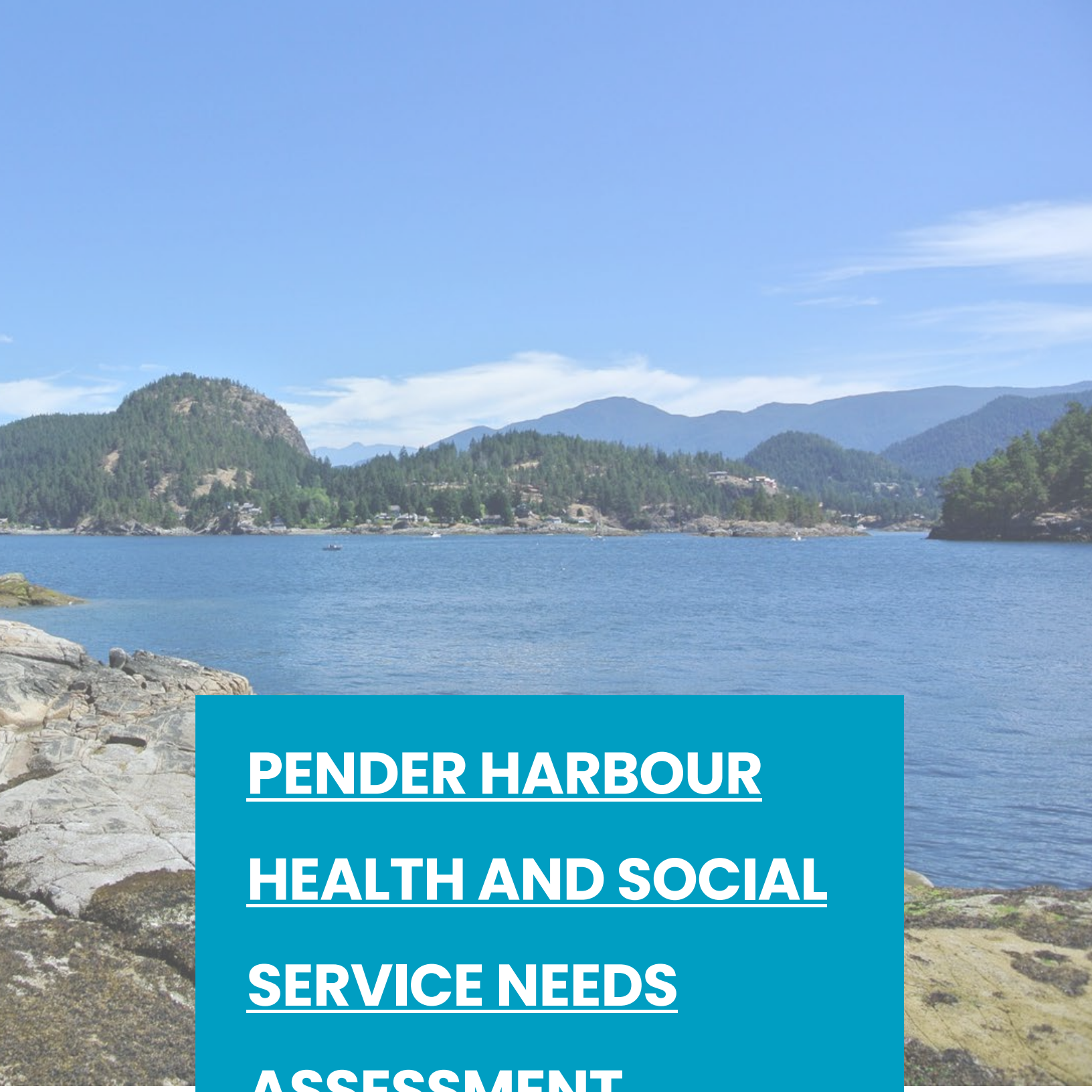

PENDER HARBOUR HEALTH AND SOCIAL SERVICE NEEDS ASSESSMENT

August 23, 2024

urban matters

PREPARED FOR:

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File: 4334.0002.01

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We acknowledge with deep gratitude that this Health and Social Needs Assessment took place on the traditional and unceded territories of the shíshálh Nation. We recognize the profound connection that the shíshálh people have to these lands, waters, and resources, which have sustained their communities for generations. We are thankful for the opportunity to work, learn, and live on these lands, and we express our respect and appreciation for the wisdom, strength, and resilience of the shíshálh Nation.

EXECUTIVE SUMMARY

This report has been prepared to assist the Pender Harbour Health Centre (PHHC), local social service stakeholders, and residents in better understanding local health service needs. Through an integrated analysis of key findings from a background review and community engagement, this report provides actionable recommendations for improving local health and social services.

COMMUNITY PROFILE

The community profile for this area provides essential context for interpreting health and social service needs. Key findings indicate the following for Pender Harbour/ Egmont:

- **Aging population**: The area has a high median age (61.2 years) and a significant proportion of residents over 65 (40.2%), indicating a likely increase in demand for age-specific health care services.
- **Household composition**: The high number of single-person households may highlight potential challenges in accessing health care and social support due to the potential social isolation and financial constraints commonly associated with these households.
- **Low-Income households:** Economic data shows that the median after-tax income in Area A is $58,400, markedly lower than the provincial median of $76,000. The area also has a high proportion of households in core housing need, with 20.2% of households spending 30% or more of their income on shelter costs. This economic vulnerability is particularly pronounced among seniors, renters, and Indigenous households.
- **Indigenous population**: A higher proportion of Indigenous residents necessitates culturally sensitive health care services.
- **Population growth**: Rapid population growth is estimated for older adult household categories, which can strain existing health care resources, and requires strategic planning and resource allocation to meet growing health and social care needs.

These demographic and economic trends underscore the need for tailored health and social services that address the unique challenges faced by these communities.

ENGAGEMENT HIGHLIGHTS

Community and service provider engagement highlighted several perceived gaps and needs for social, health, and wellness services, including:

- **A lack of primary care physicians:** A critical shortage of primary care physicians was consistently highlighted alongside the challenges this presents for continuity of care.
- **Transportation barriers:** Transportation is a significant issue, affecting access to health and wellness services, particularly for youth, seniors, individuals with low-income, and those with mobility challenges.
- **Mental health and addiction services:** There is an increased demand for mental health services and addiction and substance use support, especially among youth.
- **Aging population and related services:** The growing number of elderly residents has led to increased demand for services tailored to seniors. Aging-in-place is a common goal, and enhanced support services for seniors are necessary to meet aging needs.

- **Volunteer and community support:** The community benefits from a strong volunteer base and active community groups, however, there is concern over the loss of older volunteers and the increased stress on volunteer-based services.
- **Service accessibility and quality:** Many residents face barriers to accessing health, social, and wellness services due to provider availability, long wait times, and financial costs.
- **Financial stability and food insecurity:** Financial costs and food insecurity are significant challenges for Pender Harbour residents.
- **Communication and coordination:** Improved communication about available services, how to access them, and improved coordination among service providers are essential to address gaps and improve service delivery.
- **Increased demand for services and staffing shortages:** There is a growing demand for health services, compounded by budget cuts and staffing shortages, which negatively impact service delivery and access to care.

RECOMMENDATIONS

This report provides eight key recommendations, each linked to promising practices from other Canadian communities to address the identified gaps and needs:

1. **Establish a Health Steering Committee and Develop Strategic Priorities:** Drawing from the success of the Northern Rockies Community Health Plan Steering Committee, a local health steering committee could guide the development of strategic priorities and advocate for necessary resources.
2. **Develop Recruitment and Retention Incentives for Health care Professionals:** Inspired by the Churchill Health Centre's model, implementing incentives focused on work-life balance, housing, and cultural safety could improve staff retention and attract healthcare professionals to the area.
3. **Develop a Comprehensive Elder/ Senior Support Program:** The GAIN program in Ontario provides a model for a holistic approach to senior care, which could be adapted to meet the needs of Pender Harbour and Egmont's aging population.
4. **Enhance Telehealth Services:** Expanding telehealth services, similar to Ontario's Telehomecare and BC's Virtual Visit programs, would improve access to health care for residents, particularly those with mobility issues or chronic conditions.
5. **Explore Options for Reducing Health Travel Transportation Costs:** Leveraging grant opportunities to subsidize the existing van service could reduce the financial burden of travel for medical appointments, particularly for low-income residents.
6. **Integrate Mental Health and Substance Use Support Services:** Promoting virtual mental health and substance use services through partnerships with organizations like Foundry BC could make these services more accessible to the community.
7. **Strengthen Volunteer Engagement and Support:** Establishing a youth volunteer program in partnership with local schools, modeled after Island Health's Step Up Youth initiative, could engage younger volunteers and ensure the continuity of volunteer-driven services.
8. **Enhance Resource Sharing and Coordination:** The Health Steering Committee can facilitate better resource sharing and coordination among local healthcare providers, improving service delivery and ensuring that resources are used effectively.

1.0 INTRODUCTION

BACKGROUND & PURPOSE

The Pender Harbour Health Service Needs Assessment was prepared to help the Pender Harbour Health Centre (PHHC), local social service stakeholders, and residents better understand health service needs for Pender Harbour/ Egmont. This Health Services Needs Assessment has been driven by the PHHC, as a follow-up to their initial Service Needs Assessment, conducted in 2018. This endeavor is of paramount importance given the dynamic landscape of health care demands and priorities, especially in the wake of the COVID-19 pandemic. The primary purpose is to provide a high-level evaluation of the current health services landscape, identifying emerging health challenges, evolving priorities, and gaps in service delivery.

Pender Harbour/ Egmont is situated within the traditional territory of the shíshálh Nation and also falls within the Sunshine Coast Regional District. Officially referred to as Electoral Area A: Egmont/ Pender Harbour, this area is made up of 1,901 square kilometres of communities situated around Pender Harbour and includes Madeira Park, Beaver Island, Garden Bay and Irvines Landing. To the north are Kleindale, Sakinaw Lake, Ruby Lake, Earl's Cove, Egmont, Skookumchuck Narrows and the waterways up Jervis Inlet.

DEFINING HEALTH & COMMUNITY WELLNESS

The World Health Organization (WHO) identifies the social determinants of health (SDOH) as the conditions in which people are born, grow, live, work, and age, which are shaped by the distribution of money, power, and resources at global, national, and local levels.[1] These determinants include factors such as income and social status, education, physical environment, employment, social support networks, and access to health care. The WHO emphasizes that these social determinants are crucial in influencing the health outcomes of individuals and communities, often driving health inequities where certain populations experience disproportionate rates of illness and mortality due to their social and economic conditions.

The social determinants of health may include:

- Income and Social Status
- Education
- Physical Environment
- Employment and Working Conditions
- Social Support Networks
- Access to Health Services
- Personal Health Practices and Coping Skills
- Healthy Child Development

[1] World Health Organization, 2024

- Biology and Genetics
- Gender
- Culture
- Social Environments
- Food Security
- Housing
- Transportation

The WHO's framework on social determinants of health provides an essential lens through which to assess the characteristics and demographics of communities, households, and individuals. By applying this framework, health assessments can go beyond surface-level observations and consider the broader social and economic factors that influence health. This approach allows for a more nuanced understanding of how specific community contexts, household conditions, and individual circumstances contribute to health outcomes, enabling the development of more targeted and effective interventions.

Incorporating the WHO's framework on social determinants of health into health and social service assessments ensures that interventions are not only treating symptoms but also addressing the systemic issues that perpetuate poor health. This holistic approach is vital for creating sustainable improvements in public health and for reducing the health inequities that exist within and between populations.

2.0 METHODOLOGY

This report was developed with both qualitative and quantitative insights from the following:

- A desk study review of background documents and analysis of demographic and community health data,
- Synthesis and analysis of key findings from community engagement, and
- Review of smart and promising practices from comparable communities.

Gaps identified through an analysis of key findings from the background review and engagement were paired with smart and promising practices. This approach is meant to ensure the final assessment findings are grounded in multiple data sources, providing a well-rounded foundation for the recommendations and next steps outlined in the final report.

BACKGROUND REVIEW & COMMUNITY PROFILE

The background review and community profile, developed in 2022, incorporated a high-level review of background materials, including the 2018 Needs Assessment and other relevant documents, as well as an analysis of key community demographics based on 2021 Statistics Canada Census and BC Stats data. The background review and community profile analysis provided a foundational understanding of the community's current context and informed the direction of the subsequent engagement phase.

EFFECTS OF THE COVID-19 PANDEMIC MEASURES ON DATA ACCURACY

The 2021 census was conducted during the COVID-19 pandemic, a period marked by fluctuating travel restrictions and various income support measures, such as the transition from the Canadian Emergency Response Benefit (CERB) to Employment Insurance (EI), the Canada Recovery Benefit (CRB), the Canada Recovery Sickness Benefit (CRSB), and the Canada Recovery Caregiving Benefit (CRCB). These support programs might have influenced census data in two significant ways. First, they could have artificially increased the incomes of very low-income households, as some households earned more through these benefits than from their regular employment, particularly in cases of minimum wage or part-time work. Second, this inflation in income data could lead to an underestimation of the number of households facing core housing challenges. It's important to note that these limitations apply to all Canadian communities. Considering these data constraints, the 2021 census data related to housing affordability should be interpreted with caution, as it may not offer a fully reliable demographic profile for Pender Harbour and the SCRD.

COMMUNITY ENGAGEMENT

Engagement was facilitated during the spring of 2024, and involved consultation with Pender Harbour/ Egmont residents, local service providers, community groups, and Pender Harbour Health Clinic clients to assess their evolving health service needs and identify opportunities for improvement.

Engagement objectives included:

- Consulting with Pender Harbour/ Egmont residents to understand their health service needs.
- Consulting and collaborating with local partners and collaborators to identify opportunities to meet community need.

WHO WE HEARD FROM

Engagement participants included members of the public who are residents of the Pender Harbour/ Egmont area as well as representatives and designates from service providers, interested parties, and community groups who operate in the area. All responses have been anonymized to respect participant privacy. However, the following 12 organizations consented to having their names listed as engagement participants.

- Pender Harbour Community Club
- Pender Harbour Health Centre
- Bargain Barn
- Rotary Club
- Pender Harbour Community School
- Pender Harbour Elementary / Secondary School
- Pender Harbour Hiking Group
- Pender Harbour & District Health Centre Auxiliary Society
- Sunshine Coast Recreation Division (Pender Harbour Aquatic and Fitness Centre)
- Marina Pharmacy
- Pender Harbour Food Bank Society
- Pender Harbour Volunteer Fire Department

HOW WE ENGAGED

Table 1 presents the engagement activity or method, timelines, participants, and approach to the activity or method.

Table 1. Engagement Methods

Date(s)	Activity / Method	Participants	Approach
April 16, 2024	Town Hall	➢ 10 participants in total made up of residents and organization representatives	➢ Two in-person sessions were held on April 16th at the Pender Harbour Community Hall ➢ Posed questions related to challenges, opportunities, gaps, trends and changes, and assets and strengths of social and health services in the Pender Harbour / Egmont area ➢ Facilitated by PHCC staff
April 1 – April 30, 2024	Community Survey	➢ 216 respondents from residents of the Pender Harbour / Egmont area	➢ A virtual and paper format survey were advertised, promoted and distributed to local residents ➢ Collected demographic, health and social data to inform health services planning
April 1 – April 30, 2024	Service Provider Questionnaire	➢ 10 Respondents from service providers and community organizations	➢ A questionnaire and survey were distributed to community groups and organizations to gain input on what organization and community group staff have observed in relation to health and social needs, challenges, and opportunities ➢ Facilitated by PHHC staff
April 1 – April 30, 2024	Pender Harbour Health Centre Client Interviews	➢ 5 Interviews facilitated with PHHC clients	➢ One-on-one conversations with clients about their health needs, challenges, and goals ➢ Facilitated by PHHC staff

SMART & PROMISING PRACTICE REVIEW

Building on the insights gathered from the community engagement and background review, a review of smart and promising practices in similar communities was conducted. This review focused on identifying best practices for program and service delivery that could be adapted to address the identified needs and gaps in the Pender Harbour/ Egmont area. Recommendations within this report are informed by both the background review, community input, and best and smart practices for similar communities.

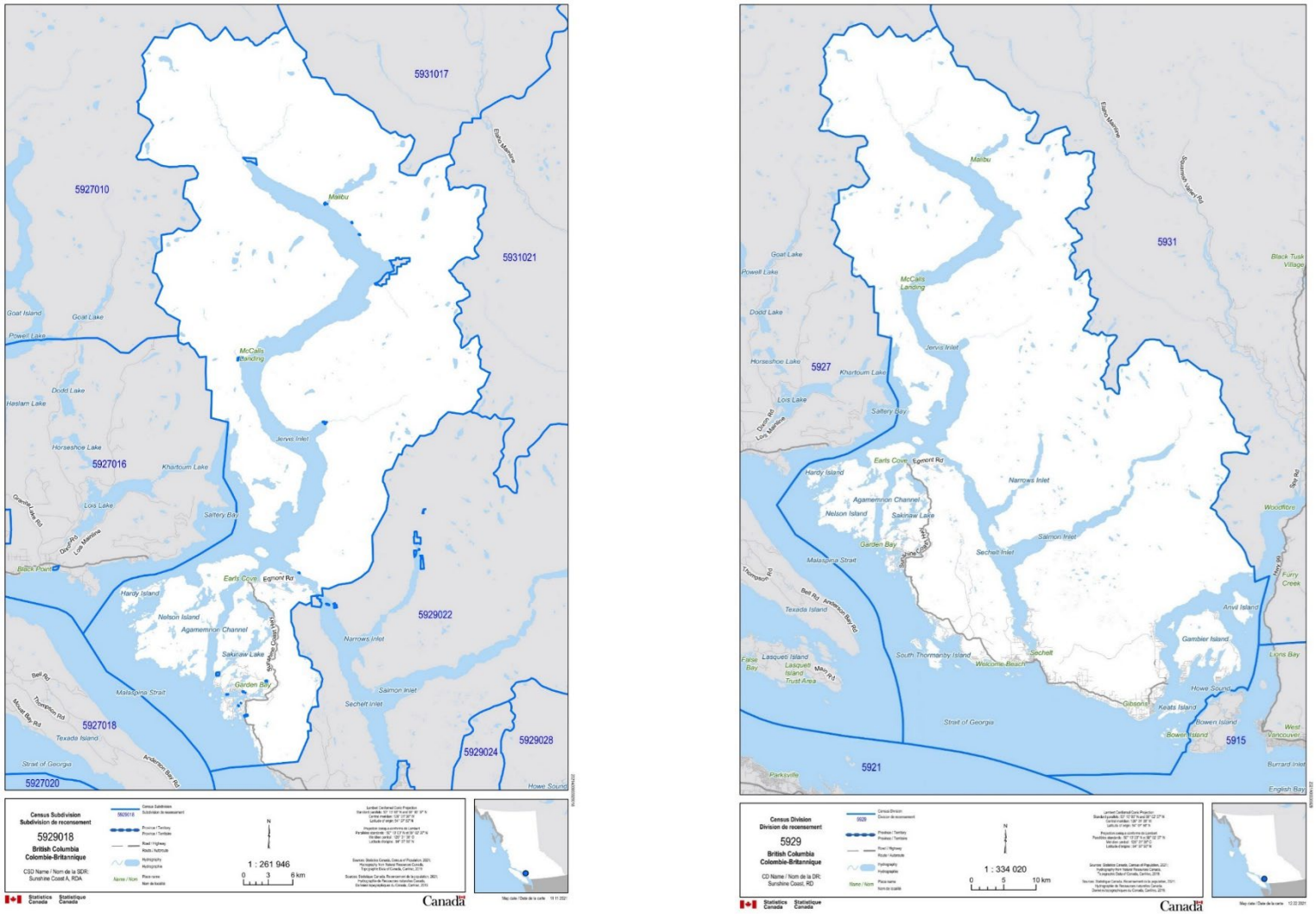
GEOGRAPHIC SCOPE

Data collected for this report vary in scale based on available data and consists primarily of Statistics Canada census data, BC Stats data, and Health Authority data.

Census data are presented for the Census Subdivision of Sunshine Coast A (Area A), the smallest area that still covers Pender Harbour/ Egmont, pictured below in Figure 1. Where such granular data is not available, it is supplemented by data for the Sunshine Coast Regional District Census Division (SCRD) as applicable.

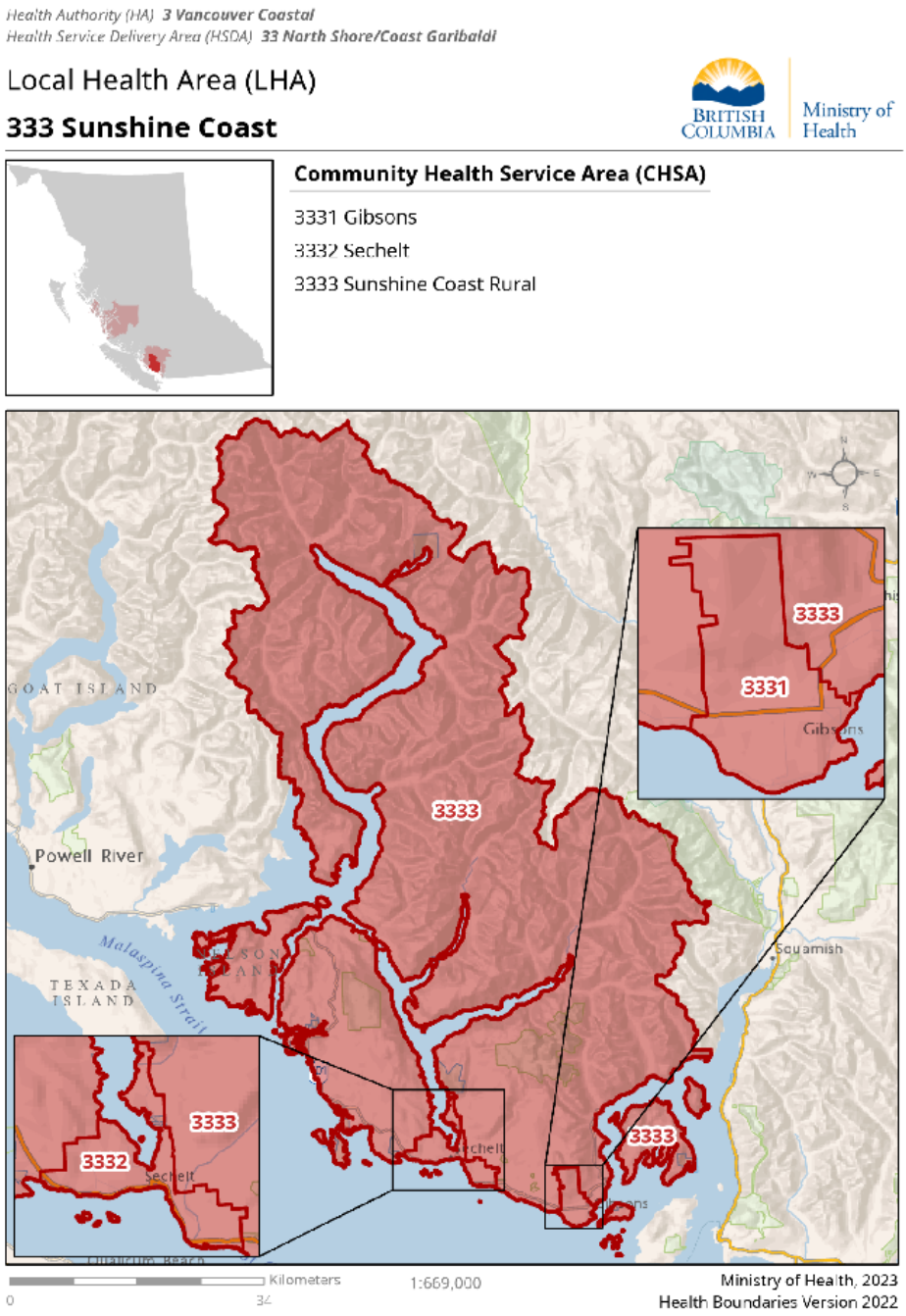
Health data presented within this report vary based on availability. The most granular scale of health data presented in this report is for the Community Health Service Area (CHSA) – 3333 Sunshine Coast Rural which mostly follows the boundaries for the SCRD, but excludes Gibsons and Sechelt, as shown in Figure 2. Where data is not available for at the CHSA level, data has been extracted from either the Sunshine Coast Local Health Authority, North Shore/ Coast Garibaldi Health Service Delivery Area, or the Vancouver Coastal Health Authority.

Figure 1. Sunshine Coast Area A Census Subdivision (Area A: Egmont/ Pender Harbour), Sunshine Coast Regional District Census Division (SCRD)



Source: Statistics Canada, Census of Population, Sunshine Coast Area A, Sunshine Coast Regional District, 2021

Figure 2. Geographic boundary of 3333 Sunshine Coast Community Health Service Area



Source: Province of British Columbia, Ministry of Health, 2024

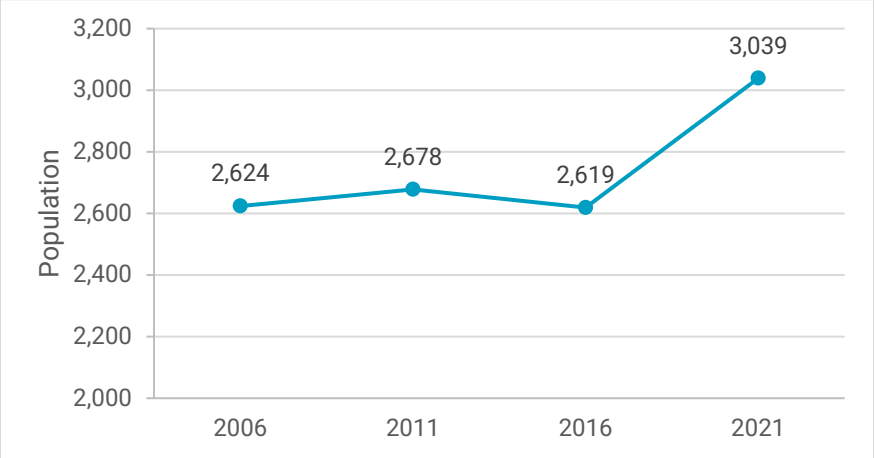
3.0 COMMUNITY PROFILE

This community demographic profile is intended to provide an understanding of the local population as highlighted through historical and projected demographic information. The Community Profile plays a vital role in needs assessment by identifying specific requirements in health care, education, housing, and social services. The profile aids efficient resource allocation based on demographic characteristics like age, income, and education. It informs policy development to address unique community challenges and opportunities. In health care planning, it identifies disparities and areas with higher health service demand. Additionally, it helps to support community engagement by developing an early sense of who should be engaged. While characteristics of communities are not necessarily indicators of health status or the effectiveness of the health system, they provide some useful contextual information that relate to the social determinants of health.

POPULATION

Between 2016 and 2021, the Sunshine Coast Area A experienced significant population growth (16.0%) after two decades of relatively steady population size (see Figure 1). This recent growth was more than double the provincial average growth (7.6%) and the broader Sunshine Coast Regional District (7.3%).

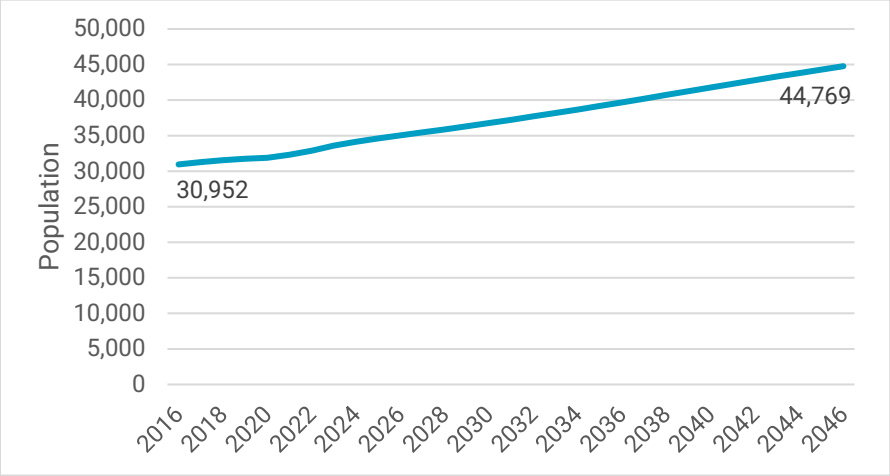
Figure 3. Changes in population, Sunshine Coast Area A, 2016 – 2021



Source: Statistics Canada Census Profiles, 2006, 2011, 2016, 2021

BC Statistics projects continued population growth in SCRD in the years to come, as indicated in Figure 2. Projections show a population increase of 13,817 people, a 44.6% from 2016 to 2046, and an increase of 31.1%, or 10,629 persons, between 2023 and 2046.

Figure 4. Estimated and projected population growth for the SCRD, 2016-2046.



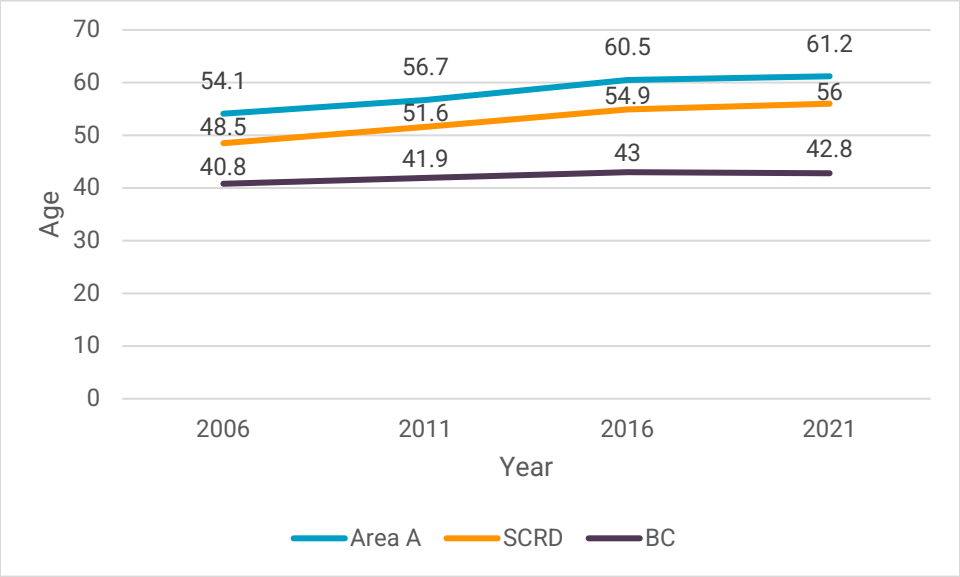
Source: BC Stats, 2023

Projections highlight slower growth occurred between 2018 and 2020, at an average rate of 0.66%. A sharp increase in growth occurred in 2021 (1.33% between 2020 and 2021). Growth was projected to increase at an average rate of 1.7% between 2021 and 2023. Following 2023, growth is estimated to continue, but follows a slower and steadier growth pattern up to 2046.

AGE & GENDER

As shown in Figure 3, median age overall has increased in BC from 2006 to 2021, and this is also true for the SCRD and Area A. Median age in Area A (61.2) is older than both the SCRD (56) and BC (42.8).

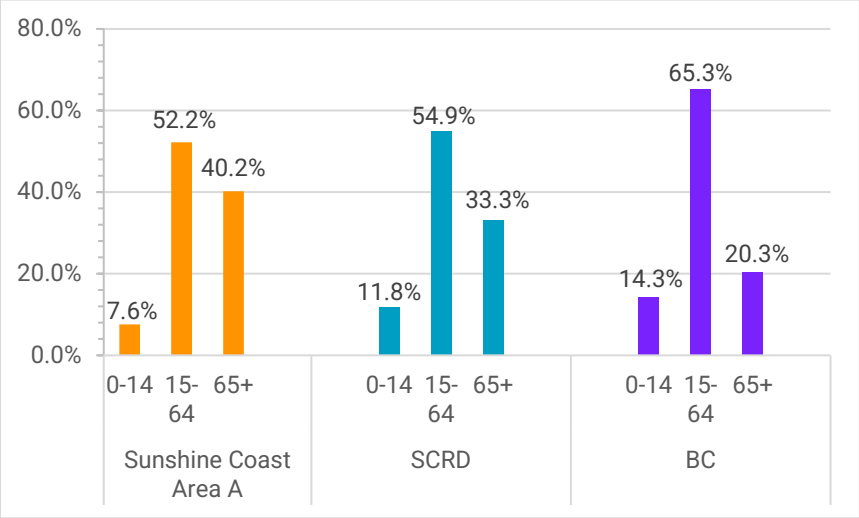
Figure 5. Change in median age, Sunshine Coast Area A, Sunshine Coast Regional District, BC, 2006, 2011, 2016, 2021.



Source: Statistics Canada Census Profiles, 2006, 2011, 2016, 2021

40.2% of Sunshine Coast Area A's population were older adults in the year leading up to the 2021 census, compared to only 33.3% in the SCRD, and 20.3% for BC (see Figure 4).

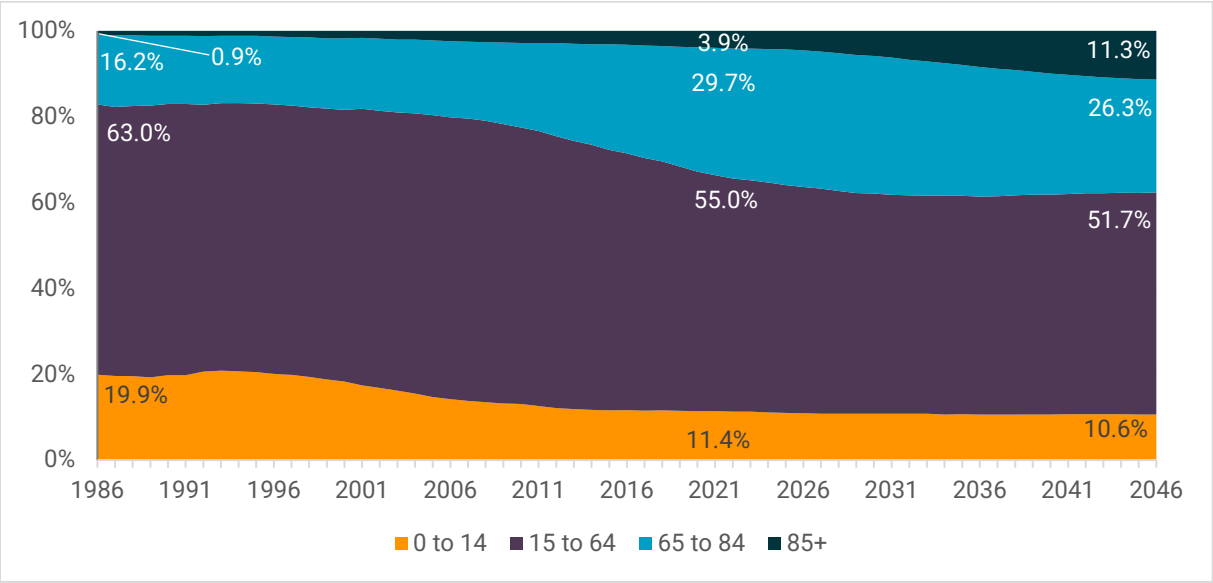
Figure 6. Population age distribution, Sunshine Coast Area A, SCRD, and BC, 2021.



Source: Statistics Canada Census Profiles, 2021

In recent years, there has been an increase in the proportion of seniors 65 years and older in the SCRD and this proportion is expected to increase, stabilizing after 2030 (see Figure 5). However, even after 2030, the proportion of seniors 85+ is predicted to grow until at least 2046. It is estimated that by 2046, seniors 65 years and older will make up 37.6% of the SCRD's population.

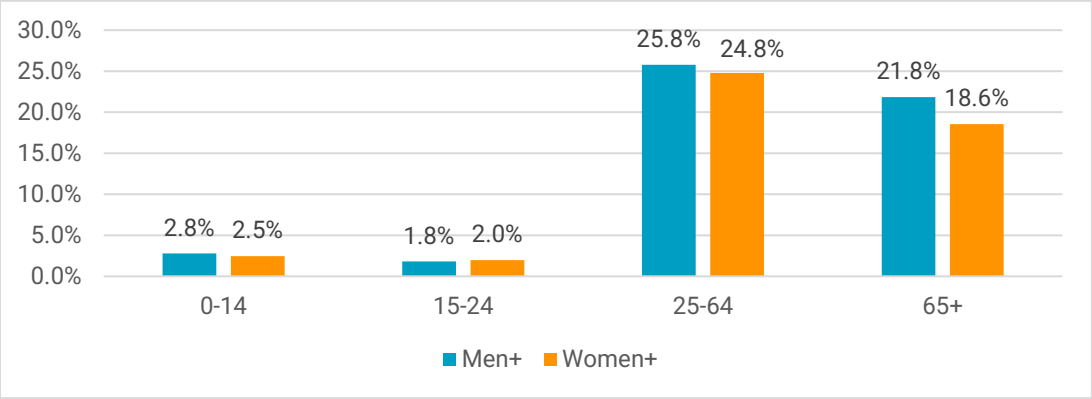
Figure 7. Projected changes in age distribution, SCRD, 1986 – 2046



Source: BC Stats, 2023

Figure 6 shows that overall, there were slightly more men (52.2%) than women (47.8%) in Area A in 2021. Men represent a slightly greater share of those ages 25 to 64 years (25.8% of the population) and a much greater share of those over 65 years old (21.8%). Women represent 24.8% of those ages 25 to 64 years and 18.6% of those ages 65 years and older.

Figure 8. Age distribution by gender, Sunshine Coast Area A, 2021.



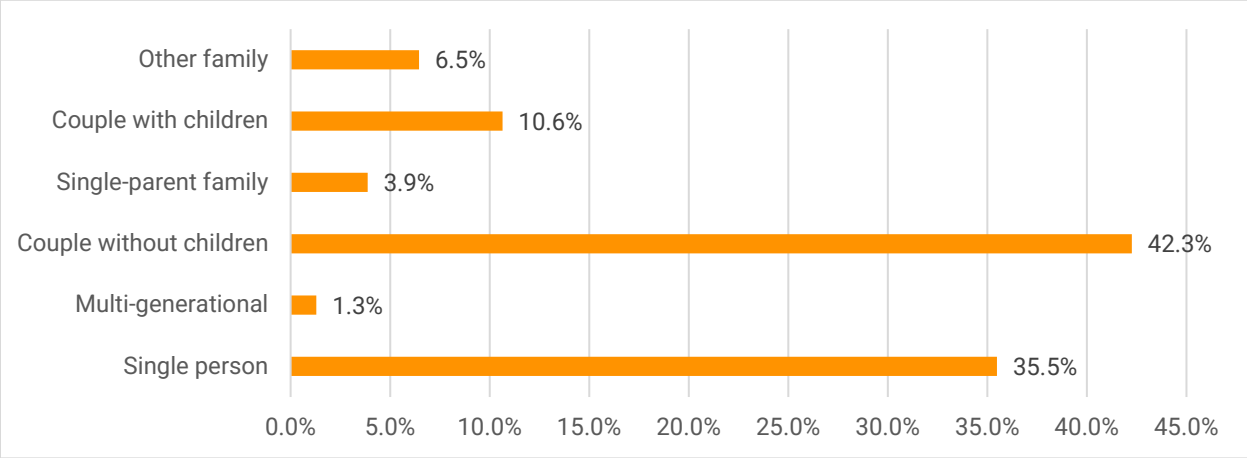
Source: Statistics Canada Census Profiles, 2021

Note: Statistics Canada aggregates gender into two categories (men+ or women+) which sometimes includes those who don't specify gender or are gender diverse.

HOUSEHOLDS

At the time of the 2021 census, most households in Area A were couples without children (42.3%), and over one third (35.5%) were single person households (see Figure 7).

Figure 9. Proportion of households by household family type, Area A, 2021.

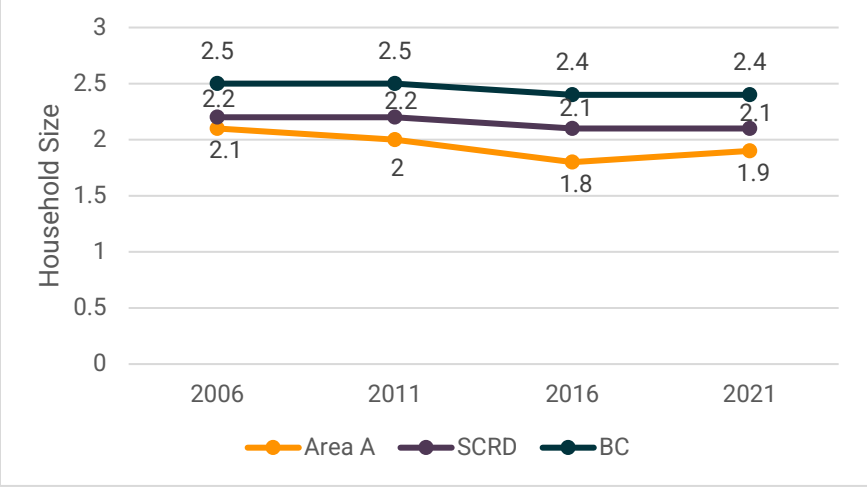


Source: Statistics Canada Census Profiles, 2021.

Note: "Other family" households include multiple-Census-family households, one-Census-family households with additional persons, and two-or-more-person non-Census-family households.

Figure 8 below shows that following the reduction in average household sizes between 2011 and 2016, the 2021 average household sizes have fluctuated only slightly (Area A up to 1.9 in 2021 from 1.8 in 2016). Overall, Area A average household size remains below the averages for both the SCRD and BC.

Figure 10. Changes in average household size for Sunshine Coast Area A, SCRD, and BC, 2006, 2011, 2016, 2021

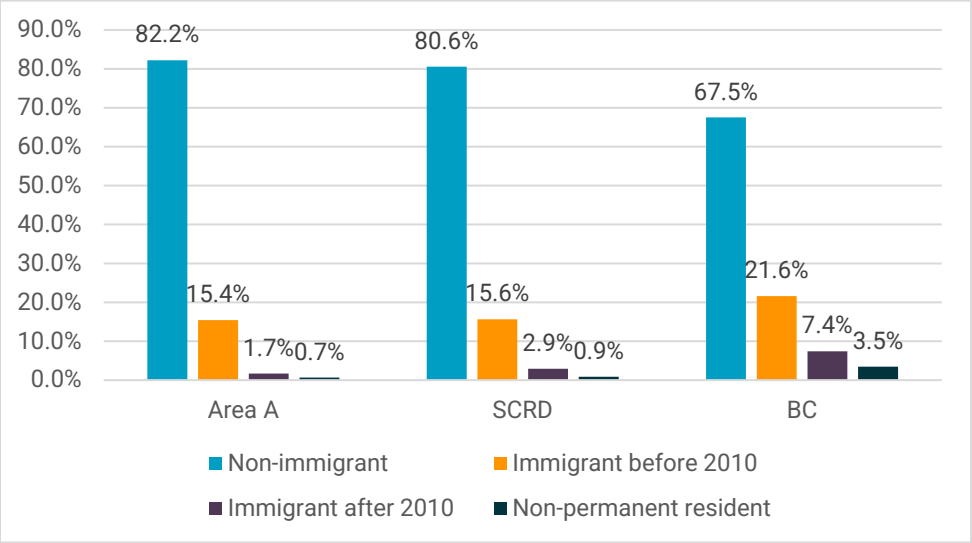


Source: Statistics Canada Census Profiles, 2006, 2011, 2016, 2021.

IMMIGRATION

Figure 9 shows that Area A and the SCRD are comprised of majority non-immigrant residents (92.2% and 80.6%), a greater share than BC as a whole. For Area A residents who are immigrants, most (15.4%) arrived in Canada before 2010 and are likely well established in their communities. Only 1.7% of immigrants in Area A arrived in Canada after 2010. Less than 1% of Area A residents are non-permanent residents of Canada.

Figure 11. Comparative distribution of residency status, Area A, SCRD, and BC, 2021.

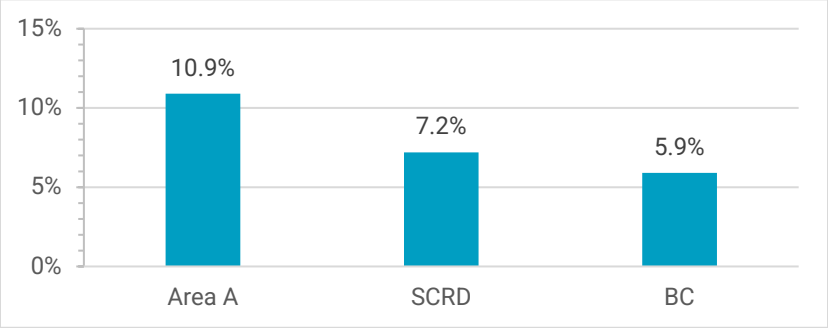


Source: Statistics Canada Census Profiles, 2021.

INDIGENOUS IDENTITY

10.9% of the population in Area A identified as Indigenous in the 2021 Census; a greater share than the SCRD (7.2%) and BC (5.9%) (see Figure 10). A large share of folks with Indigenous identity within Area A highlights the need to ensure health and social services are culturally appropriate and relevant.

Figure 12. Share of population identifying as Indigenous for Area A, SCRD, and BC, 2021.

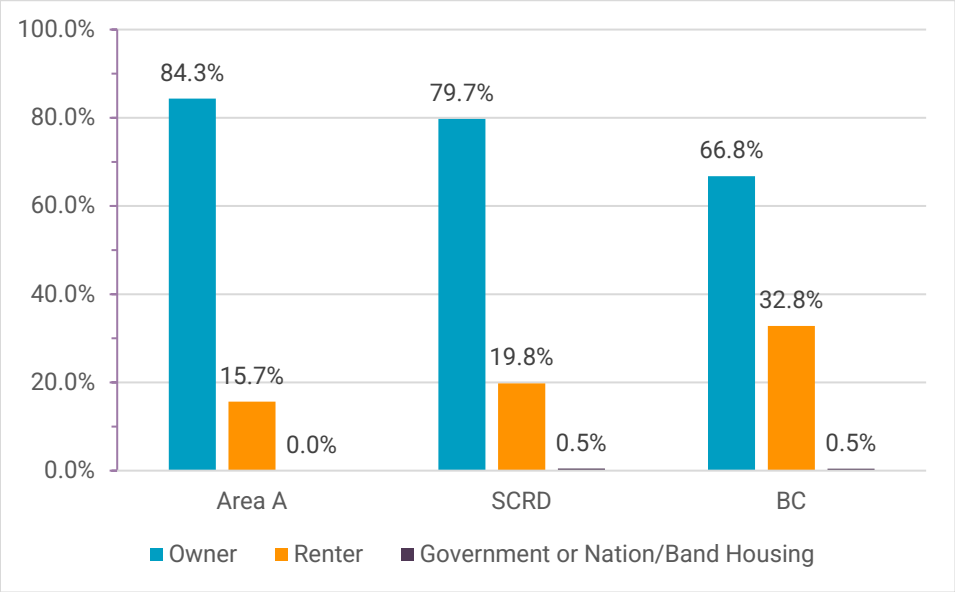


Source: Statistics Canada Census Profiles, 2021.

TENURE & CORE HOUSING NEED

In 2021, Area A had the highest proportion of owners (84.3%) compared to SCRD and BC, as highlighted in Figure 11. Secure housing is important to ensure older adults can age-in-place by using appropriate supports in the home.

Figure 13. Share of households by tenure in Area A, SCRD, and BC, 2021.



Source: Statistics Canada Census Profiles, 2021.

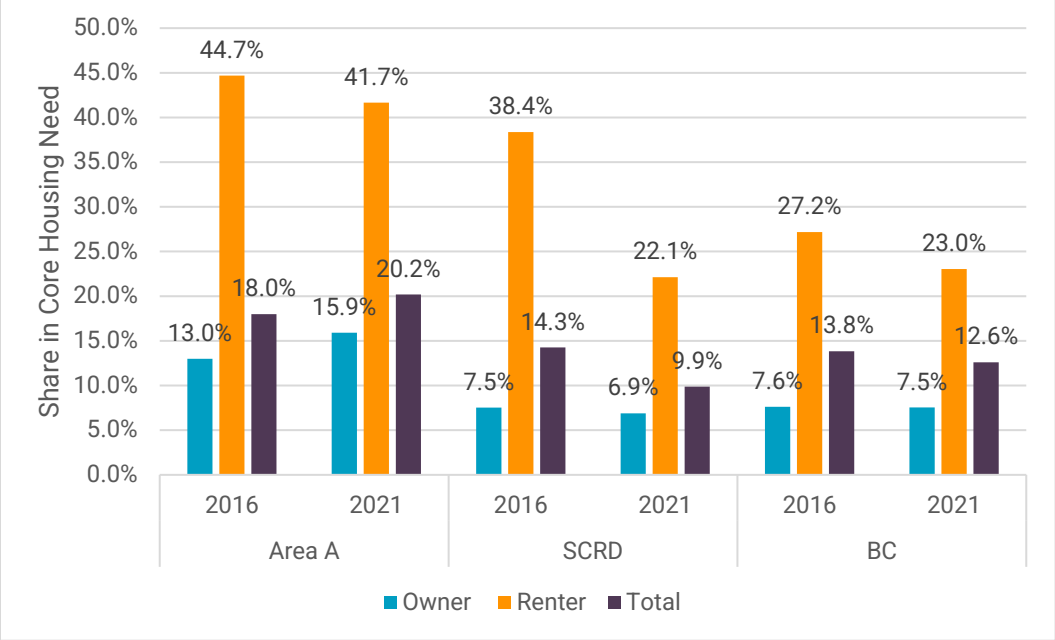
Households in core housing live in a dwelling that does not meet one or more standards of adequacy, suitability, or affordability, and spends 30% or more of its income on shelter costs. As shown in Figure 12, 20.2%, or 315 Area A households were in core housing need in 2021. Far more households in Area A experienced core housing need in 2021 than in the SCRD (1,475 households or 9.9% of households), and in BC (257,090 households or 12.6% of households).

In general, for communities across BC and Canada, the share of households in core housing need decreased slightly between 2016 to 2021. According to the University of British Columbia's Housing Assessment Resource Tools (HART) project research, core housing need expressed in the 2021 census was temporarily reduced due to the impact of the temporary CERB supports which provided temporary financial relief to households during the Covid-19 pandemic.[2] For Area A, the graph below highlights that total the share of households in core housing need did not decrease as it did in the SCRD and BC, rather it increased by just over 2 percentage points.

[2] *University of British Columbia, 2024.*

Renters are disproportionately impacted by core housing need. 41.7% of Area A renter households compared to 15.9% of owner households were in core housing need in 2021.

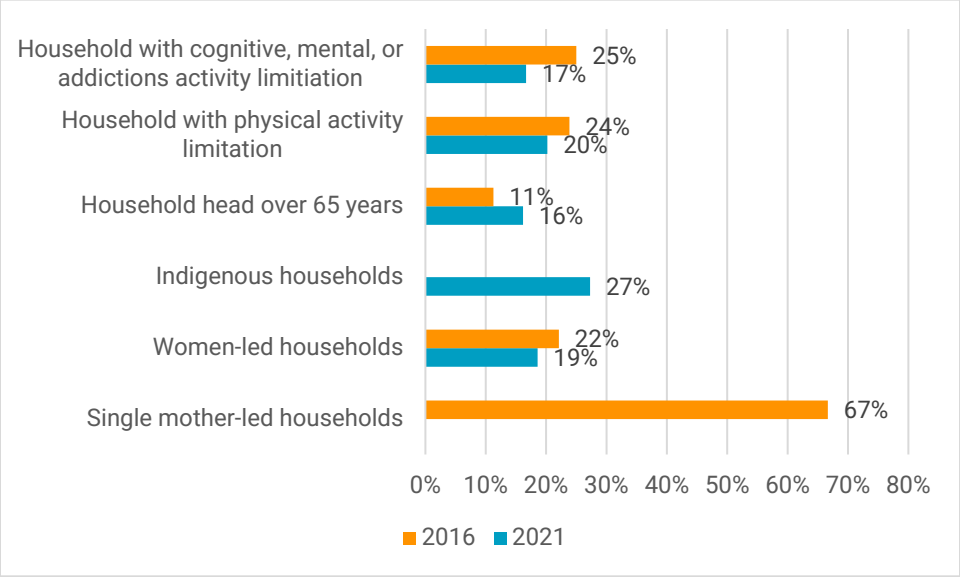
Figure 14. Share of households in core housing need by tenure in Sunshine Coast Area A, SCRD, and BC, 2016, 2021.



Source: Statistics Canada Census Profiles, 2021.

Core housing need can be a significant indicator of vulnerability, particularly when it comes to certain priority populations. There are some priority populations or equity seeking groups that are at a high risk of experiencing core housing need. When it comes to Area A, Figure 14 highlights that 27% of Indigenous households were in core housing need in 2021, the highest of all priority populations. Households with physical activity limitations had the second highest share of those in core housing need (20%), followed by women-led households (19%), households with cognitive, mental, or addictions activity limitations (17%), and households with household heads who are over 65 years old (16%).

Figure 15. Share of priority population households in core housing need, Sunshine Coast Area A, 2016, 2021



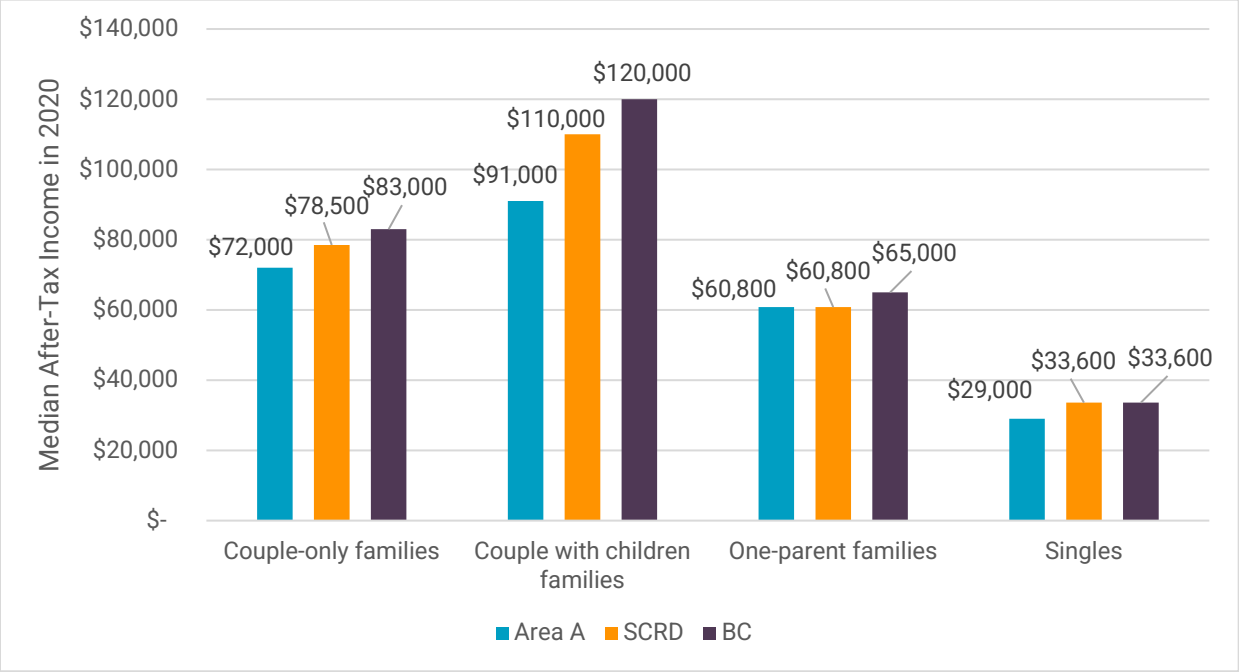
Source: Housing Assessment Resources Tool (HART), 2024

INCOME

Median after-tax income in 2020 for residents of Area A was $58,400, markedly lower than the provincial median of $76,000 and the SCRD median of $67,000.

Figure 15 shows that median after-tax income in 2020 by household groups for Area A, SCRD, and BC share a relatively similar distribution, however, both Area A and SCRD median incomes for groups are lower than provincial median incomes. Singles or individuals have the lowest median after-tax incomes in Area A at just $29,000, $4600 less than both the SCRD and BC. Median income for one-parent families in Area A were the same as in the SCRD ($60,800), $4200 less than the BC median income for this group. Couple-only families have the second highest median income in Area A ($72,000), $11,000 less than BC, and $6500 less than the SCRD. Couples with children in Area A have the highest median incomes, at $91,000, however, this is still $29,000 less a year than BC's median income and $19,000 less a year than SCRD's median income.

Figure 16. Median after-tax income in 2020 by household groups, Sunshine Coast Area A, SCRD, and BC, 2020



Source: Statistics Canada Census Profiles, 2021.

Within Area A, at least 1,995 households, or 73% earn below the median income for Area A. As the median income is the midpoint in the income distribution, meaning that 50% of households earn more and 50% earn less, having 73% of households earning below this median suggests that income distribution in Area A is skewed towards lower incomes, with a larger proportion of households earning less than the typical or household in the area. This indicates, there may be a higher concentration of lower-income households in the area.

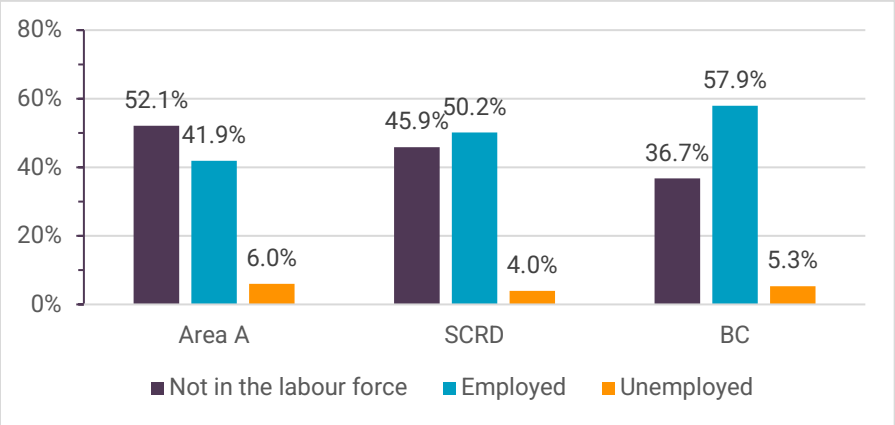
There are many ways of measuring low income, each with its own methodology and implications. Measures like LIM-AT are relative, focusing on income inequality, while others, such as the Market Basket Measure (MBM), are more absolute, considering the actual cost of living. The Low-Income Measure, After Tax (LIM-AT) is a widely used indicator of low-income in Canada. It is a relative measure that defines low income as those households with an income that is less than 50% of the median after-tax income for a given year, adjusted for household size. This means that the LIM-AT reflects the proportion of people whose income is significantly below that of the typical household, indicating a lower ability to afford basic goods and services compared to the broader population. 2021 Census data shows that 505 households out of 2,980, or 16.9% of total households were low-income status in 2020 based on the low income-measure after tax (LIM-AT). Out of those measured as low-income, 39.6% were 65 years or older.

EMPLOYMENT STATUS

Over half or 52.1% of Area A's adult population was not in the labour force in 2021 (see Figure 15). The share not in the labour force in Area A is higher than both the SCRD and BC and likely a result of Area A having an older retired population. In 2021, 41.9% of the population was employed and 6.0% of the

population was unemployed. In 2021 the unemployment rate was 12.5%, higher than the SCRD (7.3%), BC (8.4%), and Canada (10.3%).

Figure 17. Labour force status among those aged 15 years and older for Area A, SCRD, and BC, 2021.



Source: Statistics Canada Census Profiles, 2021.

HEALTH STATUS

Understanding the health status of a community is crucial for tailoring public health interventions, improving health services, and fostering overall well-being. The following section provides a high-level overview of the health indicators for the Sunshine Coast Rural (SCR) Community Health Services Area (CHSA), using data developed by the BC Centre for Disease Control and the Provincial Health Services Authority.

The BC Centre for Disease Control and Provincial Health Services Authority have developed a Community Health Services Area (CHSA) Health Profile for the CHSA – 3333 Sunshine Coast Rural (SCR).[3] This CHSA profile is mean to help health care partners, public health professionals, and community organizations in understand specific community health needs.

Table 1 compares the health indicators of the SCR CHSA to the averages of the Vancouver Coastal Health Authority and to BC. The table reveals that for most indicators, SCR is either doing better than both the HA and the province or similarly. SCR's physician or group practice attachment rates are over 10 percentage points higher than the HA and BC. The SCR can boast of having significantly higher rates of community belonging than both the HA (43.9 percentage points more) and BC (45.8 percentage points more). Communities are more physically active (11 – 14 percentage points higher), much less likely to feel lonely (59 - 69 percentage points lower) and have lower rates of poor mental health (~18 percentage points lower). There are, however, a few indicators the SCR rates poorer on compared to the HA. General health for those

[3] *Provincial Health Services Authority, 2024a.*

over 18 years old is slightly lower (0.5 percentage points lower) than the HA and a greater share of SCR residents either smoke or vape daily or occasionally (4.7 percentage points higher). Notably, the rates of babies that are small for gestational age in SCR are much higher than in both the HA and BC (24 -47 percentage points higher).

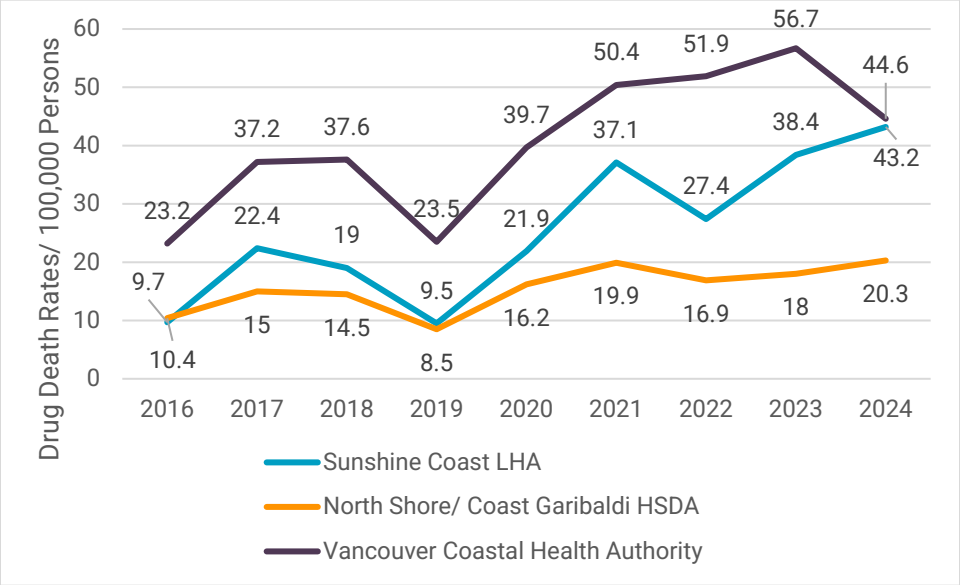
Table 2. Comparison of Sunshine Coast Rural CHSA health indicators to regional and health authority averages, 2021

		Indicator Value, %		Percent Difference of CHSA Value	
Indicator, age (year)	CHSA	HA	BC	Compared to HA	Compared to BC
Attached to GP or group practice, 0+	84.6	76.4	76.8	+10.8%	+10.1%
Community belonging – strong, 18+	67.2	46.7	46.1	+43.9%	+45.8%
General health – good, 18+	90.6	91.1	89.4	-0.5%	+1.3%
Physically active, 18+	77.2	67.	69.1	+14.0%	+11.7%
Feeling lonely – always, 18+	4.7	11.5	12.1	-59.1%	-61.2%
Mental health – poor, 18+	26.3	32.0	32.1	-17.8%	-18.1%
Smoke/ vape daily/ occasionally, 18+	13.5	12.9	13.7	+4.7%	-1.5%
Binge drink, 18+	25.8	28.0	27.1	7.9%	-4.8%
Small for gestational age, 0	9.7	7.8	6.6	+24.4%	+47.0%
Pre-term births, 0	4.2	9.8	11.4	57.1%	-63.2%
Low birth weight singletons, 0	4.2	4.2	4.7	0.0%	-10.6%
Caesarean deliveries, 0+	30.6	36.2	37.4	-15.5%	-18.2%

Source: Provincial Health Services Authority, 2021

Within the Sunshine Coast Local Health Authority, which includes Pender Harbour/ Egmont, overdose deaths due to a toxic drug supply have been steadily increasing since 2016. Figure 17 indicates that as of April 2024, drug deaths are at a rate of 43.2 per 100 000 individuals. This means that out of 100,000 individuals in a population, there were 43.2 instances of death. Sunshine Coast LHA rates are higher than for the North Shore/ Coast Garibaldi HSDA, which were 20.3 as of April 2024, and only slightly lower than for Vancouver Coastal Health Authority where they were 44.6. Rates in the Sunshine Coast indicate a substantial need for substance use supports ranging from overdose prevention and harm reduction to detox and treatment.

Figure 18. Unregulated drug death rates per 100,000 of injury in the Sunshine Coast LHA, North Shore/ Coast Garibaldi HSDA, and Vancouver Coastal Health Authority, 2016-2023



Province of British Columbia Coroners Service, 2024

Note: 2024 rate was last updated to April 2024

HEALTH SERVICE USAGE

Health service usage data is crucial for understanding the health care demands and service provision within the community. A usage profile can help to support needs identification and determine has been developed to support health care partners, public health professionals, and community organizations in identifying specific community health needs. The Pender Harbour Annual Reports from 2021 -2022 and 2022-2023[4] revealed the following:

- Nursing & Allied Services saw a decrease from 16,846 visits in 2021/2022 to 15,935 visits in 2022/2023.
- Laboratory Services maintained steady usage, with a minor increase in lab samples from 900 to 1,000 but a slight decrease in venepunctures from 2,070 to 1,857.
- Wound Treatment and Dressings showed significant growth, with wound treatments increasing from 691 to 1,263 and dressing changes from 569 to 1,217.
- Emergency Wound Treatment decreased from 122 to 46 visits.

[4] Pender Harbour Health Centre, 2023

- Home Care Nursing experienced an increase from 7,392 to 8,108 visits, reflecting a growing need for in-home health care services.
- Palliative On-Call Nursing and Dietitian and Diabetes Nurse services were newly introduced or expanded, with 300 and 1,382 visits respectively.

Despite these insights, the limited scope and duration of available data point to a broader issue: the need for more comprehensive and continuous data collection to accurately assess and address the community's health service needs. Gaps in service data usage both year over year, and in consistency of service reporting prevent a full picture of service usage for the Pender Harbour Health Clinic, and additionally so in terms of data available for the CHSDA.

4.0 ENGAGEMENT FINDINGS

Community engagement provided valuable qualitative insights that both supplemented the data gaps identified in the Community Profile and validated the existing data. Through this engagement, community members were able to voice their perspectives, contributing to a more comprehensive understanding of health service needs and priorities within Pender Harbour and Egmont. This process also allowed residents to articulate their vision for the future of health care in their communities, ensuring that local voices were heard and integrated into planning efforts.

While the findings from this engagement represent participants' perceptions, and may not always align perfectly with objective data, they are nonetheless crucial. We have made every effort to validate these findings where possible. However, even when input is incorrect or based on misunderstandings, it still highlights critical areas where communication, education, or awareness may be lacking. These discrepancies suggest next steps or actions that could be taken to bridge these gaps, ensuring that residents are better informed and more effectively engaged in their health care. By addressing these areas, health providers can better align community expectations with the realities of service provision, ultimately leading to a more cohesive and informed approach to community health.

Engagement with members of the public, clients of the PHHC, service providers and community groups highlighted several gaps and needs for social, health, and wellness services.

1. **A lack of primary care physicians:** A critical shortage of primary care physicians was consistently highlighted alongside the challenges this presents for continuity of care. Input from respondents indicated low physician attachment across Pender Harbour communities. Many residents must travel long distances or rely on virtual consultations for basic health needs. Many residents shared that they must travel significant distances, sometimes to Metro Vancouver, to access basic health services, which not only impacts their health outcomes but also their overall quality of life. The lack of local primary care also contributes to longer wait times and reduced continuity of care.
2. **Transportation barriers:** Transportation is a significant issue, affecting access to health and wellness services. Youth, seniors, individuals with low-income, and those with mobility challenges are disproportionately impacted by transportation barriers. This creates significant inequities in access to essential health services and exacerbates existing vulnerabilities within these populations. Better local transportation options are needed to ensure equitable access to health care. Engagement participants suggested developing a health services ride-sharing program and improving transportation options,

especially for those who must travel for social, health, or wellness services, were identified as key opportunities for improvement.

3. **Mental health and addiction services:** There is an increased demand for mental health services and addiction and substance use support, especially among youth. The current system is seen as unresponsive, with long wait times and insufficient local resources. Respondents view current services as insufficient to meet the demand. Long wait times and a lack of local resources contribute to unmet needs and heightened risks for this demographic.
4. **Aging population and related services:** The growing number of elderly residents has led to increased demand for services tailored to seniors, such as rehabilitation, fall prevention programs, and in-home care. Aging-in-place is a common goal, requiring better local support and transportation and more support services for seniors are necessary to meet this demand. However, the aging population's growing needs are not only for general senior services but also for specialized care, such as rehabilitation, fall prevention, and in-home care.
5. **Volunteer and community support:** The community benefits from a strong volunteer base and active community groups, which are crucial in providing various health and wellness services. However, there is concern over the loss of older volunteers and the increased stress on volunteer-based services. Many current community volunteers are aging, and there is a need to engage younger community members to ensure the continuity of these vital services. The increased stress on volunteer-based services could lead to burnout and a reduction in service availability
6. **Service accessibility and quality:** Many residents face barriers to accessing health, social, and wellness services due to provider availability, long wait times, and financial costs. There is a notable absence of specialized care services locally, such as cardiology, oncology, and mental health counseling. Financial barriers and long wait times significantly hinder access to both primary and specialized care. Many residents face delays in receiving necessary treatments, which can lead to worsened health outcomes and increased reliance on emergency services.
7. **Financial stability and food insecurity:** Financial costs and food insecurity are significant challenges for Pender Harbour residents. Affordable housing was also highlighted as a critical issue affecting overall well-being. Financial instability and food insecurity are not isolated issues but are closely linked to overall health and well-being. Addressing these challenges is critical for improving the community's health outcomes, particularly for low-income families and individuals.
8. **Communication and coordination:** Improved communication about available services, how to access them, and improved coordination among service providers are essential to address gaps and improve service delivery. Respondents suggested developing an easily accessible wellness resource list and more communication on how to access services like telehealth. Improving communication about available services, especially telehealth and other remote options is crucial. A more coordinated approach among service providers could help address gaps and ensure residents are aware of and able to access the services they need.
9. **Increased demand for services and staffing shortages:** There is a growing demand for health services, compounded by budget cuts and staffing shortages, which negatively impact service delivery and access to care. Staffing shortages may directly impact the quality and timeliness of service delivery. Addressing these shortages is crucial for improving the overall capacity of the PHHC to meet the community's growing needs.

5.0 CONNECTING INSIGHTS TO ACTION

This section integrates the key findings from community engagement with insights from the background review and community profile, providing a closer look at of the current state of social, health, and wellness services given what was heard from residents and what is known from the data. Building upon the integrated findings, some best and promising practices from similarly sized rural Canadian communities are introduced along with a set of recommendations proposed to address the identified gaps and needs.

INTEGRATED FINDINGS

LACK OF PRIMARY CARE PHYSICIANS

Community engagement highlighted a critical shortage of primary care physicians, with many residents reporting that they must travel long distances, sometimes to Metro Vancouver, for basic health services. With an aging population with increasing health care needs, the absence of local primary care not only leads to longer wait times and reduced continuity of care but also exacerbates health disparities, particularly for older adults who are more likely to require frequent medical attention.

In 2021, 84.6% of residents in the Sunshine Coast Regional District (SCRD) were attached to a physician or group practice—higher than the Vancouver Coastal Health Authority's average of 76.4% and BC's average of 76.8%.[5] However, this means that 13.6% of SCRD residents were still unattached, and it is anticipated that physician attachment has further declined since then.

Locally, in Pender Harbour/ Egmont, the situation has worsened. The Pender Harbour Health Centre lost its resident physician between 2021 and 2022, who had served a panel of 900 patients with a waitlist over the previous 3 years.[6] Despite having a local doctor during that period, the Centre was actively trying to recruit another physician and a nurse practitioner, highlighting the need for additional physician services. By 2023, the Centre lost their physician entirely and is currently without any physician services.[7] The Centre has since been working with a clinic in Sechelt, the Division of Family Practice, and a physician recruitment firm to find physicians to address this gap.

Given the growing elderly population and the projected continued growth in Area A (see section 3.0), the local recruitment of physicians and nurse practitioners is urgent. Without addressing this shortage, health outcomes are likely to deteriorate, and the strain on emergency services will increase as residents are

[5] Provincial Health Services Authority, 2024a
[6] Pender Harbour Health Centre, 2024 (2021-2022)
[7] Pender Harbour Health Centre, 2024, (2022-2023)

forced to seek care outside their community. For those with transportation barriers, this situation is even more critical, as they face heightened risks of unmet health needs and worsening health disparities.

TRANSPORTATION BARRIERS

During engagement, transportation was identified as a significant barrier to accessing health and wellness services, particularly for youth, seniors, low-income individuals, and those with mobility challenges. The background data supports these concerns, showing that a high proportion of the population in Area A are older adults and single-person households. These groups are more likely to experience transportation difficulties, as older adults may have mobility issues, and those living alone may lack access to reliable transportation. Additionally, the high unemployment rate and the prevalence of low-income households in the area suggest that financial constraints further limit transportation options. Seniors living on fixed incomes and youth from low-income families are particularly vulnerable, as they may not be able to afford transportation costs associated with traveling to access necessary health services.

Improving transportation options is critical to ensuring equitable access to health care. During community engagement, many participants suggested that targeted transportation solutions, such as a health services ride-sharing program, could effectively address these barriers, particularly for vulnerable populations.

MENTAL HEALTH & ADDICTIONS SERVICES

The increased demand for mental health and addiction services, especially among youth, was a recurring theme in the engagement findings. The Sunshine Coast Local Health Authority (LHA) Health Profile highlighted that, although the region shows lower rates of poor mental health relative to Vancouver Coastal Health and the province, with just over 26% of the population reporting poor mental health, this issue still requires significant attention.

Moreover, the alarming rate of overdose deaths due to a toxic drug supply in the Sunshine Coast LHA, at 43.2 per 100,000 individuals as of April 2024, underscores the urgent need for expanded substance use supports. This rate is higher than the North Shore/Coast Garibaldi HSDA (20.3 per 100,000) and only slightly lower than the overall rate for Vancouver Coastal Health Authority (44.6 per 100,000). Unfortunately, more granular detail specifically for Pender Harbour/ Egmont is not available, which limits the ability to fully assess the local impact.

The perceived lack of local mental health resources and long wait times by engagement participants, and rising overdose deaths indicate that there is a clear need to expand mental health and substance use support services locally. Efforts should focus on reducing wait times, improving accessibility, and integrating comprehensive mental health and addiction services into the broader health care framework in Pender Harbour/ Egmont. Addressing these issues is critical, particularly given the aging population and the increasing prevalence of chronic health conditions, which further strain existing health care resources, including emergency services and long-term support needs.

AGING POPULATION & RELATED SERVICES

The engagement findings emphasized the growing demand for services tailored to seniors, such as rehabilitation, fall prevention, and in-home care. This aligns with the background review, which highlights the high and increasing proportion of elderly residents in the area. As of the 2021 census, 40.2% of the population in Sunshine Coast Area A were older adults, a significantly higher percentage than both the Sunshine Coast Regional District (33.3%) and the province of British Columbia (20.3%). Additionally, the median age in Area A is 61.2, considerably older than the provincial median of 42.8.

Projections indicate that the proportion of seniors 65 years and older will continue to grow, stabilizing after 2030, but with the population of those aged 85 and older continuing to increase until at least 2046. By 2046, it is estimated that seniors will make up 37.6% of the SCRD's population. This demographic trend underscores the urgency of enhancing local services that allow seniors to age-in- place.

To support the aging population, there is a need for expanded specialized care options, including rehabilitation and fall prevention programs, and improved access to in-home care. As the population continues to age, these services will become increasingly necessary to ensure that seniors can maintain their independence and quality of life in their own homes and communities.

VOLUNTEER & COMMUNITY SUPPORT

The community's strong volunteer base is essential for providing health and wellness services, but concerns were raised during engagement about the sustainability of this support, given the aging volunteer population. The background review shows that a significant portion of the population is not in the labor force, likely indicating a reliance on retirees for volunteer services. However, it's important to note that the Sunshine Coast Rural CHSA has a high level of community belonging, with 67.2% of residents reporting a strong sense of connection to their community—40 to 46 percentage points higher than the average for the Vancouver Coastal Health Authority and the province.

This high sense of community belonging is an asset and could be leveraged to sustain and even grow the volunteer base. Engaging younger community members who also feel a strong connection to the area could help ensure the continuity of volunteer services. Strategies to engage and mobilize these younger volunteers are crucial for maintaining the current level of community support. Without this, there is a risk of burnout among existing volunteers and a subsequent reduction in service availability.

SERVICE ACCESSIBILITY & QUALITY

Many residents face significant barriers to accessing health, social, and wellness services due to limited provider availability, long wait times, and financial costs. The absence of specialized care services locally, as highlighted in the engagement findings, raises serious concerns about equitable access, particularly for vulnerable populations.

The background data reveals that renters, Indigenous households, and those with physical or cognitive limitations are disproportionately affected by core housing need in Area A. For example, 41.7% of renter households and 27% of Indigenous households were in core housing need in 2021, making them more likely to experience economic instability, which can limit their ability to afford and access necessary health services. Additionally, with 39.6% of low-income households being headed by individuals 65 years or older,

seniors living on fixed incomes are particularly at risk of being unable to access essential care, further exacerbating health disparities.

Furthermore, the median after-tax income in Area A is significantly lower than the provincial median, with 73% of households earning below the local median income. This skewed income distribution suggests that a substantial portion of the population faces economic challenges that may prevent them from affording out-of-pocket health expenses or transportation to distant care facilities.

Expanding local service offerings, particularly in specialized care, is essential for improving health outcomes and reducing the burden on residents who currently must travel for care. Addressing financial barriers through subsidies or support programs could also enhance accessibility, particularly for those in core housing need or living on lower incomes. Additionally, targeted outreach and support for these vulnerable groups—such as seniors, renters, and Indigenous households—will be crucial to ensure equitable access to health services.

FINANCIAL STABILITY & FOOD INSECURITY

Financial instability and food insecurity were highlighted as significant challenges, particularly for low-income residents. The background data underscores these concerns, revealing broader socioeconomic vulnerabilities within the community.

As noted in the previous section, certain groups, such as renters, Indigenous households, and seniors on fixed incomes, are especially at risk. These populations are more likely to face financial instability, which in turn increases their vulnerability to food insecurity. For many of these residents, the rising cost of living and limited income sources create difficult trade-offs between paying for essentials like housing and securing enough nutritious food.

Addressing these issues requires a holistic approach that goes beyond simply providing immediate relief. Efforts should include enhancing food security programs to ensure consistent access to nutritious food, improving access to affordable housing to reduce financial pressures, and supporting financial stability through community-based initiatives. Collaborative partnerships with local organizations, social services, and government agencies will be key in developing targeted interventions that effectively reach those most in need.

COMMUNICATION & COORDINATION

Improved communication about available services and better coordination among service providers were identified as critical needs during the engagement process. Engagement findings suggest that many residents may not be fully aware of the services available to them or struggle to navigate the health care system effectively.

This is particularly challenging for populations such as seniors, low-income households, and individuals with limited digital literacy, who may face additional barriers in accessing information and coordinating care. For these groups, the lack of clear communication and coordinated service delivery can lead to unmet health needs and increased disparities.

To address these challenges, developing a comprehensive wellness resource list that is accessible in both digital and print formats may be beneficial. Enhancing telehealth options with user support for those who

may struggle with technology is another practical step to improve service awareness and accessibility. Additionally, strengthening coordination among providers will help ensure that services are delivered more efficiently and effectively, minimizing the risk of fragmented care.

By focusing on clear, accessible communication and seamless coordination, the community can better ensure that all residents, particularly those who are most vulnerable, have the information and support they need to access essential services.

INCREASED DEMAND FOR SERVICES & STAFFING SHORTAGES

The growing demand for health services, coupled with ongoing staffing shortages, presents a significant challenge that directly impacts the quality and timeliness of care in the community. Demographic trends, such as an aging population and increasing prevalence of chronic health conditions, suggest that this demand will continue to rise, further straining the already limited local health care system.

Addressing staffing shortages is critical to expanding the capacity of the Pender Harbour Health Centre (PHHC) and ensuring that the community's growing needs are met. This will require targeted recruitment incentives to attract new health care professionals, as well as retention programs to maintain the current workforce. Additionally, it may be necessary to explore innovative solutions, such as leveraging telehealth services to alleviate some of the immediate pressures on local providers or collaborating with nearby health facilities to share resources and staff.

Without proactive measures, the community is likely to experience longer wait times, reduced access to care, and potentially worsening health outcomes. Ensuring that the health care system can keep pace with increasing demand is essential to maintaining the well-being of residents, particularly the most vulnerable populations who may be disproportionately affected by service delays and shortages.

RECOMMENDATIONS & PROMISING PRACTICES

1. ESTABLISH A HEALTH STEERING COMMITTEE AND DEVELOP STRATEGIC PRIORITIES

Promising Practice:

Community Health Plan Steering Committee – Northern Rockies Regional Municipality[8]

The Community Health Plan Steering Committee (CHP SC) is a collaborative initiative that includes Northern Health (NH), the Northern Rockies Regional Municipality (NRRM), and the Fort Nelson First

[8] *Northern Rockies Regional Municipality, 2024*

Nation. Established in 2017, this tripartite collaboration came together to develop a Community Health Plan for the region that addresses the unique health care challenges in the Fort Nelson area and Northern Rockies region. Key achievements include expanding access to health travel services, advocating for local health service needs, developing an impressive Recruitment & Retention Education & Training Incentive, and conducting ongoing work to ensure health services are responsive to local needs.

To address the various health and social service challenges in Pender Harbour/Egmont, forming a Health Steering Committee (HSC) could be highly beneficial. This committee would develop strategic priorities to ensure that all implementation efforts align with community needs. The HSC should include representatives from PHHC, Vancouver Coastal Health representatives, local health and social service providers, the Electoral Area A Director, and other relevant stakeholders. Strategic priorities should focus on key health challenges identified in this report, such as access to primary care, mental health services, and transportation (and others), while remaining adaptable to emerging needs. A diverse, community-driven steering committee would help PHHC stay connected to community needs, ensure accountability, and build partnerships that enhance the effectiveness of health initiatives through knowledge and resource sharing. Additionally, the committee could serve as an advocacy group to secure resources and support from external sources.

2. Develop Recruitment and Retention Incentives For Health Care Professionals

Promising Practice:

Churchill Health Centre – Churchill, Manitoba[9]

The Churchill Health Centre (CHC) in northern Manitoba has successfully implemented a retention strategy aimed at improving the work-life balance of its nursing staff, addressing the challenges of working in a remote location. Over four years, the strategy has included several key elements:

1. **Work-Life Balance:** Nurses work 12-hour shifts in a four-day on, four-day off rotation, with two additional 12-day unpaid breaks annually, providing extended time to leave the community and visit family.
2. **Cultural Safety:** The CHC ensures a culturally safe environment by reflecting the community's cultural makeup in its leadership (65% Indigenous) and promoting a strong land-based mental health program accessible to both staff and community members.

[9] *Healthcare Excellence Canada, n.d.*

3. **Compensation and Benefits:** Nurses at CHC are among the best paid in the province, with access to subsidized housing located near the Health Centre, reducing stress and building community among staff. The CHC also owns and operates the only licensed community daycare in Churchill, giving employees priority access to childcare services.
4. **Community Engagement and Professional Development:** Staff are deeply integrated into the community and involved in decision-making processes, enhancing job satisfaction. Additionally, the CHC offers extra vacation time to new nurses and does not require monetary or time commitment contracts, making it an attractive workplace.

As a result of these initiatives, the CHC has seen significant improvements in staff retention, with no full-time nurse leaving since June 2020.

Working with the Health Steering Committee, the PHHC may consider implementing a comprehensive staff retention and recruitment strategy or incentive package akin to that of the Churchill Health Centre in Manitoba. This strategy or incentive package could focus on improving work-life balance, offering subsidized housing, fostering a culturally safe work environment, and enhancing professional development opportunities and require a return of service. By extending these benefits to all health care staff, including physicians and nurse practitioners, PHHC may not only attract health care professionals, but also reduce turnover, addressing the challenges of recruitment in a rural health care setting.

3. Develop a Comprehensive Elder/ Senior Support Program

Promising Practice:

Geriatric Assessment and Intervention Network (GAIN) – Northumberland, Ontario[10]

The GAIN program in Eastern Ontario provides a comprehensive approach to senior care, addressing the specific needs of an aging population. GAIN is primarily funded through Ontario's Ministry of Health and Long-Term Care as part of the province's strategy to support seniors and reduce the strain on hospitals by providing specialized, community-based care. The program is designed to keep seniors out of emergency rooms by addressing their needs proactively through an interdisciplinary team approach, ensuring that they receive comprehensive care in their homes or community settings. The program focuses on delivering in-home care, rehabilitation, fall prevention, and chronic disease management services, all tailored to seniors. The goal is to help older adults remain in their homes for as long as possible, maintaining their independence and quality of life. GAIN offers interdisciplinary

[10] *Community Health Centres of Northumberland, 2019*

care teams that include physicians, nurses, physiotherapists, and social workers, ensuring that seniors receive holistic care.

For Pender Harbour/ Egmont, the GAIN program provides a promising model for how a comprehensive senior care program could be structured and funded. While direct provincial funding like that of Ontario may not be available, PHHC could explore similar funding opportunities through British Columbia's Ministry of Health or seek support from regional health authorities like Vancouver Coastal Health. Additionally, the program's reliance on interdisciplinary care teams and a focus on in-home care aligns well with the needs identified in the community, particularly given the area's aging population and the challenges related to accessing specialized care.

By adopting elements of the GAIN model, PHHC could work with the HSC to develop a sustainable and effective senior care program tailored to the specific demographic and health care challenges of Pender Harbour/ Egmont. This could include securing partnerships with local health authorities, applying for provincial grants, or collaborating with community organizations to fund and implement a similar program.

4. Enhance Telehealth Services

Promising Practice:

Telehomecare Program, Ontario[11]

Ontario's Telehomecare program is an initiative that provides remote monitoring and virtual support for patients with chronic conditions such as COPD and heart failure. Through telehealth technology, patients can regularly communicate with health care providers, receive education on managing their conditions, and have their vital signs monitored remotely. This program has successfully reduced hospital admissions and emergency room visits by allowing patients to manage their health conditions from home.

Promising Practice:

BC Virtual Visit Program, BC[12]

The BC Virtual Visit program, implemented by various health authorities in British Columbia, allows patients to connect with health care providers via secure video calls from their homes. The service is particularly valuable in rural and remote communities, where access to health care can be limited. The program has been successfully used to provide ongoing care, especially for chronic conditions and mental health support, reducing the need for in-person visits and improving healthcare accessibility.

[11] *Ontario Health at Home, 2024*
[12] *Provincial Health Services Authority, 2024b*

For Pender Harbour and Egmont, enhancing telehealth services through a model similar to the Ontario Telehomecare Program and BC Virtual Visit program could support improvements in access to health care. The program would allow residents, particularly those with mobility issues or chronic health conditions, to receive timely care without needing to travel long distances. This is crucial in a region with a high proportion of elderly residents and limited local health care resources.

PHHC could partner with Vancouver Coastal Health or other provincial initiatives to expand telehealth services. Funding could be sought through provincial telehealth initiatives or grants aimed at improving rural health care delivery in BC. Additionally, by integrating telehealth with in-person care, PHHC could ensure a seamless health care experience for all residents, enhancing both access and quality of care.

5. Explore Options for Reducing Health Travel Transportation Costs

Promising Practice:

Community Transportation Grant Program, Ontario[13]

Ontario's Community Transportation Grant Program provides funding to municipalities and community organizations to improve and expand local transportation services, particularly in rural and remote areas. This grant supports initiatives that enhance existing services, such as subsidizing fares for low-income residents, expanding routes, or increasing service frequency. The program encourages partnerships between municipalities, health services, and community organizations to create sustainable transportation solutions that address the specific needs of underserved populations.

Since the PHHC already provides transportation for residents to medical appointments on the Sunshine Coast for a fee, PHHC could seek similar grant funding through British Columbia's provincial programs or other funding bodies to subsidize transportation costs for residents. The grant could cover the operational costs of the van service, allowing PHHC to offer reduced fees or free transportation to low-income residents, seniors, and individuals with mobility challenges. Additionally, the funding could support the expansion of the service to cover more destinations or increase the frequency of trips, making health care and essential services more accessible to the community.

PHHC could apply for provincial or federal grants specifically aimed at rural health care or transportation services. This could include exploring opportunities through the Ministry of Health, the Union of BC Municipalities (UBCM), or community foundations. Using this funding, a sliding scale fee structure could be established based on income or specific needs, ensuring that transportation is affordable for all

[13] Ontario, 2024

residents. Collaboration with local governments and community organizations can support cost sharing and service expansion, ensuring sustainability beyond the initial grant period. Some potential grants include:

- New Horizons for Seniors Program (NHSP): This federal program offers funding for projects that enhance the quality of life for seniors, which could include subsidized transportation services. PHHC could apply for a grant to help reduce transportation fees for elderly residents, ensuring that they can access health care services without financial burden.
- Union of BC Municipalities (UBCM) Community Excellence Awards: These awards provide funding to communities that demonstrate excellence in delivering programs and services. PHHC could apply for the "Service Delivery" category, highlighting their innovative approach to providing subsidized transportation to enhance community health outcomes.
- BC Community Gaming Grants: These grants support non-profit organizations in delivering programs that benefit their community. PHHC could apply for funding under the Public Safety category, which includes transportation services that ensure residents can safely access healthcare facilities.

6. Integrate Mental Health and Substance Use Support Services

Promising Practice:

Foundry, BC[14]

Foundry BC offers a province-wide network of integrated health and social services for young people aged 12-24, combining mental health, substance use, primary care, peer support, and social services under one roof. The model emphasizes accessibility, with a focus on creating a welcoming, stigma-free environment where youth can receive holistic support. Foundry's approach includes walk-in access, virtual services, and community partnerships to reach underserved populations, including those in rural and remote areas.

Integrating virtual mental health and substance use support services could be a highly effective way for PHHC to meet the community's needs without the need for a physical Foundry location. PHHC could partner with Foundry BC or similar organizations to advertise and facilitate access to these virtual services. This approach would allow residents, particularly those dealing with isolation or mobility issues, to access counseling and peer support from the comfort of their own homes.

The PHHC may leverage partnerships within the HSC and others to connect with Foundry BC, the BC Ministry of Mental Health and Addictions, and other relevant organizations to promote virtual service offerings in Pender Harbour/ Egmont. This could include virtual group therapy sessions, one-on-one

[14] Foundry, n.d.

counseling, and access to online mental health resources. To ensure that residents have the necessary technology and support to access virtual services, including internet access, devices, and digital literacy training where needed, the PHHC could provide a private space with internet access for those who don't have it at home. It is also recommended that PHHC collaborate with the HSC to conduct community outreach to raise awareness about the availability of virtual mental health and substance use services. This could include workshops, social media campaigns, and informational brochures distributed throughout the community.

7. Strengthen Volunteer Engagement and Support

Promising Practice:

Step Up Youth Program at Island Health, BC[15]

Island Health has implemented a youth volunteer program in partnership with local high schools. This initiative engages students in volunteer opportunities within health care settings, providing them with valuable experience while supporting health care services. The program is designed to not only help fill volunteer roles but also to inspire a new generation of health care workers by exposing them to the field early on. Students receive training, mentorship, and recognition for their contributions, which can be used for school credits or to enhance their resumes and university applications.

PHHC could develop a similar youth volunteer program in collaboration with School District 46, encouraging students to participate in volunteer activities at the Health Centre. This approach would help address the need for a younger volunteer base, while also providing students with meaningful experiences that could spark an interest in health care careers. Engaging youth in this way could also strengthen community ties and ensure the continuity of volunteer services as older volunteers step back.

To implement a youth volunteer program at PHHC, the Health Centre could establish a formal partnership with School District 46, creating a structured program that aligns with students' academic schedules and extracurricular activities. This could include after-school programs, summer volunteer opportunities, and internships, offering students the chance to gain experience in health care while contributing to the community. PHHC would provide training sessions tailored to youth, covering essential skills such as communication, basic health care support, and digital literacy, ensuring that students are well-prepared for their roles. Additionally, pairing students with experienced volunteers or staff members for mentorship would enhance their learning and integration into the Health Centre's operations. To further encourage participation, PHHC could work with schools to offer academic credits or volunteer hours that count toward graduation requirements, along with implementing a recognition program that celebrates the achievements

[15] Island Health, 2024

of youth volunteers, such as awards ceremonies or features in local media. By building strong relationships with local educators and involving parents in the process, PHHC can maintain steady participation and ensure the long-term success of the program.

8. Enhance Resource Sharing and Coordination

The Health Steering Committee (HSC) at PHHC can play a pivotal role in enhancing resource sharing and coordination. By bringing together diverse stakeholders, including health care providers, local government, community organizations, and Vancouver Coastal Health, the HSC can facilitate more effective communication and collaboration across the health care network. The committee can serve as a central hub for coordinating shared resources, such as training programs, equipment, and best practices, ensuring that all partners are aligned and working towards common goals.

Moreover, the HSC can identify gaps in resources and advocate for necessary support, whether through partnerships, grant applications, or other means. By regularly assessing community needs and the availability of resources, the HSC can help optimize the distribution of health care services, reduce duplication of efforts, and improve overall service delivery. This coordinated approach ensures that PHHC and its partners can make the most of their collective resources, ultimately enhancing health care access and quality for residents of Pender Harbour and Egmont.

In essence, the HSC acts as the linchpin in the network, fostering collaboration and resource sharing, which are crucial for sustaining and improving healthcare services in these rural communities.

6.0 NEXT STEPS

The recommendations and promising practices outlined in this report provide a strategic roadmap for enhancing health services in the Pender Harbour/Egmont area. By establishing a Health Steering Committee, developing targeted recruitment and retention incentives, implementing comprehensive senior support programs, and expanding telehealth services, the PHHC can address current gaps and anticipate future health care needs. These initiatives are designed to be realistic and actionable, drawing from successful models across Canada while tailoring solutions to the unique context of this rural community.

Looking ahead, collaboration will be key to success. The proposed Health Steering Committee should serve as the central coordinating body, fostering partnerships between local stakeholders, health authorities, and community organizations. By working together, these groups can leverage their collective resources, share knowledge, and advocate for the necessary support to implement these initiatives effectively.

It is also crucial to maintain a focus on community engagement. Continuous feedback from residents will ensure that health services remain responsive to local needs and adaptable to changing circumstances. The PHHC should prioritize transparency and communication as they move forward with these recommendations, keeping the community informed and involved every step of the way, and responding to emergent needs identified in communities.

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