RURAL HEALTH MATTERS

British Columbia Rural Health Network September 2021

Dedicated to the development of a health services system that improves and sustains the health and well-being of residents of rural communities across British Columbia as a model of excellence and innovation in rural health care.

Letter from the President

Dear members and supporters,

In this issue of *Rural Health Matters* I'd like to comment on a variety of topics that are of importance to our Network.

Long term care (LTC) has been in the spotlight for the past several months, due in large part to the tragic loss of lives in LTC facilities during the COVID-19 pandemic. This has prompted several organizations to call for widespread and immediate action to reform policies and set standards aimed at improving the lives of people living in LTC facilities across this country.

On March 22 of this year, Paul Manly, Green Party Member of Parliament for Nanaimo-Ladysmith, introduced Motion 77 to the 2nd session of the 43rd parliament (see page 4), calling on the government to implement 14 LTC standards, including a basic care guarantee, adequate pay for LTC staff, support for LTC home family councils, and an end to private, for-profit LTC facilities. At the request of MP Manly, the Parliamentary Budget Officer has prepared a report that estimates the cost of implementing Motion 77 (see page 5).

We are in the middle of a federal election campaign. I urge all our members and supporters to bring this important information to the attention of the candidates running in your constituency and consider their views when you mark your ballot.

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This past week, Bonnie Henry, announced the return of province-wide restrictions due to the alarming increase in Covid-19 cases across the province. And we also learned that starting September 13, proof of vaccination will be required in B.C. for people attending certain social and recreational settings and events.

I don't know about you, but the spread of the delta variant feels a bit like I've been hit by a sucker punch from an opponent that I thought I'd already knocked out and down for good.

Maybe we should have seen this coming. After all there's been plenty of information available indicating that this virus is different. To start with, the fact that it mutates about every two weeks means that since this coronavirus was first discovered, it has produced millions of mutations. It stands to reason that some of them would become "escape viruses" and result in new waves. But it's still hard to take.

What I take away from all this is that we need to be constantly vigilant and follow the advice of the experts, not the people who form their opinions based on misinformation found on social media sites. This pandemic isn't over and there's every indication that this virus will be around for a long time, but through vaccination and following the restrictions, we can hopefully learn how to live with it.

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The big (and sad) news is that Connie Howe has submitted her resignation as Administrator for the BCRHN. Although it comes as no surprise - we've known for some time that she was looking for full time work in Princeton - it was still hard information to receive. Connie has been with us for 18 months and has done an outstanding job! With over 30 years of experience, she has helped shape the organization and set us on a positive course that will serve us well into the future. On behalf of the Board of Directors, I would I like to thank Connie for her contribution to the BCRHN and wish her well in her new job and all future endeavours.

Of course, this means we need to find a replacement. You can find the job posting on page 10. Please distribute this information to anyone who you think might be interested in working with us as we continue to improve access to healthcare for all rural British Columbians.

To your health,

Edward Staples, BCRHN President
telephone: 250-295-0822
email: bcruralhealthnetwork@gmail.com

Member of the Month
Centre for Rural Health Research

The Centre for Rural Health Research (CRHR) started in 2003 with the mandate to provide rigorous evidence to inform rural health services planning. Initial funding from the Canadian Institutes of Health Research, leveraged with funding from other granting agencies, provides support for a core team dedicated to building relationships, engaging in community field work and engaging with policy and decision-makers to contribute robust evidence to rural health care planning.

CRHR focuses primarily on projects looking at sustainable rural maternal care, rural surgical services and rural health-related transport. A key values proposition for all of the work is ensuring rural citizen partner voices are included in policy and decision making. Current projects include:

- The Rural Community Resilience Project (in partnership with the BC Rural Health Network), which aims to understand how rural BC communities have been impacted by and demonstrated resilience to COVID-19 and other disruptions (Funded by the BC SPOR SUPPORT Unit);
- The Rural Evidence Review, which took direction from rural citizen partners to determine research priorities and conducted literature reviews on identified topics. Recent literature reviews looked at community-level strategies for recruiting and retaining health care providers to rural and remote areas, priorities for mental health and substance use care and optimizing citizen engagement in health care decision making through rural health councils (funded by the SPOR SUPPORT Unit in conjunction with the Rural Coordination Centre of BC);
- The Rural Surgical Obstetrical Networks Evaluation, where CRHR is designing and implementing an evaluation of the program that supports safe and appropriate surgery, operative delivery and maternity care closer to home for rural communities (funded by the Joint Standing Committee on Rural Issues in conjunction with the Rural Coordination Centre of BC);
- An evaluation of the use of Point of Care Ultrasound in rural communities, which aims to support closer to home ultrasound-based assessments (Funded by the In PoCUS SuperCluster and the RCCbc), and
- The Core Services Project, which takes a systems perspective to understand issues challenging the sustainability of specialist-led services in rural settings (funded by the Doctors of BC).

Underscoring all of CRHR's work is a commitment to collaborate with communities and ensure accountability to rural priorities, to prioritize diverse voices especially those often marginalized, to develop pragmatic outputs that contribute to evidence-based health policy and to support the development of rural research capacity. For eighteen years, CRHR has conducted rigorous health research and continues to work to promote equity and reduce health disparities in BC's rural communities.
Although we work with many key stakeholders and right holders across the province, the day-to-day work is underscored by a fantastic, multi-disciplinary team of researchers and students with a strong commitment to sustainable rural health care. We are likewise delighted to be working closely with the BC Rural Health Network and appreciate the authentic community-level direction the network provides.

Dr. Jude Kornelsen
Co-Director, Centre for Rural Health Research
[website: **https://crhr.med.ubc.ca**]

NEW ON OUR WEBSITE

The Commonwealth Report 2021

The Commonwealth Fund

Authors: Eric C. Schneider, Arnav Shah, Michelle M. Doty, Roosa Tikkanen, Katharine Fields, Reginald D. Williams II

Illustrations by Michele Marconi

[Excerpts] The report found that the top-performing health systems overall are in Norway, the Netherlands, and Australia.

Switzerland, Canada and the U.S. were the countries with the worst healthcare systems, respectively.

- **Issue:** No two countries are alike when it comes to organizing and delivering health care for their people, creating an opportunity to learn about alternative approaches.

- **Goal:** To compare the performance of health care systems of 11 high-income countries.

Four features distinguish top performing countries:

1) they provide for universal coverage and remove cost barriers so people can get care when they need it and in a manner that works for them.
2) they invest in primary care systems to ensure that high-value services are equitably available in all communities to all people.
3) they reduce administrative burdens on patients and clinicians that cost them time and effort and can discourage access to care, especially for marginalized groups.
4) they invest in social services that increase equitable access to nutrition, education, child care, community safety, housing, transportation, and worker benefits that lead to a healthier population and fewer avoidable demands on health care.

Access to Care: Universal, Affordable Coverage Is Paramount

Access to care includes measures of health care's *affordability* and *timeliness.* The Netherlands performs best on this performance domain among the 11 countries, ranking at or near the top in both subdomains. Norway and Germany also performed well on access to care, but all three are outranked on affordability by the U.K. People in the countries performing the best on the timeliness subdomain are more likely to be able to get same-day care and after-hours care.

Top-performing countries achieve **near-universal coverage and much higher levels of protection against medical costs** in the form of annual out-of-pocket caps on covered benefits and full coverage for highly beneficial preventive services, primary care, and effective treatments for chronic conditions.

Germany abolished copayments for physician visits in 2013, while several countries have fixed annual out-of-pocket maximums for health expenditures (ranging from about USD 300 per year in Norway to USD 2,645 in Switzerland).

Exhibit 1. Health Care System Performance Rankings

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING	**3**	**10**	**8**	**5**	**2**	**6**	**1**	**7**	**9**	**4**	**11**
Access to Care	8	9	7	3	1	5	2	6	10	4	11
Care Process	6	4	10	9	3	1	8	11	7	5	2
Administrative Efficiency	2	7	6	9	8	3	1	5	10	4	11
Equity	1	10	7	2	5	9	8	6	3	4	11
Health Care Outcomes	1	10	6	7	4	8	2	5	3	9	11

Data: Commonwealth Fund analysis.

To read more, click on: **Fund Report ↓**

NEW ON OUR WEBSITE

IMPROVEMENTS TO LONG-TERM CARE

The following motion was presented by Paul Manly, MP for the Green Party, Nanaimo - Ladysmith, B.C. at the 2nd session of the 43rd parliament. March 22, 2021

Paul Manly

MOTION TEXT:

HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

That:

(a) the House recognize that,

(i) a humanitarian crisis has unfolded in Canada's long-term care (LTC) homes during the COVID-19 pandemic,

(ii) seniors, residents and staff in LTC are most vulnerable to COVID-19,

(iii) many LTC residents live in inhumane conditions, a longstanding issue, which has been made worse by the pandemic,

(iv) the death and suffering in Canada's LTC facilities is deplorable,

(v) Canada is known internationally as a caring nation, but that during the pandemic, we often ranked worst among OECD countries for deaths in LTC,

(vi) LTC residents must have the dignity, quality of life and care they deserve,

(b) in the opinion of the House, the government should,

(i)urgently with the provinces and LTC experts to take immediate life-saving action to get COVID-19 cases to zero in LTC,

(ii) provide proper and adequate supplies of personal protective equipment for staff, family caregivers and residents,

(iii) increase rapid testing at facilities for residents, staff and family caregivers,

(iv) implement a basic care guarantee and increase the number of trained staff in LTC facilities to ensure a minimum of four hours of regulated personal care per day for every resident,

(v) pay LTC staff adequately for their work, and provide benefits and paid sick leave,

(vi) invest in training and education to support ongoing professional development and specialization for LTC workers,

(vii) support unions to better ensure workers' safety and standards of care for residents and staff,

(viii) support LTC home family councils and ensure they are included in decision making and not kept out of the residences unnecessarily,

(ix) make LTC a publicly insured, core health care service that is accessible and universal,

(x) create a long term care act, modelled after the Canada Health Act that establishes national standards for care and staffing, and mechanisms to enforce these standards in all types of residences and facilities,

(xi) ensure enforcement of standards of care through accountability and penalties, including criminal prosecution,

(xii) end private, for-profit care and transition LTC facilities to non-profit and co-operative management structures and ownership,

(xiii) increase the proportion of LTC investment in community and home-based care from 13 to 35 per cent in order to match the OECD average,

(xiv) work with the provinces to support shifting LTC policy towards innovative community care, such as naturally occurring retirement communities, co-housing models, and enhanced home support programs, to allow people to stay in their own homes as long as possible.

FROM: **HTTPS://WWW.OURCOMMONS.CA/MEMBERS/EN/PAUL-MANLY(89485)/MOTIONS/11190967**

NEW ON OUR WEBSITE

Motion 77, presented by Paul Manly, resulted in the following report:

COST ESTIMATE FOR MOTION 77: IMPROVEMENTS TO LONG-TERM CARE

August 04, 2021

[Excerpts] The Parliamentary Budget Officer (PBO) supports Parliament by providing economic and financial analysis for the purposes of raising the quality of parliamentary debate and promoting greater budget transparency and accountability.

This report estimates the cost of implementing House of Commons Motion 77, which proposes several financially significant changes to long-term care for seniors. This report was prepared at the request of Mr. Paul Manly, MP for Nanaimo—Ladysmith.

Parts of this material are based on data and information provided by the Canadian Institute for Health Information, Statistics Canada, and various provincial administrative bodies. However, the analyses, conclusions, opinions and statements expressed herein are those of the author and not necessarily those of the Canadian Institute for Health Information, Statistics Canada, or those provincial administrative bodies.

House of Commons Motion 77 proposes several financially significant changes to long-term care for seniors, including:

- providing long-term care to all persons who need such care,
- increasing average employee pay and benefits for all non-public long-term care providers to match those paid by public sector longterm care providers,
- requiring an average of four hours of care per resident per day, and
- increasing spending on home care to 35% of public spending on long-term care.

Implementing these changes would require increasing public spending by $13.7 billion each year. This cost is expected to grow at 4.1% a year due to rising demand and costs.

These changes would:

- increase the number of long-term care beds for seniors by 52,000 (26%) at a cost of $3.1 billion each year;
- increase average wages and benefits for persons providing longterm care in the private and non-for-profit sectors by $3.24/hour (15%) to $25/hour, at a cost of $1.1 billion each year;
- increase the number of hours of care provided to residents in longterm care facilities each year by 0.95 hours per resident per day (31%) at a cost of $4.3 billion each year;
- increase the number of hours of publicly funded home care provided in Canada by 82 million hours (52%), at a cost of $5.2 billion each year.

The cost of Canada's long-term care system for seniors is shared between federal, provincial and territorial governments, but almost all direct funding is provided by provincial and territorial governments. The federal government finances long-term care indirectly through the Canada Health Transfer, which supports the capacity of provinces to offer health care services, including long-term care. However, no specific amount is allocated for long-term care within the Canada Health Transfer.

Current Spending on Long-Term Care for Seniors:

Total Public Spending $13.6 billion
Provincial Direct Spending $13.2 billion
Federal Direct Spending $0.4 billion
Federal Transfers $43 billion for health care generally

Click here to download the report–> parliamentary budget office report on fixing ltc Aug. 4, 2021Download

NEW ON OUR WEBSITE

Universal pharmacare benefits business and working families

Anita Huberman, Hassan Yussuff, Feb 10, 2019

[Excerpts] Employers currently pay about $12 billion a year to the insurance companies for employee coverage. These costs continue to rise and the reason is largely due to the runaway prices of prescription medications. This prevents Canadian businesses from remaining competitive in the global marketplace to secure the health of their workforce.

Analysis by the **Canadian Centre for Policy Alternatives** estimates that individuals and employers could spend up to $16 billion less on prescription drugs each year. This means that the pharmaceutical and insurance companies would lose significant profits.

Anyone who has ever run a business, or simply shopped for a family, knows that it's far cheaper to buy items in bulk. So why wouldn't that be Canada's approach toward the purchase of medicines? Drug prices in Canada are among the highest in the world, mostly because our myriad private drug plans dilutes the country's potential purchasing power on the world market for pharmaceuticals.

Take the example of the hypertension drug amlodipine. It's sold in both Canada and New Zealand by a Canadian company. In New Zealand, where the government is the single buyer of medicines, it cost $7 for a year's supply in 2015. In Canada, it cost $88 — more than 10 times what New Zealand paid. That added up to **$286 million spent on that drug** alone. It's businesses that are often paying these unnecessarily wasteful, inflated costs through their employee drug plans.

It continues to boggle the mind that we pay 30 per cent more for our prescription medications than the average of 14 comparable countries that offer universal drug coverage, including Germany, the UK, France, Australia, Sweden and New Zealand. It's equally puzzling that we remain the only developed nation with universal health care that lacks universal pharmacare.

To read more, click on: **Universal pharmacare benefits business and working families**

It's time to move away from fossil fuels, say doctors and nurses. Photo: Michelle Gamage.

Nurses and Doctors Take Aim at BC's LNG Ambitions

Michelle Gamage 18 Aug 2021

Campaign cites health and climate risks, and challenges claims LNG is a greener 'transition fuel'.

[Excerpts] People heading toward the Tsawwassen ferry terminal last weekend may have spotted an eerie sign of the times — a handful of doctors and nurses, standing under smoky skies, hoisting banners warning against the climate threat from liquified natural gas.

The group gathered to launch Unnatural Gas, a public awareness campaign by the Canadian Association of Physicians for the Environment and Canadian Association of Nurses for the Environment about the climate and health damage from natural gas.

Reports consistently find provincial and federal governments under-report methane emissions from the gas sector. In July, the Energy and Emissions Research Lab at Carleton University published a report saying methane emissions from B.C.'s oil and gas industry are 1.6 to 2.2 times higher than reported by the federal government. That worsens global heating, which has brought extreme weather and wildfires to the province this summer.

To read more, click on: https://thetyee.ca/News/2021/08/18/Nurses-Doctors-Take-Aim-BC-LNG-Ambitions/?utm_source=daily&utm_medium=email&utm_campaign=180821

Check our website for upcoming webinars, such as the ***Provincial Consultation on Seniors Transportation*** (September 28) by United Way - Healthy Aging
To register, click on: https://bcrhn.ca/provincial-consultation-on-seniors-transportation/ _

Photo via Shutterstock

NEW ON OUR WEBSITE

THE TYEE

On the Sunshine Coast, an Effort to Reinvent Senior Care

We want to create a co-op model of long-term care, learning from COVID-19 tragedies. By Paula Larrondo and John Richmond 29 Apr 2020 | TheTyee.ca

[Excerpt] In February [2020], B.C. Seniors Advocate Isobel Mackenzie tabled a report documenting many of the shortcomings of the for-profit care sector, such as higher administration costs and 207,000 funded but undelivered care hours. This is in contrast to a non-profit sector that actually spent more per resident than it was funded for on delivering direct care and service delivery.

While the for-profit system has clearly failed, the non-profit system has its own problems. Residents of such facilities can have their own concerns with, for example, the dilapidated state of physical facilities, overcrowding and lack of cleanliness, and the challenge of raising complaints within a big bureaucracy.

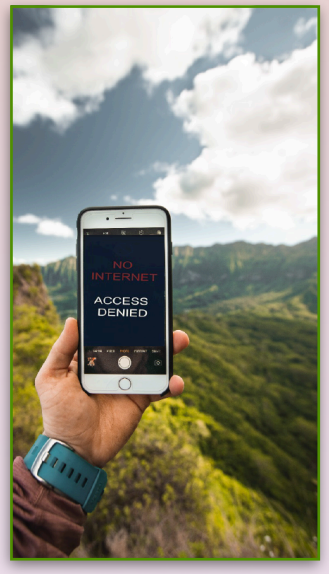
There is an alternative to our current health care and seniors care delivery models however: the co-operative model. The co-op model, in particular a type used in Quebec called the "solidarity co-op" or multi-stakeholder co-operative, would empower seniors and workers by giving them a direct say in everything from design and organization of a facility to the day-to-day operations to the negotiations with funders to budgets.

The "innovations" and reform in our seniors care models introduced in B.C. and other jurisdictions over the past 30 years have been designed not to solve the question of how to better care for an aging population, but rather how to save money for governments determined to cut taxes, quietly commodify seniors care and create investment opportunities in the lucrative health-care sector.

Read more at **https://bcrhn.ca/on-the-sunshine-coast-an-effort-to-reinvent-senior-care-2/**

Here are some articles you might find of interest. Visit our website at **http://bcrhn.ca** where you will see a tab called '*Solutions/Improvements*'. All articles are now now in pull down tabs in alphabetical order. Here are some examples: 'Cyber patients are training the world's future doctors'. Or maybe you are more interested in this one: 'B.C.acting to improve ambulance response times, support emergency workers'.

Of course we try to keep up with new COVID-19 data with articles like: **As Delta spread, Covid-19 vaccine effectiveness against infection fell from 90% to 66% in one key study** and: **COVID-19 breakthrough cases signal next phase of Canada's battle**.



THE RESULTS ARE IN!!!

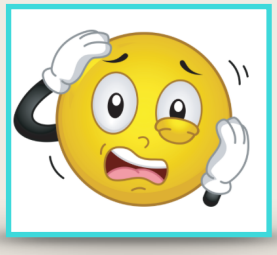
RHE-SETS RURAL HEALTH EQUITY Social Enterprise & Technology Synergies

Last year's results of 'Rural use of health service and telemedicine during COVID-19: The role of access and eHealth literacy' can be found at **https://journals.sagepub.com/doi/10.1177/14604582211020064** or **Download PDF**

The purpose of this study was to understand how adult rural citizens were using health care services, specifically telemedicine, during the first 4 months of the COVID-19 pandemic, and their overall satisfaction with these services.

With thanks to the BC Rural Health Network members who participated.

> ***"At this point the internet and access to it should be considered a utility, not a luxury"***
> – 55-year-old female rural community member



Wondering about the various acronyms and abbreviations?
Are you confused???
Don't worry, help is on the way.
Number 10 in our series *'acronyms explained'* (AE)

HEiDi = HealthLink BC Emergency iDoctor-in-assistance

B.C.'s health information telephone service (8-1-1) is a free-of-charge provincial health information and advice phone line. 8-1-1 connects callers with registered nurses who help them decide whether to visit an emergency department, a primary care clinic or manage their health concerns at home. **HEiDi (HealthLink BC Emergency iDoctor-in-assistance)** is a new addition to the 8-1-1 service. HEiDi physicians partner with 8-1-1 nurses to support callers via videoconferencing.

A recently published study describes the development and 4-month results of the HEiDi service. All 8-1-1 callers categorized as "seek care within 24 hours" by registered nurses were eligible for referral to HEiDi. HEiDi physicians connected with callers via videoconference, assessed their health complaints, provided advice and suggested care disposition. This study shares the collected demographic characteristics, health concerns and dispositions determined by the virtual physician.

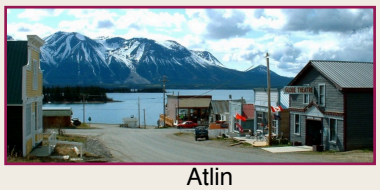
The study was led by the EM Network **Real-Time Virtual Support** Lead, **Dr. Kendall Ho**. Dr. Ho was inspired to develop and study HEiDi to help patients get the care they need, while safely reducing non-urgent visits to the ED. "In my clinical experience, many patients go to the emergency department (ED) reluctantly for health advice because of their need for just-in-time information, while others don't visit the ED even when they have major health problems requiring urgent attention," says Dr. Ho. "HEiDi physicians can give patients just-in-time information, and ensure appropriate triage to health services. This discerning triage decreases ED wait times and preserves the capacity of the ED for those patients with true emergencies."

"Dr. Ho has shown that this use of Real-Time Virtual Support has the effect of reducing unnecessary emergency visits but in other circumstances of reinforcing the need for a caller to get to an ED quickly when that is appropriate. As an integrated part of the public health care system, it can improve efficiency, safety and patient satisfaction when patients are in need of urgent advice", says Dr. Jim Christenson, Executive Medical Director, EM Network.

NEW ON OUR WEBSITE

Virtual program brings specialists, ER doctors to remote B.C. communities 24/7

[Excerpts] Virtual tools are becoming more deeply integrated into British Columbia's health system, and residents of remote, rural communities are seeing some of the biggest benefits. Some medical doctors are making themselves available 24/7 to remote communities in B.C.


Atlin

Atlin, a town of fewer than 500 just south of the Yukon border, is one of those communities. Whitehorse, more than 170 kilometres away, is the nearest major centre, and residents often struggle to access doctors and specialists.

The community is now making use of RTVS — real-time virtual support — a program that launched in April 2020, which puts a pool of 200 specialists and physicians, including ER doctors, at their fingertips 24 hours a day.

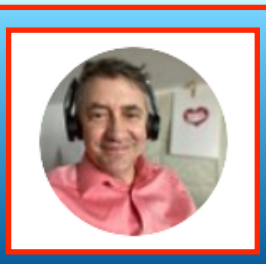
"It's been enhancing our practice and the lives of our community on a daily basis, pretty much," Atlin nurse Jen Stronge said. In past emergency cases, Stronge would have to call the ER in Whitehorse, and then wait in a queue for a doctor to return her call when possible.

"What it's like in downtown Vancouver versus what it's like on the central coast or north coast is very different," said Dr. John Pawlovich, virtual health lead for the Rural Coordination Centre of B.C.

More at: **Virtual program brings specialists, ER doctors to remote B.C. communities 24/7**

Some of Our Latest Twitter Followers

Nick Simons
Minister of Social Development and Poverty Reduction. MLA, Powell River-Sunshine Coast
https://www.leg.bc.ca/learn-about-us/members/41st-Parliament/Simons-Nicholas



Council of Canadians, Victoria
Victoria Chapter of the largest nonpartisan citizens' organization in Canada Victoria - Lekwungen Territory
website: victoriacouncilofcanadians.ca

Amber Hui
Knowledge Translation Specialist @ BC Support Unit
Galiano Island, BC, Canada
website: bcsupportunit.ca/methods-cluste…
[BC Support Unit is one of the Units of the BC Academic Health Science Network]

CIRD (Central Interior Rural Division)
The Central Interior Rural Division of Family Practice represents over 40 family physicians in the scenic Cariboo Region of BC.
website: divisionsbc.ca/CIRD/home

5-year health equity study reveals major gaps in data, knowledge and practice.

VANCOUVER, BC, JAN. 22, 2021– Sexual and gender diverse patients who are also Indigenous, Black, Multi-racial, or People of Colour report they are not getting the healthcare they have a right to in BC because of the intersecting barriers of racism and gender discrimination.

The number one barrier to care identified by study participants was a lack of health care providers knowledgeable in diversity and intersectional issues. This finding echoes other national and international studies on health equity which show that although advanced medical guidelines exist, these are subject to physician discretion, which is often guided by moral, religious or other personal views. With few exceptions, the situation is especially dire in rural BC, where a lack of appropriate care results in unaddressed health issues, including chronic pain, anxiety, severe depression and suicidality.

A lack of access to safe providers has prompted a rural urban migration of sexual and gender diverse people. Participants spoke of choosing between receiving inadequate care from someone with little education around their concerns, being put on lengthy waitlists, or attempting to find the time and resources to travel to a larger city.

Read more at: **http://peernetbc.com/lack-of-trained-healthcare-providers-puts-sexual-and-gender-diverse-people-at-risk/**

WE'RE HIRING!!!

Job Posting - Administrator

Date posted: September 1, 2021
Closing date: September 22, 2021

Job type: Part-time (0.5 FTE)

Compensation: $25.00/hour

Position Overview:

The BC Rural Health Network (BCRHN) is looking for an experienced Administrator to work with their Board of Directors and provide assistance to committees and working groups of the Network. The Administrator is a key management position of the BCRHN that will report directly to the Board of Directors.

The BCRHN is a not for profit registered society in the province of British Columbia. Its purpose is to promote and support a health services system that improves and sustains the health and well-being of residents of rural communities across British Columbia.

To receive a copy of the job description and application information, please contact:

Nienke Klaver, BCRHN Executive Assistant
email: tulameennienke@gmail.com
telephone: 250-295-0822

Visit the BCRHN website at www.bcrhn.ca

About Us

President - Edward Staples, Princeton
Vice President - Colin Moss, New Denver
Secretary/Treasurer - Peggy Skelton, East Shore Kootenay Lake
Directors: Bill Day, Hedley/Vancouver
Dave Smith, Chase
Janice Androsoff, Trail
Johanna Trimble, Roberts Creek
John Grogan, Valemount
Leonard Casley, New Denver
Pegasis McGauley, Nelson

Augmenting the Board:
Stuart Johnston - liaison with the Rural Coordination Centre of B.C.
Jude Kornelsen - liaison with the Centre for Rural Health Research at UBC
Teresa Murphy - liaison with the BC Health Coalition

Staff: **Administrator:** position vacant
Nienke Klaver, Executive Assistant, Editor *Rural Health Matters,* and Social Media Manager - Princeton

SOCIAL MEDIA

website: https://bcrhn.ca

facebook

twitter.com/bcrhnetwork

CONTACT INFORMATION

telephone: 250-295-0822

email: bcruralhealthnetwork@gmail.com