travel out of the North for life-saving diagnosis or intervention for reasons such as these:

- The intimidation of going to a larger centre and not knowing how to navigate the travel needs involved
- The difficulty in arranging the travel needs of a family member
- Because they have obligations, they cannot leave (for example, they're the primary caregiver for a person with dementia).

This is not an easy area of work to improve, especially with the demands for clinical support, the different systems care providers use, and a shortage of primary care providers and Northern Health staff in some locations. However, addressing these issues more fully may improve patient experience, and health outcomes.

Strategies to consider

REDUCE THE GAPS IN COORDINATION OF CARE

- Strengthen the coordination of cardiac patient care by ensuring interprofessional teams provide structured support. This includes basic help like helping patients set up referrals that consider their schedules and travel requirements. It can also include telling care providers in Southern BC about Northern community locations and distances.
- Provide more standardized, detailed information and weblinks for those diagnosed with heart disease in Northern BC and promote its use.
- Increase the direct engagement of primary care teams with local Indigenous health leaders. This will help improve the coordination of care and enhance the care providers' understanding of the unique assets and needs of Indigenous communities, from prevention through to rehabilitation.

IMPROVE TRAVEL SUPPORT

- Explore creating a Northern Health advocacy position for enhancing support for patient transportation, both emergency transfers and travel for specialized care. Examine other policies in Canada's Northern regions. This may involve engagement with other agencies and local government.
- Increase staff and physician education around the psychosocial aspects of receiving care for a heart event.

INTRODUCTION

The people of Northern BC tend to be strong and resilient. They live in a vast, mostly rural area and are used to coping with the challenges this brings to daily life. A significant portion of the population are Indigenous people, who have thrived for thousands of years in this region. Northern Health's primary concern is the health and well-being of all residents of Northern BC.

Northern Health's Board of Directors regularly consults with residents on issues important to planning for health care. In previous years, public consultations have included:

- Let's Talk About Health (2004);
- Premier's Consultation for Improved Cancer Care in Northern BC (2006);
- Let's Talk about Mental Health and Addictions (2007);
- Let's Talk About Primary Health Care (2009);
- Let's Talk About Men's Health (2011);
- Let's Talk About Healthy Ageing and Seniors' Wellness (2013); and
- Growing up Healthy in Northern BC (2016).

After all these consultations, a public report was produced, and the findings were used to guide Northern Health plans and operations. In some cases, the work also led to new approaches with communities and other partners, since the health of Northern BC residents is not solely the responsibility of the health care system.

The 2018 consultation

In 2018, the consultation was focused on Heart Health in Northern BC. This report on that consultation will complement and help guide the work outlined in the 2017 Northern Health (NH) Cardiac Strategy, which provides direction for bringing access to appropriate, seamless, quality cardiac care across Northern BC.

The report is not a scientific survey. It does, however, represent the thoughts of hundreds of residents of Northern BC, many with direct experience with heart disease and the health care system. While participants certainly provided insight into what needs to improve, many also expressed gratitude for the health care providers who help them or their loved ones.

PHOTO BY SJ KERR

BACKGROUND

Cardiovascular diseases are the most common cause of death globally and the second most common in Canada. They include atherosclerosis or ischemic heart disease, malfunctioning heart valves, arrhythmias, heart failure, and structural heart disease. The most current data from the Public Health Agency of Canada's Canadian Chronic Disease Surveillance System (CCDSS) indicate that about one in 12 (or 2.4 million) Canadian adults age 20 and over live with diagnosed heart disease (2013).

This disease costs the Canadian economy over $22 billion a year, including its impact on the health system, lost wages, and reduced productivity. Most cases of heart disease are preventable, or can be significantly mitigated, by addressing lifestyle risk factors.

Figure 1

Compared to people in other areas of the province, people in Northern BC have lifestyle behaviours that are less healthy, more challenges in accessing cardiac services (such as screening, diagnostics, interventions and rehabilitation), and poorer health outcomes. All of this combines to make this topic particularly relevant to Northern Health and those it serves.

The 2018 consultation invited discussion on heart health and cardiac services, across a full spectrum, from prevention through to followup or rehabilitation for heart disease treatment (Figure 2 below). As indicated by the arrow, this process can by cyclical.

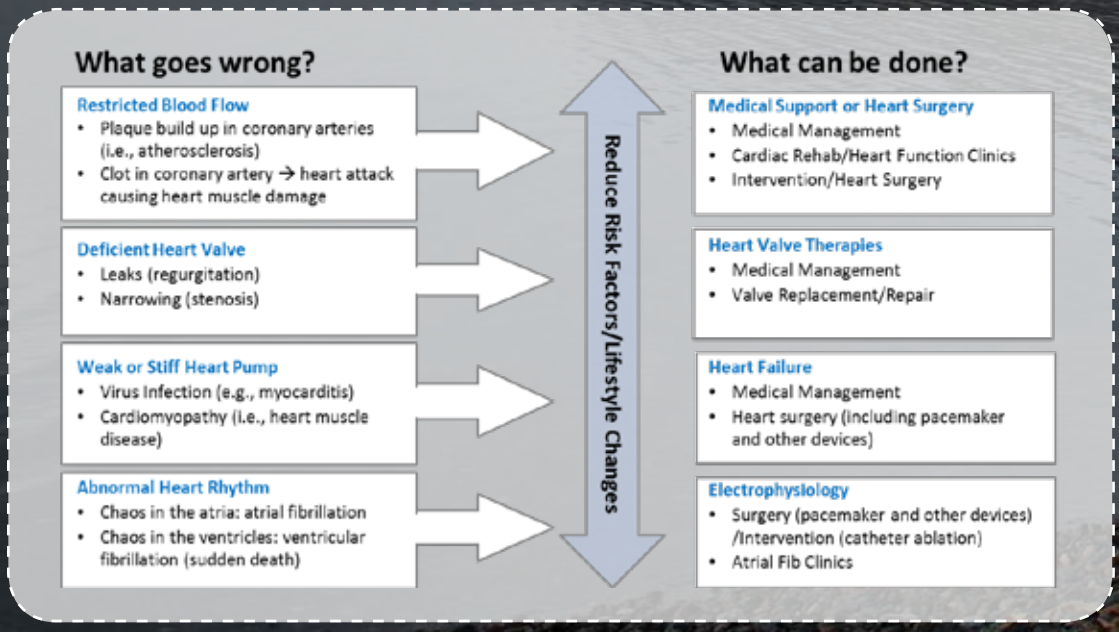


Figure 1 provides a basic overview of common cardiovascular diseases, showing the conditions and treatments.

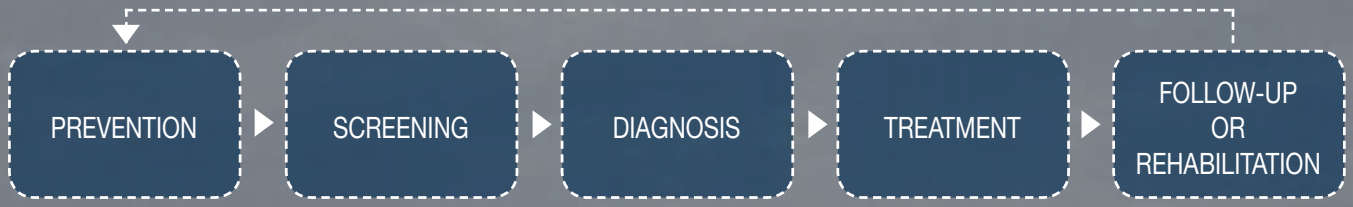


Figure 2

We know that much of what influences heart health is outside the health care system. The heart is strongly influenced by personal lifestyle choices around smoking, diet, exercise and stress, and by the context of people's lives: their families and communities, resources available to them, and their sense of connectedness with their peers, family and community.

Northern Health has a role to play in prevention of heart disease, but we also need the efforts of local, provincial and Indigenous leaders and the services they govern; the education sector; not-for-profit organizations; and public and private health care providers.

This report summarizes what was heard across the North and provides recommendations for future planning. It also includes highlights from each community meeting and an overview of the results of the online Thoughtexchange process.

This information will be used by Northern Health's Board of Directors and senior management to guide their planning and to make ongoing improvements across the entire region, and community by community. The report will be available to the public at www.Northernhealth.ca.

PHOTO OF FORT ST. JAMES BY SJ KERR

CONSULTATION PROCESS

The 2018 consultation was promoted through media and Northern Health sites. It was also communicated to local governments, Indigenous and community organizations, and by distributing posters.

Meetings included open public sessions, stakeholder and service provider meetings, patient and family focus groups, and discussions with Indigenous residents and health leaders. The meetings were facilitated by Gary Ockenden and Penny Lane (Withinsight) and included a short presentation on heart health and the 2017 Northern Health Cardiac Strategy. Presenters were Jessica Place, Executive Lead, Regional Chronic Diseases Programs; Kristin Massey, Lead, Cardiac and Stroke Care; and Susan Kerr, Clinical Nurse Specialist at Cardiac Services BC.

Executive sponsors of the consultation were Dr. Ronald Chapman, Vice President, Medicine; and Steve Raper, Chief, Communications and External Relations.

Many participants arrived with personal questions about heart disease or cardiac services, and in most cases team members could address these. Patients and family members from across the region shared direct, moving and courageous personal stories.

COMMUNITIES VISITED:

- Burns Lake
- Burns Lake & area Indigenous community
- Chetwynd
- Dawson Creek
- Fort Nelson
- Fort Nelson First Nation
- Fort St. James
- Fort St. John
- Hazelton
- Kitimat
- Masset & Old Masset
- McBride
- Nak'azdli & area Indigenous community
- Prince George
- Prince Rupert
- Queen Charlotte
- Quesnel
- Smithers
- Terrace
- Valemount
- Vanderhoof

FIRST NATIONS HEALTH COUNCIL MEETINGS ATTENDED

- Northeast Sub-Regional Caucus
- Northwest Sub-Regional Caucus
- North Central Sub-Regional Caucus

PARTIAL LIST OF REPRESENTATION/PERSPECTIVES AT MEETINGS

Participants represented a range of roles, views and life experiences:

- BC Ambulance
- BC Ferries
- CAO of Municipality
- Child Youth Mental Health Action Team
- Community members
- Dietitians
- Division of Family Practice
- Elders
- Family members of people living with heart disease
- Family physicians
- First Nation Chiefs
- First Nation Councillors
- First Nations health leaders
- Friendship House
- Healthy Community Board
- Heart and Stroke Foundation
- Home Support workers
- Internists
- Librarians
- Mayors and Councillors
- Men's Shed community group
- Mental Health workers
- Nisga'a Health Board
- NH local/regional leaders
- NH Primary Care Team Leaders
- Nurses
- People living with heart disease
- Pharmacists
- Physiotherapists
- Recreation managers
- Regional Hospital District members
- Retired nurses
- Retired teachers
- School Districts
- School Principals
- Seniors

Northern BC residents, including Northern Health staff, were also encouraged to contribute ideas and rank others' ideas through the innovative online Thoughtexchange process https://thoughtexchange.com.

Participation

Communities visited	21	Meeting participants	452
Meetings hosted	34	Online participants	330

The 330 people who actively participated in Thoughtexchange online offered 423 ideas on heart health and cardiac care, and reviewed others' ideas, indicating which resonated most by placing stars on them (8,297 total stars). Online participants were 48% community members, 50% NH staff members, and 2% private health care providers.

In creating this report, written comments received directly at Northern Health offices or handed to meeting facilitators were also reviewed.

What were participants asked?

PEOPLE WERE ASKED THE QUESTIONS BELOW (MODIFIED, DEPENDING ON THE MEETING).

What is working well to promote heart health and prevent heart disease in your community?

When you think about heart health and cardiac services, what is working well?

What are opportunities for improving heart health and cardiac care in your community and in the North?

PARTICIPANTS ONLINE (THROUGH THOUGHTEXCHANGE) WERE ASKED THIS QUESTION:

What are some things about heart health and cardiac care that are working well, and what are some things we should focus on in order to improve?

PHOTO OF VALEMOUNT BY SJ KERR

FINDINGS

Residents of Northern BC are appreciative of the services they have to help them prevent and live through and with heart disease. However, without exception, every community expressed the desire, in some cases insistence, that services improve, both locally and away from home.

The views of more than 700 residents of Northern BC are represented in this report. While there was diversity in how the questions were answered, broad themes arose. These are described below, based on their frequent mention and degree of emphasis. Detailed community-by-community themes are in Section 7.

There is overlap in what is working well and what could be improved, as many issues elicit thoughts on both.

Prevention and promotion

With no prompting, participants were able to identify individual behaviours and community and health care supports that help prevent heart disease. These include broad health promotion and reducing individual risk factors, and the next step of screening at-risk people to control risk factors and provide early intervention. Ideas were consistent from location to location, although how well communities or groups were doing with actions that may prevent heart disease varied.

INDIVIDUAL BEHAVIOUR

Participants had a good understanding about personal behaviours that help prevent heart disease or help people recover after a cardiac event. These include exercising regularly, eating a healthy diet, managing weight, not smoking, and managing stress. As noted in the community reports in Section 7, there are many assets in communities that support physical activity and some services or programs that support a healthy diet and tobacco cessation.

There is a sense that health promotion activities by Northern Health have waned at the local level and that more can be done with active education about heart disease and ways to prevent it. This includes more health fairs, patient education in hospitals and clinics, and providing more access to dietitians and nutrition support

"In our community, you can self-refer to register for dietitian support. That helps!" – Meeting participant

A COMMUNITY CONTEXT FOR HEALTHY LIVING

While personal behaviour and some of the education, local programs, services and culture that reinforce healthy behaviour are important, there are still factors in some people's lives that make it challenging to achieve a healthy life. These include the basic determinants of health, such as a secure supply of good food, safe and appropriate housing, an adequate income, access to community activities, and public transportation.

Other barriers that make healthy personal behaviour challenging are mental health and substance use issues, lack of knowledge or information, and a feeling of exclusion or stigma.

As well, Northern BC culture may influence health behaviour: it includes strong notions of independence and stoic behaviour, the use of alcohol and tobacco, tough and sometimes dangerous work, and eating poorly. (This is not universal, however and may be changing.)

"It's easy to tell someone what they should do to improve their health, but they need resources."
– Thoughtexchange participant

SUPPORTING PREVENTION

Participants described many community and organizational resources that can help prevent illness or with early identification of risk. They also noted areas where this could improve.

- Community infrastructure and recreation facilities: Rinks, playing fields, community centres, gyms, walking trails, and tracks, ski hills, walking groups, sports, school programs, good sidewalks, bike trails and more. The role of local governments and band councils was seen as important, and many leaders also understand that. Removing financial, transportation and stigmatizing barriers to accessing programs and facilities will help more people participate.
- The great outdoors: Every community in Northern BC has relatively easy access to hiking trails, ATV-ing, water activities, hunting, fishing, and simply being outside in fresh air. Most also have access to outdoor winter activities like downhill and cross-country skiing, snowshoeing, snowmobiling, and skating.
- For many people in Northern BC, including many children, access to adequate healthy food is limited. Poverty is an underlying issue. There are food banks, community gardens, informative "walk-throughs" in grocery stores, access to dietitians and nutritionists, and a movement in Indigenous communities to return to a more traditional diet.
- Specialized programs for men contribute to prevention: Two examples are Men's Sheds, which are friendly, inclusive, creative, shared workshop spaces, and the Indigenous men's DUDES Clubs—spaces that facilitate a participant-led community for men's wellness.
- Fitness challenges and organized outdoor events also foster physical activity, community involvement and lead to improved health.
- The public and health care providers need more education on how men and women can present differently with heart disease.
- As well as the community-based contributions noted above, the health care system is described as helpful. This includes screening and prevention advice and support through family doctors, nurse practitioners, and others on interprofessional teams (IPTs). It also includes health promotion programs, with information and screening for heart health (and other issues). This is recognized as useful, although perceived to have waned in most locations.
- A shortage of health care providers (for example, physicians, dietitians, and nurses) is seen as limiting Northern Health's ability to support promotion and prevention, including more screening clinics. The evolution of interprofessional teams (IPTs) should provide increased capacity over time for education, screening and health promotion, but is not seen as being in place yet.

PHOTO OF PRINCE RUPERT BY SJ KERR

Cardiac care services – local

Patients in all Northern communities must travel for most specialized cardiac diagnosis and treatment. In fact, many must travel for basic primary care. Many issues were raised around this.

PRIMARY CARE

"Patients with chronic illness need continuity of care."
– Thoughtexchange participant

Good cardiac care, from prevention to coordination of specialized treatment, starts with primary care. Where there is adequate access to family physicians or nurse practitioners and where there is success with interprofessional teams, care was praised. However, in some communities, this access isn't available. This could be due to recruitment issues, vacancies in health care positions or other factors, but it clearly limits the quality of care. The transition to the new model of primary care is seen as promising, but with some distance to go before the benefits are realized.

Many stories were heard of patients not feeling heard, believed, or understood by family doctors, or hospital or emergency staff. This included women and patients with atypical symptoms. Those who are strong advocates for their care, or who have a family member play that role, have better outcomes than those disappointed with care.

ACCESS TO DIAGNOSIS AND TREATMENT

"Expand or brush up GPs'/NPs' knowledge and skills and resources for managing heart health, and provide expert consultation support when they need it." – Thoughtexchange participant

There is good access to diagnostic support in, or near, some communities, such as internal medicine physicians, stress tests and echocardiograms. In some cases, more local services are possible, but technicians are unavailable.

There are long waitlists for some services, which may be the result of staff shortages. There is a perception that people in centres with more services, such as Prince George, receive them first. However, there is also a recognition that patient capacity and staffing shortages make access particularly challenging in Prince George as well.

Local access to specialist care is limited, but some larger centres have internists, who are greatly appreciated.

"We have a long QT specialist who visits and collaborates with a cardiologist from Terrace." – Indigenous participant

The NORTH (Network of Regional to Tertiary Healthcare) heart function clinics were mentioned with appreciation by those who used them. These clinics provide advice, medication adjustments, monitoring and education. However, they are not well known and may have limited capacity.

CLOSER TO HOME

There is strong support for bringing services as close to home as possible. This means providing every service possible in a community, and when this isn't possible (or doesn't make sense, such as for many specialized services), bringing in as many services on a visiting/virtual basis as possible.

Telehealth is being used in all Northern Health locations and its use is growing, including for cardiology consults. However, there doesn't seem to be a concerted effort to expand this by allocating space, technology, staff time, and communications to making it more available, or to the work of recruiting more specialized service providers to use it. Telehealth could be used much more for education, heart disease or chronic disease groups, and peer support groups.

"Going off-island for a two-minute appointment makes no sense at all. Let's increase the use of telehealth and videoconferencing."
– Meeting participant

The same can be said for visiting services, whether diagnostic (echocardiograms, for example), consultative (internists, cardiologists), or monitoring and rehabilitative (pacemaker reviews). More concerted effort could be made to expand this approach.

Community paramedics are a great boost to monitoring and providing support to people at risk, including cardiac patients. This position is still not widely known about or understood.

PRINCE GEORGE AND FORT ST. JOHN

Some patients, particularly within the Northern Interior Health Service Delivery Area (HSDA), are referred to Prince George for cardiac diagnostic services not available locally, or for cardiology consults. This care is appreciated, although many comments were made, particularly online, about overcrowding and staff shortages at University Hospital of Northern BC (UHNBC). Similar concerns were heard about Fort St. John Hospital, which provides cardiac diagnostic services for the entire Northeast Health Service Delivery Area.

Cardiac care services out of the region

No one asks to develop a health problem that needs them to travel many hours from home, sometimes for days, and for some, this travel is by emergency transport. Yet for most in Northern BC with heart disease, this is the reality. Whether it's scheduled travel, for an angiogram, echocardiogram or a visit with a cardiologist or other specialist, or emergency travel by vehicle or aircraft, it's difficult for the patient and their loved ones.

COMMUNICATIONS AND COORDINATION

"Once discharged from the hospital, it feels like you are left hanging."
– Thoughtexchange participant

For the best outcome for a cardiac patient, there should be a seamless journey through the various processes and services they must travel through, often more than once. Examples of good primary care that links care to all the other stations on the journey were provided, yet most participants described the gaps.

Although advocating for oneself or one's family member is important, it is unreasonable to think that a patient should know much before encountering disease. Northern residents frequently voiced concerns about being lost in the system; about having to repeat the same information multiple times (even at one site); about not being given critical information; about not being given a chance to ask questions; and about there being a gap between specialized care away from their community and ongoing monitoring, guidance, and followup with their local physician or nurse practitioner (and local specialist, for some).

Some gaps are attributable to multiple electronic record systems that are not yet fully integrated into health care. Some are due to scarcity in the health care system of capacity and personnel. And other gaps are due to workers who are caring, yet too busy to listen patiently; to ensure information and education have reached the patient and family; to understand the patient's home context, or even where on the map they're from; or to follow up and be sure needed steps in care have been achieved.

In some cases, specialists and primary care physicians work together well, communicating patient information and sharing care. The participants praised many family physicians, nurse practitioners and specialists. In other situations, communications and coordination appeared almost non-existent to patients and family.

ST. PAUL'S HOSPITAL

There are five cardiac centres in Southern BC, and patients may be referred to any of them. As well, some patients from the Northeast have received care in Alberta. However, most Northern BC referrals to specialized cardiac care, whether emergency triage or scheduled appointments, are to St. Paul's Hospital in Vancouver. While there are many suggestions as to how to improve the entire process from emergency transport to

communications between specialists and local doctors, the majority agreed that care at the cardiac centres is excellent and compassionate. St. Paul's Hospital and Kelowna General Hospital were mentioned often.

DISCHARGE

Praise aside, many patients had poor experiences with discharge from St. Paul's Hospital or elsewhere. This seems largely based on two factors: the burden and distance of travel isn't always appreciated, and communications around discharge and followup are often lost in translation—or sometimes literally lost.

There is a sense that one is cared for well, then put on the street to find the way home, even if flown down originally in an air ambulance. The costs — financial, physical, emotional, family, community, and health — for a patient from Northern BC are sometimes huge. Because of this, some patients simply chose not to travel for treatment because.

As well, discharge information isn't always connected to the reality at home; most small communities lack structured rehabilitation programs, for example, yet many patients are told to find one upon their return. Positive stories about a smooth transition between out-of-region care and local services were the exception.

A cardiac care centre in Northern BC

In some meetings, and in comments online, the question of establishing more specialized services in Northern BC was discussed. When specifics were provided, a catheterization laboratory or "cath lab" was the most mentioned service, although not the only one.

A cath lab is an examination room with diagnostic imaging equipment used to visualize the arteries and chambers of the heart,and treat any stenosis or abnormality found. Currently all Northern patients who need this must travel elsewhere — even with a cath lab, patients would need to travel south for some procedures..

The degree of support for creating a cardiac centre in Prince George as an additional option for all BC patients, particularly those in the North, varied with distance to Prince George. In the Northern Interior, there is very strong support for this direction. In other areas (Smithers, for example), support is mixed, and for communities at great distance from Prince George, such as Prince Rupert or Fort Nelson, not much support was expressed, and some skepticism was shown; instead, participants thought a focus on local services would benefit them more. It was recognized widely, however, that if a patient has family in, or knows Prince George, it would be a good choice. For some distant communities, vehicle travel is risky in winter, and air travel is inconvenient compared with flying directly to Vancouver.

"I would love to see a cath lab in Prince George. We would be able to give better care to clients in a timely fashion and recruit/retain cardiologists in the North." – Thoughtexchange participant

On the question of whether to set up a cardiac centre in Northern BC, several helpful points arose:

- The need for more capacity would have to be evident, and the option of St. Paul's Hospital or other centres must still be in place; "first available bed" is a strong principle;
- Attracting and retaining cardiologists, surgeons and other specialized services may be challenging;
- The quality of care provided would need to equal that of centres in Southern BC;
- Northern patterns of referral would change, and there would be an opportunity to strengthen the continuum of cardiac care across the North, through an enhanced Northern network;
- It should coincide with improving cardiac services across Northern BC, and should not reduce other resources;
- Patient Transfer Services (PTS) would need to prepare for a changing pattern of critical care transfers for cardiac patients;
- The Northern Health Connections

bus service would need to review its traffic patterns and routes; and

- Physicians across the North would need to provide feedback around the potential concerns and benefits of establishing new referral and coordination models for cardiac patients.

The BC Cancer Centre for the North provides an example of establishing specialized care to Northern BC that is worth reviewing; in a 2006 consultation, the initial response to the idea was very similar to the above.

Rehabilitation services

Cardiac rehabilitation teaches a patient to be more active and to make lifestyle changes that can lead to a stronger heart and better health, reducing the risk of future heart problems. People with many types of heart or blood vessel disease can benefit from cardiac rehabilitation.

- Heart attacks
- Coronary artery disease with stable angina
- Heart failure
- Angioplasty or bypass surgery
- Heart valve surgery
- Heart transplants

Why is cardiac rehabilitation so important? It helps patients manage their heart problems, exercise safely, take medicine correctly, eat a healthy diet, quit smoking if needed, reduce stress, and manage depression or other issues.

Some communities in Northern BC have a formal rehabilitation program or a defined community resource, such as a doctor who does group sessions or weekly walks. Participants appreciated the NORTH Clinic, and the followup calls some patients spoke of were of great benefit. Many communities have access to a dietitian and diabetic educator, device outreach clinics, and telehealth support. Some communities also have exercise programs tailored for cardiac rehabiliation.

While it's understandable that a patient in a remote or small community may not have access to the professional help needed for coordinated, supportive and ongoing rehabilitation, it was alarming to hear from patients who either had no access to rehabilitation or simply didn't know what was available in their communities. In more than one session, patients from a community gave important rehabilitation information to other participants who were not aware of it.

"Why is there no cardiac rehabilitation in the Northwest? We know there is significant benefit to patients who attend rehab after treatment for heart attack, but it isn't available to Northern residents." – Thoughtexchange participant

As already noted, specialists or discharge coordinators from Vancouver or elsewhere often recommend rehabilitation services to cardiac patients from Northern BC, with seemingly little or no idea of what's actually available.

While some patients and family members find information on their own or ask for support from their doctor or primary care team, many simply do not.

A lack of rehabilitation support has one outcome that's very important to recognize: increased stress and anxiety for a cardiac patient and those who support them.

The burden of travel

"I personally know five people who had to go to Vancouver to receive emergency cardiac care in the past 13 months. The patients were not charged for flights to Vancouver, but had to find their own way home upon discharge. For three of them, it caused significant hardship." – Thoughtexchange participant

Travel away from home for health care can be stressful, costly, and difficult to arrange. It can challenge families, workplaces and communities – and of course, patients. This is true whether the travel is emergency-oriented (e.g., land or air ambulance) or planned in advance. People who live in Northern BC understand this better than many others in the province.

Northern Health Connections, the medical travel bus service provided by Northern Health, operates both within the North and also to and from Kamloops and the Lower Mainland. Participants valued and appreciated it. That said, it doesn't meet all needs and situations.

The Patient Transfer Coordination Centre (PTCC), based in Vancouver, coordinates all critical care transport (both air and ground), and non-critical air transport within BC. Many cardiac patients need this service, and stories abound about how valuable they found it. However, there are two significant concerns with critical care transports:

- Whether they can move patients without dangerous delays caused by weather or higher priority transfers
- Unless the patient needs a paramedic with them, they're on their own to find their way home.

Even with planning and support, this is difficult. It can be extremely difficult for people who have no one coordinating travel for them, and who are already weak and/or not in a position to cover costs. Some consultation participants described considerable hardship. This is also true of planned travel (non-emergency). In both cases, there's also often the cost of private accommodation, plus meals and local travel for the patient and the people supporting them.

Indigenous community services

Most ideas raised in discussions with Indigenous community members and health care leaders mirror those heard elsewhere. Some unique issues or ideas were raised as well:

- Health services in Indigenous communities are a part of self-determination and having a healthy community. They are sometimes fragmented from provincially funded primary care, hospital and other services that community members must access. However, the following are helpful:
  - Better coordination and communication with Northern Health interprofessional teams;
  - Physician visits to Indigenous communities;
  - Improved communication locally and regionally.

"Time is heart muscle; early intervention is key not only to improve mortality and morbidity but to decrease health care spending." – Thoughtexchange participant

- Northern Health and the First Nations Health Authority strive to work together and to coordinate their efforts.
- Some Indigenous people have access to help coordinating their health travel, and to reimbursement for some costs, although it's clear this isn't always adequate, particularly when family members are also travelling.
- Northern Health is striving to support increased cultural competency and safety throughout all its health care facilities and operations, and this initiative is appreciated.
- The 10 Aboriginal Patient Liaison roles available across the North to help Indigenous people and their families access high-quality, culturally safe health care.
- Indigenous communities recognize and are acting on the knowledge that their traditional ways of eating and being active were healthy. The Haida Fork to Table program in Old Masset is a good example of this.

However, some Indigenous voices in the consultation confirm that there remain subtle (and sometimes not so subtle) discrimination during some health care encounters. A patient's level of trust in care providers, and the belief that they're being understood and treated with dignity, are important elements in receiving care and feeling well.

PHOTO OF FERRY TERMINAL AT ALLIFORD BAY BY SJ KERR

RECOMMENDATIONS

This report provides a summary and analysis of what Northern BC residents expressed about heart health and cardiac care in Northern BC. Recommendations arising from the consultation are described below. These are not meant to replicate or replace the strategies and goals in the 2017 Northern Health Cardiac Strategy; they should complement that document, providing additional guidance on approaches and priorities.

The recommendations are not listed in order of importance, and are not meant to be prescriptive. Once reviewed by the Board of Directors, Northern Health staff will integrate agreed-upon changes into operational plans. Each recommendation includes a rationale and strategies to consider when acting on it.

Recommendation 1: Prevent heart disease

Work with local governments, Indigenous groups, community organizations, and Northern Health primary care teams to increase education and screening, and to contribute to improving access to recreation, healthy food, adequate housing, and inclusion.

Rationale

The best approach to dealing with heart disease is to prevent it in the first place. It's useful that the same approaches to preventing other chronic diseases also help prevent cardiac conditions from worsening or recurring.

Prevention of heart disease (and other chronic illnesses) is supported through healthy personal behaviours that reduce the risk of illness. These include having a healthy diet, being physically active, monitoring body weight, and not using tobacco.

Disease prevention is also supported through a person's living situation, which isn't necessarily dependent on personal behaviour or choices. This means access to the necessities of a healthy life: adequate and healthy food, safe and appropriate housing, access to community facilities and transportation, not being stigmatized for differences, and having a sense of belonging to a family, community, and culture.

Providing useful and accessible information and education on heart disease and providing screening for risk factors are also key elements in prevention.

Northern Health is only one partner in providing services and supports that can help individuals and communities prevent heart disease. This is why a collaborative effort is needed.

Strategies to consider

BUILD ON EXISTING NORTHERN HEALTH PREVENTION EFFORTS

Northern Health's Population Health programs and efforts to embed promotion and prevention in primary care interprofessional teams (IPTs) already contribute to this work. During the current transition of public health staff and resources into local interprofessional teams, there are challenges in maintaining some activities. These can be addressed by:

- Re-emphasizing the importance of school and community health promotion work as roles evolve within IPTs;

- Systematically integrating more education on screening and prevention into individual patient visits;
- Ensuring services that provide nutrition and diet education and smoking cessation are more widely available, and well-communicated;
- Continuing to offer IMAGINE Grants for community health promotion (with an emphasis on preventing heart disease upon release of this report); and
- Ensuring the regional Population Health's team resources and expertise are understood and used, and that they have a good understanding of how IPTs work.

REINVIGORATE COMMUNITY AND INDIGENOUS PARTNERSHIPS

Community leadership in creating indoor and outdoor recreation opportunities, addressing community issues like access to food, affordable housing, economic development, transportation, safety, and education, all impact the prevention of heart disease. Northern Health's vision is to lead the way in promoting health and providing health services for Northern and rural populations. Much of its work in promoting health, beyond providing direct health care services, is as a partner. Efforts to further support prevention of heart disease include:

- Ensuring Northern Health community leaders (Health Service Administrators, Community Service Managers, IPT Leads) contribute to First Nations Health Authority – Northern Region, community health, local Indigenous community and social service tables and gatherings. This engagement allows Northern Health to bring expertise, evidence-based practice, resources and moral support to efforts to address community issues which affect the prevention of disease. This includes ongoing efforts to work with Indigenous community efforts; and
- Advocating for local, provincial, and federal policies that address the determinants of health, using evidence-based approaches and building on current work with the University of Northern British Columbia (UNBC) and other research partners.

Recommendation 2: Improve access to quality cardiac care services

Develop a more integrated system of cardiac care in Northern BC, with a network that includes the smallest communities and links to services outside the region.

Rationale

Residents of Northern BC understand that not every health care service can be provided in every health facility. They do, however, believe that as residents of British Columbia, services should be fully available to them in an effective, coordinated way, and available as close to home as possible. While appreciative of care provided for screening, diagnosis, treatment and rehabilitation for heart disease, residents find the current system is fragmented, has gaps and isn't well understood or easy to navigate. Some health care providers share these feelings.

Many pieces of an integrated service are in place now or are being developed. A concerted effort, building on the 2017 Northern Health Cardiac Strategy, is needed to pull those pieces together, build capacity in services, improve coordination and use a closer-to-home lens in meeting patient and family needs.

The strategies below are aimed at improving both access to services, and services themselves, both locally and when patients must leave the North for care.

Strategies to consider

BRING CARDIAC SERVICES CLOSER TO PATIENTS

Almost every time a patient has a consultation or meeting via videoconference or with a visiting specialist or technician, a trip out of town is avoided. This is a tremendous benefit to people in Northern BC, where travel is often over long distances and roads can be

PHOTO OF QUEEN CHARLOTTE SUNSET BY SJ KERR

dangerous due to animals and weather. The cost in time, dollars, and stress can be significant.

- Expand the use of telehealth, which is widely available across Northern Health facilities. Northern Health and physicians can expand this service further by using existing technologies for videoconferencing, such as computers, tablets, and smartphones. Any room can then become a videoconferencing room; patients can be at a different location to their primary service provider; and all can participate in a conversation with a specialist. Primary care teams can make sure patients know about the videoconference option, and physicians, nurse practitioners and IPTs can systematically request telehealth/videoconferencing from specialists when referring patients.
- Similarly, Northern Health can increase efforts and systems that support an increase in services from visiting specialists, whether it be the cardiologists who visit Haida Gwaii, the internist who visits Fort Nelson, travelling pacemaker clinics or other services. This includes recruitment, incentives such as housing (or recreation), support for scheduling, and local space and equipment.

IMPROVE ACCESS TO SERVICES

- Work with Cardiac Services BC to contribute to finalizing and then using the tiers of cardiac services model being developed, which should provide guidance about the types of a service a community might expect to find locally (and elsewhere).
- Expand the reach of some services in Northern Health: Sometimes there are constraints caused by staffing, equipment and low levels of local use (for example, echocardiogram equipment is available, but no technician). However, we can test innovative approaches to recruiting and scheduling staff, sharing resources, and providing access to services like stress tests, echocardiograms and patient education.

IMPROVE COORDINATION OF CARE

Northern cardiac patients and their families feel considerable anxiety because of the following:

- Gaps in information
- Uncertainty about how to ask questions
- Poor communication between specialists and local health care providers
- Not knowing about next steps or referrals
- Unexplained wait times
- Not feeling their concerns were properly heard, understood or believed.

Strategies to consider:

- Develop an established, documented community cardiac care pathway, including
  - Community awareness and information
  - Integrated care locally (through primary care)
  - Defined and well-coordinated community followup and supports when returning from out-of-region care
- Work with St. Paul's, Kelowna General and the other three cardiac centres to develop a more consistent and coordinated approach to social supports (travel, accommodation, etc.) and information provided upon discharge.
- Expand Northern Health's online cardiac care links with detailed information on local support for cardiac patients, including information on rehabilitation services, peer support networks, and NORTH (Network of Regional to Tertiary Healthcare) heart function clinics.

Recommendation 3: A regional cardiac centre in Northern BC

Take steps toward creating a regional cardiac centre based in Prince George.

Rationale

The geographic, environmental, social and economic challenges of living in Northern BC impact health. People living in the North exhibit more risk factors that have a direct bearing on chronic disease than seen elsewhere in BC, and travel challenges can be daunting. In all regions of BC, the proportion of seniors in the population is increasing, leading to an increased need to address chronic disease, including cardiac disease.

While some procedures would still require travel south, a cardiac centre in Prince George would offer specialized diagnostics and treatment for Northern BC residents, and other BC regions would also benefit through referrals. Such a centre would enable Northern Health, Cardiac Services BC, UNBC, the Divisions of Family Practice, and other partners to develop a more fully integrated system for Northern cardiac care. This would provide support for a fuller continuum of services; improved patient coordination; recruitment of health care staff; education; and research relevant to the population.

The consultation showed that support for this direction is strongest in communities nearer Prince George, moderate as the distance increases, and weaker at extreme distances. It is important to understand that all cardiac patients in Northern BC could benefit from a more comprehensive approach to needed services, but many patients and referring physicians would continue to use specialized services in Southern BC.

Strategies to consider

- Develop plans that ensure people with cardiac disease have access to cardiac programs and services across all regions in the North, with a regional centre integrated into a network of care, complementing and expanding specialized services in the North.
- Complete the analysis and feasibility work needed to determine whether a regional cardiac centre in Northern BC will fill unmet needs and will be successful (usage, effectiveness, impact, quality).
- Review the Cancer Centre for Northern BC for lessons learned: history, staff recruitment, usage, travel patterns, and other relevant information for.

Recommendation 4: Rehabilitation services

Ensure cardiac rehabilitation services are consistently offered, are understood by health care providers and patients and are coordinated with out-of-region specialized care.

Rationale

People living with cardiac disease must often reorder their lives to remain as healthy as possible, enjoy day-to-day life, and reduce the risk of serious cardiac events. This means learning about appropriate ways to exercise; eating an appropriate diet; monitoring their own state of health; using prescribed medications properly; and more. Patients also often need advice and encouragement to make lifestyle choices and to help family, friends, and co-workers understand their needs. This may need professional and structured services.

The consultation revealed a significant lack of knowledge about what rehabilitation supports and services are available, and a perception that there are not enough available in many communities.

Strategies to consider

INCREASE AVAILABLE REHABILITATION PROGRAMMING

- Clarify what good cardiac rehabilitation practice looks like in each size of community and work with health care providers and community partners to put visible and scheduled rehabilitation services in place.
- Develop models of cardiac patient peer support that are widespread, structured and well-promoted. These could be based on the UVic Chronic Disease Self-Management Program or other existing models .
- Use telehealth facilities or community video meeting spaces, such as libraries, to provide education and group meetings from better resourced centres to those more remote.

REFERRALS AND INFORMATION

- Ensure existing NORTH heart function clinics are adequately staffed and well promoted to primary care practices and patients. This will help provide heart failure patients with advice, medication adjustments, monitoring, education and care. The clinics also support education for health care workers.
- Give specialized centres, such as St. Paul's Hospital, written and online information to give Northern BC patients on discharge. Strive to put accurate information and contacts directly in the hand of patients and their families.

Recommendation 5: Support for patients and families

Improve support for cardiac patients and families through enhanced coordination of their health care journey and finding ways to reduce the burden of travel.

Rationale

Some of the strongest sentiments, stories and suggestions in the consultation were about

- Struggles patients and families have around getting timely information
- Difficulties in getting answers to their questions
- A lack of coordination and communication between their care providers
- Struggles with travel
- Feeling left alone to deal with their anxieties and fears

Where these problems seemed less intense, there was helpful primary care being provided by doctors, nurse practitioners and other team members; compassionate care providers along the way; and access to needed information. Those who are already are, or became, effective self-advocates also felt less frustration.

Some patients actually choose not to travel out of the North for life-saving diagnosis or intervention for reasons such as these:

- The intimidation of going to a larger centre and not knowing how to navigate the travel needs involved
- The difficulty in arranging the travel needs of a family member
- Because they have obligations, they cannot leave (for example, they are the primary caregiver for a person with dementia).

This is not an easy area of work to improve, especially with the demands for clinical support, the different systems care providers use, and a shortage of primary care providers and Northern Health staff in some locations. However, addressing these issues more fully may improve patient experience, and health outcomes.

Strategies to consider

REDUCE THE GAPS IN COORDINATION OF CARE

- Strengthen the coordination of cardiac patient care by ensuring interprofessional teams provide structured support. This includes basic help like helping patients set up referrals that consider their schedules and travel requirements. It can also include telling care providers in Southern BC about Northern community locations and distances.
- Provide more standardized, detailed information and weblinks for those diagnosed with heart disease in Northern BC and promote its use. (This information doesn't need to be re-created – it can be collated from existing sources and more consistently promoted.)
- Increase the direct engagement of primary care teams with local Indigenous health leaders. This will help improve the coordination of care and enhance the care providers' understanding of the unique assets and needs of Indigenous communities, from prevention through to rehabilitation.

IMPROVE TRAVEL SUPPORT

- Explore creating a Northern Health advocacy position for enhancing support for patient transportation—both emergency transfers and travel for specialized care. Examine other policies in Canada's Northern regions. This may involve engagement with other agencies and local government.
- Increase staff and physician education around the psychosocial aspects of receiving care for a heart event.

COMMUNITY SUMMARIES

Northwest Health Service Delivery Area

FIRST NATIONS HEALTH COUNCIL – NORTHWEST SUB-REGIONAL CAUCUS MEETING

Date: November 7, 2018
Participants: 91 (Community Health Directors, Chiefs and Community Leadership, First Nations Health Authority staff and Northern Health leaders)

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Local screening, prevention and support

Heart health screening, exercise programs and partnerships with health professionals, such as community paramedics, all contribute to heart health. Healthbeat Screening, a program in Gitanmaax, provides six stations and includes counselling as well as directing people to existing programs, such as Brighter Futures, which includes an Elders' walking club with 70 participant). A pharmacy review also helps Elders make medication changes.

PHOTO OF ANCIENT FOREST HEMLOCK BY SJ KERR

FIRST NATIONS HEALTH COUNCIL – NORTHWEST SUB-REGIONAL CAUCUS MEETING

Date: November 7, 2018
Participants: 91 (Community Health Directors, Chiefs and Community Leadership, First Nations Health Authority staff and Northern Health leaders)

Partnerships

Community partnerships with Carrier Sekani Family Services in Prince George bring mobile diabetes nursing staff into a community, providing an opportunity to invite in people from other communities and to talk about holistic health (because most people don't have only one health issue). Partnerships with pharmacists and the local hospital can help to mitigate the impact of the doctor shortages that some communities are experiencing. Pharmacists can be advocates, and the chronic disease nurses can teach people about defibrillators, nutrition, living with diabetes, grocery shopping, CPR, etc.

Care at St. Paul's Hospital in Vancouver

Accessing cardiac care in Vancouver works well, despite the travel time needed. The care received was described as "amazing, reassuring and nice."

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITIES?

Screening and education

Holding annual events for Indigenous people to be screened and receive education from nurses, pharmacists and others around heart health, and other chronic diseases, is a start. Regular followup is also needed, particularly with community nurses. Emergency Medical Responders (EMR) are an important part of support, for education and assessment as well as in emergencies.

Receiving a timely and accurate diagnosis can be a challenge, sometimes because physicians may miss things, particularly with Indigenous people.

"I had a rapid heartbeat at one point in time three years ago and the doctor in Terrace put me on pills. Over time, I had to improve the way look after my health. I took my doctor seriously and changed my diet and started running and exercising. Two years later, I didn't need to be on the medication anymore." – Meeting participant

HAZELTON – PUBLIC MEETING

Date: September 26, 2018
Participants: 10

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Activity and food

A new community centre is close to opening and will support sports and activity. The Gitanmaax Hall welcomes people for walking three times a week. Children at Majagaleehl Gali Aks Elementary School are learning to garden, and more people are recognizing that eating fish and home-gardened food is wise. There used to be a community rototilling program, which could be revived.

Persistence and services

Once someone is flagged with a heart problem, things do happen, and the doctors are quick to search out a specialist if needed. Persistence and self-advocacy are valuable traits to have when working through the system. There is a long QT[1] specialist who collaborates with an intern (with cardiology) in Terrace. Stress tests have been available in Smithers and Terrace.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Awareness and prevention

There is not enough awareness of lifestyle changes that can help prevent heart disease and other chronic illnesses. How do we reach those who don't participate (in the Elders' group, for example)? It's important to understand that it's about healthy eating and exercise, but also about reducing stress, and that's sometimes beyond personal control. There's a lot of hypertension and high blood pressure in this community, making screening critical.

Access and wait times

While some participants had good experiences in cardiac care, others expressed concerns about wait times for transportation and for a bed in a cardiac centre.

Better support and information

Patients and families need more help dealing with the trauma of heart problems. The chapel in Wrinch Hospital could be a good place to help people deal with fear and get the information they need. When someone's sick, it affects their whole family. Having records available both locally and down South would be helpful.

"It's hard to live in our community with lateral violence, racism and the impacts of residential schools and a loss of culture. This adds stress. It's the hidden elephant in the room."
– Meeting participant

Cardiac centre in Prince George

While it's a long drive to Prince George, and some may continue to prefer going to Vancouver for heart care, especially in winter, Hazelton residents supported the idea of a cardiac centre in Prince George: it's familiar, there may be family there and Hazleton doctors work with them already. Better flights from Smithers to Prince George would help.

"I am going to start advocating more strongly for my family member and push for more followup care." – Meeting participant

1 Long QT syndrome (LQTS) is a condition which affects repolarization of the heart after a heartbeat and it is more common in some Indigenous populations.

KITIMAT – PUBLIC MEETING

Date: September 24, 2018
Participants: 24

WHAT SUPPORTS PREVENTION OF HEART DISEASE IN YOUR COMMUNITY?

Healthy community

Kitimat is a welcoming community with a wealth of opportunities to stay active and healthy. It's an excellent walking community, including in the arena in the winter. There are two pools, an excellent recreation centre, (50% discount for seniors), a golf course, 45 kilometres of trails (many lighted), an active seniors' centre, and nature at everyone's doorstep.

There seems to be a good attitude toward staying healthy. Education sessions are useful, including a diabetes session on diet and food.

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Services

In addition to a culture that supports healthy living, there are good services in Kitimat, beginning with much-appreciated doctors and nurses and a modern hospital. Starting in January 2019, an ultrasound technician should be available to do echocardiograms.

Access

Access to cardiac care has improved through the expanded use of telehealth appointments with specialists, and there is a medical bus to Terrace.

There's a successful six-week-long rehabilitation group that has run for 10 years using physiotherapy students; it's available to anyone.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Coordination and communication

There are breakdowns in the parts of the health system that support someone with heart disease. This is particularly true when someone's discharged from the specialty hospital (usually St. Paul's Hospital in Vancouver). Caregivers want more information and support and there needs to be an improved loop back to the Kitimat family doctor and hospital services. It seemed to some Kitimat residents that once they walk out the door after a serious procedure, they're on their own. Examples included a lack of followup after receiving a pacemaker. Information on what's available locally is difficult to find; could all health services be listed in one place?

Physicians who share patients in a practice are not always consistent in the advice they give on heart health. The new approach to integrating services around primary care (doctors and nurse practitioners) should help with this locally.

"We have amazing paramedics and firefighters in town." – Meeting participant

Access

It takes a long time to reach specialized hospitals in other cities, for both emergency travel and scheduled appointments. The burden of travel for special services is difficult for everyone (costs, time, disruption) and especially so for people who are already vulnerable.

Telehealth and visiting specialists are appreciated, but there could be more. Could a cardiologist visit regularly? Support to coordinate all that is involved in travel would be useful, particularly for seniors.

Followup care

While there is some support for rehabilitation from heart disease, it's not enough and it isn't clear how to access what's needed. Followup after a procedure (such as stents or valve surgery) relies on family doctors, who may not have the information and don't have much they can refer a patient and family to. Could occupational therapists be engaged in followup and home visits?

PHOTO OF NAKAZLI BY PENNY LANE

MASSET (AND OLD MASSET) – PUBLIC MEETING

Date: October 16, 2018
Participants: 7

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Healthy living

There are programs now to help children eat well and exercise regularly, including gardening in school and opportunities for kids to learn about hunting, fishing, and food gathering (Fork to Table, for example). The traditional Haida lifestyle was, and is, active and healthy. There's a greenhouse connected to the assisted living building.

There are walking programs for Elders (Biggest Loser), an adult day program and cross-generational activities. Not everyone is connected to these activities, so more promotion would be useful.

Physicians

Local physicians are appreciated, and it was noted that some make home visits and are quite engaged with the community.

Travel

Oddly, the isolation from many off-island services sometimes results in quicker and easier access to specialized services.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Closer to home

The more services that can be provided locally or brought in through technology or visiting health care providers, the better. More video rooms, better scheduling and more attention paid to video followup after cardiac treatment would help.

Better support

Home care and home support could be improved for cardiac (and other) patients. This could help with access to equipment, coordination of followup and help for those who struggle.

There could be more group visits with physicians and a heart health group. Peer support is built this way, as well as medical support.

"We need to reduce the difficulties families face including stress, diet, and financial cost when they have to leave the island for services — sometimes a 10-minute visit." – Meeting participant

PRINCE RUPERT – PUBLIC MEETING

Date: October 17, 2018
Participants: 4

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Local programs and services

The interprofessional teams (IPTs) are working more closely with internal medicine and specialists to coordinate care for patients with heart disease. There is also a great health promotion team getting information out about how to be well (eating, exercise, etc.). There are support groups for people with diabetes or cardiovascular disease.

Also working well are a local program that identifies high-risk pregnancies, then provides support through increased doctor visits and testing; the chronic disease management team (IPT); and support groups. These approaches could also be used for heart disease.

Prevention and activity

There are lots of opportunities to be active in Prince Rupert, including the benefits of simply walking, in the city or on the many trails in the area.

There are fruit and vegetable snack programs in the schools and lots of opportunities for youth to be active. The youth worker can access funds from Northern Health to cover costs if needed.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Travel

Remote living brings challenges, and the lack of understanding of distances makes visits out of the area difficult. One patient described being called from Vancouver for "an opening tomorrow morning." While the Northern Health Connections bus is useful, it's still difficult and expensive to get treatment. Added to this challenge is the lack of well-coordinated discharge planning when patients leave Vancouver. One patient described being stuck for several days in Vancouver after they were discharged.

The value of videoconferencing with specialists and for education was highlighted, because it works well and eliminates some travel.

Healthy Hearts

Programs to support people with heart issues are limited. There's one physician who provides stress tests, but there's a general lack of testing. There used to be a Healthy Hearts program, but the exercise portion ended and the equipment was given to the Civic Centre. This has created some accessibility challenges.

Quality of care

Some concerns were expressed around the lack of coordination by some physicians. Some use the chronic disease management team, and some don't, for example. Coordination of care between physicians and specialists seems hit and miss. Some patients (or family members) are successful advocates for care, but many simply don't know what they can do.

A trained public

A meeting participant provided information on a movement to expand access to learning CPR/AED (Automatic External Defibrillator) life-saving skills, noting that this would prevent many untimely deaths.

"We have fresh air and so many places to walk; the best prescription for chronic disease is to maintain the body and mind through walking." – Meeting participant

PRINCE RUPERT – STAKEHOLDER INPUT

Date: October 18, 2018
Participants: 5 (information from meeting physicians and staff at their work stations)

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Rehabilitation services

Staff and physicians recommend reviving the Healthy Heart Clinic and providing more coordination and support for rehabilitation from heart procedures.

Access and travel

Access to angiograms and other procedures is difficult at times, not just due to the travel barriers, but because of difficulties with scheduling them through the triage system as it works now.

Hospital services

More access to training for nurses around cardiac issues and other topics would be useful. Telemetry (transmission of monitoring data) needs to be improved, because it doesn't always work well, and monitors are needed on the ward.

PHOTO OF VALEMOUNT BY SJ KERR

QUEEN CHARLOTTE – PUBLIC MEETING

Date: October 15, 2018
Participants: 3

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Emergency care

A participant described the quick and effective response to a heart attack by first aid, ambulance and a physician. Within four hours, they and their spouse were on a flight south, and the care received at St. Paul's Hospital was excellent. The NORTH Clinic from Prince George contacted the patient by phone to offer education and answer questions about stress, depression, and eating.

Primary care

Local primary care is well-coordinated and seems to be more personalized, with long-term doctors, nurses and other staff providing good information and support. The clinic uses WelTel, a secure texting service, which is linked to the electronic medical record and allows both patient–physician communication and sharing of information to a group of patients.

Specialist care

Four visits a year are approved for outreach cardiology to Queen Charlotte. Two physicians associated with St. Paul's Hospital are regular visitors, providing great service for patients. However, there is little or no telehealth used for cardiology, in spite of four rooms available for booking.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Patient travel

As with other remote communities, the timeliness of travel is critical, but rapid air evacuation is the exception. Getting to the local airport requires a drive, a ferry and another drive. The Patient Transfer Network is a bottleneck.

The cost of patient and family travel is a huge burden for many. Flights, hotel, food, transfers: it adds up quickly. Could BC consider funding patient and family flights in some situations?

Group support

It would be useful to have a monthly health group, with time for questions, reviewing medication, and peer support. There might be enough people to have a specific cardiac group. This could be led by the integrated primary care team, which needs to eventually lead the work of understanding community needs and developing systems to address them. Haida Gwaii Hospital and Health Centre, Xaayda Gwaay Ngaaysdll Naay, could be used for this work.

Echocardiogram and stress testing

Would it be possible to do echocardiograms here with a travelling western-cluster technician, because it's difficult to keep them in a smaller community? This would reduce travel and improve quality of care. Treadmill testing could be developed, with a physician champion and an understanding of the need on the island.

Patient communication

There is sometimes a breakdown of communications within the triangle of patient–physician–cardiologist. During the critical period in St. Paul's Hospital, there may not be the time or information to properly understand the situation—even how bad (or not) the prognosis is.

SMITHERS – PUBLIC MEETING

Date: September 27, 2018
Participants: 22

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Active community

Smithers is an active community in general, with lots of opportunities for exercise. This includes a new rink, with walking circle, swimming for seniors, activities for children and an abundance of trails and parks.

Local services

Participants had a good deal to say about the strength of local services, in general and related to heart health. There are enough physicians for the population; a reasonably well-equipped hospital; excellent nurses and first responders; and many supportive services such as a dietitian, community medicine that does home health checks, and a lab.

There is help for cardiac issues through a local specialist, visiting internists, and telehealth consults. Stress tests are available locally, as is a program for chronic disease management. The ability to monitor cardiac patients with telemetry has been improved.

Emergency cardiac care

Emergency service for heart attacks basically works well, with a referral process for out-of-town requirements and excellent first response. Cardiac nurses from Prince George are available by phone.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

More prevention

While Smithers is a health-oriented community, ways to support heart health and prevent problems are particularly important as the population ages. There's not enough outreach to vulnerable people, who are more at risk. More community education and more public testing opportunities would help everyone. Men need more support to act on their health issues, and women need specific information about what a heart problem may look like for them.

Communications and followup care

There is a lack of clear and organized followup after a cardiac event. St. Paul's Hospital provides recommendations that can't be met in most Northern BC communities. It was suggested that there could be a common cardiac followup package describing what's available in Smithers, with contact information. Rehabilitation care is not consistent and there's inadequate support for family members. Mended Hearts, a San Diego program provided by Scripps Health, was described and promoted. It includes peer coaching from recovered patients. Could Smithers establish a "Heart Club" locally?

Improved services in the North

While telehealth is a great benefit for access, it could be used more and be better understood, and there could be more effort to engage specialists in using it. Internist support is appreciated, but more specialized cardiology expertise from local physicians would be useful, as would visits from cardiologists.

Establishing a cardiac centre in Prince George with a cath lab and other services was generally seen positively. It would offer a closer option for those who choose to drive or use the Northern Health Connections bus, and might induce more flights between Smithers and Prince George. For this to be a good option, it would have to provide excellent service, as that is what people have experienced at St. Paul's Hospital.

"The people at St. Paul's are upbeat and encourage comments and questions from patients and families. Support for a spouse is so important." – Meeting participant

SMITHERS – STAKEHOLDERS AND SERVICE PROVIDERS MEETING

Date: September 27, 2018
Participants: 7

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Prevention

Smithers is a generally active and engaged community, with access to sports, yoga, a pool and fitness centre (with indoor track), a myriad of outdoor activities, and increasing involvement in cultural activities. There is growing interest in and action around food security as well. Clearly, heart health (and all health) relies on adequate nutrition. The Smithers Health Hub is an important link to wellness.

Services that promote heart health and aim at prevention include trauma-informed practice, which addresses many chronic conditions; education on stress reduction; an excellent nutrition and diabetic educator; and improving integrated and community care: all work well. The UVic-developed peer-led Chronic Disease Self-Management Program is also available.

Services

There are enough physicians in Smithers, with fairly good access to care, although some people don't have a GP. Integrated health care teams are providing good comprehensive care for patients and families, including care related to cardiac issues. Access to common patient electronic records is increasing. Patients can do stress tests locally and echocardiograms are available (though somewhat limited by staffing). Local internists and visiting specialists are useful.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Increase the focus on prevention

Preventing heart disease helps prevent other diseases as well, and there are a number of ways we could improve education and see change in Smithers. Ensuring there's a strong population health component in primary care will help, and there are many ways to reach people, including adding education or information to existing local events and activities. Education and action can be focused on food security, signs and symptoms, screening, and the therapeutic benefit of relationships. They could sometimes tailored to particular groups, such as men and parents.

Provide cardiac care closer to home

This group strongly advocated for increased investment in primary care services and in post-care for people who have had cardiac health interventions. The earlier investment should be in screening, education, reaching families more at risk and in linking people to healthy food and activity. Primary care is a good focal point for making these shifts.

For post-care, Smithers residents were interested in better coordination of followup care after cardiac tests/surgery in specialized centres. Discharge planning, both in the North and elsewhere, needs to improve and have more communication with the patient's primary care home. A Healthy Hearts program and improved post-event and self-management support would also be useful.

Smithers participants strongly supported the idea of having more specialized services available in the North was, including the idea of a cardiac centre in Prince George. To reduce travel, participants want full use of telehealth and visiting specialists, but they also see the benefits of a Prince George option for out-of-town care. They feel the links between local primary care and specialists might grow over time across the North.

The barriers of cost, time and inconvenience in travel were noted. As in other locations, it was also noted that the return trip after a supported emergency evacuation is a real burden on many patients.

There needs to be more collaboration with community exercise specialists, and more clear access to cardiac rehabilitation exercise programs.

Improve urgent care

After-hours and urgent-care access needs to improve, perhaps with another walk-in clinic or improved after-hours options with existing clinics. This is an issue for workers in industrial camp too, as well as residents. Primary care is going to be a more useful location to receive comprehensive health care, which leads to better heart health outcomes.

"This consultation process is a good example of coming to us to get ideas for improvement. Keep it up." – Meeting participant

TERRACE – PATIENT AND FAMILY FOCUS GROUP

Date: September 24, 2018
Participants: 5 (one from Gitlaxt'aamiks – formerly New Aiyansh)

Note: Patient stories covered a range of heart conditions and treatments, including stents, bypass surgery, cardioversions, ablations, congestive heart failure, and pacemaker implants.

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Medical support

All patients had positive reports about the care they received at St. Paul's Hospital in Vancouver. A local specialist in Terrace is very much appreciated, and patients felt they received good medical care overall.

Telemedicine worked well, one patient described using video consults many times. While this is not as common a practice as it could be, it certainly reduces the burden of travel and allows for better communication between specialists and local care providers.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Preventing heart disease (or worsening conditions)

People don't realize the risk they're at, and they don't do basic screening. It was interesting that everyone in the meeting was initially surprised when they learned they had heart problems. In addition to more public education about healthy living, and making this topic more visible, things can be done to improve public health. For example, Terrace is built to support driving, not walking: new developments don't even have sidewalks. Encouraging walking would lead to better health.

There is poverty in this community and without that being addressed, some people will continue to struggle with poor health.

Travel challenges

There's very little support or coordination for accommodation for patients and families. This is the case for out-of-town visits to Terrace or Prince George, as well as for those who must travel to Vancouver or Kelowna. Couldn't there be designated, inexpensive accommodation set up or coordinated for health care needs? Telehealth and visiting specialists would help reduce this stress too.

Coordination and aftercare

Those attending all had issues with the apparent inability to share records between the care providers, including those in the South. One patient carries a small notebook with all his records (ECG results etc.) with him, to avoid all the questions and confusion that sometimes arise.

Aftercare could be improved, beginning from discharge after tests or treatment/surgery. It begins with people in Vancouver not knowing where Terrace is, which makes appointments and travel plans awkward and difficult at times. After returning home, there's no coordinated information on what support is available in Terrace,

"When you work hard all your life, you're used to doing things; no one could talk to you, you just did it. Suddenly you're sick and need help." – Meeting participant

for either the patient or their spouse, who may have needs as well. There needs to be better coordination with the local physician, the specialists and local rehabilitation or support programs.

One person is becoming engaged in the Patient Voices Network, which can help improve systems.

Services in the North

It was agreed that it would be useful to have access to more specialized services in the North. However, it was also acknowledged that the important thing is to get access to care quickly, and that Prince George is a long bus trip (or drive) away. It would be a benefit if specialists in Prince George developed strong links with Northern specialists, GPs and other staff involved in heart care and rehabilitation.

PHOTO OF ANCIENT FOREST BY SJ KERR

TERRACE – PUBLIC MEETING

Date: September 25, 2018
Participants: 24

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Access to services

Terrace has good family doctors (not everyone has one, however); a proactive and appreciated internal medicine specialist; an active dietitian (who accepts self-referrals); and access to visiting specialists, including one who enjoys fishing in the North. Access to some appointments via video is also appreciated. People in this meeting praised what they do have, despite a list of improvements they need.

Prevention

Terrace and area have lots of opportunities to be physically active, including recreation and sports programming; the aquatic centre; the Millennium Trail (and others); yoga; dance; Tai Chi; and outdoor activities like biking, skiing and hiking. There are programs aimed at seniors, and the Healthy Hearts program. Save On Foods offers a guided shopping program to help people understand nutrition and their food purchases.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Education and awareness

The group would like to see much deeper community awareness of heart disease, and the information surrounding it. There are also stereotypes at play that need to be challenged, including:

- Men are more at risk than women for heart disease
- If you're heavy you have a problem and if you're thin you don't
- If you look healthy, you can't possibly have a heart problem
- If you have heart disease, you're "damaged goods", this includes the belief that you must now need to rest and are a frail person.

Young people should have more education about the impacts of unhealthy living. That said, it's important to look beneath behaviours; for example, eating healthily in Northern BC is expensive, and there are deep pockets of poverty.

People need to understand how to be responsible for their own health and how to work with the health care system. Those unable to advocate for themselves or those who find it difficult to engage are at a health disadvantage. Patients and family members can ask questions, request services or information, and bring someone with them to an appointment.

"I was given the wrong discharge papers in Kelowna... and saw rehab support programs that we just don't seem to have." – Meeting participant

Rehabilitation and support services

There needs to be more support for patients after cardiac events. This includes clear and accessible information on local services, on heart disease, and on ways to ask questions, perhaps to peers. There is also simply a shortage of good cardiac rehabilitation programming, unlike many towns in Southern BC. This includes access to physiotherapy. Patients should be linked to local programs at discharge from treatment, or through their local primary care team. There could also be more peer support, starting from diagnosis.

Long QT syndrome (LQTS) is a heart rhythm disorder that can potentially cause fast, chaotic heartbeats and it is more common in some Indigenous populations. This could be more widely understood.

Access to care

The shortage of local doctors and difficult access to cardiology are problems to solve. Added to this, there seem to be inconsistent communications between practitioners, and some GPs may not be up to date on what local and regional services are available. There's a perception that more specialized diagnostic and treatment services are needed in BC, and that waitlists are long for some. There is some openness to this being addressed in Northern BC, probably in Prince George, although it's still a great distance from Terrace.

PHOTO OFQUEEN CHARLOTTE HOSPITAL BY SJ KERR

TERRACE – STAKEHOLDER AND SERVICE PROVIDERS MEETING

Date: September 27, 2018
Participants: 10

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Strong health services

Terrace has a good basis for cardiac care, from strong primary care teams, with quickly improving electronic medical records (Community Medical Office Information System, MOIS), to well-appreciated internists. Connections to sub-specialties outside Terrace are also well established. Diagnostics are available locally, including echocardiogram, Myocardial Perfusion Imaging test (MPI), and a technologist trained to recognize rare diagnoses. Pharmacists in Terrace are engaged and integrated into the care process.

Telehealth between Vancouver, Terrace, and more rural areas is in place and is being used more often. Routine nutrition screening is used in the hospital. The Healthy Terrace program provides great information and support, and some providers see its effects on patients' level of knowledge (the pharmacist, for example).

Recreation opportunities

The community has a focus on preventive health, including a mayor who promotes the role of municipalities in health. This translates to excellent recreation opportunities, from organized sports and good recreation facilities, to great trails close to town.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Continuity of care

Terrace participants noted a significant lack of integrated cardiac care, with breakdowns all along the continuum of care, starting with the information and support patients receive on diagnosis through to poor communications and coordination to help patients when they return to their community after specialized care (usually in Vancouver).

This group was supportive of developing an established, documented community cardiac care pathway, including:

- Community awareness and information
- Integrated care locally (through primary care)
- When returning home, defined and well-coordinated community followup and supports.

All of the above need to be based in a preventive approach to care, which itself also requires a better system of record-sharing. Participants were pleased to learn that Cardiac Services BC is developing tiers of service to describe what services a community of a certain size and context could expect to have.

The group was supportive of having a cardiac coordinator in the community to support patients, but also to work on removing the kinks in the continuum of care. Examples of gaps include discharge summaries from St. Paul's Hospital not being forwarded; pacemakers provided in Southern BC not getting linked to the Northern clinic; and the often-described issues around problems with travel and accommodation.

One element of continuity of care is ensuring the patient has the information they need to empower them to be active in their own care.

Access to cardiac services

Some services that could be enhanced (if they're local) or made more accessible, if they're located elsewhere. These include:

- Finding a GP or nurse practitioner, which is a starting point for integrated care
- Having access to electronic ECGs
- The ability to interrogate pacemakers (this means checking pacemakers with a wand held over the patient's skin, to ensure the device is working correctly; the skills to do this are available, but not the equipment)
- Outreach to Smithers and Terrace to read Holter monitors
- Increased specialist visits
- More dietitian support
- Increasing mobile screening services

There was support in Terrace for a catheterization laboratory (cath lab) and other specialized services being available in Northern BC, but people noted that travel to Prince George from Terrace is challenging, especially in winter.

And finally, Terrace participants noted a need for a coordinated interdisciplinary cardiac rehabilitation program consisting of a specific basket of services (kinesiologist, dietitian, physiotherapist, links to recreation programs, peer support, etc.).

Address determinants of health

Participants thought that a broad focus on healthy behaviours and a community effort to ensure access to housing, security, healthy food, and other supports, especially for vulnerable people, could help prevent heart disease in the first place (or help people mitigate their risks). The Heart and Stroke Foundation and other agencies can also provide information and useful tools for staying healthy.

More publicly visible and accessible heart health clinics could be provided through gyms, pharmacies, grocery stores, recreation facilities, etc. Indigenous communities are focusing on a strengths-based approach to health, celebrating and reinforcing their culture and the traditional Indigenous lifestyles.

As integrated primary care teams become more established, they're in a good position to provide a greater focus on prevention and screening, both individually, and through community institutions such as schools.

Northern Interior Health Service Delivery Area

FIRST NATIONS HEALTH COUNCIL – NORTH CENTRAL SUB-REGIONAL CAUCUS MEETING

Date: October 31, 2018
Participants: Approximately 72 (Community Health Directors, Chiefs and Community Leadership, FNHA staff and Northern Health leaders)

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Local wellness support

Indigenous communities focus on wellness, with a growing emphasis on eating healthy, locally sourced foods and introducing youth to hunting, fishing, and food gathering. Cultural activities incorporate healthy practices, including a "run for the drum" and "30 for 30" (30 minutes exercise for 30 days) as part of Aboriginal Days. There are also programs for supporting Elders to walk, with indoor spaces in winter.

Health care providers

Several communities identified the work done by community health care providers as being particularly helpful. There's good physician engagement with Elders, and in some communities, physicians visit and work with the nurse practitioner, a much appreciated role in itself.

Health care staff including clerks, support services, nurses, paramedics, and others provide a lot of support and run different programs to ensure community members' needs are met. Examples include walking programs, informal lunches to address concerns and de-escalate situations, heart days, health days, diabetes days, men's groups and screening, and smoking cessation programs.

Home visits ensure people have working phones in their homes in case of emergencies. In anticipation of the first snow day, they run awareness programs because of the increased risk of heart attacks from shovelling snow. Genetic screening programs are also available.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITIES?

Communication

Hearing first-hand cardiac care stories would be useful to leaders. Social media could be better used to reach young people with health education messages.

Transportation

Travel remains a significant barrier and challenge for many communities. It's also a local barrier for community members wanting to attend programs. Either transportation needs to improve, or programs could be offered in different venues (e.g., Band spaces) and not just at wellness centres. Off-reserve transportation costs remain a significant issue, including transportation to Prince George.

Local barriers

In many communities, it's difficult to exercise because of the increased number of bears and wolves coming into communities as a result of wildfires. Poor air quality from the fires also makes exercising difficult. Having access to gyms and exercise equipment would help.

Education

Many people still don't know how to keep their hearts healthy or don't understand the importance of taking their medications correctly. Additional resources and support for programs such as heart days, diabetes days, etc., would help these programs reach more people. Combining programs such as heart health and diabetes would address more than one need at the same time.

Access to traditional medicines and traditional practitioners is important, as is good access to primary care providers, especially for working to ensure consistency within a community.

Cultural sensitivity

There's an important role for advocates as part of the provider and patient interaction. Patients don't always feel comfortable saying they did not understand information provided. Information needs to be provided in ways that are sensitive to culture and language. There should also be Aboriginal Patient Liaison Workers in every hospital.

Specialized services in Prince George

When a person has a cardiac problem, transfer to a bigger centre for an angiogram is a waiting game. Physicians in small communities could be better trained to deal with heart issues, and there should be more advanced services in Prince George. The family members of a person with a cardiac event need to be involved in the process, so that they can provide support. Referrals to a cardiac specialist can take months.

BURNS LAKE – PUBLIC MEETING

Date: October 10, 2018
Participants: 12 (most from Francois Lake)

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Prevention

There's a new multiplex centre with a gym, and there are biking and ski trails. There are community gardens and people grow their own vegetables, which helps with good nutrition. People in the North have a vigorous lifestyle, which is an important part of surviving in the North.

The primary care team is doing more prevention work with patients, and there are smoking cessation programs.

Care services

Care received at the local hospital was good: one patient received a diagnosis of a heart attack and was "shipped out" quickly.

"When we went out of the community for care, people met us at different points in our journey who connected us to the next step." – Meeting participant

When returning to the community after an event, patients were connected to a primary care practice. After return to the community, the first cardiac rehabilitation visit could be done by video/teleconference, and a booklet was provided on how to look after the heart post-event.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Education and screening

An education program would be "low hanging fruit" for improvements in heart health, participants thought. Providing different levels of information, coaching aimed at different levels, and outreach to at-risk populations in the area would all be useful. Staff at the multiplex could develop an exercise program that includes information on how to use the different pieces of equipment effectively.

More screening for heart health is needed. Opportunities could be created through wellness fairs or outreach to workplaces.

Improve public and health care providers' knowledge about the different ways people can present with heart attacks or heart problems. There are atypical presentations and women don't always present with the same symptoms as men.

Cardiac care services

Burns Lake participants agreed that there needs to be a regional service in Prince George. People in the North need access to services along with transportation infrastructure. Even without a centre in the North, air ambulance transport remains important. Improvements have been made to the local airport; however, it doesn't seem to be used as much as it could be for air ambulance transports.

"We have become complacent about screening and there is a lack of knowledge; we have to know what a heart attack is." – Meeting participant

After someone's diagnosed with a heart issue, the referral process is between the physician in Burns Lake and the cardiologist in another centre. It's the decision of the receiving cardiologist and hospital to accept the referral, and timelines vary based on how acute the condition is. Non-acute referrals can take six months. Having a cardiac catheterization lab in Prince George would be an improvement.

Patients and their families need advocates who can listen to the information being shared, understand the system of care, and provide practical help with travel plans and post-intervention care. Barriers to care include the financial burden of going to the Lower Mainland for care and the weak transportation linkages. People with family members working in the health care system have some advantages when urgent or emergent care needs arise, because those family members can advocate for the patient and help them navigate the system.

Rehab services

Burns Lake has no resources to support cardiac rehabilitation. Although it's helpful for avoiding return trips to cardiac care centres, not all cardiologists offer teleconference support. Participants thought technology could be better used to link outside experts to the needs in their community.

If outcomes from cardiac events are different for Northerners, this needs to be addressed. We should be collecting health data to measure the effectiveness of community health interventions.

PHOTO OF CEDAR AT ALLIFORD BAY BY SJ KERR

BURNS LAKE AND AREA – INDIGENOUS COMMUNITY

Date: December 10, 2018
Participants: 2 (service providers)

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL IN THE INDIGENOUS COMMUNITIES IN THE BURNS LAKE AREA?

Prevention

Some places have community kitchen programs, funded through maternal-child health programs, which primarily target young moms. These programs need both the resources to run the program, and staff who can run the program for the community.

Some communities also offer screening programs. Carrier Sekani Family Services works in 10 communities; they provide basic screening, such as blood pressure and blood glucose monitoring. They'll go to a client's home, and they do followup as well.

Community-relevant services

What is working well depends on whether a community has been able to recruit and retain nurses who are culturally competent. In Wet'suwet'en, for example, the nurse has been there for a while and knows the cardiac patients and is able to support them and to provide followup. They use telehealth services well and support patient appointments with the specialists involved in their care. The Aboriginal Patient Liaison role in the hospital works well.

Community members have access to travel dollars, but this is a supplementary program and doesn't cover all their costs. However, there's good coordination to get patients out of the community when they need to go to another centre for care, and the cardiac care they receive in the Lower Mainland is excellent.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR INDIGENOUS COMMUNITIES IN THE BURNS LAKE AREA?

Continuity and discharge planning

All communities have the capability to do telehealth; however, there needs to be someone in place who knows how to use it.

Continuity of care when returning to the community after receiving services in another health authority can be missing.

The primary care physician and the community health nurse are part of different systems. It's unclear who receives the discharge information when a community member returns from the Lower Mainland.

Participants agreed that we need to bring services, such as angiograms, closer to home. They noted that it's very difficult to get a frail elderly family member to Vancouver to receive care. We need a centre in Prince George, because travel to Vancouver is a huge strain. Patients want their families with them, but they only get coverage for one person to travel. It's very difficult financially; some people can take time off work, but not everyone can do that.

It's difficult to recruit and retain nurses in these communities and this has a detrimental effect on the health of the community members. Services are not provided, trust is not built, cultural sensitivity is often absent, and improvements don't get developed.

Rehabilitation and followup

There is a lack of cardiac rehabilitation here. Community members respond better to professional advice about diet and exercise following a heart event. It's more difficult to take advice from a family member.

When people return to the community following a heart event, they're looking for information and resources. Telling people to exercise more doesn't give them the tools to make changes. Break it down into a plan with clear first steps. Cost can also be a barrier. It's best if the whole family can be a part of it.

Having a nutritionist who can speak to people about how to change their cooking practices would be helpful in addressing all chronic diseases. They could come to the community every six months and see how things are going.

Stress management approaches are also needed. When patients come back from receiving treatment, they're under a lot of strain and trauma. Patients don't always understand what the problem was, and they're scared and overwhelmed with trying to figure out how to deal with diet, medications and followup appointments. It can be too stressful, so they just return to their old routines. Even a group visit would be helpful. Counselling services here in Burns Lake are booked solid and probably cannot take on any more patients.

Improve prevention

The community kitchen programs are important. If you learn to eat well as a child, it can carry into your adult life. More of these programs are needed, and they need to expand. There is a need to get rid of junk foods: this is where communities can act. Having life skills workers who connect with patients can help them learn to shop for healthy food.

"My mother came back from Kelowna and the local doctors took her off her meds and put her on something else. Her specialist was in Kelowna and said she should not have been taken off her meds." – Meeting participant

FORT ST. JAMES – PUBLIC MEETING

Date: October 11, 2018
Participants: 2

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Prevention

Heart health is affected by the same conditions as other health issues. It's important to consider diet, and there are opportunities in Fort St. James to exercise and to stay active. There are gyms, hunting, and trails for biking and hiking. Nak'azdli has a running group. There's a seniors' driving program that helps with grocery shopping and travel to medical appointments; as well, there's the Northern Health Connections bus.

Services

There's a blood pressure station in the pharmacy, a physiotherapist will come to the gym to help with routines, and most tests that are available in the community can be done in a day or two.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Access to care

It has been challenging to maintain a stable group of physicians in the community, which means Emergency isn't always open, although closures are usually announced in advance. At times community members must wait two months to see their GP. Accessing the health care system for appointments can have an impact on work, because people often need to book time off to get to their appointments.

With Greyhound no longer coming to the community, transportation options are reduced. The Northern Health Connections bus does help.

There could be more emphasis on prevention and screening along with providing information on what resources are available to support healthy lifestyles and reduce risk.

The current pattern of referrals is to Vanderhoof and then to Prince George.

NAK'AZDLI AND AREA – INDIGENOUS COMMUNITY

Date: December 11, 2018
Participants: 6

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL IN NAK'AZDLI AND AREA INDIGENOUS COMMUNITIES?

Prevention and screening

The nurse practitioner working at the Health Centre in Nak'azdli screens for heart health and prescribes physical activity to clients. There's an annual "walk with a doc" event in the community. First Nations Health Authority (FNHA) did a Fitbit challenge, which was taken up by the Nak'azdli Health Centre.

The Health Centre has used a Northern Health IMAGINE grant to develop a mindfulness trail in the community, which supports walking and reflection. Eating healthily and exercise are seen as important for maintaining health. There's also a community kitchen at the Health Centre in Nak'azdli that's well used.

Quality of care

Community members in the Fort St. James area typically go to Vanderhoof and on to Prince George. When necessary, they're transferred to the Lower Mainland.

A participant with direct experience with care in the Lower Mainland found the experience to be good. The staff at St. Paul's Hospital were professional. Before the surgery he could only walk half a block. Physicians in Fort St. James and Prince George provide followup. Living on a traditional diet of fish and meat and managing their own exercise and diet is part of the followup.

Having health practitioners in the local community helps with maintaining heart health.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN NAK'AZDLI AND AREA INDIGENOUS COMMUNITIES?

Improve prevention

Getting started on an exercise program is difficult. The nurse practitioner confirmed, from research, that community-based initiatives help increase the effectiveness of prescribing exercise to patients living in lower socioeconomic conditions.

ParticipACTION could be a community-based initiative; however, it takes money to get the programs up and running. There's an opportunity to get a grant for buying walking poles (Nordic walking). A letter of support from Northern Health would help the grant application.

The Heart and Stroke Foundation had a program for distributing AED (Automated External Defibrillator) devices, but Indigenous communities did not receive the information in time to get access. Programs like this are important to help small communities obtain and install the devices.

Offering preventive programs for heart health needs resources. Video-based exercise and stretching programs could be offered.

Access to services

There's disparity in the health services available in the different First Nation communities around Nak'azdli.

Transportation to and from the remoter communities makes it difficult for people to access health services. Most people are on social assistance and can't afford the transportation and the cost of food when they need to go to Prince George or elsewhere.

Having specialized services in Prince George would be better for the patient and for the family. When a family member is sent out of the community for care, the whole family is deeply concerned. However, it's difficult and expensive for the family members to travel with their loved ones. There's a hope that Prince George can become a centre of excellence for cardiac care.

When a person must go out of the community for care, there's a lot of travel needed. The band will buy bus tickets for the return trip from the Lower Mainland for the patient and a family member.

PRINCE GEORGE – PUBLIC MEETING

Date: November 13, 2018

Participants: 9 (Participants included members of the public, physicians and Northern Health staff)

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Prevention

In the past there were programs offered to teach people about healthy eating. Topics included how to read labels and how to cook.

The community has created walking trails, bike paths and community gardens. These may not be accessible to more vulnerable people; however, there are now community grants to help people in need access programs. Within the school district there are fruit and vegetable programs for children and exercise programs have increased.

In Prince George there are pools, gyms, and an abundance of choices for healthy activity. The YMCA offers discounts based on financial circumstances. People can also seek support with diet, exercise, and other modifiable risk factors, such as smoking cessation and managing stress.

Quality of care

There are great health care providers in the community. They notice changes in a patient's health and start the ball rolling for care. This includes many specialists, especially compared to other communities that struggle to attract and retain physicians. Staffing at the Department of Medicine in Prince George has tripled in number over the last 10 years.

The NORTH Clinic is a valued resource and provides educational sessions that are helpful and support self-management of a health condition. The Northern Health Connections bus is also a valued resource.

The care received in hospital here in Prince George and then in the air ambulance to St. Paul's Hospital was great.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Access to specialized care

When care is received in the Lower Mainland but not at Vancouver General Hospital or St. Paul's Hospital, the Northern Health Connections bus is less helpful (for example, if the appointment is in Langley, then you're dropped off in Abbotsford and must rent a car to drive to Langley). When a family member is being transported by air for inpatient care, the drive down can be very stressful for other family members, such as their spouse, especially in the winter.

Having access to a resource about the care a person is about to receive would be helpful, especially if provided in advance of the surgery. To sustain lifestyle changes and to understand the recovery process, longer-term cardiac rehabilitation and education would be helpful.

Greater use of technology, such as video meetings, to avoid having to make trips to the Lower Mainland for half-hour appointments is needed. This would eliminate the costs to a family when trips are needed to the Lower Mainland.

Family support is critical for the person experiencing an acute health situation. The family needs to be supported as well. It's hard to go to a faraway place for care when there are no familiar faces around.

Regional services in Prince George would keep patients close to home where they have family and care providers who they know. Transportation in the North will remain a challenge for some communities, where access to Vancouver is easier than to Prince George.

Education and information

Most people don't think about making healthy choices until they have a problem. It can be hard to find resources in the community, both private and public, and even health professionals don't always know what resources exist. Northern Health could develop a list of current resources; perhaps the primary care homes could develop this.

Using local media such as Channel 10 could be an opportunity to offer exercise classes to people in their own homes: e.g., Tai Chi or yoga, with a focus on people with limitations.

Resources such as the NORTH Clinic could use technology to support patients with self-management. For example, email notifications for sessions and resources would be welcomed.

PHOTO OF FORT ST. JAMES BY SJ KERR

PRINCE GEORGE – PATIENT AND FAMILY FOCUS GROUP

Date: November 14, 2018
Participants: 5

Note: Each participant was given adequate time to tell their story, providing much of the information below.

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Most patients found some elements of their care to work very well. One participant felt fortunate that they had their heart attack while having tests in the hospital: they were able to receive care immediately. St. Paul's Hospital and Kelowna General provide good care, and some patients also considered their local physicians to be excellent in providing support in their heart health journey.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Communication and coordination

These patients had stories of gaps in care; poor coordination between their doctor, the hospital, and the specialist; and physicians who were in a rush or seemed to miss important steps. The fragmented system left some patients with long delays. It was clear in this group that those who advocated strongly for themselves seemed to experience better and more timely care. For some, the Healthy Heart program offered more support than their primary care providers.

Access to specialized services

This group strongly supports establishing a cardiac centre in Prince George, as it would reduce delays in immediate or scheduled care; eliminate expensive and draining travel; and should improve the coordination of GP and specialist roles.

While many services still are only accessible in Southern BC, the government should consider better support for people to travel back from emergency care. Access to affordable accommodation is also a challenge.

Rehabilitation

Some patients were aware of the rehabilitation program and how to access it and others had never heard of it. There's some tailored support at the Y, but it was seen as less effective than a specialized rehabilitation service.

Guidelines for recovery should be provided in a consistent way locally, including a to-do list, links to other services, and clarity on what a patient can do physically rather than simply noting what they shouldn't do.

"I felt great confidence in the care I received at St. Paul's. I was happy to be asked to participate in a followup study." – Meeting participant

PHOTO OF SMITHERS BOVILL SQUARE BY SJ KERR

PRINCE GEORGE – STAKEHOLDERS AND SERVICE PROVIDERS MEETING

Date: November 15, 2018
Participants: 4

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

The NORTH Clinic offers education to patients on cardiac risk factors, including how to identify the risks and how to change their lifestyles to mitigate risk. This is secondary prevention. Primary prevention is seen as the responsibility of the primary care teams. The NORTH Clinic sessions are offered in a group setting with a focus on heart function, heart failure, and the education component of cardiac rehabilitation. Referrals come from the triage coordinator.

Locally in Prince George, staff are dedicated and committed to providing excellent care. Regionally, it can be a challenge to support patients in other communities due to limited resources.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Primary care prevention role

There's a need for primary prevention resources to be available, especially for healthy eating and active living. It seems that the competency for this still needs to be built up within the primary care homes and more time needs to be made available for this role. It's disheartening to hear that the interprofessional teams don't feel they have the time or the knowledge. It might be beneficial to assess the tiers of service being provided in terms of primary care and specialized care to see if this can be improved.

One of the issues is that patients aren't always interested in learning about prevention until they have a problem. To implement early prevention, we could be starting with children and at-home education for parents. There are three critical points for interventions around prevention: when the patient recognizes there's a problem; when the patient goes to ask for help; and when the physician recognizes there's a problem.

Access and improvement

Regional services have many benefits to the population in the North. There are challenges accessing services in the North, as well as knowing what services and supports are available. Providers in the Lower Mainland can be unrealistic about what's involved for patients and their families to receive care out of the region. Expanding services in the North, however, does need to be responsive to the patient volumes needed to maintain clinician competency for the specialists involved.

Recognition of the psychosocial aspects of receiving care for a cardiac event needs to be recognized. Some people choose to not leave the North for life-saving diagnoses or interventions because of:

- The intimidation of going to a larger centre
- Not knowing how to navigate the travel needed
- The difficulty in arranging the travel needs of a family member
- Because they have obligations they can't leave (e.g.., they're the primary caregiver for a person with dementia)

Having specialized services in Prince George would overcome these concerns.

Integrating or co-locating the NORTH Clinic with other chronic disease programs would improve care coordination to patients who have more than one condition and facilitate sharing of resources.

While urgent care is accessible, there are perceptions about access, for example: waitlists for specialists are long.

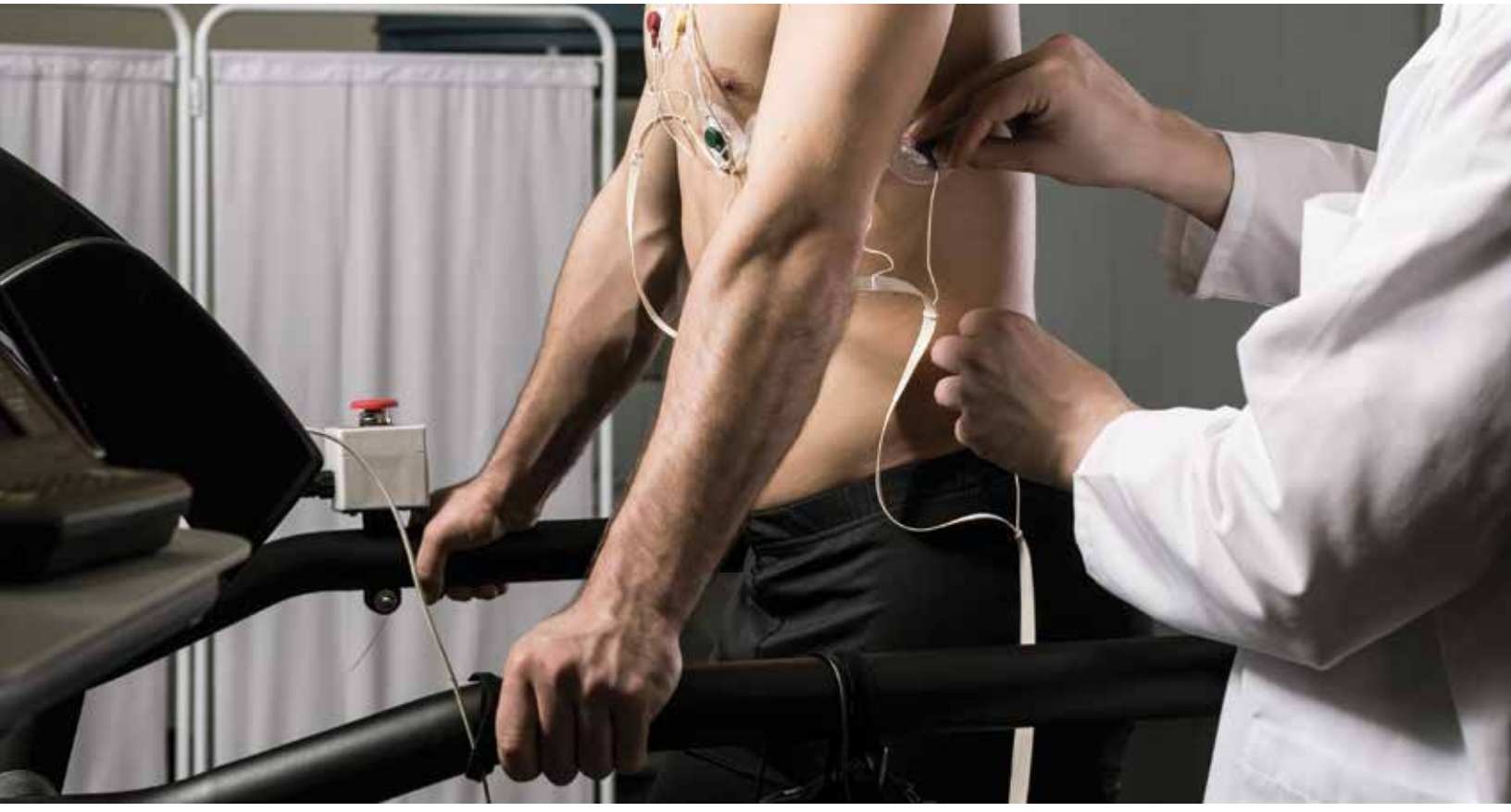
Telehealth can be made much more accessible and usable for patients and providers. In smaller communities, patients sometimes need to go to a

larger town to access the technology (for example, Hudson's Hope patients go to Fort St. John). The NORTH Clinic telehealth schedule is dependent on the RNs in the receiving community, including their schedules, availability, and willingness to provide telehealth support.

Telehealth could be used for group education, if the supports were in place in other communities. There needs to be a shift in thinking about how telehealth fits within the system of care. It's a major opportunity to improve chronic disease care management across the North. Pre-recording education sessions and running them as webinars would provide flexibility for the patients in terms of when and where they can access the information they need.

Staff at the NORTH Clinic hear that patients have a lot of questions and don't know where to go to ask them. Clinic staff receive a lot of calls from people trying to navigate the system, and try to help them find services closer to their community.

Expanding the NORTH Clinic to include an internist cardiologist who attends more than once a week or to include a nurse practitioner and a full team with a dietitian would allow outreach to the hospital and more support to patients.



QUESNEL – PUBLIC MEETING

Date: November 1, 2018
Participants: 5 (all participants came with personal cardiac care stories)

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Diagnosis and support

People who have an atypical presentation of a cardiac event often don't feel heard. People also need information, education, and emotional support, after an event.

The system and the providers need to see the whole patient. Health care providers put pressure on one participant to take her father home from hospital within two days of her own return from the Lower Mainland. The nurse had approached her while she was still in ICU, and there didn't seem to be any understanding of her own stressors and the need to heal.

There seemed to be a real gap in communication with everyone who worked at the hospital. Physicians, nurses, and kitchen staff did not seem to read or share the information they already had about the patient's needs. Patients had to tell their story repeatedly and, while staff members were nice, they did not seem to talk to each other.

Post-event and rehab

Participants felt strongly that they needed more information and education, especially during and after a cardiac event. They had a lot of questions about how to adjust their diet and lifestyle in order to be healthy and to prevent a subsequent event, and they often didn't know what questions to ask. There's a need for specific information and not just a general "Whatever you're doing, you are doing well." More information was needed about the Chronic Disease Management Clinic, as it was unclear who could access it and whether they could go there for more information. There's also a need for more emotional support. After a cardiac-related event, there's a fear that "something will happen again" as well as a need to have an advocate. A comment was made to one of the participants that "you need to be your own advocate," but he was unsure what that meant.

The idea of developing specialized services in Prince George was supported by the participants. It would mean less travel and minimize the need for overnight stays.

PHOTO OF HAIDA GWAII TO RUPERT BY SJ KERR

QUESNEL – STAKEHOLDERS AND PROVIDERS MEETING

Date: November 1, 2018
Participants: 8

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Strong services

The shift towards interdisciplinary care and to a primary care model allows staff to work in a different way. Skills are being adapted and used in new ways.

There's a Chronic Disease Management Clinic in Quesnel providing primary prevention, secondary prevention, and cardiac rehabilitation. However, cardiac rehabilitation is fragmented and there are gaps in services because of silos between programs. People with high cholesterol are identified and offered a class. Work is under way to improve the referral process, and the NORTH Clinic is working better. It can take up to six weeks to connect with a patient, and this could be shorter.

Prevention

There are many health resources in the community, including gyms, yoga studios, winter activities, walking trails and a pool. There's also a "Healthy Community" committee working on initiatives such as seniors' health.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Information and communication

It's difficult to find information about a newly diagnosed heart problem. There are new physicians in the community, and they don't always have information on the resources available in the community. Perhaps Northern Health should ensure that Medical Office Assistants have the information needed. Improving the connections within the system would better support patients.

Improve services

The benefit of having more services in Prince George would be the ease of travel, as the city is a known entity for people from Quesnel, and cheaper to travel to and from. There still needs to be a person-centred aspect to the services provided, though. For example, a navigator could support people with their next steps and provide emotional support.

Any planning for Northern Health must be realistic about the demand for services. Patients don't always mind going to Vancouver, but more information and support is needed.

The group sessions offered through the Chronic Disease Management Clinic (CDMC) should be full, but they're not. The program doesn't need a physician referral. However, having referrals for people having ECGs, Holter monitors, and ultrasounds would be an opportunity to connect patients with the service.

As clinicians move towards delivering care under the primary care model, they don't always have needed tools. For example, while doing home visits, they're doing assessments, yet don't have the toolkits needed to address the risk factors identified.

There's always opportunity to look at the risk factors for heart disease for people living in

"It feels as though there's no one to answer my questions. The physician doesn't return phone calls...and the result is I'm forced to sit and just wait until the next appointment." – Meeting participant

Quesnel. Many jobs are becoming sedentary and this increases risk, as does smoking. There's some screening for heart risk; however, the next step of connecting to resources is not taken.

The connection with the NORTH Clinic is beneficial; however, it's only upon the patient's return and it can feel isolating for the nursing practice at the Chronic Disease Management Clinic.

We need to think about using technology better; how can we bring the services to people rather than expecting people to go to the service?

WE NEED TO THINK ABOUT USING TECHNOLOGY BETTER; HOW CAN WE BRING THE SERVICES TO PEOPLE RATHER THAN EXPECTING PEOPLE TO GO TO THE SERVICE?

Travel

Travelling out of the community for diagnosis and treatment is hard for patients, both psychosocially and financially. There's fear of the unknown, and often patients are sent to an unfamiliar centre where they have no family support and have to take on financial burdens for the travel. People understand that they need to be transferred out for care, but not always what this means for their personal lives. Having an advocate (e.g., a family member) who travels with the patient can be helpful. The Northern Health Connections bus is fantastic; however, it may not be running the day you're discharged and its stop may not be close to you.

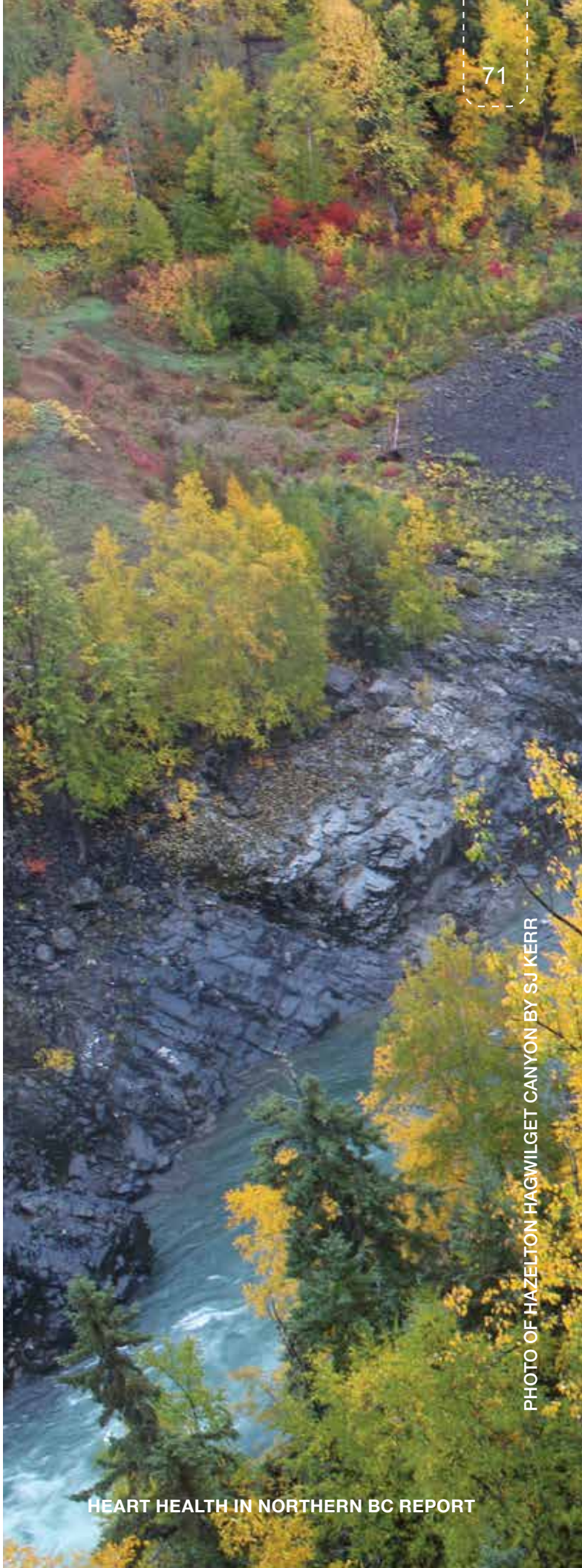


PHOTO OF HAZELTON HAGWILGET CANYON BY SJ KERR

VALEMOUNT – PUBLIC MEETING

Date: October 29, 2018
Participants: 3

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Primary care

There's a cohesive and well-developed physician practice and primary care team in the community. Patients have same-day access to a physician, there are walk-in clinic hours every day, and there's a full complement of support staff working with the physicians. Quality improvement is a group effort. After-hours ER support is taxing on the team; however, it's an important support to the community. The team also uses Drop-in Group Medical Appointments (DIGMA) for specific chronic health conditions, and there's the potential to bring specialists into the appointment via videoconference.

The electronic medical record is used to share clinical and screening information with the patient, and there are flags when certain indicators are present to identify strategies for managing their health condition.

The physicians access the CODI app, which gives them access to specialist, critical care, and diagnostic support within seconds - an application that's critical for rural physicians.

Healthy living

Valemount is a small cohesive community that has an abundance of outdoor activities, including ski trails, biking, and horseback riding. There are local groups such as mom and tots that meet regularly to foster relationships and support networks. Recently, more farmers' markets have been developing. Both Meals on Wheels and the Legion offer meals during the week.

Out-of-town services

There are good connections for diagnostic and treatment services in Prince George and with provincial centres. There's some access to Kamloops when needed. Patients feel well supported.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Primary care

The primary care integration is working well in many ways, yet there are glitches: for example, the challenge that nurses are pulled in multiple directions, including Emergency. There's no longer a distinct role for a nurse with healthy heart activities.

The community benefits from home-grown solutions. For example, with a local weight reduction program, 20% of the patients were able to maintain their new weights.

Access to services

Patients must leave the community for most cardiac care, going to Edmonton, Kamloops, Prince George, or Vancouver. Travel is often difficult, always takes time, and can be expensive. The Northern Health Connections bus is appreciated, but only meets some needs.

"It feels like we're left on the curb after treatment in Vancouver."
– Meeting participant

People in the Robson Valley would prefer to see specialized services, such as angioplasty, located in Prince George.

There's great potential in using videoconferencing more. In addition to using it for patient consults, it could be used to share information on prevention, to host peer discussions, and for rehabilitation webinars for cardiac patients.

VALEMOUNT – PATIENT AND FAMILY FOCUS GROUP

Date: October 29, 2018
Participants: 1 (brought feedback from two other patients)

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Primary care

The clinic is small, and physicians have the patient's best interest in mind. Clinic staff are respectful, and patients feel supported. Local physicians listen well, follow up properly, and share information well.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Travel and discharge

Patients often have to travel for care. They should be supported to go to a centre that is located near family, to enable easier travel and lower costs, and they should be supported to build a relationship with their specialist. Discharge needs to improve and not be so hasty. For example, one patient was discharged from Prince George without their shoes.

If a regional cardiac service centre is established in Prince George, there must be an improvement in sharing clinical information, and records must be available to the patient.

VANDERHOOF – PUBLIC MEETING

Date: October 9, 2018
Participants: 7

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Prevention

A dietitian is available to community members and visits are covered by MSP. There are opportunities to exercise: trails, walking, parks, and plans to build a pool. Community groups such as the Men's Shed encourage healthy activities and provide opportunities to connect .

Cardiac services

There's a skilled, talented, and stable physician group in the community, with two MDs specializing in heart health. Vanderhoof's proximity to Prince George means there's access to specialty care, and some specialists come to the community. The NH Heart Function Clinic outreaches to Vanderhoof, and telehealth (the NORTH Clinic) is available as well.

Primary care

Local physicians provide good care and followup. Group visits are scheduled for patients who have common issues, and the primary care team provides holistic care. The new community paramedic also provides clinics on vital signs. It's recognized that good heart health also includes mental, emotional and psychosocial aspects of well-being.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Travel and wait times

Getting out to other centres can be unsettling. Delays in getting to regional and provincial centres are frustrating for patients and for staff. Staff prepare patients and know they need to get out quickly in some cases.

Greater support is needed for patients and their families when they're dealing with transportation and other needs related to receiving care out of community. There are Hope Air and other supports, but people need to know about them and what to ask for. After diagnosis there are specialized supports; however, before diagnosis those supports aren't accessible. There are social workers in community care but it's unclear how much they're involved with acute care needs. Families are responsible for the costs, which can be next to impossible to meet on a limited income, or when you have to pay first before being reimbursed.

"Getting out took 11 hours. It wasn't a problem here and there was a bed at St. Paul's. The problem was patient transport... and having pilots available." – Meeting participant

Rehabilitation and communication

Local cardiac rehabilitation is needed, including mental wellness supports after a significant heart event. People need the physical and emotional readiness to return to work. This support needs to be accessible after hours for people who have returned to work.

Better communication is also needed between out-of-community care providers and local health care teams to coordinate support after a cardiac event. Care notes are often unavailable to local health care teams.

Regional services

If more services are established in Prince George, we must be able to stabilize patients in smaller centres while they wait for transfer. There's a sense that UHNBC is at capacity and that there's increased workload for allied health professionals when more services are brought on, and that this is not acknowledged.

Activity and education

There's a need for space to walk that's accessible and safe year-round. A lot of services have small fees attached to them; for people on limited incomes, this can be a barrier.

Where there's education available on heart health, it seems hit and miss, especially for people who don't visit a doctor frequently. Could there be outreach to employers to include heart health in Occupational Health and Safety, since every walk of life has risk factors? There could also be greater use of social media to reach people with information about heart health.

PHOTO OF VALEMOUNT BY SJ KERR

VANDERHOOF – STAKEHOLDERS AND PROVIDERS MEETING

Date: October 9, 2018
Participants: 7

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Prevention

The Men's Shed is a grassroots community organization in Vanderhoof that promotes activity and socialization. They do walking initiatives to encourage exercise, they have a kitchen, and they're looking for ways to teach their members and others in the community about healthy eating. They also support the transportation needs of people who must leave the community for care.

There's a Northern Health dietitian on staff who works across program areas, and there are opportunities to work with community groups to teach healthy eating.

The community has Automated External Defibrillators (AEDs) available.

Primary care

There's a strong physician team providing good services and working to improve. Group medical appointments are offered that offer teaching and support to patients. Physicians do health screening, refer patients to other services when needed, and advocate for patients to access beds outside the community.

A dietitian receives referrals for nutrition when a patient has a cardiac event, and tries to see the patient after they return.

There's faith in the system. Community members believe they will be seen, they expect to be sent out of the community when necessary, and when they come back they expect to have received good care. When people need help to get to a faraway appointment, community members will often reach out and help.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Activity, education and food

There's opportunity to improve heart health in the community through exercise; many need to exercise but don't know how to go about it, or need information about how much and what type of exercise they should be doing. It's hard to exercise outside during the winter months. People need to be aware of the Men's Shed.

People need information about heart health and the benefits of exercise and diet, and the links with other health conditions such as diabetes. The Men's Shed has a kitchen, but needs help to become set up for healthier eating. The dietitian(s) in the community would like to contribute to health promotion and prevention; perhaps collaboration with the Men's Shed would help. More education on using the AED units in the community would be helpful as well.

Limited income is a barrier to healthy eating and exercise. Food is expensive in Vanderhoof.

Closer to home

Building up telehealth services would create more capacity to support patients locally.

The local cancer clinic provides a good model for other health services such as cardiac care. Having a regional centre in Prince George is a good idea; however, providing more services across the North is also needed. Building up services in other communities (e.g., Fort St. John and Terrace) would help support more specialized services in Prince George. If specialized services have to be in one place, then Prince George makes sense.

There's a sense that more capacity within existing services and facilities is needed. Emergency Health Services must continue to be funded. Finding staff is challenging (e.g., physiotherapists). One dietitian serves three communities, including acute care and residential care sites.

Burden of travel

When a patient is sent out of the community, it is stressful for the family, especially if they don't know where their family member will be sent. They must make plans for who will go with the patient, and who will stay behind. It's easier to support the family and the family member receiving care if they're receiving care in Prince George. Supporting family members is an important part of care, because they serve as advocates, and also provide comfort and decrease anxiety for the patient.

When patients are sent out of the community, care providers in the South often misunderstand the services the person's returning to. Discharge plans are hard to follow up on and followup appointments are challenging. When discharged from services in the South, the patient and family feel "just turned out" and often don't have a transportation plan for returning home. A navigator role is needed to ensure people don't fall through the cracks.

The discharging centre may assume there's cardiac rehabilitation available in the person's home community; however, in Vanderhoof there's currently only one occupational therapist, and the physiotherapist position is vacant. More dietitian services would also help. Sending people out of the community for cardiac rehabilitation doesn't work, because there's not a lot offered in Prince George and the distance is a barrier.

Northeast Health Service Delivery Area

FIRST NATIONS HEALTH COUNCIL – NORTHEAST SUB-REGIONAL CAUCUS MEETING

Date: October 10, 2018
Participants: 49 (Community Health Directors, Chiefs and Community Leadership, FNHA staff and Northern Health leaders)

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Prevention and wellness

There's a wide array of prevention activities in communities in the Northeast, some supported by wellness funds from industry. These include supports for activity and exercise, such as providing Fitbits and having local gyms. Diet is addressed through focusing more on traditional foods, providing Meals on Wheels to Elders, meeting with dietitians one-on-one, and providing support for healthy shopping. Smoking cessation support is available and screening blood pressure checks take place.

Health challenges for 6–8 weeks focus on some aspect of health and wellness. A focus on men's health, through programs like the DUDES Club, includes heart health.

Visiting services

Visiting services (to Fort Nelson) are useful, including physiotherapy, occupational therapy, and a visiting internist.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITIES?

Increased awareness

While prevention and screening education has increased over the years, there's a need to improve awareness and knowledge about heart health, including education on stress reduction and signs and symptoms, and building on existing community events and groups (like men's health groups). Better information on what specialized services come to the area would also help. While the emphasis on healthy eating has grown, there's still some way to go, such as improving the food available at some gas station/grocery outlets.

Better access to services

The Northern Health Connections bus is appreciated, as are telehealth and visiting services, but challenging travel remains a barrier to heart health. Anything that can bring services closer to the community is welcome. Similarly, medical evacuations are sometimes slow or delayed.

Because of challenges in distances and recruitment, there are many services that are difficult to access. Locally these include timely access to primary care, more rehabilitation support, adequate local nursing, and more community paramedics. Specialist access is limited in the area and often a long wait elsewhere, and there's some support for looking at catheterization laboratory support in Northern BC.

There are concerns for Elders, who need more home support and better management of their care, including medications. More use of emergency alert devices would be useful.

Communication and coordination

GPs and specialists don't communicate well, or at all, other than through referrals. There needs to be better communication about what to expect, about medications, and about followup care and discharge planning. Even when there's a patient advocate escorting someone, they often don't know what they need to ask.

CHETWYND – PUBLIC MEETING

Date: September 20, 2018
Participants: 5

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Prevention

Chetwynd's recreation centre, walking trails and pool help people stay active. At the seniors' home, there are also chair yoga and stretching programs.

Blood pressure checks can be done at Walmart, and community paramedics do wellness checks on a doctor's referral. The primary care nurses do wellness check-ups and the community health team does wellness and healthy heart checks in the workplace. Every year there's a health checkup held at the local recreation centre. The interprofessional team is starting to increase screening. There's collaboration with West Moberly and Saulteau First Nations, and they do a great job of educating their members.

Services

A local physician is exploring ways to help patients who need cardiac rehabilitation, and there's a private physiotherapy clinic in the community. Telehealth is available at the hospital.

Residents of Chetwynd can get in to see a doctor when they need to. Some diagnostic tests are available locally, including blood tests, ECG and Holter monitors. If someone has a cardiac event, they're transported out of the community and sent either to Fort St. John, Prince George, Grande Prairie or Edmonton. Patients have been able to access a social worker when medically evacuated to Vancouver and were provided a discounted ticket for the return flight.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Prevention and awareness

Having a community champion for heart health would create awareness. Weather is a concern, particularly in the winter; transportation remains a challenge; and there's a transient population that can be hard to reach with prevention and screening services.

There's always the opportunity to do more prevention. Coordination and a champion would help with creating more awareness of heart disease, and more awareness of the prevention and screening help available. People are not aware of home-based services or that they can self-refer to community services. Many community exercise programs also have a cost, which can be a barrier.

Staffing

There's high turnover among Chetwynd health care professionals. With the turnover in family physicians (they're often in Chetwynd for three-year contracts), relationships with specialists are not strong and have to be rebuilt every time a physician departs. If providers were able to mentor one another, information about the system could be passed on and kept current. Telehealth could be used more.

Some key health care professionals are also missing from the team. The interprofessional team doesn't have an occupational therapist or a physiotherapist.

Travel and rehab

For patients who have been sent out of the community for care, there's a sense of abandonment when they're discharged from the cardiac care centre.

When returning to the community, there's often no proper plan of care. Specialists don't seem to know what's available in Chetwynd, so when there's a plan of care, it may include options that aren't actually available. There is no cardiac rehabilitation program available in Chetwynd.

Participants think it would be positive to have more services in Prince George, although there's also a need for more diagnostics and prevention in Chetwynd itself. Could there be a mobile heart unit that comes to the community?

"You are alone being transported out of the community, alone while in Vancouver, and then abandoned when discharged." – Meeting participant

DAWSON CREEK – PUBLIC MEETING

Date: September 19, 2018
Participants: 21

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Prevention

Participants defined heart health from two perspectives: maintaining a healthy lifestyle to avoid heart disease, and having access to needed services.

In Dawson Creek, there are "wonderful" exercise programs and a farmers' market where fresh locally grown food can be purchased. Many people have strong social networks and there's a strong community spirit. There are programs for seniors, health education is offered by the college, and pharmacists offer education and support. There's also a private physiotherapy practice in town that is working towards the development of a cardiac rehabilitation program.

Northern Health

Participants reported that Northern Health staff are good at what they do, the care in the Emergency is great, and the Northern Health website is helpful. The Northern Health Connections bus was identified as being an important support for meeting health transportation needs.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Travel

Transportation to and from services outside the community is a significant issue. In the Northeast, many services are offered in Fort St. John. For programs such as cardiac rehab, travelling from Dawson Creek twice a week (particularly in winter) makes access difficult. Medical evacuation for treatment at a higher level of care is sometimes delayed. Wait times are often due to the lack of availability of planes or beds. From Dawson Creek, the travel time to Edmonton is shorter than it is to Kelowna or the Lower Mainland.

There's a lack of information and support for the return trip home: It's expensive and there are no supports to help with planning. There's a need for both navigation and advocacy support for the patient and the family. Some people can't easily find their way through the system. There's a social worker at the hospital in Vancouver and Hope Air can help get some people home; however, not everyone seems to get the support they need. Patients need someone with them who can take notes about the information being communicated.

Coordination and communication

Returning to Dawson Creek after getting care in Alberta or the Lower Mainland is problematic. There's a lack of communication related to the clinical needs of the returning patient. Once back in the community, followup care has gaps and post-surgical issues have sometimes been missed.

Participants shared experiences about not being heard by clinicians in the community when a family member was having significant health problems.

Cardiac services

The diagnostic process in Dawson Creek needs improvements. It can take three to six months to get a test, and often tests are redone at the referral centres anyway.

There's a historical referral pattern for cardiac care from Dawson Creek to Alberta. Some patients have an established relationship with cardiologists there and when health issues arise again it's disruptive to not be able to go to Alberta for care. Waiting for a bed in BC doesn't always make sense. Clinical coordination problems do arise, however, when health information can't be shared because of interprovincial differences.

Participants believe the development of regional cardiac care services in Prince George could improve access to better care. Transportation issues for reaching Prince George, however, are still significant. The Pine Pass isn't reliable in the winter, and the air ambulance system would need to be able to support transport needs. Many people in the Northeast may still prefer to see more services in Grande Prairie, Alberta.

PHOTO OF HAIDA GWAII BALANCING ROCK CANYON BY SJ KERR

DAWSON CREEK – STAKEHOLDERS AND PROVIDERS MEETING

Date: September 20, 2018
Participants: 3

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Prevention

There are several community-based heart health initiatives in the community including Heart and Stroke, information on exercising and quitting smoking, a Wellness Fair, and a Jump Rope for Heart event in the schools. There are also health practitioners in the community, including a naturopath, an acupuncturist, a physiotherapist, and a chapter of the Victorian Order of Nurses. Community members can self-refer to the Health Unit, and physicians can refer to Home Care Nursing for hypertension monitoring. A nurse goes into the local schools to do heath education.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Staffing

Staffing challenges appear in several ways. Screenings are reduced, and it would be helpful to have nurses at flu clinics to do screenings for heart health and other conditions. Holter monitoring exists in the Northeast; however, there's a struggle with staff recruitment and retention, which creates waitlists.

There are also challenges in the Northeast around maintaining the roster for internal medicine. Engagement with and support to GPs could be improved to help support patients when they return to the community post-treatment.

Transportation

There are issues with transporting patients out of the community, mainly related to pilots requiring downtime before flying again, or to weather conditions at the airport.

When a patient needs to be transported out of the community, physician-to-physician communication is needed to determine priorities. At times, the Nurse Manager may step in to help provide information to facilitate the transport. Some physicians don't see this as their role.

Services

More physiotherapy in the hospital and/or the community is needed. There's no cardiac rehabilitation program and staff have tried to use the NORTH Clinic; however, it can't meet all the needs.

Having more regional services in the North would be helpful. The Cancer Centre has demonstrated the benefits of this type of service well.

FORT NELSON – PUBLIC MEETING

Date: September 17, 2018
Participants: 7

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Prevention

Fort Nelson has well-supported recreational facilities that encourage year-round exercise. These include a walking track and walking program. There's access to a dietitian and a "really great" health food store. More could be done to support heart health, perhaps through partnering with other health promotion initiatives in the community.

Cardiac services locally

Access to diagnostic services is good. Doctors' appointments are accessible and there's generally not a wait in Emergency. There's good coordination between physicians, and Fort Nelson has a lab and stress-testing. The hospital staff and the services they provide are well regarded in the community. Thrombolytic treatment is available, as well as pacemaker support.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Travel and patient support

Staff at the hospital would benefit from having more training to support the care needed while waiting for a patient to be transported out of Fort Nelson. There can be significant delays (e.g., days) in transporting patients to higher levels of care in Vancouver. Transfers to Alberta seem to be faster.

Fort Nelson is many hours from the nearest community. Navigation support to help patients who leave the community for cardiac care is needed. This includes ensuring a connection with that navigator when the patient is discharged and ready to return home. People who can't coordinate their own care or who don't know who to call for problems that may arise are in particular need of this kind of help. Other challenges include the financial burden the return journey poses for patients and their families.

When patients are discharged from cardiac care centres, health authorities must share clinical information. Providing care to patients with complex needs is difficult, and there can be lack of knowledge by health professionals, which can delay getting appropriate treatment.

In the past, specialists have come to Fort Nelson, so patients didn't need to travel.

Rehab

The Northern Rockies Regional Municipality offers exercise programs for people who've had a cardiac event, and there's a regional dietitian who can videoconference into the community. Improvements are still needed in the coordination of cardiac rehabilitation and in receiving support from the tertiary centre.

FORT NELSON FIRST NATION

Date: September 18, 2018
Participants: 12

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Activity and monitoring

Members use the walking track in Fort Nelson to keep fit throughout the year. Prevention initiatives have been implemented in partnership with the RCMP (bimonthly heart pacers exercise), and the nurse at the Health Centre monitors blood pressure and brings in the pharmacist for prescription reconciliation. Wellness checks are offered and there's a coordinator who supports access to services by arranging transportation and accommodation.

Travel support

There are strong advocates in the community and home support staff who let the community nurse know when her involvement is needed. There are also excellent staff at the health centre at the Fort Nelson First Nation, and patient travel coordination is great. For cardiac care outside the community, some go to Fort St. John or Grande Prairie, or they may travel to Edmonton or Vancouver for diagnostics and/or treatment.

When community members must leave the community, there's support for the cost of travel and care; however, funds don't cover all costs, especially when family members need to travel. Sometimes people also need a translator, which can increase costs.

The Northern Health Connections bus helps; however, it only runs on Tuesdays with the return on Thursday, which means clients need to pay for two nights of accommodation plus meals. Taking the bus to Prince George is a long trip.

Telehealth

The telehealth service at the hospital works well to reduce the need to go out of the community for a consult.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY?

Prevention

Participants from the Fort Nelson First Nation brought personal, professional and community perspectives to the conversation. There's support for more initiatives focused on prevention, particularly for youth, and for more services closer to, or accessible for, their community.

Quality of care

A significant concern is the quality of care that Indigenous people receive from the local hospital and physicians. There's a level of mistrust of the health staff in Fort Nelson. Participants expressed frustration with not being heard and in experiencing a lack of compassion, which makes them less willing to seek help when needed.

Access

The great distances to many services can be mitigated through access to specialized knowledge and supports. Access to an occupational therapist would be helpful, as patients must currently leave the community to access rehabilitation support. Support in monitoring medication could be improved.

Transportation

The time and costs related to travelling outside the community are significant barriers. The cost for meals, a place to stay, and transportation while away often exceed the funding available. If reimbursements are provided, families may not have the funds to incur the costs up front. Family members often use their vacation time to take family members to appointments.

Coordination and communication

We need to improve coordination and communication about care plans. It would be helpful to have area physicians offer a clinic in the Fort Nelson First Nation. There's a social worker now working with the interprofessional team (IPT), and greater involvement in Fort Nelson First Nations health would be helpful. Holding IPT meetings on-reserve in the community would make it easier for the community nurse to participate.

Linking local, regional and Vancouver computer records would improve communications.

Northern cardiac services

Views on the best location for improved regional cardiac services vary. For some, the preference remains Vancouver, and for others, Prince George would be better because it's easier for community members to navigate a smaller community. Having support from family would also be easier in Prince George.

FORT ST. JOHN – PUBLIC MEETING

Date: September 18, 2018

Participants: 13

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Prevention

Taking personal responsibility through healthy eating, exercise and other lifestyle practices such as meditation and yoga can prevent disease and support health. A healthy community promotes these practices, as well as creating formal and informal support group networks. In Fort St. John, there are gyms and studios to take advantage of, as well as a community-provided free walking track, walking trails and fitness centres. Some physicians are also active outside their clinic hours, engaging with community members to talk about heart health and other topics. Some Fort St. John workplaces have health and wellness committees that promote healthy eating and exercise.

Individual responsibility

Participants described a practice of mindfulness and maintaining informal support networks. They aimed to think of themselves as part of the team, or as the "manager of care" by:

- Keeping a binder of medical records and requisitions
- Asking questions
- Keeping a notebook
- Creating a relationship with your care provider.

For the patient, knowledge is power.

Participants emphasized the importance of letting your physicians know your family history to ensure appropriate screening.

Cardiac care

There's generally good care in Emergency, as well as doctors who go the extra mile and nurses who advocate. There does, however, need to be more consistency. Fort St. John also has post-surgery rehabilitation available. There may be a wait for chronic disease management rehabilitation, but the service is offered and the physiotherapists were praised. Participants thought the hours of access could be better, however.

Once a person reaches the next level of care (e.g., in Vancouver), care is good, and some participants noted that they're emailed personally by their care team. There are good doctors both at St. Paul's Hospital and in Edmonton. Rapid Access to Consultative Expertise (RACE) works well and can provide a quick medication review if needed.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Communication and navigation

There are significant gaps in how information is shared within the health care system. There are gaps between primary care providers, between regions, and between specialists and primary care providers. Information technology is advancing rapidly, and there's an expectation that the medical health record should follow the patient and be accessible to providers and to the patient. Status information while waiting for referrals, services, and test results should be easily available. Examples were given of tests done in Fort St. John being redone in other centres because the first set of results was not available to the physician.

Patients need help to navigate the complex system of health care services and providers. It's unclear who's responsible for supporting patients and families to navigate the system. Examples were provided of booking clerks triaging the

importance of diagnostic tests, and no followup on the booking of tests. People who can't advocate for themselves need better support; suggestions include creating facilitated support groups.

There's a burden placed on patients and families to be advocates for themselves in the journey of care, and many of the "pinch points" are exacerbated for patients with chronic and complex care issues. Diagnosis is considered a significant issue; the question was raised as to why a patient's record isn't flagged as "chronic and complex" so a specialist could be called in sooner. Often for these patients, test results may be unusual and should not be discounted. What are standards for reasonable wait times when care's transferred to another physician? Who provides oversight when opinions differ, and who ensures that requisitions for service are followed up on? At times, a specialist may prescribe a medication and the GP is unaware of it; what are the processes for communication between health care providers and for accountability for medication reviews?

Cardiac services

There's a need for more trained staff in the community, including staff for diagnostic services such as ECGs. Accessing specialized cardiac services outside the community needs to be timely. If the local services are unable to meet the need, then patients should be sent elsewhere. These services are being provided well in Vancouver and Edmonton (once you're there). One concern about providing these services in Prince George is the possibility of needing yet another transfer route.

Waits for cardiac rehabilitation are long. Patients need mental health and psychosocial support after a heart event. There's difficulty getting in to see the dietitian. Better access in the evenings would be helpful to avoid the need to miss work.

Transportation

Suggestions were made for improving the Patient Transfer Network (PTF). Communication with the patient and the family could be improved with transparency of the decision-making around why transport is delayed. Can the planes accommodate more patients once a plane has arrived?

"My physician knows my family history of hereditary heart disease, so I have blood tests and cholesterol checks. My physician is on it!" – Meeting participant

FORT ST. JOHN – SERVICE PROVIDERS AND STAKEHOLDERS

Date: September 21, 2018
Participants: 13

WHEN YOU THINK ABOUT HEART HEALTH AND CARDIAC SERVICES, WHAT IS WORKING WELL?

Prevention

The community has walking trails, a free indoor walking track, outdoor exercise equipment in parks, a recreation department with a targeted focus on sports and recreation, and an indoor soccer pitch. The city's Recreation and Leisure guide promotes active living and the city has signed on to a Winter Cities initiative that focuses on making the city accessible to pedestrians in the winter. Winter activity initiatives include a flooded pathway for skating (to be expanded this year) and a site for playing crokicurl (a new winter sport that combines curling with the board game Crokinole). Fort St. John also has many fitness centres, with some offering personal trainers.

There are also several partnerships in the community. These include SONS (Save our Northern Seniors; it helps seniors be active), programs for youth, and programs for people with COPD or asthma. Work is underway with UNBC to develop a social framework with community indicators so that trends can be tracked and gaps identified.

There are training programs for staff on smoking cessation, along with protocols and links with local pharmacies so that nurses can initiate nicotine reduction. The city has a no-smoking bylaw and there's also the provincial bylaw. All parks and playgrounds are non-smoking.

Northern Health has supported the work camps in the area in promoting men's health. There's work being done with employer Health and Resource Development committees, and there's an incentive to support health promotion. A research study will look at the mobile workforce and how their health has been managed.

Rehabilitation

Cardiac rehabilitation is offered as part of the chronic disease management program. This is an eight-week program with followup offered on a drop-in basis. A kinesiologist in private practice in the community offers a continuation of the program, with a focus on preventive exercise before a heart attack.

WHAT ARE OPPORTUNITIES FOR IMPROVING HEART HEALTH AND CARDIAC CARE IN YOUR COMMUNITY AND IN THE NORTH?

Promotion and prevention

There could be more upstream work. With staffing constraints (vacant positions) it has been a few years since wellness fairs were supported by Northern Health. There's some screening at flu clinics. The data show that youth in Fort St. John are generally healthy; however, indicators decrease in the adult population. There may be opportunities to work with employers and to provide screening in the workplace, as many people are too busy to seek screening elsewhere.

There's opportunity for greater promotion of what is available in the community and for providing more information on the damage done by a sedentary lifestyle. Other barriers to access health-promoting activities include a lack of day care.

The cost of living in Fort St. John can also create barriers to healthy living. There's a society starting to help people access fruits and vegetables at a lower cost once a week.

Staffing and equipment

Fort St. John has a wider range of services available than other communities in the Northeast; however, maintaining staffing is a challenge (particularly in diagnostic services). It's a precarious situation, because a change in one position affects the complement of available skills, and often leads to a decrease in the availability of some tests. Most technologists are highly skilled, and it's difficult to recruit for vacancies. Physicians sometimes stop ordering tests because they know they can't get them done.

The surrounding smaller communities also have staffing challenges. For example, in Hudson's Hope there's a physician, a nurse, a medical office assistant, and a lab technician. It's challenging to recruit to that community.

Fort St. John also has challenges in maintaining a full roster of internists, which limits the number of tests that can be performed.

The existing supports to recruit and retain staff in Fort St. John are helpful. For example, if staff know what scholarships are available, they can encourage staff to upgrade their skills. With a return of service agreement in place, staff with needed skills stay for a period of time and that helps to stabilize staffing.

It's a struggle to maintain the internal medicine roster. Northern Health is working with the Ministry of Health to look at alternative payment plan options. More patients are sent out because of a lack of coverage. This puts a strain on ER physicians, because Fort St. John is the referral centre for the other communities in the Northeast.

More paramedics with Advanced Life Support (ALS) skills are needed to better serve the more remote communities.

There are also constraints caused by equipment: because older equipment is slower, which decreases the number of patients that can be seen. The Hospital Foundation helps support the purchase of new equipment, however.

Rehab

Home and Community Care in Fort St. John used to provide a cardiac rehabilitation program; however, with the hospital program it became redundant. There was a local physician with a strong interest in cardiac rehabilitation, and he was a strong advocate for getting patients into the program. Local physicians could do a better job referring patients. There's a risk of patients going back to work too soon and having poorer outcomes.

The program has been integrated with chronic disease management services and this is working well; however, there are more referrals than spaces, and a continual waitlist. The program was reduced from three months to four weeks, and those who have undergone open heart surgery are prioritized. It's a group rehabilitation model. Resource polices and practice standards are still needed.

Indigenous health

There are health disparities with the Indigenous in the area, and while there are GPs who go to the communities, there needs to be better information on what other services are needed in order to decrease these disparities.

Cardiac services

More clinical pharmacy support is needed for staff to do medication reconciliations, and to support patients to understand their medications.

Access to cardiac care services for stents must improve. Waits are longer to transport people to these services. The Patient Transport Network seeks services in BC first, and Alberta has pushed back on our access to their services. Communication on referrals and discharge plans is better when care is provided in BC.

When patients are transferred for care outside the community, they're informed that they have to take clothes and credit cards. There's documentation to help them with the process. In the moment of crisis, patients don't always hear all the information about the process of care and what they need to take with them. Some people can't afford the travel back to Fort St. John; however, the Fire Fighters have a charity that can help people with the cost of flights back. There's also a hospital-based social worker who can help navigate the system.

There's currently a working group addressing some of the Patient Transport Network issues. Higher care needs are the priority. Sometimes local patients requiring high care levels must remain here while they wait for transport.

There's a wait to see a cardiologist. Often patients travel back to the community where they received specialized care for a followup appointment that only takes a few minutes. Telehealth would help to reduce this.

Participants thought that developing regional cardiac services or a regional cardiac centre in Prince George could be beneficial, and they noted that the Cancer Centre has demonstrated success in providing services to the North in an equitable way. With a regional approach, there's the opportunity to develop standardized care pathways across the North. Prince George is becoming the regional centre, and people understand the demands and challenges of travel in the North. However, investment to improve services in Terrace and Fort St. John should be a priority. Cautions about a regional centre include assuring patients outside Prince George that they would have equal access to services, and that adequate services would be offered to prevent, subsequent transfers to the Lower Mainland.

Travel connections to a centre such as Prince George would need to be improved. Weather is an impediment for accessing local services and would also be an impediment for accessing services elsewhere.

PHOTO OF HUDSON BAY MOUNTAIN BY SJ KERR

APPENDIX 1 – SUMMARY OF FINDINGS FROM THOUGHTEXCHANGE

What is Thoughtexchange?

This method of collecting input from Northern BC residents offered anyone interested the opportunity to participate online. Participants were asked to respond to this question: *What are some things about heart health and cardiac care that are working well, and what are some things we should focus on in order to improve?*

Participants were then able to see other ideas and rank them by placing stars next to them, more stars indicating more resonance with, or support of, the idea. All ideas submitted were reviewed and considered as input for the consultation. To see the ideas and which were most supported, see the full online report. Using the Demographic tabs at the top of the web page, you can sort ideas by location and/or by role.

Demographic Groups

There were 390 unique visitors to the site; 330 of these contributed ideas and/or ranked ideas. The table below indicates their home communities.

Table 1

Area	#
Interior (Mackenzie, Prince George, Quesnel)	153
Northwest Coast (Kitimat, Prince Rupert, Terrace)	49
North Peace (Fort Nelson, Fort St. John, Hudson Hope, Taylor)	47
Bulkley Valley (Hazelton, Houston, Smithers)	26
Nechako Valley (Burns Lake, Vanderhoof, Fort St. James, Fraser Lake)	17
South Peace (Chetwynd, Dawson Creek, Tumbler Ridge)	22
Haida Gwaii (Masset, Queen Charlotte)	6
Robson Valley (McBride, Valemount)	4
Stikine (Atlin, Dease Lake, Nass Valley, Stewart)	6
Total participants	330

Table 2
Participants identified their role or perspective as in the table below.

Role	#	%
Community member	156	48
Private health care provider	6	2
Northern Health staff member	163	50

PHOTO OF VALEMOUNT BY SJ KERR

Top ranked ideas by theme

Ideas were separated by theme. The lists below present the top five ideas for each theme — those that had the highest level of support from other participants. Note: These ideas have not been edited, but appear as they were written online.

THEME: PREVENTION AND SCREENING

1. **Early recognition of cardiac events**: Fast treatment leads to better outcomes.
2. **Healthy eating options in hospital:** Nutrition is part of healing and heart healthy options like fresh real fruit should be available.
3. **Heart health resources:** Why does Northern Health have no information as to how to be heart healthy? Refer to Island Health Cardiac program for what I mean is missing.
4. **Dietary habits should be explored and corrected:** Most of our heart health issues begin and end in the kitchen. Patients must learn what to eat and how to easily prepare proper meals.
5. **There needs to be better education provided for prevention of cardiac diseases:** There are programs for education on cardiac diseases but not how to prevent them.

THEME: CARDIAC CARE SERVICES

1. **I need an echocardiogram:** It is a year wait!?! Most of the treatment options are based on the results of the echo. Do I remain untreated for a year?
2. **Having better access to a cardiologist in a timely matter:** The wait time for specialists is long and can take up to 6 months or more before someone is seen by one, causing a lot of anxiety in patients.
3. **Access to services:** Demand for services is needed in rural areas; population needs to be able to access service in a timely manner. Increase availability of Cardiac Clinic services to rural communities. So many communities remain distant from cardiologists, dieticians etc.
4. **Wait times need to be addressed for diagnostic tests:** Many people have heart issues but are stuck waiting a year for testing (e.g. stress test).

THEME: REHABILITATION AND FOLLOWUP

1. **Home nursing visits post cardiac event:** Give them a connection to health care services if needed and teach proper return to full activity level.
2. **I feel there is no support for heart patients.**
3. **Recovering from surgery:** We are very isolated in the North. After major surgery and information given to us in Vancouver we return to the North with no supports. There needs to be better follow-up with patients who we are sending down South for cardiac procedures. Patients are left on their own to find transportation back home.
4. **Why is there no cardiac rehabilitation in the Northwest?** We know there is significant benefit to patients who attend rehab after treatment for heart attacks but it isn't available to northern residents.
5. **More education for families and cardiac patients:** For successful disease management and reasonable outcome expectations.

THEME: SPECIALIZED SERVICES IN PRINCE GEORGE

1. **Bring services closer to home:** So many people are admitted throughout the year for cardiac services and require immediate transfer to Kelowna or Vancouver but are in our bed waiting.
2. **Prince George needs a cardiac cath lab to do angio treatments for patients:** All patients from Northern BC need to be transferred to Vancouver or Kelowna for this. It separates them from family and causes discharge issues.
3. **UHNBC needs a cath lab!!** This is the rate-limiting step in growing cardiac and interventional-based services in the North. If you build it, they will come!!
4. **I would love to see a cath lab in Prince George:** We would be able to give better care to clients in a timely fashion and recruit/retain cardiologists in the North.
5. **PG needs its own cath lab:** Coordination of PTN and bed availability at Southern sites makes wait times too long.

THEME: PRIMARY CARE

1. **Better medication review:** GPs need support for complex cases. A quick medication review every time something was changed could have prevented a near-death experience.
2. **Many people won't have access for heart services because they don't have a family doctor:** Patients with chronic illness need continuity of care.
3. **GP using RACE Line:** Quick real-time support may avoid unnecessary long wait times for specialist support or confirm urgency of appointment required.
4. **Internal medicine support for physicians to consult with, Practice Support Programs CHF training module and resources:** Expand or brush up GPs'NPs' knowledge and skills and resources for managing heart health and provide expert consultation support when they need it.
5. **Medication review:** When there are any health changes this should be a priority.

THEME: TRAVEL/TRANSPORTATION

1. **Waiting time:** Waiting for transportation to go to Vancouver.
2. **Interventional cardiology requires transport to Vancouver and can involve delays in transfer for subacute/UA patients:** It is often difficult to align air ambulance, weather and bed availability at St. Paul's Hospital or Vancouver General Hospital.
3. **Unfortunately, due to limited flights it sometimes takes far too long to get cardiac patients to the coast for further treatment; i.e., for angio:** Faster care equals better outcomes.
4. **We need to improve the process of transfers to advanced cardiac care, patient transfer network:** Time is heart muscle, early intervention is key not only to improve mortality and morbidity but to decrease health care spending.
5. **The travel to receive testing/treatment is an unreasonable burden on those in the North who have heart issues and is disheartening:** People with these issues are already unwell in some way and the distances and lack of

local treatment discourages follow-up.

THEME: VISITING SERVICES AND TELEHEALTH

1. **Would like to see more options for remote access for monitoring of chronic conditions:** It is difficult for many northerners who may not have vehicles to get to clinics. Especially true now that the Greyhound co. has stopped service.
2. **I'd like to see some sort of videoconferencing here so we can communicate/follow up with the Vancouver specialists perhaps without needing to go down:** This would be even better if we could videoconference with our specialist here and the one in Vancouver at the same time.
3. **The partnership with BC Children's Hospital where they send a team North works well:** It is difficult for families who need specialized cardiac care to always travel to Vancouver; local support is appreciated.
4. **Access to cardiologists in the North is essential:** Travel to Vancouver can be prohibitive. Costs and time...heart issues should be dealt with quickly and waiting to go to Vancouver can mean death for some.
5. **Having to travel out to another community from Fort Nelson for a 10-minute check-up before appointment is set for cardiac workup 10 weeks later:** The 10-minute check-up should be done by phone or Telehealth. Cost away from work. Dangerous drive in winter conditions and cost of travel for a 10-minute appointment.

THEME: STAFFING AND CAPACITY

1. **MORE STAFF:** I cannot speak for every staff member, but I think I speak for many when I say: we try to care for everyone as we would want our loved ones cared for. But we are burnt out. We can't copy ourselves to do the work we are expected to do.
2. **We don't have enough medical staff:** Wait times are long or we have to travel out of the area.
3. **We have most of the supplies we need but are limited by staffing numbers:** We do the best we can with the limited resources.
4. **Inadequate number of nurses working in our hospitals and clinics in the North.**
5. **Need a bigger hospital with more specialists and more training (specialty) for staff:** UHNBC is overflowing, people are getting older and sicker and we need more beds for patients. So many are in HALLWAYS; would you want your loved one there?

THEME: COORDINATION AND COMMUNICATION

1. **Cardiac protocol and being sent out:** Person waits in a bed to go to another hospital often without family or support. Teaching heart health education is not appropriate at this time.
2. **Why does it take so long for test results to get back to the cardiologist?** I have been waiting for almost 1 month. Burning up the 15 weeks of medical EI for working people for no reason is frustrating.
3. **The care is disjointed:** Once discharged from the hospital, it feels like you are left hanging. Wondering how you will see the cardiologist. How do they know?
4. **Needed:** Communication improvements: Let people know what services are available and where to find them. People can't take advantage of services they don't know are available. Better informed community, better health awareness and healthy living outcomes.
5. **Not enough people are aware of the program!** Needs better publicity and people need to know that they don't need a referral to come to the program.

PHOTO OF HAGWILGET CANYON BY SJ KERR

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