OCEANSIDE HEALTH AND WELLNESS NETWORK LONG-RANGE PLAN 2022-2027

PLANNING CONTEXT

The Oceanside Health & Wellness Network (OHWN) is a network of organizations and individuals working together to enhance community health and wellness in Oceanside. OHWN evolved out of a stakeholder group that was formed in 2013 to identify and address health-related issues together. OHWN's work is done by planning together and taking collective action on complex health-related issues.

In late 2021, the OHWN Circle of Partners (CoP) embarked on a process of updating its long-range plan. The previous plan was in effect from 2019 to 2021.

The approach to creating the new strategic plan had two parts.

First, a survey of OHWN members was conducted to help identify emerging priorities and satisfaction with the current capacity to do the work. Respondents were also asked to consider the context of pressing contemporary issues including Truth and Reconciliation, the climate crisis, and the COVID-19 pandemic. A report on the survey was prepared and provided to the CoP in February 2022.

Second, two planning workshops with the CoP and other involved parties were held on March 14 and June 16, 2022, to identify the vision, values, mandate and mission and priority goals and objectives to guide OHWN over the next five years. The survey results and local health area data provided important information for the workshop process, and the potential impacts of Truth and Reconciliation, the climate crisis, and the COVID-19 pandemic were considered.

This document outlines new vision, values, mission, and mandate statements and strategic goals and objectives that arose from the workshops. Note that the CoP reviewed and approved the vision, values, and mandate statements on May 26, 2022. Suggestions for improvements made at the June 16 workshop are included as comments for the CoP's consideration below.

Some key Local Health Area Profile data is included in Appendix 4 of this document. While the data is somewhat out of date, it paints a picture of Oceanside as a primarily middle-aged, aging, White, Canadian-born community of educated couples with moderate incomes who own their own homes, but with certain groups in the community having specific needs that are not being met as well as they could be – for example, single parents, children, working age adults, and renters. Poverty and lack of supports for families is negatively impacting the community's youngest citizens, and lack of preventive programming is claiming the lives of the eldest.

VISION

Oceanside residents are part of a healthy, caring, collaborative community that builds on strengths to address unique and common needs

VALUES

Collaboration – Building relationships and partnerships with integrity, honesty, transparency and having a willingness for open dialogue and sharing

Belonging – Creating an inclusive and culturally safe space for all

Respect – Honouring each other's strengths and celebrating different voices

Courage – Taking a leadership role when appropriate, staying strong when faced with adversity, speaking up when others cannot, and being willing to listen to ideas other than our own

Compassion — Meeting people where they are at and taking action to build equity and resilience

MISSION

The Oceanside Health and Wellness Network strives to facilitate a collaborative environment which engages a broad range of members that reflects the diversity of our region and supports grassroots informed initiatives to improve wellness in measurable ways.

MANDATE

The Oceanside Health and Wellness Network accomplishes its mission by carrying out the following activities:

1. To convene dialogue regarding social determinants of health and modifiable risk factors informed by credible data (e.g., LHA profile), context experts (e.g., medical health officers, academics, planners), and front-line community experience (e.g., health care providers, collaborative service committees, primary care networks and community service providers) to:
    - Foster common understanding of community health priorities
    - Create shared vision for a healthy community
    - Reach agreement on joint priorities for shared action/intervention
    - Develop/maintain and/or renew time-limited strategy documents reflecting vision, priorities, and action plans.
2. Facilitate coordinated action amongst partners to address joint priorities
3. Engage policy makers around system level changes required to enable action on joint priorities

4. Support and coordinate the procurement of additional funding (from sources outside of Island Health), in-kind contributions and other resources to support actions addressing joint priorities
5. Facilitate ongoing collection and dissemination of data from partners regarding aligned community action in support of joint priorities and observable outcomes of aligned actions.
6. Conduct outreach to build community awareness and support for the CHN
7. Ensure broad and equitable participation at all levels of the network structure including participation from multi-sector community partners with active participation from foundations, charitable organizations, Island Health, local government, local First Nations, school districts/boards, post-secondary institutions and sectors representing a spectrum of expertise, ages, and populations perspectives spanning the entire region
8. Collaborate with Island health regarding ongoing alignment of evolving priorities tied to strategic initiatives of the Ministry of Health and Island Health which may change over time such as:
    - The Primary Care Networks (PCN) Initiative (requiring PCNs and Collaborative Services Committees (CSCs) to partner with the community sector regarding upstream prevention of locally prevalent illnesses and risk factors). This initiative seeks to link the health priorities identified through PCNs to specific population-based initiatives that are mutually reinforcing to improve health and wellness of the population (for example, physical literacy initiatives in response to high incidence of frailty in seniors or air quality improvement strategies in response to high respiratory illness hospitalization rates)
    - The Health Communities Initiative (requiring partnerships between Island Health, Local governments, Aboriginal Communities, and other Community Partners on planning for upstream prevention.

As noted above, the CoP reviewed and approved the vision, values, and mandate statements on May 26, 2022. Comments from June 16 workshop included:

- The notion of being “inclusive” may need to be included in the vision, alongside being “collaborative”. As well, the vision could be truncated to end after the word “community”, to acknowledge that “strengths” are not the starting place for everyone and could include a sense of progress being made. A revised vision could read:
    - *Oceanside residents are part of an increasingly healthy, caring, collaborative, and inclusive community*

- The phrase “broad range of members” in the mission may not be meaningful enough; ensuring there is trust around the table and that the Network is a safe space for all to participate is critically important to achieving the long-range goals.

STRATEGIC GOALS

GOAL 1: OHWN HAS THE GOVERNANCE, STRUCTURE, AND CAPACITY TO OPTIMIZE ITS PERFORMANCE

OBJECTIVES

OHWN will achieve this Strategic Goal by:

1. Developing vision, values and mission statements that clearly communicate what the Network is about.
2. Implementing a governance structure that:
   a. Ensures broad and equitable participation of multi-sector partners, foundations, charitable organizations, Island Health, local government, local first Nations, school districts/boards, post-secondary institutions and sectors representing a spectrum of expertise, ages, and populations spanning the entire region (see Appendix 3 for a list of potential participants)
   b. Identifies the functions necessary (e.g., member input, data collection and analysis, planning, implementation, coordination, and administration) to enable the Network to achieve its mandate and its strategic goals, and
   c. Articulates an organizational structure that will achieve that.
3. Clearly defining the roles and responsibilities of all parts of the organization and the relationships of each to the other including:
   a. The role members, coordinating circle and action tables play and what is expected of them
   b. How the work of the Network is managed.

CONTEXT / COMMENTARY

The member survey conducted in January 2022 and the subsequent May planning workshop identified several issues that the Network needs to address, including:

- Articulating what being a 'member' of the Network means
- Ensuring the Network has diverse and comprehensive representation including underrepresented voices
- Defining the roles and responsibilities of different actors (e.g., Network members, coordinating circle, action table) and the functions performed by each (e.g., input, data collection and analysis, planning, coordination, administration, etc.).
- Ensuring that the Circle of Partners (CoP) is the steward of the community's vision, not the author of it.

Comments at the June workshop included:

- The CoP is planning a broader community event for the fall to review the components of this document and engage community members in the work of the Network
- Reciprocity and more interaction / liaison between the CoP and the Action Tables is required to reduce silos and ensure mutual support to achieve the Network's goals
- The CoP should serve a coordination and navigation function, and should have the capacity to reach out to anyone in community who can join action tables as necessary to address identified issues
- The Cowichan Health Network or Gabriola Health and Wellness Collaborative may be good examples to look at for models for restructuring OHWN.

GOAL 2: OHWN UNDERSTANDS THE HEALTH STATUS OF THE COMMUNITY AND HAS SET PRIORITIES TO ADDRESS THE MOST PRESSING NEEDS

OBJECTIVES

OHWN will achieve this Strategic Goal by:

1. Ensuring that all planning decisions incorporate supporting data by:
   a. Creating a common repository of data on which to base decisions including growth predictions
   b. Sharing data widely with members.
2. Ensuring IH, RDN and MoH related strategic priorities related to community health and wellbeing are considered in all planning decisions.
3. Ensuring the capacity to address Truth and Reconciliation, the climate crisis and post-COVID recovery as discrete objectives as well as considerations in all other priorities.
4. Identifying priorities to be addressed over the next five years and establishing an action plan for each priority. (This may include regional priorities as well as local priorities that require regional support to be addressed such as transportation.)

CONTEXT / COMMENTARY

Understanding and prioritizing the needs of Oceanside communities will require having data to understand the current health status of the community at large and the unique needs and characteristics of different parts of the region and growth projections. Data such as the LHA report provided by the Medical Health Officer, as well as data provided by Network members will provide an important foundation for planning, priority setting and decision making.

Discussions at the May planning workshop identified the following priorities:

- Access to safe, affordable housing
- Improved early childhood outcomes and family supports
- Improved access to transportation
- Improved mental health and addictions outcomes
- Strengthening the community service sector
- Developing relationships with First Nations
- Learning from the pandemic
- Responding to local impacts from global events (e.g., the war in Ukraine
- Ensuring a healthy environment
- Literacy.

Planning decisions will need to take the climate crisis, post-COVID recovery, and Truth and Reconciliation into account as well as the capacity to address Island Health, RDN and MoH strategic priorities related to community health and wellbeing.

Participants at the June workshop identified these additional priorities:

- Addressing food security for seniors who can't afford to eat
- Social prescribing – e.g., ensuring doctors are engaged in efforts to improve incomes
- Undertaking advocacy work – e.g., data-driven position papers sent to decision-makers.

GOAL 3: OHWN HAS THE RELATIONSHIPS, RESOURCES AND PROCESSES IN PLACE TO ADDRESS COMMUNITY PRIORITIES

OBJECTIVES

The OHWN will achieve its Strategic Goal by:

1. Ensuring the funding is in place to continue the work. This will include:
   a. Assessing the funding needed to achieve the Network's objectives, and,
   b. Developing and implementing a funding plan.
2. Ensuring the Network is made up of individuals and organizations with access to and the ability to activate the necessary mechanisms to address OHWN priorities (for instance, provincial, regional, and local policies and regulations, providing access to necessary data, etc.). This will include:
   a. Establishing clear and appropriate roles and responsibilities for Network members
   b. Ensuring expectations of members makes the best use of their time
   c. Identifying capacities required and implementing a recruitment plan.
3. Ensuring Network members understand their roles and relationships to each part of the Network.
4. Building strong, respectful relationships with First Nations, Métis, and Inuit communities.
5. Strengthening the Island Health relationship to ensure the Network has IH support to appropriately participate in IH and MoH strategic initiatives.
6. Establishing relationships with adjacent communities that have the potential to impact outcomes in Oceanside (e.g., workers residing in Port Alberni and Nanaimo and the issues of housing and transportation).

CONTEXT / COMMENTARY

The Network will need to draw on a range of resources (member survey, LHA data, and CoP input) to have a clear understanding of the community's priority needs, the barriers to addressing those needs, and the collaborative mechanisms required to address the issues. To do that, the CoP membership must be able to draw on multiple levers to effect systems level change. Problems requiring systems level change are often described as 'wicked problems':

> "a **wicked problem** is a problem that is difficult or impossible to solve because of incomplete, contradictory, and changing requirements that are often difficult to recognize". It is characterized by social complexity involving multiple interdependencies (https://en.wikipedia.org/wiki/Wicked_problem).

Addressing these complex problems requires collaborative action across multiple interests. Specifically, the Network needs to enhance its ability to engage with policy makers to address the system level changes required to enable collaborative action on joint priorities. The Network will also need to strengthen its relationship with Island Health (IH) to ensure it can take advantage of IH and Ministry of Health (MoH) strategic initiatives such as Primary Care Networks and the Healthy Communities Initiative.

Significantly, the disconnect between the funder (Island Health) and the fund administrator (Regional District of Nanaimo) will need to be addressed to ensure continued support for the Network.

GOAL 4: NETWORK MEMBERS AND THE COMMUNITY AT LARGE UNDERSTAND AND SUPPORT OHWN

OBJECTIVES

OHWN will achieve this Strategic Goal by:

1. Developing and implementing an outreach plan that sets clear objectives for member engagement and the ways that will be achieved. This may include:
   a. Member communications, and regular events to involve members in supporting key priorities.
2. Developing and implementing a communication plan to ensure community members are aware of the work of the Network and understand how they can support it. This may include:
   a. Network 'branding' and establishment of key messages
   b. Development of an independent OHWN website
   c. Consideration of multiple media resources such as local news outlets, website, individual community Facebook page posts.
3. Ensuring the Network has a voice where critical decisions are being made (e.g., Island Health, Regional District of Nanaimo, Municipal Council meetings).

CONTEXT / COMMENTARY

Prior to COVID, the Network had established communication and outreach activities. Work needs to be done to reconnect with Network members to ensure alignment on processes and priorities, and then to reach out to the broader community. Consideration should also be given to the needs of different member communities to ensure the messages resonate locally as well as regionally and the unique needs of different populations (e.g., seniors, working age adults, families, vulnerable and marginalized populations).

Participants at the June planning workshop identified the following issues:

- The lack of community knowledge about OHWN and its work is hampering the Network's ability to achieve its goals
- An outreach plan involving speaking to groups about the work of OHWN and opportunities to participate may be helpful
- Engaging with local government staff on issues of mutual concern is an important way of both understanding what is happening at the local government level and connecting with local decision-makers.

APPENDIX 1: LONG-RANGE PLANNING PARTICIPANTS - WORKSHOP 1

Name	Organization/Affiliations
Scott Beam	OBLT Manager,
Kristina Bell	VIU Student, Masters Community Planning
Bernie Brochu	OSAG Member, QEWS
Caron Byrne, M.D.	Child Youth Wellness Action Group Lead, Psychiatrist (retired)
Marlys Diamond	OHWN CoP, FOR A, Perfect Storm Group
Dr. Jim Dimmick	FORA, PSG, Board Member CIDFP
Natasha Dumont	Manager, Public Health Services, Island Health, OHWN CoP
Jaclyn Ekhert	Island Health
Gerry Herkel	OHWN Co-Chair CoP, Rotary Club
Keeva Kehler	CAO, City of Parksville
Susanna Newton	OHWN CoP, SOS Executive Director
Jane Osborne	OHWN CoP, BC CRN Vancouver Island Regional Mentor
Julia Tippet	VIU Student Masters Community Planning
Jane Vinet	OHWN Regional Coordinator
Sharon Welch	OHWN CoP, Forward House Executive Director
Elaine Young	OHWN Co-Chair, CoP, SD 69 School Board Trustee

APPENDIX 2: LONG-RANGE PLANNING PARTICIPANTS - WORKSHOP 2

Name	Organization/Affiliations
Judi Malcolm	OHWN Child and Youth Action Group
Marlys Diamond	OHWN CoP, FOR A, Perfect Storm Group
Helene Dufour	Public Health Services, Island Health
Natasha Dumont	Manager, Public Health Services, Island Health, OHWN CoP
Gerry Herkel	OHWN Co-Chair CoP, Rotary Club
Del Kristalovic	Central Island Division of Family Practice, Flowerstone Clinic
Angie Legault	Director of Corporate Services, City of Parksville
Susanna Newton	OHWN CoP, SOS Executive Director
Alyssa Noble	Coordinator, Arrowsmith Restorative Justice Program
Jane Osborne	OHWN CoP, BC CRN Vancouver Island Regional Mentor
Jane Vinet	OHWN Regional Coordinator
Amanda Weeks	Manager of Administrative Services, City of Parksville
Sharon Welch	OHWN CoP, Forward House Executive Director
Elaine Young	OHWN Co-Chair, CoP, SD 69 School Board Trustee

APPENDIX 3: POTENTIAL NETWORK MEMBERSHIP

- Sectors representing a spectrum of expertise, ages, and populations perspectives spanning the entire region
- Geographic representation
- Foundations and other charitable organizations
- Island health
- Division of family practice
- BC Nurse Practitioner Association
- Rural and remote division of family practice
- Collaborative service committee (IH)
- Office of the medical health officer
- Local governments (municipal and regional)
- Local first nations
- School districts/boards
- Post-secondary institutions
- Library
- First responders (e.g., ambulance and firefighters)
- Law enforcement
- Emergency preparedness
- Arts and culture
- Recreation
- Environmental and ecological organizations
- Faith communities
- Residents' associations
- Large employers
- Chambers of commerce
- Downtown business associations

APPENDIX 4: KEY LOCAL HEALTH AREA PROFILE DATA POINTS

The data below are from the 2019 Oceanside Local Health Area Profile, which is available at the Island Health Local Health Area Profiles page (https://www.islandhealth.ca/about-us/medical-health-office/population-health-statistics/local-health-area-profiles). Data from the 2021 Census are being released throughout 2022. The Network may wish to contact Island Health for information about when the Local Health Area Profile will be updated.

POPULATION AND DEMOGRAPHICS

- 50,720 people with a median age of 53 (BC's median is 42)
- The largest population age group is 45–64-year-olds (29.7%)
- The 75+ age group is expected to nearly double over the next 20 years, with a modest increase among 20–44-year-olds
- Indigenous peoples make up 4.9% of the population
- People who identify as a visible minority make up 3.2% of the population
- Most of the population were born in Canada (82.7%)
- Two-thirds of the adult population are married or common law (66.4%)

OTHER DETERMINANTS OF HEALTH DATA

- Income:
  - Gross median household income in 2015: $62,649. This is slightly less than the median for BC ($69,979).
- Low income:
  - One-fifth of children <6 and children/youth <18 (21.5%) (i.e., same rate for both)
  - One-sixth of adults 18-64 (16.4%)
  - One-tenth of seniors 65+ (10.6%) (only indicator lower than BC rate).
- Education:
  - Nearly two-thirds of the population has a post-secondary education (62.1%), and high school completion rates are high (71%) although lower than for BC (80%).
- Housing:
  - Half of renters (49.9%) and slightly less than one-sixth of homeowners (14.4%) spend 30% or more of their income on shelter.
  - 5% of dwellings need major repairs.
- Households:
  - Lone parent families make up less than one-sixth of households (13.3%).
  - There are very few multi-family / crowded households (1.1% / 3.6%).
  - Most households are owner-occupied (81.7%).

KEY DATA POINTS OF CONCERN

The table on page 12 contains key data points in areas where Oceanside was doing worse than the rest of Island Health. The table on page 13 contains more current data for some of these points; improvements can be seen in some areas and declines in others. Additional current data and a more robust comparison of data over time would be helpful to best assess Oceanside's performance on these indicators.

Sub-Group Description	Indicator Description	Time Period	BC	Island Health	Oceanside
Employment	Population aged 15 and over who are unemployed (%)	2016	6.7	6.8	7.5
Transportation	Employed population aged 15+ walking, biking, or busing to work (%)	2016	22.4	19.6	8.2
Child Health	Child hospitalizations – Injury / Poisoning (rate per 1,000 aged 0 to 14) - (2yr Agg)	2016-2018	4.4	5.5	7.6
Early Development	Kindergarten children rated as vulnerable for physical development (%)	2013-2016	14.8	16.2	19.0
	Kindergarten children rated as vulnerable for emotional development (%)	2013-2016	16.1	16.6	21.0
	Kindergarten children rated as vulnerable for language development (%)	2013-2016	9.4	9.0	12.0
	Kindergarten children rated as vulnerable on one or more domains (%)	2013-2016	32.2	31.1	37.0
	Kindergarten children rated as vulnerable on one or more domains, excl. communication (%)	2013-2016	28.6	23.5	35.0
Income	Median lone-parent family income ($)	2016	50,894	48,366	43,457
Income inequality	Low income (after-tax low-income measure), ages less than 18 years (%)	2016	18.4	19.2	21.5
	Low income (after-tax low-income measure), ages 18 to 64 years (%)	2016	14.9	14.7	16.4
	Households (rented) spending more than 30% of income on housing (%)	2016	43.3	45.0	49.9
Deaths	Alcohol-related deaths (age standardized rate per 100,000)	2016	83.0	94.6	122.5
Health matrix	Healthy (%)	2017	--	33.6	28.1
	Medium Chronic Conditions (%)	2017	--	10.0	14.0
	High Chronic w/ Frailty (%)	2017	--	4.6	6.5
	Cancer (%)	2017	--	1.7	2.4
	Frail in Residential Care (%)	2017	--	1.0	1.5
	End of Life (%)	2017	--	0.7	0.9
Potential years of lost life	Arteries, arterioles and capillaries - PYLL rate (age standardized rate per 1,000)	2013-2017	0.3	0.3	0.7
	Accidental Falls - PYLL rate (age standardized rate per 1,000)	2013-2017	0.4	0.4	0.7
	Suicide - PYLL rate (age standardized rate per 1,000)	2013-2017	3.2	3.9	5.8
	Motor vehicle accidents - PYLL rate (age standardized rate per 1,000)	2013-2017	1.6	1.5	2.4
Health service use: Emergency	Emergency Visits with CTAS of 1, 2 or 3 (%)	2017	--	67.8	52.4
	Emergency Visits with CTAS of 1, 2 or 3 (%) for 75+ population	2017	--	78.3	67.2
Health service use: Hospital Inpatient Care	Maternity Acute Care Utilization (case rate per 1,000 population)	2018	10.2	9.9	11.3

As noted above, the table below contains more current data, which demonstrate improvement in some areas, particularly early development, and declines in others.

Sub-Group Description	Indicator Description	Time Period	BC	Island Health	Oceanside
Child Health	Child hospitalizations – Injury / Poisoning (rate per 1,000 aged 0 to 14) - (2yr Agg)	2020	--	5.8	5.1
Early Development	Kindergarten children rated as vulnerable for physical development (%)	2016-2019	15.4	16.5	17.2
	Kindergarten children rated as vulnerable for emotional development (%)	2016-2019	17.7	17.8	18.8
	Kindergarten children rated as vulnerable for language development (%)	2016-2019	10.6	11.4	9.7
	Kindergarten children rated as vulnerable on one or more domains (%)	2016-2019	33.4	32.5	31.4
	Kindergarten children rated as vulnerable on one or more domains, excl. communication (%)	2016-2019	30.1	30.4	29.9
Deaths	Alcohol-related deaths (age standardized rate per 100,000)	2019	33.62	37.56	28397
Health matrix	Healthy (%)	FY 2019/20	--	32.19	27.14
	Medium Chronic Conditions (%)	FY 2019/20	--	11.06	15.35
	High Chronic w/ Frailty (%)	FY 2019/20	--	5.69	7.84
	Cancer (%)	FY 2019/20	--	1.86	2.27
	Frail in Residential Care (%)	FY 2019/20	--	0.9	1.48
	End of Life (%)	FY 2019/20	--	0.81	1.03
Potential years of lost life	Arteries, arterioles and capillaries - PYLL rate (age standardized rate per 1,000)	2015-2019	0.27	0.3	1.06
	Accidental Falls - PYLL rate (age standardized rate per 1,000)	2015-2019	0.34	0.33	0.19
	Suicide - PYLL rate (age standardized rate per 1,000)	2015-2019	2.87	3.22	4.23
	Motor vehicle accidents - PYLL rate (age standardized rate per 1,000)	2015-2019	1.25	0.89	2.68
Health service use: Emergency	Emergency Visits with CTAS of 1, 2 or 3 (%)	2020	--	58.2	48.2
	Emergency Visits with CTAS of 1, 2 or 3 (%) for 75+ population	2020	--	68.7	56.8
Health service use: Hospital, Inpatient care	Maternity Acute Care Utilization (case rate per 1,000 population)	2020	--	--	--