DISTRICT OF 100 MILE HOUSE

AGENDA FOR THE REGULAR MEETING OF THE MUNICIPAL COUNCIL TO BE HELD IN MUNICIPAL COUNCIL CHAMBERS
Tuesday, May 28th at 5:00 PM

A.	**CALL TO ORDER**
	Mayor to call the regular meeting to order at 5:00 PM. Acknowledgement that this meeting is being held on Tsq̓escencúl̓ecw.
B.	**APPROVAL OF AGENDA:**
	B1 **BE IT RESOLVED THAT** the May 28th, 2024 Regular Council agenda be approved.
C.	**INTRODUCTION OF LATE ITEMS AND FROM COMMITTEE OF THE WHOLE:**
D.	**DELEGATIONS / PUBLIC HEARING:**
E.	**MINUTES:**
Regular Council –April 9th, 2024	**E1** **BE IT RESOLVED THAT** the minutes of the Regular Council meeting of April 9th, 2024 be adopted as amended.
Committee of the Whole – April 23rd, 2024	**E2** **BE IT RESOLVED THAT** the minutes of the Committee of the Whole meeting of April 23rd, 2024 be adopted

Regular Council –April 23rd, 2024	**E3** **BE IT RESOLVED THAT** the minutes of the Regular meeting of April 23rd, 2024 be adopted
Regular Council –April 25th, 2024	**E4** **BE IT RESOLVED THAT** the minutes of the Regular meeting of April 25th, 2024 be adopted
Accessibility Committee –March 13th, 2024	**E5** **BE IT RESOLVED THAT** the minutes of the Accessibility Committee meeting of March 13th, 2024 be received
F.	**UNFINISHED BUSINESS:**
G.	**MAYOR'S REPORT:**
H.	**CORRESPONDENCE:**
2024 PSO Grad Parade Street Closure	**H1** **BE IT RESOLVED THAT** the memo from Administration dated May 16th 2024, regarding the PSO Graduation Parade Route be received; and further; **BE IT RESOLVED THAT** the Council of the District of 100 Mile House approve the PSO graduation parade route through the downtown core of 100 Mile House into Centennial Park on Saturday, June 15th, 2024, between 2:00pm and 3:00 pm, and further; **BE IT RESOLVED THAT** the PSO Grad Committee be directed to work closely with District of 100 Mile House Community Services Dept to coordinate the event.

Infrastructure Planning Grant Application – Council Support	**H2** **BE IT RESOLVED THAT** the Council Report dated May 15th, 2024 from the Director of Economic Development & Planning regarding the endorsement of the infrastructure planning grant submission be received; and further **BE IT RESOLVED THAT** Council of the District of 100 Mile House supports the submission of an infrastructure planning grant application for the Centennial Park Washroom Design Project
Request for financial support – Hillbilly Choir Band Retreat	**H3** **BE IT RESOLVED THAT** the correspondence from representative of the Hillbilly Choir Band Treat requesting financial support be received. ***Further direction at the discretion of Council***
Request for letter of support – Cariboo Brain Injury Association	**H4** **BE IT RESOLVED THAT** the correspondence from the Cariboo Brain Injury Association requesting a letter of support be received ***Further direction at the discretion of Council***
For Information Correspondence	**H5** **BE IT RESOLVED THAT** the For Information Correspondence List dated May 28th, 2024 be received.
I.	**STAFF REPORTS:**
Community Services Fleet Upgrades / Terrain & Front Mowers	**I1** **BE IT RESOLVED THAT** the Council Report dated May 21st, 2024 from the Director of Finance regarding the RFQ for the supply of two commercial mowers be received; and further **BE IT RESOLVED THAT** the RFQ to supply the District of 100 Mile House with a new Commercial Terrain Mower be awarded to Prairie Coast Equipment for the stated price of $123,562 plus applicable taxes; and further

	BE IT RESOLVED THAT the RFQ supply to supply the District of 100 Mile House with a new Commercial Front Mower be awarded to Prairie Coast Equipment for the stated price of $64,126 plus applicable taxes.
2023 Annual Report	**I2** **BE IT RESOLVED THAT** the 2023 Annual Report be received and made available for public inspection.
J.	**BYLAWS:**
Zoning Amendment Bylaw No. 1421, 2024	**J1** **BE IT RESOLVED THAT** the Zoning Amendment Bylaw No. 1421, 2024 be adopted this 28th day of May, 2024.
K.	**VOUCHERS**
Paid Vouchers (April 16th – May 15th, 2024) #29589 – 29630 & EFTs	**K1** **BE IT RESOLVED THAT** the paid manual vouchers #29589 to #29630 and EFT's totaling $396,709.62 be received.
L.	**OTHER BUSINESS:**
M.	**QUESTION PERIOD:**
N.	**ADJOURNMENT :** **BE IT RESOLVED THAT** this May 28th, meeting of Council be adjourned: Time:

E1

DISTRICT OF 100 MILE HOUSE

MEETING HELD IN DISTRICT COUNCIL CHAMBERS
Tuesday, April 9th, 2024, AT 5:00 PM

PRESENT:	Mayor	Maureen Pinkney (Via Teams)
	Councillor	Donna Barnett (Via Teams)
	Councillor	Jenni Guimond
	Councillor	Dave Mingo
STAFF:	CAO	Tammy Boulanger
	Dir. of Com. Services	Todd Conway
	Dir. of Finance	Sheena Elias
Other:	(3)	
Media:	(1)	

A	**CALL TO ORDER** Mayor Pinkney called the meeting to order at 5:00 PM Mayor Pinkney acknowledged that this meeting is being held on Tsq̓escenc̓ul̓ecw .
B	**APPROVAL OF AGENDA**
	B1 **Res: 63/24** Moved By: Councillor Barnett Seconded By: Councillor Mingo **BE IT RESOLVED THAT** the April 9th, 2024, Regular Council agenda be approved. CARRIED

C	**INTRODUCTION OF LATE ITEMS AND FROM THE COMMITTEE OF THE WHOLE:**
	Water conservation discussion to be added as a late item under I5.
D	**DELEGATIONS / PUBLIC HEARINGS:**
100 Mile Youth Initiative	**D1** Delegation - Maria Reti, representing the 100 Mile Youth Initiative presented the community skate/bike park plaza concept and requested a letter of support for their application to the NDIT Healthy Communities Fund. **Res: 64/24** Moved By: Councillor Barnett Seconded By: Councillor Guimond **BE IT RESOLVED THAT** the District of 100 Mile House supports the 100 Mile Youth Initiatives application in principle to the NDIT Healthy Communities Fund for the purpose of pursuing a professionally designed skate plaza. CARRIED Council fully supports the initiative and requested that the 100 Mile Youth Initiative and any associated contractors work with the Director of Community Services on determining appropriate plaza locations.
Court of Revision	**D2** **Res: 65/24** Moved By: Councillor Mingo Seconded By: Councillor Guimond **BE IT RESOLVED** that the frontage tax rolls for Water, Sewer and Blackstock Specified Area Sewer Parcel Tax be confirmed. CARRIED

	The Director of Finance noted the purpose of the Court of Revision is to hear any objections to the Sewer and Water Frontage Tax Rolls, and Blackstock Specified Area Sewer Parcel Tax Roll. The Director of Finance also provided a brief overview of roll changes and noted that there were no written appeals or verbal inquiries.
Financial Plan Presentation	**D3** Pursuant to the Community Charter s. 166 Council must undertake a process of public consultation with respect to its five (5) year financial plan. Director of Finance S. Elias presented an overview of the 2024-2028 District of 100 Mile House Financial Plan. The main highlights included: ➢ Revenues, Funding Sources, and the decline in major industrial taxation ➢ Property Tax Rates & Utility Fees ➢ Overall Expenditures by function ➢ Completion of Blackstock Specified Sewer debt ➢ Major capital projects Mrs. Elias highlighted methods of contacting the District and the available subscription service encouraging residents to stay informed with District news and events.
E	**MINUTES**
Committee of the Whole – March 26th, 2024	**E1** **Res: 66/24** Moved By: Councillor Mingo Seconded By: Councillor Barnett **BE IT RESOLVED THAT** the minutes of the Committee of the Whole meeting of March 26th, 2024, be adopted. CARRIED.

Regular Council – March 26th, 2024	**E2** **Res: 67/24** Moved By: Councillor Guimond Seconded By: Councillor Mingo **BE IT RESOLVED THAT** the minutes of the Regular Council meeting of March 26th, 2024, be adopted. CARRIED.
F	**UNFINISHED BUSINESS:**
G	**MAYORS REPORT:** Mayor Pinkey attended the Shriners fundraiser dinner, a heartfelt thank you to all the volunteers that make this event possible. The recent grant funding intake for NDIT funding was a success whereas all applicants received funding. Councillor Mingo welcomed the new hockey teams to Williams Lake and Quesnel. This will provide more regional opportunities for games and a little less travel for the Wranglers. Councillor Guimond also had the honour of attending the Shriners fundraiser dinner and noted what a fantastic community event it was. Councillor Barnett was the auctioneer at the Shriners dinner and she is still awaiting the final total, an estimated thirty thousand raised! Councillor Barnett also attended the monthly ESS meeting. Reminder to all of the upcoming Volunteer fair on April 21st, please call in and reserve your table or mark on the calendar to attend.
H	**CORRESPONDENCE:**

Commissionaires Report March 2024	**H1** **Res: 68/24** Moved By: Councillor Mingo Seconded By: Councillor Guimond **BE IT RESOLVED THAT** the Bylaw report for the period of March 1st to 31st, 2024 be received: CARRIED.
100 Mile & District Outriders	**H2** **Res: 69/24** Moved By: Councillor Barnett Seconded By: Councillor Guimond **BE IT RESOLVED THAT** the correspondence dated March 31st, 2024, from the 100 Mile & District Outriders requesting a letter of support for a NDIT grant application be received; and further **BE IT RESOLVED THAT**; a letter of support in principle be provided to the 100 Mile & District Outriders. CARRIED.
100 Mile & District Community Band	**H3** **Res: 70/24** Moved By: Councillor Barnett Seconded By: Councillor Mingo **BE IT RESOLVED THAT** the correspondence dated March 18th, 2024, from the 100 Mile Community Band requesting a contribution of $500.00 be received; and further **BE IT RESOLVED THAT**; the request be referred to the South Cariboo Joint Committee and the 100 Mile Community Band organization be notified of the Grants for Assistance application and policy. CARRIED.

100 Mile House Pride Society Road Closure Request	**H4** **Res: 71/24** Moved By: Councillor Barnett Seconded By: Councillor Mingo **BE IT RESOLVED THAT** the correspondence dated April 2nd, 2024 from the 100 Mile Pride Society requesting a parade route road closure on July 27th, 2024 from the hours of 9:30 am to 11:30 am be received; and further **BE IT RESOLVED THAT** the Council of the District of 100 Mile House authorizes the closure of Birch Avenue from First Street to Fourth Street and Fourth Street from Birch Avenue to Cedar Avenue, and further **BE IT RESOLVED THAT** the proponent be directed to coordinate all activities with the Director of Community Services and notify businesses along parade route. CARRIED
For Information Correspondence	**H5** **Res: 72/24** Moved By: Councillor Mingo Seconded By: Councillor Guimond **BE IT RESOLVED THAT** the For Information Correspondence List dated April 4th, 2024, be received. CARRIED
I	**STAFF REPORTS:**
Freedom of the Municipality – Councillor Ralph Fossum	**I1** **Res: 73/24** Moved By: Councillor Barnett Seconded By: Councillor Guimond **BE IT RESOLVED THAT** the memo from Administration dated March 28th, 2024, regarding the Freedom of the Municipality honours be received; and further

	BE IT RESOLVED THAT the honour of the Freedom of the Municipality be bestowed upon Ralph Fossum in recognition of his record which evokes the highest degree of administration; and further **BE IT RESOLVED THAT** the celebration of Freedom of the Municipality for Ralph Fossum be conducted at a future regular meeting of Council. CARRIED
Parks Facilities Attendant RFQ	**I2** **Res: 74/24** Moved By: Councillor Barnett Seconded By: Councillor Guimond **BE IT RESOLVED THAT** the Council of the District of 100 Mile House award the Parks Facilities Attendant contract to South Cariboo Property Management for a one (1) year term for the total quoted amount of $50./day plus applicable taxes. CARRIED
Columbaria RFQ	**I3** **Res: 75/24** Moved By: Councillor Mingo Seconded By: Councillor Guimond **BE IT RESOLVED THAT** the Council of the District of 100 Mile House award the supply and installation of two columbaria in the 100 Mile Cemetery to Sunset Memorial & Stone Ltd. for the total quoted amount of $54,252 plus applicable taxes. CARRIED

By-Election Appointment of Election Officials	**I4** **Res: 76/24** Moved By: Councillor Barnett Seconded By: Councillor Guimond **BE IT RESOLVED THAT** pursuant to Section 58 (1) and (2) of the Local Government Act, Sheena Elias be appointed Chief Election Officer, effective immediately, for conducting the 2024 by-Election, with power to appoint other election officials as required for the administration and conduct of the 2024 by-election; and further **BE IT RESOLVED THAT** Andria Frisby be appointed Deputy Chief Election Officer for the 2024 by-Election. CARRIED
Water Conservation	**I5** Council discussed the usage of water within the District of 100 Mile House and the importance of conservation. Council directed staff to promote water conservation tips through media platforms and mailouts to residents and commercial consumers. Staff will continue to monitor Provincial water and drought conditions and will adjust water restrictions if needed. CARRIED
J	**BYLAWS:**
Fees & Charges Amendment Bylaw No. 1418, 2024	**J1** **Res: 77/24** Moved By: Councillor Mingo Seconded By: Councillor Barnett **BE IT RESOLVED THAT** the Fees & Charges Amendment Bylaw 1418, 2024 be adopted this 9th day of April 2024. CARRIED

Public Notice Bylaw No. 1420, 2024	**J2** **Res: 78/24** Moved By: Councillor Mingo Seconded By: Councillor Guimond **BE IT RESOLVED THAT** the Public Notice Bylaw No. 1420-2024 be adopted this 9th day of April 2024. CARRIED
Financial Plan Bylaw No. 1422, 2024	**J3** **Res: 79/24** Moved By: Councillor Barnett Seconded By: Councillor Guimond **BE IT RESOLVED THAT** the Financial Plan Bylaw No. 1422-2024 be read a first, second and third time this 9th day of April 2024. CARRIED
K	**GENERAL VOUCHERS:**
Paid Vouchers (March 16th – 31st, 2024) #29490 to #29528 & EFTs	**K1** **Res: 80/24** Moved By: Councillor Mingo Seconded By: Councillor Barnett **BE IT RESOLVED THAT** the paid manual vouchers #29490 to #29528 and EFT's totaling **$129,900.** be received. CARRIED.
L	**OTHER BUSINESS:**
M	**QUESTION PERIOD:**

N	**ADJOURNMENT:** **Res: 81/24** Moved By: Councillor Mingo Seconded By: Councillor Guimond **BE IT RESOLVED THAT** this April 9th, 2024 meeting of Council be adjourned: 6:00 PM CARRIED.
	I hereby certify these minutes to be correct. _____ _____ Mayor Corporate Officer

E2

DISTRICT OF 100 MILE HOUSE

MINUTES OF THE COMMITTEE OF THE WHOLE MEETING OF THE MUNICIPAL COUNCIL HELD IN DISTRICT COUNCIL CHAMBERS

Tuesday, April 23rd, 2024, AT 4:00 PM

PRESENT:	Mayor	Maureen Pinkney
	Councillor	Jenni Guimond
	Councillor	Dave Mingo
	Councillor	Donna Barnett
STAFF:	CAO	Tammy Boulanger
	Dir. Of Com. Services	Todd Conway
	Dir. of Ec. Dev. & Planning	Joanne Doddridge (via teams)
	Dir. Of Finance	Sheena Elias
OTHERS:	(2 – Delegation (Teams))	MEDIA: (1)

	CALL TO ORDER Mayor Pinkney called the Committee of the Whole meeting to order at 4:00 PM Mayor Pinkney acknowledged that this meeting is being held on Tsq'escencúl'ecw.
A	**APPROVAL OF AGENDA**
	A1 **Res: 11/24** Moved By: Councillor Guimond Seconded By: Councillor Mingo **BE IT RESOLVED THAT** the April 23rd, 2024 Committee of the Whole agenda be approved. CARRIED.

B	**INTRODUCTION OF LATE ITEMS**
C	**DELEGATIONS**
Expedition Management	**C1** Representatives from Expedition Management presented the District of 100 Mile House Tourism Plan and reviewed the top recommendations. Councillor Barnett believed hosting a South Cariboo Tourism forum to be a good idea for this coming fall. Noted it is difficult to attract new events and conventions with the lack of amenities. The District should do their part at promoting the area/lands available for development. Councillor Mingo echoed previous comments, the lack of facilities and the challenges surrounding development. Noted it is necessary to have a budget allocated tourism/marketing. Councillor Guimond stressed how important tourism is to the economy. Mayor Pinkney welcomed the District of 100 Mile House Tourism Plan and supports the recommendations and establishing the 100 Mile House Visitor Center/100 Mile Development Corporation to be the local go-to tourism organization. **Res: 12/24** Moved By: Councillor Barnett Seconded By: Councillor Mingo **BE IT RESOLVED THAT** the Tourism Plan be referred to the 100 Mile House Development Corporation Board meeting for further discussion; and further **BE IT RESOLVED THAT** The Committee of the Whole is in support of hosting and facilitating a South Cariboo Tourism Forum in the fall of 2024.
D	**UNFINISHED BUSINESS**
E	**CORRESPONDENCE**

F	**STAFF REPORTS**
G	**BYLAWS**
H	**OTHER BUSINESS**
I	**QUESTION PERIOD**
J	**ADJOURNMENT** **Res: 13/24** Moved By: Councillor Barnett Seconded By: Councillor Mingo **BE IT RESOLVED THAT** this Committee of the Whole meeting for April 23rd, 2024, be adjourned at 4:45 PM. CARRIED.

I hereby certify these minutes to be correct.

_____ _____

Mayor Corporate Officer

E3

DISTRICT OF 100 MILE HOUSE

MEETING HELD IN DISTRICT COUNCIL CHAMBERS
Tuesday, April 23rd , 2024, AT 5:00 PM

PRESENT:	Mayor	Maureen Pinkney
	Councillor	Donna Barnett
	Councillor	Jenni Guimond
	Councillor	Dave Mingo
STAFF:	CAO	Tammy Boulanger
	Dir. of Com. Services	Todd Conway
	Dir. of Finance	Sheena Elias
	Dir. of Ec. Dev. & Planning	Joanne Doddridge (via teams)
Other:	(1 – Delegation M. Henderson)	
Media:	(1)	

A	**CALL TO ORDER** Mayor Pinkney called the meeting to order at 5:00 PM Mayor Pinkney acknowledged that this meeting is being held on Tsq'escencúl'ecw .
B	**APPROVAL OF AGENDA**
	B1 **Res: 81/24** Moved By: Councillor Seconded By: Councillor **BE IT RESOLVED THAT** the April 23rd, 2024, Regular Council agenda be approved. CARRIED

C	**INTRODUCTION OF LATE ITEMS AND FROM THE COMMITTEE OF THE WHOLE:**
D	**DELEGATIONS / PUBLIC HEARINGS:**
Matt Henderson	**D1** Delegation – Matt Henderson
E	**MINUTES**
Regular Meeting – April 9th, 2024	**E1** **Res: 82/24** Moved By: Councillor Mingo Seconded By: Councillor Guimond **BE IT RESOLVED THAT** the minutes of the Regular meeting of April 9th, 2024, be adopted. CARRIED.
F	**UNFINISHED BUSINESS:**
G	**MAYORS REPORT:** Mayor Pinkey was proud to be part of numerous events over the past few weeks, some highlights included: COFI in Smithers, BC , the event was extremely positive and touched on the changing landscape of forestry business in BC. Congratulations to the local Bantam bowlers who won gold at the recent provincials hosted by 100 Mile House. Skate Carnival was spectacular! Meetings with different Ministries were positive, advocating for additional funding and support on major capital projects. Councillor Mingo was proud to be the MC for the Skate Carnival and was overly impressed with quality of the performance. Councillor Barnett also attended meetings with Ministries to lobby support. The recent Performing Arts showcase was an amazing opportunity to see all of the talent in 100

	Mile House and surrounding area. Attending a well organized ESS NEST conference with the 100 Mile House team of ESS Volunteers was successful. The Volunteer fair did not see a good public turnout but a great opportunity for volunteer organizations to network with one another. Women's fair is this coming weekend, all are welcome to attend. The Shriners released their final tally from the fundraiser dinner, a total of $40,900! The Canadian Energy Regulator held an open house on the sunrise expansion project, attendance was minimal.
H	**CORRESPONDENCE:**
For Information Correspondence	**H1** **Res: 83/24** Moved By: Councillor Mingo Seconded By: Councillor Barnett **BE IT RESOLVED THAT** the For Information Correspondence List dated April 18th, 2024, be received. CARRIED
I	**STAFF REPORTS:**
Final Tourism Plan	**I1** **Res: 84/24** Moved By: Councillor Barnett Seconded By: Councillor Mingo **BE IT RESOLVED THAT** the District of 100 Mile House Community Tourism Plan be received; and further **BE IT RESOLVED THAT** District Council is in support of facilitating and hosting a South Cariboo Tourism Forum in the fall of 2024; and further **BE IT RESOLVED THAT** the District of 100 Mile House Community Tourism Plan be referred to the next 100 Mile Development Corporation Board meeting CARRIED

Garbage & Recycling Contract	**I2** **Res: 85/24** Moved By: Councillor Barnett Seconded By: Councillor Mingo **BE IT RESOLVED THAT** the contract for curbside garbage & recycling collection for the District of 100 Mile House be awarded to Environmental 360 Solutions Ltd. for the five-(5) year period commencing May 2024. CARRIED
Janitorial Contract	**I3** **Res: 86/24** Moved By: Councillor Mingo Seconded By: Councillor Barnett **BE IT RESOLVED THAT** the Council of the District of 100 Mile House award the Janitorial Services contract to Smitty's Janitorial Services (1993) for a three (3) year term with the option of a one-year extension for the total annual tendered amount of $32,400. plus applicable taxes. CARRIED
Facilities Attendant	**I4** **Res: 87/24** Moved By: Councillor Barnett Seconded By: Councillor Guimond **BE IT RESOLVED THAT** the District of 100 Mile House award the Facilities Attendant (MEH & Community Hall) contract to South Cariboo Property Management for a one (1) year term for the total quoted amount of $25./hr plus applicable taxes. CARRIED

J	**BYLAWS:**
Zoning Amendment Bylaw No. 1421, 2024	**J1** **Res: 88/24** Moved By: Councillor Barnett Seconded By: Councillor Mingo **BE IT RESOLVED THAT** Zoning Amendment Bylaw No. 1421, 2024 be read a first, second and third time his 23rd day of April 2024 CARRIED
Tax Rates Bylaw No. 1423, 2024	**J2** **Res: 89/24** Moved By: Councillor Mingo Seconded By: Councillor Guimond **BE IT RESOLVED THAT** the memo from Administration regarding Tax Rate Bylaw 1423, 2024 be received; and further **BE IT RESOLVED THAT** the Tax Rates Bylaw No. 1423, 2024 be read a first, second and third time this 23rd day of April, 2024. CARRIED
Financial Plan Bylaw No. 1422, 2024	**J3** **Res: 90/24** Moved By: Councillor Barnett Seconded By: Councillor Mingo **BE IT RESOLVED THAT** the Financial Plan Bylaw No. 1422-2024 be adopted this 23rd day of April 2024. CARRIED
K	**GENERAL VOUCHERS:**

Paid Vouchers (April 1st to April 15th, 2024) #29529 to #29588 & EFTs	**K1** **Res: 91/24** Moved By: Councillor Guimond Seconded By: Councillor Mingo **BE IT RESOLVED THAT** the paid manual vouchers #29529 to 29588 and EFT's totaling **$386,033.90.** be received. CARRIED.
L	**OTHER BUSINESS:**
M	**QUESTION PERIOD:**
N	**ADJOURNMENT:** **Res: 92/24** Moved By: Councillor Guimond Seconded By: Councillor Mingo **BE IT RESOLVED THAT** this April 23rd, 2024 meeting of Council be adjourned: 5:40 PM CARRIED.
	I hereby certify these minutes to be correct. _____ _____ Mayor Corporate Officer

E4

DISTRICT OF 100 MILE HOUSE

MEETING HELD IN DISTRICT COUNCIL CHAMBERS
Tuesday, April 25th, 2024, AT 4:30 PM

PRESENT:	Mayor	Maureen Pinkney
	Councillor	Donna Barnett
	Councillor	Jenni Guimond
	Councillor	Dave Mingo
STAFF:	CAO	Tammy Boulanger
	Dir. of Com. Services	Todd Conway
	Dir. of Finance	Sheena Elias
	Policy Analyst	Flori Vincenzi
Other:	(2) (Delegation M. Paroddi)	
Media:	(1)	

A	**CALL TO ORDER** Mayor Pinkney called the meeting to order at 4:30 PM Mayor Pinkney acknowledged that this meeting is being held on Tsq'escencúl'ecw . **Res: 93/24** Moved By: Councillor Barnett Seconded By: Councillor Guimond **BE IT RESOLVED THAT**, pursuant to Section 92 of the *Community Charter*, that this meeting of Council be closed to the public under Section 90 (1)(l) of the Community Charter. CARRIED
B	**APPROVAL OF AGENDA**

	B1 **Res: 94/24** Moved By: Councillor Guimond Seconded By: Councillor Barnett **BE IT RESOLVED THAT** the April 25th, 2024, Regular Council agenda be approved. CARRIED
C	**INTRODUCTION OF LATE ITEMS AND FROM THE COMMITTEE OF THE WHOLE:**
D	**DELEGATIONS / PUBLIC HEARINGS:**
BDO Canada LLP – M. Piroddi	**D1** Delegation – M. Piroddi from BDO Canada LLP appeared before Mayor & Council to present the 2023 Audited Financial Statements **Res: 95/24** Moved By: Councillor Mingo Seconded By: Councillor Barnett **BE IT RESOLVED THAT** the District of 100 Mile House 2023 Audited Financial Statements be approved as presented.
E	**MINUTES**
F	**UNFINISHED BUSINESS:**
G	**MAYORS REPORT:**
H	**CORRESPONDENCE:**
I	**STAFF REPORTS:**
Community Services Fleet Upgrade / ½ Ton RFQ	**I1** **Res: 96/24** Moved By: Councillor Barnett Seconded By: Councillor Guimond

	BE IT RESOLVED THAT the report from Administration dated April 22nd, 2024 regarding the RFQ for the supply of a ½ Ton be received; and further **BE IT RESOLVED THAT** the RFQ to supply the District of 100 Mile House with a new 2025 Dodge ½ ton pickup be awarded to Regency Chrysler for the stated price of $57,017.90 plus applicable taxes. CARRIED
Community Services Building Equipment / Mobile Column Lift RFQ	**I2** **Res: 97/24** Moved By: Councillor Mingo Seconded By: Councillor Guimond **BE IT RESOLVED THAT** the report from Administration dated April 22nd, 2024 regarding the RFQ for the supply of a Mobile Column Lift be received; and further **BE IT RESOLVED THAT** the RFQ to supply the District of 100 Mile House with a new Mobile Column Lift be awarded to ISN Canada for the stated price of $83,196. plus applicable taxes. CARRIED
J	**BYLAWS:**
Tax Rates Bylaw No. 1423, 2024	**J1** **Res: 98/24** Moved By: Councillor Barnett Seconded By: Councillor Guimond **BE IT RESOLVED THAT** the Tax Rates Bylaw No. 1423, 2024 be adopted this 25th day of April, 2024. CARRIED
K	**GENERAL VOUCHERS:**
L	**OTHER BUSINESS:**

M	**QUESTION PERIOD:**
N	**ADJOURNMENT:** **Res: 99/24** Moved By: Councillor Mingo Seconded By: Councillor Barnett **BE IT RESOLVED THAT** this April 25th, 2024 meeting of Council be adjourned: 5:20 PM CARRIED.
	I hereby certify these minutes to be correct. _____ _____ Mayor Corporate Officer

100 MILE HOUSE ACCESSIBILITY COMMITTEE

MINUTES OF ACCESSIBILITY COMMITTEE MEETING HELD IN DISTRICT COUNCIL CHAMBERS

WEDNESDAY MARCH 13th, 2024, AT 12:00 PM

PRESENT: Lori Fry
Brian Brown
Ben Vinje (Via Teams)
Kristin Wells

District Staff: S. Elias, T. Conway

Absent: Kim Irvine

	CALL TO ORDER Chair L. Fry called the meeting to order at 12:00 PM
	APPROVAL OF AGENDA
	Moved By: K. Wells Seconded By: B. Brown That the March 13th, 2024, Accessibility Committee meeting agenda be approved.
	MINUTES
	Moved By: K. Wells Seconded By: B. Vinje That the minutes from the November 8th, 2023 meeting be approved as received.

	UNFINISHED BUSINESS
	L. Fry started the meeting off by recognizing that R. Fossum will be very missed from the committee. His experience in perspective will be hard to replace. The District of 100 Mile House website now has an accessibility page. The Committee was happy with the page. The suggestion was made to work towards seasonal information on the accessibility page to match the season. B. Brown mentioned that in other communities (Kelowna) there is a reporting process for accessibility concerns (sidewalks, roads) and when complaints are received, they are actioned on quite quickly. The Committee suggested rack cards for the accessibility committee to be displayed in various locations to gain awareness that the committee is here to receive feedback from the community. Business cards for the committee members. Setting the date for the accessibility tour will be discussed in the other business section of the agenda.
	NEW BUSINESS
	District Director of Community Services, Todd Conway was in attendance to answer questions regarding accessibility and the BC Building Code. T. Conway explained that there is an accessibility handbook that is published in conjunction with the BC Building Code to make the understanding of this section easier in comparison to reading the legislation and code. Based on the code small business renovations can trigger accessibility requirements sooner than larger buildings. L. Fry asked how information from the Committee reaches Council, wanting to make sure that recommendations from the Committee that reach Council are polished and complete. S. Elias explained that the information and recommendations from the Committee can be compiled into a report that would be added to a regular council agenda.

	The Committee would like a clear process for recommendations to Council. B. Brown asked how the committee can support change and if bylaws and policies will be changed based on recommendations? S. Elias replied that once a clear process is in place the recommendations will go to Council and it is their choice how they are acted upon. L. Fry spoke on the Sign Bylaw and inconsistencies with sandwich board signs.
	L. Fry was invited to speak on her perspective on living life with vision loss. L. Fry explained that vision loss is a spectrum and that 90% of the low vision community have some level of sight. The different causes of vision loss include genetics, aging and injury. Vision loss or low vision can be an exhausting when trying to live with one foot in the vision world and one foot in the low vision world. B. Brown interjected the presentation to request moving on with the agenda. S. Elias clarified that the presentation was part of the agenda at the request of the committee; at this time it is appropriate for L. Fry to continue her presentation and B.Brown's matter can be tabled and discussed within other business. Due to the interruption in the presentation L. Fry was unable to continue the presentation and the committee proceeded to the next agenda item.

	CORRESPONDENCE
	The correspondence from the agenda package was received and the Committee had a conversation on how they would like to see correspondence in the future. It was decided that any correspondence received regarding accessibility to any member would be forwarded on, to be included in the agenda package. The District website feedback form received one submission from Micheal McMurray, he would like to speak to the committee on challenges of a manual wheelchair in our community. When the Committee is ready for guest speakers, they would like to invite Mr. McMurray to speak. The Committee would like to add to the Correspondence heading to include feedback from website.
	OTHER BUSINESS
	With the upcoming District of 100 Mile House By-Election the June 12th meeting will need to be rescheduled. The next meeting is now scheduled for May 15th, 2024, including an accessibility tour of Birch Ave. B. Brown offered the use of wheel chairs from Red Cross for the tour. B. Vinje commented that every second Wednesday does not work for his work schedule, this will be kept in mind when setting meetings.
	Request for an update on a permanent Council member to chair the committee. S. Elias informed the committee that a permanent Chair will not be assigned until after the election but will try to have a Council member attend on a temporary basis.

	B. Brown has a few suggestions on activities the committee could be doing to promote visibility of the committee: • Change location of the meetings. • Committee to speak at Creekside • Tables at various fairs and events around the community The Committee agreed that the meetings should continue in the Council Chambers to give them an official appearance. Speaking events and tables at fairs or events are something to work towards and think about in the future once the Committee has had more time to work together and prepare. It was agreed that the first action item could be awareness of accessibility and the committee through rack cards and District Social Media. Kristin volunteered to help produce awareness materials.
	ADJOURNMENT The Committee meeting was adjourned at 12:50 PM.

H1

DISTRICT OF 100 MILE HOUSE

M E M O

Date: May 16th, 2024

To: Mayor & Council

From: Administration

Subject: 2024 PSO Grad Parade – Street Closure (Birch Avenue)

The Peter Skene Ogden (PSO) Dry Grad Committee has submitted a request letter to the District to authorize the closure of Birch Avenue between First Street and Fourth Street for the parade to continue to travel to Centennial Park on Saturday June 15th, 2024 during the hours of 2:00 PM to 3 PM for the purpose of hosting the annual parade of the graduating class of 2024

If Council is supportive of this closure of Birch Avenue for the event the following recommendation is provided for Council consideration.

Recommendation:

BE IT RESOLVED THAT the memo from Administration dated May 16th, 2024 regarding the PSO Graduation Parade Route be received; and further

BE IT RESOLVED THAT the Council of the District of 100 Mile House approve the PSO graduation parade route through the downtown core of 100 Mile House into Centennial Park on Saturday, June 15th 2024, between 2:00 pm and 3:00 pm; and further

BE IT RESOLVED THAT the PSO Grad Committee be directed to work closely with the District of 100 Mile House Community Services Dept. to coordinate the event.

T. Boulanger, CAO

File No. 570-01

Peter Skene Ogden Dry Grad Committee

Peter Skene Ogden Secondary School

200 - 7th Street

100 Mile House, BC V0K 2E0

May 15, 2024

District of 100 Mile House

385 Birch Ave.

100 Mile House, BC, V0K 2E0

To District of 100 Mile House Council

I would like to make a request to the Council to have portions of Birch Ave., 4th Ave., and Cedar Ave. closed temporary, June 15, 2024 at 2pm for the Parade of the Graduating Class 2024 of Peter Skene Ogden. The parade route will start behind Save On Foods cross First Ave., left on 4th Ave., right Cedar Ave. and into Centennial Park.

Thank you for your support

Sincerely

Kelly Kelsey

Parent

Peter Skene Ogden Dry Grad Committee

H2

District of
100 MILE HOUSE

COUNCIL REPORT
File No. 570-01

Regular Council Meeting
May 28, 2024

REPORT DATE: May 15, 2024

TITLE: Infrastructure Planning Grant Application

PREPARED BY: J. Doddridge, Director Economic Development & Planning

---

PURPOSE: To obtain Council endorsement of the grant submission

RECOMMENDATION: Recommended Resolution:

BE IT RESOLVED THAT Council of the District of 100 Mile House supports the submission of an Infrastructure Planning Grant application for the Centennial Park Washroom Design Project.

BACKGROUND INFORMATION / DISCUSSION:

This project is to obtain design and engineering for new, accessible washrooms at Centennial Park, and includes the engineering for a new lift station to accommodate the washrooms and re-fitting the existing lift station for spray park use only. Proceeding with the design and engineering was endorsed by Committee of the Whole on Jan. 23rd, 2024.

OPTIONS: N/A

BUDGETARY IMPACT: The total cost for this project is estimated at $40,000 and the Infrastructure Planning Grant will pay up to $10,000 of eligible costs, if approved. The remaining funds have been identified in the Utility Infrastructure Reserve Funds budget.

LEGISLATIVE CONSIDERATIONS (Applicable Policies and/or Bylaws): N/A

ATTACHMENTS: Infrastructure Planning Grant application and Supplementary Form.

Prepared By: Doddridge — **Date:** May 15/24
J. Doddridge, Dir Ec Dev & Planning

Reviewed By: — **Date:** May 17/24
T. Boulanger, CAO

PLEASE READ THE PROGRAM GUIDE before completing this Application Supplementary Form. An application for each project must be completed using the Local Government Information System (LGIS). The Application Supplementary Form and all other relevant documentation must be uploaded to the "Attachment" tab of the online application form in LGIS.

Applicants should be aware that information collected is subject to *Freedom of Information and Protection of Privacy Act* (FOIPPA).

This Application Supplementary Form is designed to be filled in electronically using word processing software. If you have any questions, please contact the Local Government Infrastructure and Finance Branch by phone at: 250 387-4060 or by email at: Infra@gov.bc.ca.

For Administrative Use Only

A. Applicant Information

Legal Name of Local Government: **District of 100 Mile House**
Project Title: **Centennial Park Washroom Design**

B. Project Information

1. What are the main objectives of the project? **The main objectives of the project are to plan for upgrades to the Centennial Park washrooms, including all engineering and design of the sewer lift station that will also be required.**
2. What is the deliverable that will result from this project? **A complete engineering package that will be construction-ready.**
3. If multiple applications are being submitted, this project is ranked as priority __ out of ___applications. **Only 1 application is being submitted.**
4. Explain how this project integrates ecological services, resources recovery, and/or other initiatives to manage climate change in the community. **In a recently completed Heat Response Plan, the District of 100 Mile House documented the various cooling spaces in town where residents could seek relief during extreme heat events. Centennial Park in general and the spray park area adjacent to the washrooms more particularly, were identified as important public cooling spaces. With the increased use of the park, the creek that flows through it, and the shade trees found there, the washroom use also increases. It is important for the District to maintain these cooling spaces and offer appropriate amenities there.**
5. Explain how this project will improve public health and safety / community wellness. **We plan to construct a new expanded washroom facility at Centennial Park to accommodate change rooms and additional capacity, as our park continues to see increased usage. In addition, the washrooms will be designed to accessible standards. The current lift station cannot accommodate the additional sewer capacity, so will be redesigned to service the spray**

park only.

6. Explain how this project supports community sustainability goals and indicate how this project is integrated into the development or implementation of any long-term plans.

The District of 100 Mile House has been working to create greater accessibility in our park for the past several years. We have added covered picnic table areas, constructed a spray park in partnership with the community, refurbished the only tennis courts in town, constructed a bandshell, and many other amenities. Over the long term, we plan to make the park increasingly accessible and draw visitors to the park during our peak tourist seasons. Necessary water and sewer capacity upgrades need to be in place to accommodate these longer term plans.

7. a) Will the project be developed in partnership or collaboration with any First Nations, organizations or/and local governments? ☐ **Yes** ☒ **No**

b) If yes, list the partners and describe their role in this project:

8. a) Will (has) this project receive(d) any funding or in-kind contributions from a third party? ☐ **Yes** ☒ **No**

b) If yes, list the parties and describe their contributions:

9. a) Will there be any public consultation and/or participation? ☐ **Yes** ☒ **No**

b) What consultation will occur, if any?

c) If consultation has occurred what was the outcome?

10. a) What is the population of the community? **1928**

b) What is the estimated population that will be served by this project?

10,000+ In addition to local residents, this park is visited by residents throughout the entire South Cariboo as well as tourists who visit the community. Many events are held in the park each year, which draw large numbers of visitors.

The Supplementary Application Form must be completed and submitted online using the Local Government Information System (LGIS). You must have a BCeID account to access the online application form. To set up your BCeID account, for assistance with completing the application form and program details, please refer to the Program Website.

Full and Accurate Information: applicants are responsible for ensuring that full and accurate information is submitted to the Ministry of Municipal Affairs and any applicable supporting information has also been submitted. If a question in the Application Supplementary Form is not applicable to the project, provide a brief explanation of why it is not applicable.

Please ensure to upload all the required materials (refer to section 3.1.1 of the Infrastructure

Planning Grant Program) under the "Attachment" tab of the online application in LGIS prior to submission as the form (including the attachment section) will be locked by the system post submission. Applications will not be assessed until the Application Supplementary Form is received by the Ministry of Municipal Affairs.

If you have any questions, please contact the Local Government Infrastructure and Finance Branch by phone at: 250 387-4060 or email at: Infra@gov.bc.ca

Application Form for Infrastructure Planning Grant Program

Proponent
District of 100 Mile House

Application Number
IPG250011

Application Submitted On
Incomplete

Application Contact Information

First Name
Joanne

Last Name
Doddridge

Title
Director of Economic Development & Planning

Telephone Number
1(250) 395-2434

Telephone Extension
102

Email Address
jdoddridge@100milehouse.com

Project Information

Project Title
Centennial Park Washroom Design

Project Type
Wastewater

Brief Project Description
This project is to design and engineer new washrooms in Centennial Park. The existing washrooms are past their useful life and are inadequate for the current level of use in the park and they are not accessible. The design and engineering will include a new lift station and refitting the current lift station for spray park use only.

Estimated Project Completion Date
2024-12-31

Financial Information

Estimated Gross Project Costs
$40,000

Estimated Ineligible Project Costs
$0

Estimated Eligible Project Costs
$40,000

Attachments

Document

No records available.

Submission Details

This will certify that the following authorities have reviewed and approved this Application

name title Project Manager

name title Financial Approver

I applicant name certify that I

am authorized to submit this application on behalf of District of 100 Mile House

H3

[redacted]

April 22, 2024

District of 100 Mile House
#1-385 Birch Ave.,
Box 340, 100 Mile House, BC, V0K 2E0

RE: EVENT SUPPORT REQUEST

Dear District Office representative,

I request the District's support for a two-day music workshop event I am planning in 100 Mile House this summer. My goal in organizing this event is to promote community singing and music-making as a fun way to make positive connections, to feel a sense of belonging and to spark our own innate creativity, and at the same time provide local entertainment.

I am partnering with the 100 Mile and District Arts Council with support from Parkside Art Gallery. We have also applied for the CRD Continuous Intake Grant. If the District of 100 Mile House is able and willing to offer any financial support, we would acknowledge your organization in any way we can, including our posters and marketing activities.

More about me: I currently facilitate a community singing group and I have hosted local musical events in the past. I do this because I strongly believe in community music-making.

Event details: Hillbilly Choir Band Retreat and Harmony Singing Workshop on June 23 and 24, 2024 in 100 Mile House (Creekside Seniors Centre and Parkside Art Gallery respectively). Fees range from $25 to $75. Workshops are followed by informal shows open to the public, where people can mingle, dance and be inspired.

I have included a budget of the estimated event costs on the following page. I expect costs to be offset by ticket sales, but I am not confident in the number of participants.

I very much appreciate your consideration of this request and would be pleased to answer your questions at any time.

Thank you for your time,

Demian Pettman

Demian Pettman,

[redacted]

EVENT EXPENSE BUDGET

Project Title:	**HILLBILLY CHOIR BAND RETREAT**
Project Duration:	**June 23 and 24, 2024 in 100 Mile House, BC**
Instructor:	Jenny Lester / jennylester.com
Project Contact:	Demian Pettman / demianp@hotmail.com / 250-706-9358

Item Description	Cash Required	In-Kind Contribution*	Total Budget
Program Expenses			
Jenny Lester fee (Sunday)	900.00		900.00
Jenny Lester fee (Monday)	600.00		600.00
Accommodation / travel		500.00	500.00
Advertising - Facebook Ads	50.00		50.00
Advertising - 100 Mile Free Press	250.00		250.00
Marketing materials design and distribution		200.00	200.00
Printing	100.00		100.00
Event Refreshments	200.00		200.00
Rental - Creekside Seniors Centre (Sunday)	300.00		300.00
Rental - Parkside (Monday)	30.00		30.00
Insurance	250.00		250.00
Honoraria			
Total	**2680.00**	**700.00**	**3380.00**

* In-kind contributions include Demian's time spent on marketing activities and hosting the instructor.

Our goal is to have a minimum of 20 participants sign up, which will cover half of the anticipated costs. If we receive a CRD grant, we may still be short by a few hundred dollars. If we cannot sign up 20 participants, then we will charge a small entrance fee to the public for the shows. Jenny has already agreed to give us a lower ticket price for our event compared to similar events in other communities. With the financial support, I intend to pay her regular fee and contribute to her travel costs. If there is extra money, this will be paid as honoraria and carried forward into future events.


JENNY LESTER'S
HILLBILLY
CHOIR BAND RETREAT!
100 MILE HOUSE, BC
Early Bird! Discount $5
Sunday June 23, 2024
2-5pm Instruments & Voices WORKSHOP $50
5:30pm Potluck & Jam Session
Bundle All $75!
Monday June 24
5-7pm PM 3-Part Harmony WORKSHOP $30
7:30pm Hillbilly Open Mic Coffee House
REGISTER: Eventbrite info: www.jennylester.com

H4

Subject: FW: CBIA Recognition

From: [redacted]
Sent: Wednesday, April 24, 2024 1:10 PM
To: District of 100 Mile <district@100milehouse.com>
Subject: CBIA Recognition?

Is it possible to get a letter of support and possible a certificate of appreciation from the District office – it would help with our grant applications and marketing efforts

Thank you

Mike
Cariboo Brain Injury Association

H5

DISTRICT OF 100 MILE HOUSE

FOR INFORMATION CORRESPONDENCE
May 28th, 2024 Regular Council Meeting

1. South Cariboo Joint Committee Minutes – March 13th, 2024
2. Communities in Bloom Newsletter.
3. Correspondence from the District of Logan Lake re: Support for Bill-34
4. Correspondence from Mr. Friss re: Community Paramedic
5. Correspondence from Mr. Pawliuk re: Wildfire Prevention and Suppression.
6. Correspondence from the BC Rural Health Network re: Advancing Rural Community Engagement in Health Care Planning and general newsletter.

FOR INFORMATION CORRESPONDENCE

Cariboo Regional District

CARIBOO REGIONAL DISTRICT

SOUTH CARIBOO JOINT COMMITTEE MINUTES

March 13, 2024
1:30 p.m.
District of 100 Mile House Council Chambers
385 Birch Avenue
100 Mile House, BC

PRESENT:	Director A. Richmond (via phone), Director E. de Vries, Co-Chair M. Pinkney, Councillor J. Guimond, Councillor D. Mingo
ABSENT:	Co-Chair M. Wagner, Councillor D. Barnett
STAFF:	D. Campbell, Manager of Community Services, Cariboo Regional District, Sheena Elias, Deputy Director of Corporate Administration, District of 100 Mile House, Todd Conway, Director of Community Services, District of 100 Mile House, Kevin Welsh, Manager of Finance, Cariboo Regional District

1. CALL TO ORDER

1.1 Adoption of Agenda

SCJ.2024-3-1

That the agenda be adopted as presented.

By Consensus

2. ADOPTION OF MINUTES

2.1 Minutes of the South Cariboo Joint Committee Meeting - February 12, 2024

SCJ.2024-3-2

That the minutes of the South Cariboo Joint Committee meeting, held February 12, 2024, be adopted.

1

By Consensus

3. ACTION ITEMS

3.1 South Cariboo Recreation Management Agreement (2024-2029) Between the District of 100 Mile House and the Cariboo Regional District

SCJ.2024-3-3

That the proposed South Cariboo Recreation Management agreement between the Cariboo Regional District and the 100 Mile Economic Development Corporation be approved for a five-year term (2024-2029) and that the appropriate signatories be authorized to execute the agreement.

By Consensus

4. ADJOURNMENT

SCJ.2024-3-4

That the meeting of the South Cariboo Joint Committee be adjourned at 2:00 p.m., March 13, 2024.

By Consensus

_____

Co-Chair

2

FOR INFORMATION CORRESPONDENCE

May 2024

Growing Great Places Together

B.C. COMMUNITIES IN BLOOM NEWSLETTER

IN THIS ISSUE:

GOLD SPONSORS:

URBAN SYSTEMS

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Gardens BC
BC Council of Garden Clubs

CiB Cef

British Columbia Communities in Bloom

UPDATED MAILING ADDRESS:
4451 212-Street, Langley, V3A 7Z8
(604) 576-6506
www.bccib.ca

Facebook

BC CiB Privacy Policy

Meet some of our Participants.

Welcome to the Village of Chase a first-year participant in Communities in Bloom! Chase is located between Kamloops and Salmon Arm along the Trans Canada Highway. It is a wonderful place to base your Shuswap experience.

District of 100 Mile House is a community anchored by the forest industry. They are proud of its rich history and agricultural community. The area has an abundance of recreational opportunities such as beautiful lakes, multi-use trails, waterfalls and diverse lands.

Volume 19 Issue 05 May 2024

Thank you to our Gold Bloom 2024 Provincial Sponsors!

Teck

URBAN SYSTEMS

We would also like to thank the National program sponsors who also provide additional provincial support.

Scotts

Communities in Bloom / Collectivités en fleurs
CANADA
Growing Great Places Together
Cultivons ensemble de beaux espaces

e-Equinox environmental products

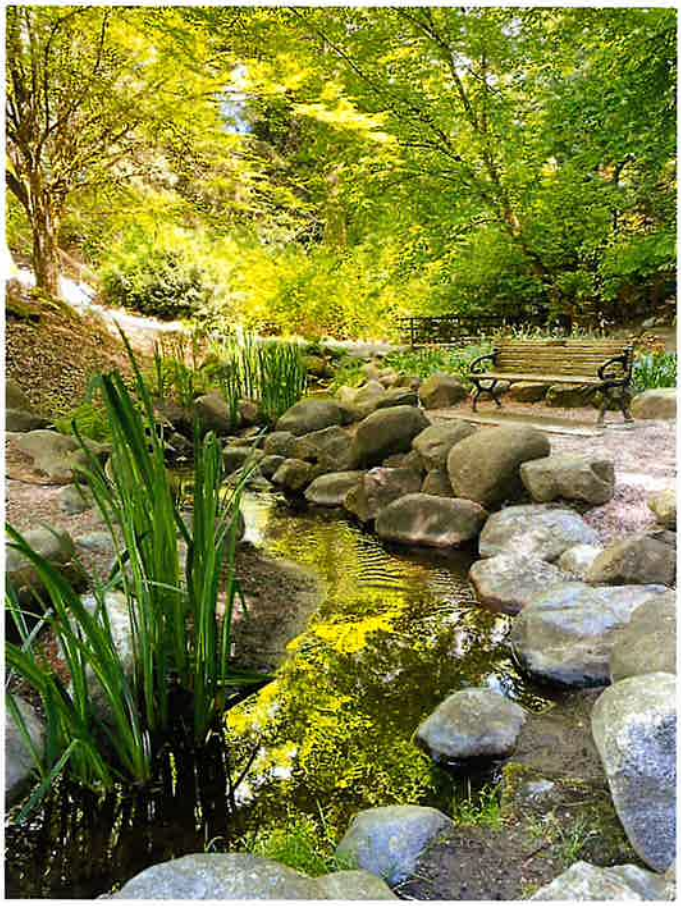
LOOKING GOOD!

You've been NOTICED by a BC CiB AMBASSADOR

We are launching a new initiative to recognize smaller communities and special places around the province. Every community has special gems that often go unnoticed or are under appreciated.

Photos from Ambassadors will recognize a special green space or a community enhancing project. They will prepare a photo nomination that we would like to share in our newsletter.

Nominees will also be invited to submit a Great Places Showcase as a way to provide additional information about the place or project and to recognize the people who made it possible.



Looking Good Langley City!

Sendall Gardens is a horticultural treasure. Our BC CiB Ambassador Catherine regularly walks through this natural park that features a few seasonally planted garden beds.

We would like to say 'Looking Good' to the park's maintenance staff and the Municipality of Langley City for this lovely space.

Volume 19 Issue 05 May 2024

GROWING Great Places TOGETHER

SHOWCASE PROGRAM

Showcase a Place or Project that is unique to your community.

Get recognition for special green spaces or community enhancing projects.
This is also a great opportunity to acknowledge volunteers and service groups.

How to Get Involved:

- Submit a Showcase Entry with 3 photos and a 250-word description.
- Register in the appropriate population category before Aug. 31, 2024

Details:

- All entries will be featured in the BC CiB Growing Together Newsletter, website and social media as they are received.
- All entries will receive special recognition and a frameable certificate if submitted before August deadline.
- **Prizes will be awarded for three outstanding submissions.**
- Photos must be from the 2024 season.
- Submit 3 of your best photos with full rights in high resolution (a minimum of 300dpi at print size or a minimum weight of 800kb). These photos will be used by BC Communities in Bloom for the promotion of your community and the BC CiB Program.

CiB Cef
British Columbia Communities in Bloom
www.bccib.ca

CITY OF COQUITLAM – TREE SPREE EVENT as featured in the BC CiB Growing Together Newsletter Oct, 2022 issue.

LAKE COUNTRY GARDEN CLUB Xeriscape, Pollinator Garden with bug hotel project as featured in the BC CiB Growing Together Newsletter Aug 2023 issue.

To be recognized in this year's BC CiB Provincial Awards, please enter **before August 31**

CATEGORY		POPULATION	FEE	+ 5% GST
Individual Membership	1	1	$20	($21.00)
Small OR Club/Group	2	up to 1000	$50	($52.50)
Medium	3	up to 10,000	$100	($105.00)
Large	4	up to 20,000	$250	(262.50)
Ex-Large	5	20,000+	$500	($525.00)

PROJECT NAME:	
Name of Individual, Group or Municipality	
City/Province/Postal Code:	
Contact Person	
Phone	Email (required)
Social Media/Facebook	Website
Please supply a Description (250 words Maximum) and three JPEG or TIFF photos (Ideally 1MB each)	

Category #_____ FEE $ _____+ GST 5% = _____

☐ **New Option:** PAY BY CREDIT CARD at www.bccib.ca
and send email of completed form to c.kennedy@telus.net

☐ Form and Fee enclosed
Cheque Payable to:
BC Communities in Bloom
19951 Fraser Highway Langley, BC V3A 4E2

☐ Please invoice and send form to: c.kennedy@telus.net

FOR OFFICE USE ONLY:

☐ Fee Paid online

☐ Fee Paid by cheque

☐ Sent Invoice
#_____

www.bccib.ca
604 576-6506

FOR INFORMATION CORRESPONDENCE

DISTRICT OF
Logan Lake
Discover our Nature

BC CLIMATE ACTION COMMUNITY 2015

PO Box 190, #1 Opal Drive
Logan Lake, BC V0K 1W0
P: 250.523.6225 F: 250.523.6678
www.loganlake.ca

May 6, 2024

File: 4900.03

The Honourable David Eby, MLA
Premier of the Province of British Columbia
premier@gov.bc.ca

Delivered *Via Email*

Dear Premier Eby:

Re: Support for Bill-34

District of Logan Lake Council at the April 2, 2024 Regular Meeting, passed the following resolution:

> *"THAT Council send a letter in Support for Bill-34 and the Restricting of Consumption of Illegal Substances Act."*

The District of Logan Lake supports Bill-34 and believes this is a necessary step in addressing the ongoing crisis of drug addiction and overdose in our community. By restricting public consumption of illegal substances, we can create a safer and more welcoming environment for all residents, including children and families.

We feel that public spaces should be freely enjoyed by all community members and used for their intended purpose. While Council acknowledges that no person should feel compelled to engage in substance abuse alone and privately, but this should not come at the expense of degrading our public spaces.

Yours truly,

Laurel Grimm
Director of Corporate Affairs

LG/sv

B.C. Municipalities and Regional Districts
Dan Albas, MP Central Okanagan-Similkameen-Nicola
Jackie Tegart, MLA Fraser-Nicola
District of Hudson's Hope

FOR INFORMATION CORRESPONDENCE

Dear Mayor and Council Members

My name is Noams (Noah) Friss and I am an experienced and motivated Paramedic.

My Family and I moved to 100 Mile House area recently and I have noticed the stressors placed upon the medical community, including the ER, in town. I think some of the issues arise mostly from:

1. Increased demand for medical services.
2. Medical short staffing or vacant positions.
3. Natural accessibility issues living in rural and remote areas.

Coming from rural communities myself, I struggle with the idea of areas that are, or may become burdened with moderate to severe health problems and hinder the quality of life of the residents. From personal experience I know this is a serious problem with (older) generations moving around the area, or having to relocate altogether.

I want to put forth my candidacy to serve as a Community Paramedic. Some of the immediate benefits a municipal Community Paramedic would provide, could include; (but certainly not limited to)

1. The ability to apply specific medical and health protocols that take in account our unique environment and population.
2. A personal touch to patient care and inclusive access for patient contact.
3. Intimate knowledge of the area and access roads.
4. Unconventional work schedule and flexibility.

Persons that will register for the initiative will be able to access services such as; (but not limited to)

1. In-person, at home comprehensive medical assessment.
2. With an associated Physicians consultation, a tentative diagnosis and health plan formation.
3. Non-emergency treatment, if needed, under the supervision and guidance of an associated Physician.
4. Prescription collection/instruction/education etc, for medications, with an associated Physicians consultation.
5. If necessary, respond to and provide life saving procedures and measures.

This initiative will benefit not just individuals within our community, but the town and surrounding areas as a whole. It will decrease the burden to the existing health care providers and will prove to be an example for all other municipalities struggling with the same issues.

I will gladly provide any additional information about my education, knowledge, abilities and experience.

Please feel free to contact me either by:

[redacted]

Thank you very much for your time,

Respectfully

Noams (Noah) Friss.

FOR INFORMATION CORRESPONDENCE

Subject: FW: Wildfire Prevention and Suppression

From: Alex Pawliuk [redacted]
Sent: Thursday, April 25, 2024 11:43 AM
To: District of 100 Mile <district@100milehouse.com>;
Subject: Wildfire Prevention and Suppression

To: The Mayor and all Councillors of British Columbia's Municipalities
Hello Dear Council Members:
With recent wildfire experiences in many parts of Canada I thought all elected Members of British Columbia's Municipalities may be interested in these Wildfire Prevention and Suppression suggestions and observations. They can be easily applied in your area of B.C.

Am sending the following suggestions to B.C.'s EMCR Minister, Bowinn Ma and to the B.C. Ministry of Forest, B.C.'s elected officials and Canada's MP's in hopes with your help, we can safely with lower costs, substantially improve our Wildfire Prevention and Suppression while reducing our CO2 emissions.

I am a retired senior with over 50 years of varied coastal forest industry experience including engineering, management, helicopter salvage of dead or dying timber and even participating in disaster planning exercises held at Arnprior, Ontario by Civil Defence Canada.

I am quite concerned that recently many are now advocating a policy of widespread prescribed burning of flammable forest biomass debris, which creates much CO2 pollution, is costly and there is always the danger of wildfire escape as past history illustrates.

As a sustainable, environmentally friendly and potentially profitable alternative, I believe wherever possible we should try to mulch and collect and utilize the flammable biomass fuels as a valuable feedstock resource for further process into biomass pellets and briquettes.

It is very possible that Drax and or other biomass pellet companies would be interested in helping to develop the field practices and purchase the biomass feedstock.

FYI I've attached a 5 page PDF with a more detailed description of the suggested policy and system to help improve the safety, effectiveness and costs of B.C.'s Wildfire Prevention & Suppression.

Thank you for your consideration of my suggestions.

Best Regards,
Alex Pawliuk

[redacted]

To Whom It May concern:

Consider Managing for Safer, Lower Cost Prevention and Outcomes of Wildfires by Using;

- **"Primary Firebreaks"** with the flammable biomass debris removed and wide reaching water sprinkler systems installed where possible.

- **"Quick Detection"** by increasing ground and aerial fire patrols aided with real time monitoring with infrared satellite Imaging.

- **"Prompt Effective First Response"** with large volume 4,000 to 6,000 gallon plus aerial water or retardant drops as opposed to the current use of small volume drops or monsoon buckets.

Natural Resources Canada reports:

http://www.nrcan.gc.ca/forests/fire-insects-disturbances/fire/14444

"On average, 8,600 wildfires burn 2.5 million hectares in Canada each year, often threatening communities and resulting in the evacuation of residents and sometimes the loss of homes."

Only 3% of all wild land fires that start each year in Canada grow to more than 200 hectares in area. However, these fires account for 97% of the total area burned across the country.

Fire suppression costs over the last decade in Canada have ranged from about $800 million to $1.5 billion a year.

In 2023: *https://cwfis.cfs.nrcan.gc.ca/report*

"According to the Canadian Interagency Forest Fire Centre National Fire Summary, 6,623 fires have been recorded nationally in 2023, burning a total of 18,401,197 hectares (ha). For comparative purposes, the total number of fires and area burned last year (4,883 fires; 1,467,970 ha), and the 10-year average (5,597 fires; 2,751,161 ha) as reported in the Canadian National Fire Database (CNFDB). According to the CNFDB, in terms of area burned, this year was the highest ever recorded with the previous recorded in 1989 (7,597,266 ha)".

"British Columbia saw the most wildfires so far this year (2,245), followed by Alberta (1,022). British Columbia (2.82M ha), Alberta (2.52M ha), Northwest Territories (4.16 M ha), Saskatchewan (1.85M ha), and Quebec (5.03 M ha) each had over a million hectares burned. Estimated area burned was above the 10-year average in British Columbia, Yukon, Alberta, Northwest Territories, Saskatchewan, Ontario, Quebec, Newfoundland, New Brunswick, Nova Scotia, and Parks Canada, but lower than average in Manitoba and Prince Edward Island.

The total area burned may change as provinces and territories continue to map their respective fires."

Forest fires can be caused by natural events like lightening, accidently by power line faults, friction, explosions or sparks, and unfortunately very often by human carelessness or lack of an individuals fire safety knowledge and practices.

It has become a generally accepted view that as a result of changes in atmospheric levels of Green House Gases (GHG's) a global warming of earth's climate conditions is now under way. The resulting increase in naturally occurring dry flammable organic fuels in our forests and grasslands is expected to continue to lead to an increase in number and severity of wildfires in the areas surrounding many Canadian and global rural communities.

Many small communities including 1st Nations can be at greater risk, as they often are located in remote areas surrounded by forests that can be frequently threatened by out of control wildfires. As a result thousands of people are forced to evacuate each year with many residents facing personal threats to life and property as well as the potential severe environmental, economic and social consequences for the communities they live in.

My Personal Observations:

In 1969 while working in the Forest Engineering Dept. at MacMillan Bloedel's, Sproat Lake Division in Port Alberni, B.C., Canada, as a standard practice we planned for, established and maintained ½ mile wide "Primary Firebreaks" with the purpose of surrounding and separating active log harvesting areas of + - 4,000 to 8,000 acres into more manageable fire protection units in case of wildfire and or operationally caused forest fires occurring in the more flammable post logging slash and dry bio-mass debris.

The "Primary Firebreaks" were planned into lower risk landscapes, when ever possible using; mature Hemlock dominant stands and or deciduous inclusive stands containing low amounts of ground level fuels as well where possible inclusive of lakes, rivers, creeks or rock bluffs, all of which could help reduce forest fire flame spread.

The "Primary Firebreaks" (other than thru access roads) were to stay intact and unlogged until the adjacent second growth stands were old enough to serve the same purpose.

As well during "Fire Season" we did daily after-shift ground and aerial fire patrols of all operating areas, and did the same during periods of lightening strikes.

If we observed any signs of smoke or fire we could act quickly to call in the Mars water bomber to do 6,000 gallon drops until the fire was out or under control, and well before it could grow unmanageable in size and too out of control and dangerous for the ground based fire suppression crews.

A combination of preventative measures, quick identification, location & response using readily available appropriate technology and common sense helps ensure the safest, lowest cost wildfire prevention, mitigation and defense.

The idea being if we had an operationally caused or natural forest fire, our "Primary Firebreak" units with lower flame spread potential, helped our fire suppression crews efforts and the locally available 6,000 gallon Mars water bombers to quickly gain control of fires before they could spread to become dangerous, expensive and large out of control wild fires.

We need a modern version of water bomber type aircraft with the "Mars 6,000 gallon capacity". Its "Effective Volume of Water or Retardant" combined with "Early Detection", "Prompt Response and use of "Primary Firebreaks" worked really well for us and as a result we had very few run away wildfires occur.

I am confident that using the **"Primary Firebreak**" approach to encircle and protect communities, or important infrastructure and residences, augmented with high volume sprinkler systems where-ever possible will pro-actively and safely help to protect residents and land owners from out of control wild fires, saving lives, loss of property and building assets at the lowest possible cost.

"Primary Firebreaks" Should:

1 - be ½ mile (or wider) to encircle a subject community or protect an infrastructure and narrower if necessary for isolated residential and farm buildings.

2 - also be used to divide and isolate drainages or forest areas into smaller potential compartmented wildfire areas surrounded by semi-natural fire stops.

3 - be of less flammable stands like mature Hemlock trees and deciduous inclusive stands preferably that have been thinned, spaced and pruned.

4 - be inclusive of adjacent lakes, rivers, creeks or rock bluffs, all of which could help reduce a forest fires flame spread.

5 - if where sufficient water supply is available, be equipped with an effective far-reaching sprinkler system preferably elevated on poles or posts, with an independent back up system including generator.

6 - contain low amounts of, or be cleared of easy to ignite ground level bio-mass fuels and woody debris.

7 - Where-ever possible the easily flammable leaves, needles, branches and woody debri should be collected and mulched for processing into biomass pellets or briquettes for companies like Drax or other producers, **as opposed to prescribed burning which should only be the last option**. Prescribed burns do not make sustainable use of our existing resources, they cost money, create pollution and can be dangerous particularly if they escape.

The 5 links below are just a few equipment types & or companies that could be used by existing local Forestry Silviculture crews for "**environmentally friendly and hopefully profitable",** self funded bio-mass recovery from the naturally occurring leaves, needles, branches & woody debris they may collect and recover while establishing Primary Firebreaks.

Thank you for considering my suggestions regarding "Wildfire Prevention and Suppression".

Regards, Alex Pawliuk
Cell: 1-778-229-2640
Email: aopawliuk@gmail.com

https://www.billygoat.com/au/en_au/products/debris-loaders.html

FOR INFORMATION CORRESPONDENCE

Centre for Rural Health Research
rigorous evidence for sustainable rural health services

BCRHN
British Columbia
Rural Health Network

Advancing Rural Community Engagement in Health Care Planning: A Gap Analysis

Executive Summary

Background

People living in rural BC are often not involved in health services planning for their communities. This means that these communities might not get the health services they really need, and it makes people feel less involved. This lack of engagement also means that valuable input from rural residents is missed.

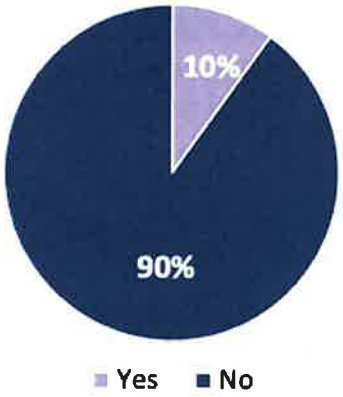
Methods and Approach

1. An electronic survey to people who live in rural areas across BC. There were 22 questions including yes/no questions, scale ratings, and multiple-choice questions with space for extra comments. Survey responses were collected over 4 months from June 20 – October 20, 2023. We received 707 responses to the online survey.
2. We also interviewed 10 health decision makers at both regional and provincial levels, and 14 community leaders from rural areas.

Overview of Survey Findings

Most of the people who filled out the survey lived in the Interior Health Authority, with others from Vancouver Island Health Authority, Northern Health Authority, and Vancouver Coastal Health Authority. There were 4 respondents from Fraser Health, 3 respondents from outside BC and 96 did not say where they were from.

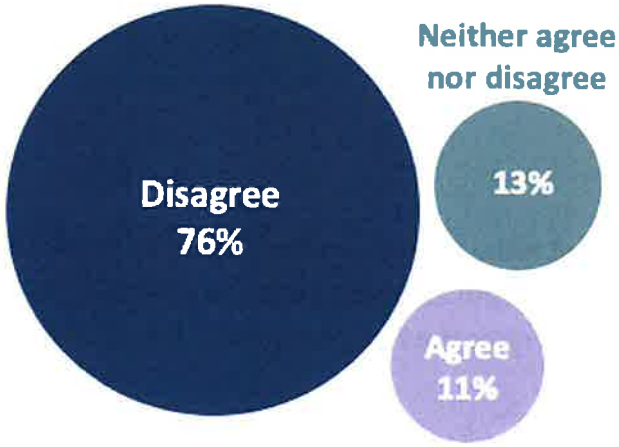
"Do you feel that your community's healthcare needs are adequately represented in the healthcare planning process?"



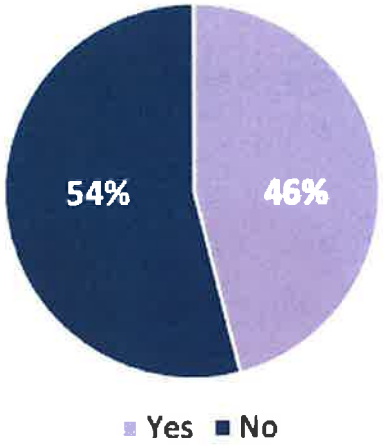
People who felt unrepresented shared three major concerns:

1. Many said there wasn't a good way for them to share their opinions on health planning. They felt left out of decisions and said there wasn't a good way to work with health authorities.
2. Many said that they thought health planning tends to focus more on cities, leaving rural areas feeling overlooked. This approach doesn't fit well with the unique needs of rural communities, and there's not enough local power to make quick and effective changes. There is not enough information about the experiences of rural residents.
3. There isn't a good system to make sure that rural health authorities are accountable and engage with communities effectively. People noticed a lack of follow-up after they provided their input.

"Do you agree that your community's needs are met through the health planning process?"



"Have you been engaged in healthcare planning in BC?"



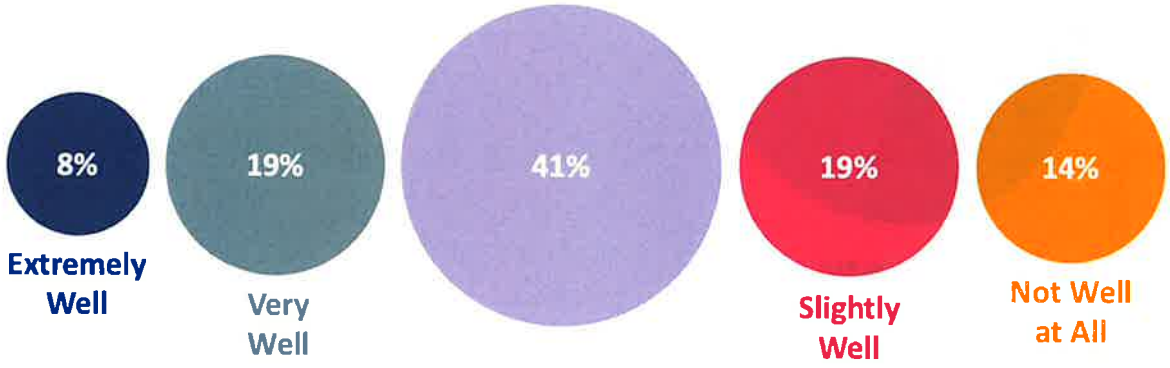
- The way they were engaged included public meetings, workshops and forums, writing letters, participating in town councils or sitting on local health boards, or participating in local planning as a local leader who was elected.

Suggestions for improvement:

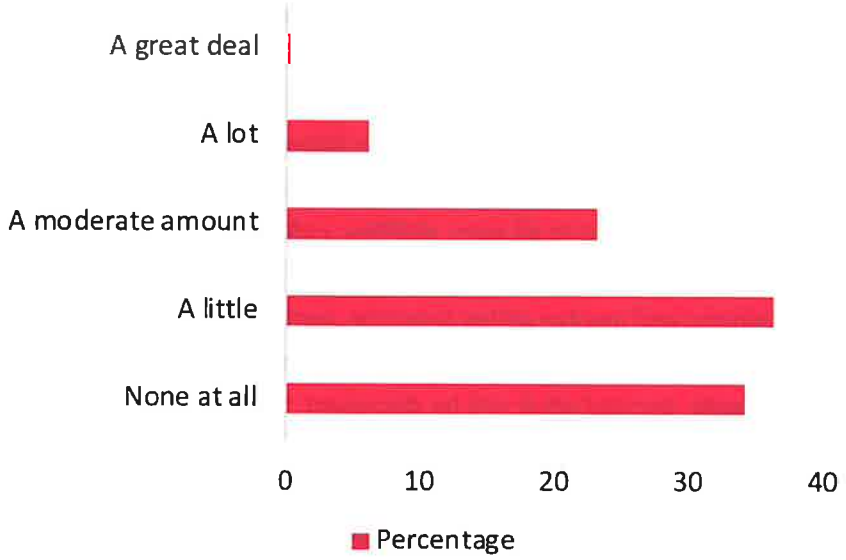
- Many people who filled out the survey mentioned that an engagement process that includes local, regional and provincial participants is needed.
- Engagement processes must focus on **diversity and inclusion**. Participants who do not usually have a voice in decision-making need to be given the opportunity to be heard so that there is more effective communication between communities and decision-makers. Engagement events need to be accessible to all ages, abilities, cultures, education levels and languages.
- Engagement must be meaningful and involve active listening, continual engagement and action being taken in response to the findings. Decision makers must listen to community members without having already decided what will be discussed. Decision makers must be open with community members and understand what it is like to live in a rural community.
- **Hold more community meetings:** Have more gatherings where people can share their thoughts and learn what's going on.
- **Change how services are managed:** Let local people have more control and be involved in managing their health services.
- **Better communication:** Make sure when health leaders and community members talk, both sides listen and respond to each other.

- **Update how healthcare is handled:** Start using new methods that try to solve problems before they get big.
- **Check on progress:** Set up ways to ensure what was promised is happening.

"How well-equipped are you to engage in healthcare decision-making about issues that concern your community?"



"How much confidence do you have in healthcare decision-makers making decisions that will be best for your community"

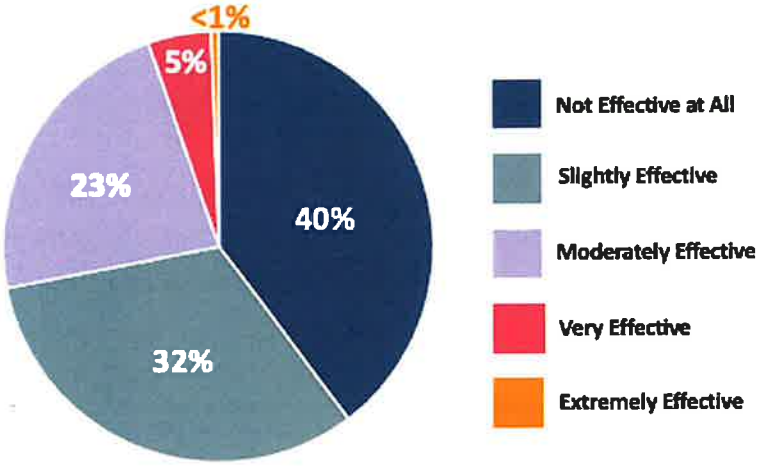


- 86% felt needs and concerns were not genuinely acted upon. There are too many confusing systems in place that make it hard for people to know where to go or who to talk to about health services. People don't have enough opportunities to tell leaders what

they need or what their worries are about healthcare. When people do give their opinions, they often don't see any clear changes happening because of what they said.

- There isn't enough money and resources that are needed, which makes it hard for healthcare workers to do their jobs well.

"How effectively are policies communicated to you in a way you understand"



- 89% of participants said that their language and culture did not affect their ability to understand policies.
- 85% felt that communication with communities regarding health policies was not effective. They felt that there is no way to openly communicate with health authorities, their communication with decision makers only goes one way, and many of the methods for communication no longer exist because their funding was lost.
- The participants who felt like the communication was enough still felt as though communication happened too late, usually after the policy had already been made. When information is shared, it is usually not easily available to everyone. Communication is usually more about politics than facts.
- Some felt like they were given information when it was needed, and they received enough information from the Health Authority.

"Is there anything you would like to add?"

157 people responded:

Problems with how healthcare is politically organized:

- Healthcare is too centralized and ignores the different needs of each local area, especially in rural places. It usually focuses more on urban areas and does not account for what living in rural BC is like.
- There are concerns that private companies might get too much influence over healthcare, which could lead to healthcare becoming more about making money than helping people.
- Leaders are not held accountable. There is often a difference between what they say compared to what is done. There is not an effective structure for holding decision makers accountable. Decisions are being made because of politics rather than facts.

Models of care:

- Primary Care Networks were disappointing. There was little to no effective engagement.
- Community Health Centres are needed. Community Health Centres have a rule to respond to the needs of the community.

Responses specific to a region: (Most of these are form the North)

- Larger cities are prioritized in healthcare.
- Virtual care is challenging when some areas do not have access to good cellular and internet connection.
- Rural community members must be asked about what policy and healthcare would be best.
- Some people said that there has been progress, but they still want to be more involved.
- Some people were grateful to fill out a survey, while others said that there needs to be more action rather than just talking about the issues.

Rural Community Leaders' Experiences of Engagement in Health Planning in BC

- 14 leaders were interviewed. These leaders were mostly from Northern Health, Interior Health, Vancouver Coastal Health. Two of these leaders were in roles where they work with the whole province.
- Holding decision makers accountable ensures that mistakes are dealt with.
- Having communities involved could improve accountability.
- Communities should be paid back when they must cover gaps.
- When decisions must go through many steps before they are put into action, it's hard to know who is responsible if things go wrong. This is because many people are involved and there are often changes in who is handling what. People who manage parts of a large

organization can sometimes make things slow and complicated. In big organizations, it's tough to talk clearly and make sure everyone understands each other.

- Participants felt that too much control and ownership by institutions can hurt creativity and new ideas. They talked about problems in healthcare that vary by region and said that big changes are needed to make sure people are responsible for their actions. Many described the healthcare system as "broken." Initially, there was hope that Primary Care Networks (PCNs) would improve responsibility, but this hasn't happened.
- When communities are engaged on a project, this creates a better relationship between the community and the health authority.

Ways to ensure health authorities are held accountable:

- Using local media to get the attention of the decision-makers.
- Writing letters to decision makers was a common strategy.
- Many participants mentioned that rural communities and residents across the province must unite so their voices are heard, and change is made. Many mentioned that the BC Rural Health Network plays an important role in this.
- Progress in getting people involved must be shown by having regular meetings, updating agreements, and changing local budgets to support working together.
- People found informal group discussions and taking part in regional panels helpful. However, there's still uncertainty about what these efforts will achieve and their overall impact.

Larger solutions:

- People suggested a total makeover of the system, beginning with money for changes to healthcare.
- They talked about setting up clear signs of accountability (for example, in official documents) that include expectations for participation.
- Others thought it would be good to give local governments more power in planning and providing health services to better meet local needs.
- Some even suggested going back to the previous system of local health boards and councils.

Community Advocacy:

- Participants pointed out that it's important for decision-makers to really know about the local community and to value the real experiences of people living in rural areas.

- They saw a big need for lots of community members to be involved in planning and making decisions, and for connections between different parts of the community and healthcare system.
- They stressed that including everyone is key to successful involvement at the community level. People also felt a need to educate themselves and their community about issues that matter to them.
- Some people struggle with using digital tools, which makes it hard for them to join in on conversations and decisions. Respondents mentioned that sometimes they must be forceful to get noticed, but they also need to keep open to working together.
- Some described this as a "constant fight".
- Some described taking action on their own through local advocacy as a response to not seeing changes initiated by others.
- There was also a positive note about community advocacy, particularly when health authorities take part in regular meetings, which helps create a direct connection to decision-making.
- However, they noted that any actions resulting from community involvement are often slow and lack proper follow-through.

Engagement:

- People expressed dissatisfaction and frustration with their interactions with decision-makers. Many of these decision-makers were new to their roles, and high turnover rates led to a lack of action being taken.
- There is a struggle with how slowly practical responses to community needs happen.
- There aren't clear standards for how to engage with the community effectively.
- Health Authorities often don't have enough information about the specific healthcare needs of rural communities.
- Some suggested that local elected officials should receive more training to improve their interactions with Health Authorities.
- Participants said there should be more public involvement, both in casual and formal settings.
- Creating roles that connect leaders at the municipal, regional, and provincial levels could help link their activities better.
- The large areas covered by health authorities make it hard to engage with and respond to community needs because of the great distances between communities and decision-makers.

- Virtual communication tools can help overcome the challenges of distance. The COVID-19 pandemic led to more regular virtual meetings, which improved communication.
- However, there is still a problem with a lack of action and follow-through after communities engage with decision-makers.

Vulnerable populations:

- Many noted that services need to meet the needs of vulnerable people in the community.
- It is important to include individuals who are not usually included in conversations.

Health Planning focused on urban areas:

- Leaders said that often health planning only focused on cities.
- It was noted that decision makers are disconnected from rural communities and rural communities are not engaged with. Many decision makers do not understand what living in rural BC is really like.

Policy and Decision-Makers Experience of how change is made in British Columbia:

Main themes: How decisions are made during a health care crisis, how data is used in making decisions, good leadership is important, the challenges of planning health services for rural communities, and the impact of politics and elections on health care.

Making decisions during a healthcare crisis:

- All the policymakers noted the challenges the BC Healthcare system is facing and said they wanted to make improvements.
- Making sure that the changes made are meaningful is challenging because decisions are made by elected officials.
- They said that it was important to use data and community engagement to make decisions.
- Healthcare changes are influenced by the guidelines or 'health mandates' laid out by the Minister. Different views from various groups within the healthcare system can make it hard to put these changes into practice.
- The disconnected nature of British Columbia's healthcare systems could be bettered by fostering stronger relationships.
- Policy leaders talked about making changes by looking at the system as a whole, understanding what the population needs, and considering the availability and

management of healthcare workers, which involves practical and budget-related decisions.
- Limited funding and resources make meaningful change challenging.

Using data to make decisions about healthcare:

- Policy makers use numbers to understand how the current system is working and what needs to change.
- Numbers can be used to identify the needs, how to best deliver a service, and demonstrate a need for more funding.
- Numbers do not show us what healthcare in rural BC is really like for rural residents.
- It is hard to use stories and experiences to make changes in the current system.
- Many leaders said they must be careful when they engage with rural communities because it might give them expectations they can't meet.
- Policy makers said that they want all patients to get good quality care.
- Surveys and committees are used for patients to engage with policymakers. It is challenging to decide the quality of care that is necessary and have policies that make sure the needs are met.
- Not very many leaders mentioned that community engagement was important.

The importance of leadership:

- Having policy makers and leaders in the Ministry of Health want to improve the healthcare system is the first step.
- Many want to make policies better and advocate for change.
- Many looked at the long-term goal and how they can make these changes last. This would stop people from repeating the same work and rather focus on new areas of change.
- Many participants said they must focus on the immediate needs of the healthcare crisis. They said they need a way to learn about and advocate for the needs of the health authority and the ministers.

The challenge of rural health service planning:

- Low patient volume in rural health sites lead to health centers not having enough staff, expertise or technology to provide quality care.

Challenges applying urban successes to rural communities:

- Many leaders mentioned that policies need to be flexible to account for the uniqueness of different areas in BC.

- Success in one rural area may be challenging to apply to another rural community.

The impacts of politics and elections on healthcare:

- Ministers are not driven to make changes to healthcare if it is not supportive of their political goals even if there is evidence saying it is needed.
- Leaders are more likely to go for solutions that will help them in the upcoming elections.
- Changes to the system must be based on collective needs, rather than the needs expressed by an individual.
- Politicians can ignore facts and data because of politics.
- Many are reluctant to make big changes because of politics and how complicated it is to make change.
- Advocating for change is challenging when healthcare resources are limited.

Recommendations:

Community Engagement and openness:

- Each rural health authority should have a unit dedicated to community engagement.
- There needs to be systems for reports and information to be shared honestly.
- Communities should have a board of advisors to inform decision makers.
- Organizing annual community health forums and implementing feedback loops that include patient and community storytelling are ways to improve engagement and communication in healthcare. By holding these forums every year, communities can consistently discuss their health needs, share updates, and provide feedback directly to healthcare providers and decision-makers.
- Annual community health meetings should take place.
- There should be opportunity for patient/community storytelling.

Collaboration and knowledge sharing between rural Health Authorities:

- There should be a way for knowledge to be shared between health authorities.
- Conferences and workshops should be held.
- Transparent roadmaps of implementing change are needed.

Overcoming Political and Bureaucratic Challenges

- 'Policy Sandbox" Approach
- Public accountability measures

Effective Communication with rural and remote communities

- There should be teams in the Rural Health Authorities who are dedicated to outreach.
- Local media can be used to communicate with rural communities.
- Consulting with communities should be regular and ongoing.
- Better digital technology is needed to ensure effective virtual engagement.

Advancing Rural Community Engagement in Health Care Planning: A Gap Analysis

Abstract

Background and Study Goal:

Many people living in rural areas in British Columbia feel that they are not involved in healthcare planning. This means their ideas and needs are often overlooked, which makes them feel disconnected.

How We Studied This:

We used two ways to gather information for this study. First, we talked with people online who make decisions about healthcare. Second, we asked people living in rural BC to fill out an online survey about their experiences.

What We Found from the Survey:

Most of the people who answered the survey (90%) felt that the healthcare planning did not really reflect what their community needs. They mentioned that there aren't enough ways to get involved, that the planning often focuses too much on cities rather than rural areas, and that the people making decisions aren't held accountable. Many said that the current way of planning doesn't meet their community's needs and that it's hard for them to trust those in charge. They also talked about how political issues can get in the way of making the right decisions for rural residents. Many mentioned that it was important for them to be able to share information with those in charge but also for those in charge to share information with them.

What Rural Community Leaders Told Us:

Community leaders from rural areas said it's very important for decision-makers to listen to community members. They said that decision makers should have to engage with communities. They believe that local voices can lead to more positive change than waiting for those who in government to do something.

They also mentioned problems like being too far from decision-makers and not enough follow-up actions after they try to get involved. They also talked about needing special ways to include people who might be left out or feel unsafe speaking up. Local leaders think health planning often focuses too much on cities, which leaves rural areas feeling even more disconnected from decision makers and the rest of the province.

What the Decision and Policy Makers Said:

Decision makers recognized that making decisions during difficult times, e.g., during the COVID-19 Pandemic and as we struggle to find enough healthcare providers, is challenging. They want to make improvements but find it hard to balance different needs and opinions. They recognized that using numbers to figure out what services are needed is important, but they said that real-life stories from rural residents might help them understand the current challenges better to make change. They mentioned challenges like not having enough medical staff or the right facilities and equipment in rural areas to provide quality care. They also said it's hard to duplicate solutions and ideas from one rural place to another. They mentioned that elections and politics often influence the speed of changes in healthcare, which can prevent long-term solutions.

Recommendations for the Future:

We must create better ways for rural communities to get involved and make sure decision-makers are clear and open about what they are doing. There should be more sharing of ideas and collaboration between different healthcare areas. We need to find ways to address challenges associated with policy and bureaucracy and to better reach out and communicate with people living in rural and remote areas.

Results from UBC Centre for Rural Health Research/BC Rural Health Network Gap Analysis study

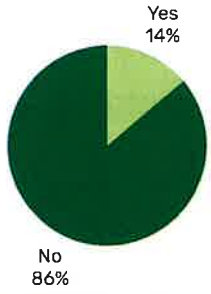
NAVIGATING THE GAPS

RURAL COMMUNITY ENGAGEMENT IN HEALTHCARE PLANNING IN BC

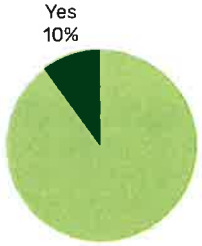
BCRHN British Columbia Rural Health Network

HOW DO RURAL COMMUNITIES FEEL ABOUT RURAL COMMUNITY ENGAGEMENT IN HEALTH CARE PLANNING?

"Do you feel that your needs and concerns are genuinely considered and acted upon?"



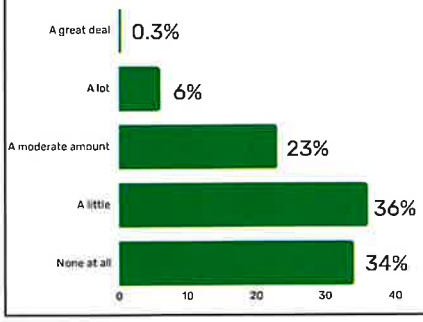
"Do you feel that your community's healthcare needs are adequately represented in the healthcare process?"



WHY?

- **Lack of mechanisms for engagement**
- **Urban-oriented healthcare planning**
- **Lack of decision-maker accountability**

How much confidence do you have in health care decision-makers making decisions that will benefit your community?



WHY?

- **Lack of an engagement process**
- **Lack of visible consequence to output given**
- **Lack of acknowledgement by decision-makers for communication**

"How can my needs and concerns be acted upon if I wasn't asked for input?"

"[We] have been giving input for years, and nothing is getting better"

What can be done to improve the engagement process?

Establishment of an engagement process that includes local, regional, and provincial participation

Approach engagement through a diversity lens and correct power imbalances

Increase *authentic* engagement through active listening, repeated engagement, and responsive actions

Decision-maker exposure to rural community life and an alignment of values

Funded by: sparc bc people. planning. positive change.

Results from UBC Centre for Rural Health Research/BC Rural Health Network Gap Analysis study

NAVIGATING THE GAPS

RURAL COMMUNITY ENGAGEMENT IN HEALTHCARE PLANNING IN BC

BCRHN British Columbia Rural Health Network

RURAL COMMUNITY LEADERS PERSPECTIVES ON ENGAGEMENT IN HEALTH CARE PLANNING

POOR ACCOUNTABILITY	• There is a lack of mechanisms for accountability • Challenges in effective engagement and accountability due to bureaucratic organization of decision-making and regionalization
COMMUNITY ADVOCACY	• Need for the inclusion of locally-derived solutions in decision making • Local advocacy-based change is filling in gaps left by decision-makers
URBAN-CENTRIC POLICIES AND DECISIONS	• Urban-centric decision-making prevails due to disconnect between rura communities and decision-makers • Decision makers lack understanding of rural life
LACK OF FOLLOW-UP AND FOLLOW-THROUGH	• Lack of availability of decision-makers and high turnover makes engagement and follow-up challenging • There is a lack of action from decision-makers following engagement
DIVERSITY OF ENGAGEMENT	• There is a need to tailor services to meet the needs of vulnerable communities • Implementation of different modes of engagement for diverse populatio is needed

DECISION-MAKERS PERSPECTIVES ON RURAL ENGAGEMENT IN HEALTH CARE PLANNING

Decision-Making During a Healthcare Crisis

- Decision-makers recognize challenges facing the healthcare system
- There are challenges in decision-making due to diverse interests of stakeholders
- Fiscal and resource constraints limit meaningful change

The Use of Data in Decision-Making

- Decisions are often guided by quantitative research
- Decision-makers recognize the need for qualitative research using community engagement

Challenges in Rural Health Service Planning

- Resource-based constraints and clustering of resources in large urban centers leads to barriers in rural healthcare
- There is a need for a more flexible approach in policy and decision-making

Impact of the Electoral Process on Health Care Reform

- Decision-making collides with politics
- Solutions appeal to public interests for elections
- Decision-makers emphasize importance of system change based on aggregate need

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Advancing Community Engagement in Healthcare in Rural BC:

A gap analysis to improve community involvement in healthcare planning

2024

February 1, 2024

Final Report

UBC

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Table of Contents

Message from the Project Team

In 2020, the Centre for Rural Health Research (CRHR) undertook a provincial survey to understand and document the healthcare priorities of rural communities across British Columbia (BC).* Although the findings were as expected regarding health care concerns for rural communities (lack of access to primary care, support for aging in place and subsidized transport), the open-text boxes for additional comments yielded an unanticipated finding: general dissatisfaction over engagement with health care policymakers and planners and the consequential desire for better mechanisms of communication. At the same time, the BC Rural Health Network (BCRHN), a pan-provincial, community-based organization advocating for issues of concern to and identified by rural communities, was gaining traction due to their strategic approach of bringing community issues forward within a solutions-based framework. Through intensive outreach activities, the Network was also witnessing the growing disillusionment of rural communities who expressed the desire for connection with policy and decision-makers. The alignment of values and complementary approach of the two organizations – the former focused on creating a robust evidence base for rural health care planning and the latter working at a grass-roots community level to inform decision-making through the experiences of rural communities – led to a natural and productive relationship. The two organizations partnered to form the BCRHNs 'Implementation Committee', an open and virtual provincial group that meets regularly to focus on issues of concern to rural communities and, importantly, develop position statements to share with regional and provincial decision-makers, social service agencies and, where appropriate, the media.

It was based on this natural alignment of interests and productive confluence of weaving evidence with advocacy, that the two organizations committed to further understanding how to bridge the gap between rural community evidence-based advocacy and including these voices in policy and planning. Although the 'end-game' objective was to develop a provincial platform to allow such communication to flow, conversations with SPARC alerted us to a need for a preliminary step: to understand and document the organizational barriers faced by policy and decision-makers that made the inclusion of such experience-based data difficult. We recognized this to be a missing piece and a necessary antecedent to the proposed communications platform. That is, if we did not thoroughly understand the *cultural* challenges of the uptake of community solutions for health care planning, the *structural* solutions would be ineffective. Given this, we set out to work with regional and provincial policy and decision makers to understand the institutional, cultural, and practical realities of engaging with rural communities for the purpose of health care planning. A core value held by both organizations was the

* Kornelsen, J., Carthew, C., Miguez, K. et al. Rural citizen-patient priorities for healthcare in British Columbia, Canada: findings from a mixed methods study. BMC Health Serv Res 21, 987 (2021). https://doi.org/10.1186/s12913-021-06933-z

recognition that those in public service had the best of intentions to actualize the provincial commitment to community-based planning but were constrained. That is, we clearly recognized the commitment of decision-makers to do the best job they could.

Through the initial stages of the project, however, we heard the assertion that there *was* successful and effective community outreach occurring in parts of the province and on discrete topic areas both by regional and provincial governments, but also through arms-length agencies that report back to the Health Authorities and Ministry. As this was not congruent with what CRHR had found through previous research and what the Network was learning through their outreach initiatives, we determined the emergent need for more robust data on community experience and quickly developed an online survey to gather these data. The survey was intended to provide context for the focus of the research, understanding and documenting the experience of municipal, regional, and provincial leaders. We had a solid response from across the province, slightly surprising given the niche topic of the survey. This led to a more fulsome process with leaders at all levels of governance and is a significant contribution to our understanding of community engagement in BC.

The efficacy of this study was based on the strength of the pre-existing relationship that has developed between the CRHR and BCRHN. The natural alignment seems obvious: robust evidence combined with grass-roots connection to ensure the practical utility of the data gathered and effective relationship-based knowledge translation *back to the communities*. This commitment to longitudinal engagement and returning data to the communities was a necessary starting point as it reflects the system-level commitment we are advocating for to actualize community-based planning.

We believe that the yield of this SPARC-funded work contributes meaningfully to building a culture of inclusivity and to the democratization of health policy and planning. However, it is still early days. We have already leveraged these findings to apply for and receive a small grant to do virtual regional engagement sessions with communities from across the province to take their direction on how the data should be used and what practical actions should be taken. This work will be occurring through the spring and will add to the initial findings presented in this report.

We – and the rural communities across BC that we have the privilege of working with – are profoundly grateful for the opportunity to better understand the issues at hand that the SPARC grant has afforded. We look forward to continuing to provide updates to SPARC and additional,

related projects enhance our understand and as we work with government to affect the evidence-based recommendation.

Sincerely,

Jude Kornelsen
Associate Professor, Department of Family Practice,
Co-Director, Centre for Rural Health Research

Paul Adams
Executive Director
BC Rural Health Network

Project Overview

This project was borne out of the respective experiences of both co-collaborators through feedback received from rural communities regarding both the innovative ways in which they are solving health service delivery challenges at a local level and their desires for their innovation to be recognized and integrated into system-level planning. Although the intention was to move towards the development of a provincial communications platform, helpful feedback from SPARC alerted us to the importance of understanding the *culture* of decision-making as until the normative values, constraints and enablers were understood, any communications platform would remain dormant. That is, we needed to understand the antecedents to and characteristics of the communications *gap*.

To this end, our immediate goal became to understand and address the gap between the outputs of rural community-oriented voice in policy and decision-making and its uptake in health planning at regional and provincial levels. We decided to do this by endeavouring to understand the *cultural change* that needs to need to occur in increasing the receptivity of the output of community-oriented voices into policy and decision-making. This is a significant task as much 'cultural' behaviour is normalized and stays in the background. However, we felt that with meaningful discussion we could elucidate some of the main influences. This would necessarily need to build from an understanding of the experiences of those 'at the coal-face'. This was done through the pressing desire to understand how diverse voices – those not usually heard but in urgent need of responsive services – are or can be blended into the provincial discussions without losing their authenticity. Ultimately, both organizations have directly experienced the integrity and idealism that most healthcare planners have when they undertake their responsibilities, so beyond culture, framed any 'gaps' around resources available.

This work is based on evidence of the importance of pluralistic health planning in identifying local priorities and needs; this is particularly relevant across rural communities that often suffer the consequences of centralized, urban-based decision-making. It is further underscored by the

role of the community voice in promoting equity and increasing engagement and trust in health services, whether they be embedded in the health and social system or private models of care, and the assumed relationship between equity and trust in improved health outcomes. The long-term goals of the project are to improve health outcomes, equity, and access in rural BC, through decisions and policies that respond to community-identified needs and health services priorities. We feel these fit well under SPARC's priority area of *'Systems Perspective and Impacts.'* Additionally, SPARC's mission to make research more open, efficient, and accessible aligns well with the goals of this analysis. SPARC has a strong track record of funding and supporting initiatives that promote open access to research, increasing collaboration between researchers and institutions, and advancing the use of innovative technologies in research. This, alongside SPARC's experience and dedication to supporting rigorous research, makes them an ideal funding partner to not only provide financial resources but also valuable expertise and guidance to help ensure the success of the project.

Addition of Survey Data

As noted above, pushback early in the project implementation to the contention that rural residents are not engaged in meaningful outreach across levels of policy and decision-making posed a challenge for the research team. That is, if there is no consensus with our research partners that there *is* in fact a lack of community engagement, it is very difficult to derive evidence-based solutions. To this end, we recognized early on the need to rigorously collect evidence and document rural community's experiences of engagement, not only to create a foundation for discussion with research partners, but also to ensure that we were not relying on anecdotal information based on our respective organizations' frames of reference. In retrospect, this was a strong and validating approach which underscores both advocacy for amends but also contributes significantly to our understanding of systems-based community engagement, as the question itself had not been posed previously.

Alignment with SPARC's Mission and Goals

At its foundation, this work was underscored by a commitment to rural community inclusion in health care decision and policy-making to mitigate the current emphasis on urban-based planning and promote health equity for rural populations. Although from an ethical perspective, we appreciate the need to respond to the population concentration in urban and urban-adjacent communities, we juxtapose this with the federal imperative, through the Canada Health Act, to provide accessible health care to *all* Canadians. The lack of accessible health care for many rural communities is an issue of social justice, and there is evidence to suggest that addressing this, will lead to a more just and healthy society for all. In fact, in 2004, Nagarajan concluded "[I]f there is two-tiered medicine in Canada, it [is] not rich and poor, it [is] urban versus rural" (Nagarajan, 2004).

A strong case has been made in the research literature regarding the healthcare-related vulnerability of rural communities: they have limited or inadequate access to primary care, diagnostic and treatment services, health promotion resources and illness prevention services (Beiser & Stewart, 2005; O'Neil & Gilbert, 1990). Choices in types and models of care, for example, female physicians and women-centred care, are almost non-existent (Gaston, 2001). In response to the cumulative research on rural health, Ryan-Nicholls concludes that a "community's health is inversely proportional to the remoteness of its location [and] rurality is internationally recognized as a risk factor towards progressive deterioration in health the greater the distance from urban areas." (Kirby & Le Breton, 2002).

The implications of a lack of access are severe. Kirby observed that "in terms of the health status of the rural population, compared with urban areas, life expectancy in rural areas is shorter and infant death rates are higher. Overall, the health of rural residents is worse than their urban counterparts." (Kirby & Le Breton, 2002). Likewise, research has shown that a lack of local maternity services is linked with increased incidence of perinatal deaths and premature births,[9] and women forced to deliver away from home due to lack of local services were more likely to experience complications in birth (Grzybowski et al., 2011, 2015). Soon after regionalization in BC, a study by Koch noted that when a hospital closes and health care services are reduced, the costs associated with travel are downloaded to patients, families, and friends (Koch, 2003). Leipert, referring specifically to the impact of lack of local access to care on women's health status suggests that the system-dissociated costs may lead to compromised health status (Leipert & Reutter, 2005).

Rurality has been correlated with compromised health outcomes when compared to the outcomes of urban residents (Mitura & Bollman, 2003; Pitblado et al., 1999; Shields & Tremblay, 2002). Rural and small-town populations are often characterized by higher rates of infant mortality, lower life expectancies, and higher rates of illness (Northern Secretariat of the BC Centre of Excellence for Women's Health, 2001). Accident rates, levels of disability, high levels of unemployment, low incomes, low education levels, and sub-standard housing are all highest in rural and small-town regions (Kilshaw, 2002). Globally, "the health status of people in rural areas is generally worse than in urban areas... despite the huge differences between developing and developed countries, access is the major issue in rural health around the world." (Strasser, 2003).

Consequences of the lack of access to care for rural residents are compounded by other vulnerabilities such as rates of chronic conditions (arthritis, back disorders, bursitis, and hearing and visual impairments) (Strasser, 2003), higher risks of dying from a motor vehicle accidents, poisoning, suicide, diabetes, and cancer, and higher risk of violence, economic insecurity, primary industry occupational hazards and problems associated with lack of confidentiality (Reimer, 2010) in comparison to their urban counterparts. These confounding vulnerabilities may be the result, in part, of differential determinants of health; rural residents tend to have less formal education than urban residents (Reimer, 2010) and have higher rates of smoking, heavy alcohol consumption, obesity and physical inactivity (Ryan-Nicholls, 2003). The combined effect of the confluence of these factors on health outcomes has been identified in the literature (Kilshaw, 2002; Reimer, 2010). The result of having access to health care dependent on such factors as income and finances is that residents who have low incomes, who are unemployed, or ill, may not have the resources, financial or social, to access non-local health care (Beiser & Stewart, 2005; Greig, 1990). Cultural inequities based on Aboriginal ethnicity have also been well-documented, leading to the further vulnerability of rural Aboriginal peoples due to the legacy of exclusion and discrimination they have faced since pre-Confederation times (*Report of the Royal Commission on Aboriginal Peoples. Volume 3: Gathering Strength.*, 1996).

It is also evident that addressing the health disparities in rural communities is a *systems issue:* that is, perturbations in one service delivery level (rural) will inevitably have consequences across other strata and addressing the challenges in one level of care without attending to the others will lead to further destabilization. To advance system-wide health equity, then, it is essential to focus attention on the most vulnerable populations to avoid unintended, downstream consequences. This aligns directly with SPARC's commitment to both *equity* and, at a systems level, *social inclusion.* Specifically in reference to the latter, our emphasis on the diversity *of* and *between* rural communities was a key guidepost for our approach to this work.

Finally, this work aligns closely with SPARCs commitment to *equality:* analysis of the project data confirms that a commitment to increasing equality "builds social cohesion, improves health, increases safety... and contributes to sustainable and vibrant communities" (Sparc BC, n.d.).

Background

Based on anecdotal information from rural residents across BC and previously published research, there is a lack of rural community engagement in healthcare planning in BC (Johnston et al., 2021). This gap is leading to centralized, urban-based decision-making, which is not always reflective of the needs and priorities of rural communities (Kornelsen et al., 2021). This scoping review of the literature aims to provide an understanding of and the mechanisms to address the gap between rural community-oriented voices and uptake into health policy and decision-making at regional and provincial levels. Please see Appendix A for a description of the search strategy.

Defining Community Engagement

There are a variety of terms for community engagement, including 'lay participation', 'public participation', 'civic engagement' and 'citizen participation' (Farmer et al., 2018). After considering the nuances of the various terms, we felt most congruence with the term "community engagement," which Fagnan defines as, "communities collaborating with other [partners] in the planning, design, governance, and delivery of health services to tackle health related matters and promote wellbeing" (Fagnan & Dolor, 2015).

A Call for Community Engagement in Healthcare Planning

While rurality does not always translate into poorer health outcomes, there are certain health system problems specific to rural areas, including access to services and delayed treatment that leads to an increased prevalence of chronic diseases attributed to restricted access of primary care (K. B. Smith et al., 2008). Furthermore, rural areas typically have a lower socioeconomic status which affects health outcomes (Karly et al, 2008). Karly et al argue that healthcare policies should focus on health promotion, illness prevention and early interventions to improve rural health outcomes (K. B. Smith et al., 2008). This is in addition to the growing body of evidence which demonstrates positive outcomes in response to patient involvement in health planning (Kornelsen et al., 2022).

Community engagement is recognised as an important process to improve the responsiveness of the healthcare systems to address the needs and priorities of the communities accessing the health service (Boivin et al., 2014; Farmer et al., 2018; McClean & Trigger, 2018; Pagatpatan &

Ward, 2017; W. C. Smith & Benavot, 2019). It serves an essential role in policy planning and evaluation, providing community members opportunities to voice their unique needs and help shape local healthcare services that address their needs (W. C. Smith & Benavot, 2019). Mechanisms such as forums, committees, and surveys help facilitate meaningful dialogue and contribute to the design of services. The Alma Ata Declaration of 1978 acknowledges that "people have the right and duty to participate individually and collectively in the planning and implementation of their health care" (Johnston et al., 2021; Safaei, 2015). Despite the Declaration and growing recognition of the importance of community engagement (Johnston et al., 2021; Safaei, 2015), there remains a gap between community voices and implementation of healthcare services that represent local community needs (McClean & Trigger, 2018; Pagatpatan & Ward, 2017; Safaei, 2015).

In Canada, the planning and delivery of healthcare services falls under the jurisdiction of provincial governments (Safaei, 2015). While BC has acknowledged the importance of patient-centred health care and has taken measures to include patient voices in health care planning (see 'The British Columbia Patient-Centred Care Framework'), (British Columbia Ministry of Health, 2015)), this framework fails to address the inclusion of a *community* perspective, rather than solely patient perspective in addressing the collective health care needs and challenges of rural communities of BC.

In BC, the Ministerial Mandate for Honourable Adrian Dix, the Minister of Health, establishes the accountabilities of the Minister of Health to the Premier and the people of BC (BC Ministry of Health, 2022). One of the four priority areas include improvements to and the strengthening of the public health care system. Furthermore, the Mandate Letter for Jennifer Rice, the Parliamentary Secretary for Rural Health, "Work with rural, remote, and First Nations communities as well as stakeholders to identify gaps in health care services (BC Ministry of Health & Eby, 2023)." Mandate letters emphasize that the Ministry of Health has an obligation to "listen" and "respond" to the priorities of British Columbians—and in effect calls for community engagement in health (BC Ministry of Health, 2022). In addition to the Ministerial Mandate, in the 2024 Budget Consultation Report, the Select Standing Committee on Finance and Government Services of B.C. recommends "a shift towards community-driven planning" for rural and remote communities (Legislative Assembly of BC, 2023). Despite the Government's recognition of the importance of community engagement in rural healthcare planning, there is limited information on how this is undertaken in BC.

The Rural Coordination Centre of BC, an arm's length organization funded by the Joint Standing Committee on Rural Issues, has initiated a series of community visits ('The Sites Visits Project'). The visits are predicated on bringing together rural physicians and other healthcare providers,

health administrators, municipal leadership, First Nation leadership, first responders, academics, and policy makers to better understand how to achieve sustainable, beneficial rural health system changes through community engagement processes in BC (Johnston et al., 2021). During the initial roll-out of the program, 107 communities were visited, and qualitative data was analysed from 185 meetings in 80 communities (Johnston et al., 2021). Significant findings include an understanding of the primacy of relationships built on communication, trust, transparency, and collaboration. While good communication helped build trust among healthcare providers, poor communication resulted in adverse relationships. Another finding was that autonomy for decisions to be made at the local level in response to the local context without approval from hierarchical, top-down systems. Furthermore, the authors suggest that healthcare systems need to adapt to changes in communities, such as demographic changes that can impact the need for resources, funding, patient access, staffing and infrastructure (Johnston et al., 2021). Although this program highlighted best practices in community engagement, it was not undertaken directly by policy and decision-makers.

Challenges and Best Practices

While the importance of community engagement in healthcare design, delivery, and evaluation is recognized internationally (Boivin et al., 2014; Kenny et al., 2018; McClean & Trigger, 2018; Pagatpatan & Ward, 2017), there is a lack of clarity on engagement processes, ambiguous expectations and roles for community members, insufficient evaluation, and inadequate adaptive strategies have prevented meaningful change (Abelson et al., 2004; Anton et al., 2007; Aronson, 1993; Charles & DeMaio, 1993; Farmer et al., 2018; Pagatpatan & Ward, 2017).

From the literature, it is apparent that there is a disconnect between the intent and execution of several government-led long-term healthcare initiatives. Initiatives focused on integrating community voices into healthcare planning often fall short of the promised democratizing potential. Many authors discuss how participants in community engagement initiatives feel like they lack the power to influence decision-making (Abelson et al., 2004; Anton et al., 2007; Montesanti et al., 2017). Community engagement initiatives should provide "consumers" a chance to express their needs and offer possible solutions. Aronson states that initiatives "elicit only particular kinds of information from consumers and do not live up to their democratizing promise" (Aronson, 1993). Well-defined goals and a vision for the inclusion of community voices into the decision-making process are crucial to the sustainability and effectiveness of community engagement initiatives (Abelson et al., 2004). Furthermore, information sharing with participants and the greater community should be transparent, accessible and include the how community voices will be incorporated into the policies and decision-making processes (Anton et al., 2007; Montesanti et al., 2017).

By giving a voice to communities, there is increased accountability and an opportunity to build ownership of policies and develop effective implementation strategies (W. C. Smith & Benavot, 2019). Furthermore, the inclusion of community members demonstrates transparency in decision-making, helps safeguard public interests, provides the perspective of service users, and brings diversity of experiences (Abelson et al., 2004; Anton et al., 2007; Hogg et al., 2001. These are all important elements of accountability in healthcare planning and decision-making, which is vital to increase trust in the healthcare system, transparency in decision-making, and improve policy ownership of services (Abelson et al., 2004; Kenny et al., 2018; W. C. Smith & Benavot, 2019.

Another underlying mechanism that influences the effectiveness of community engagement in health policy and planning is political commitment (Pagatpatan & Ward, 2017). Pagatpatan describes political commitment as the willingness of political leaders to commit to engagement exercises to actively engage and support public input. Political commitment entails a willingness to listen, dedicate resources to the engagement process, educate the public on healthcare choices and consequences, and provide feedback loops in the spirit of transparency and accountability to the public. The outcome of political commitment is increased understanding of and community influence on policy decisions (Pagatpatan & Ward, 2017).

Other challenges impact the success of community engagement in healthcare, including imbalances of resources between participants and decision-makers; inadequate training in community engagement; mitigating for vested interests; lack of diverse representation; varied public willingness and ability to participate; time pressures; disregard for public input due to the political climate; and the exclusion of disadvantaged and vulnerable populations (Safaei, 2015). These challenges often lead to dissatisfaction and a lack of trust in healthcare planning and by extension democratic systems (Safaei, 2015).

Diversity and Inclusion in Community Engagement

Inclusivity is an essential element of community engagement. Inclusivity can be achieved by involving a wide range of stakeholders, including marginalized groups and hard-to-reach groups. Inclusivity includes maintaining clear and regular communication when working with stakeholders to ensure their active and meaningful participation (Pagatpatan & Ward, 2017). On the flip-side, tokenistic involvement and siloed thinking restricts the potential of community engagement (Abelson et al., 2004; Kenny et al., 2018). Community engagement should include a diverse representation of community voices (Abelson et al., 2004; Kenny et al., 2018). Therefore, promoting inclusivity and diversity by dismantling barriers through strategic efforts are crucial for deliberative healthcare planning to reflect the diverse perspectives and needs of the community.

Effective community engagement approaches should proactively address barriers to participation, including but not limited to the social and economic circumstances leading to distrust, language barriers for marginalized populations, and economic barriers for new migrants (Montesanti et al., 2017). Strategies to address these barriers to participating include strengthening the capacities of marginalized people and building trusting relationships (Montesanti et al., 2017; Boivin et al., 2014). It is also important to address the power dynamics among stakeholders participating in deliberative processes and to legitimize the value of the individual and collective experience of community members to increase trust in the process (Boivin et al., 2014). It has been found that participants who have positive perceptions of community engagement processes have built relationships with decision makers over time (Abelson et al., 2004).

Conclusion

An overview of literature consulted revealed that there is a lack of *rural* community voices in healthcare planning and decision-making. The literature emphasized the importance for communities to be involved in the design, delivery, and evaluation of healthcare services. Communities need to see their diverse voices, priorities and needs represented in the design and implementation of healthcare systems, which not only helps build trust but also a sense of ownership in healthcare services. There also needs to be regular and transparent information sharing about healthcare planning processes and how community input will be incorporated into the final decisions and policies.

Research Methods

To understand the gaps between the inclusion of community voice and current healthcare planning practices in BC, Canada, the research team used mixed method approach including in-depth virtual interviews with policy and decision makers (n=8) at a regional and provincial level, rural community leaders (n=14) and an electronic survey for self-identify as rural community members (n=707). The triangulation of qualitative and quantitative data yielded a richness and validity to the findings presented. The study received ethical approval from the University of British Columbia's Behavioural Research Ethics Board (BREB). All participants consented to participate in the study. Participant confidentiality and anonymity was maintained throughout the study and survey and interview responses were analysed as an aggregate. Our interview and survey approaches are discussed in-depth below.

Rural Residents' Experiences of Engagement in Health Planning: Findings from a Pan-Provincial Survey in British Columbia

The Survey Story

At the outset of this project, we began engaging with regional and provincial policy and decision-makers to talk about what rural residents had told us, both in direct conversation and through previous research (Kornelsen et al., 2021): that they felt disengaged from health care decision-making and that locally derived health service solutions were not incorporated into strategy. 'Where is the logjam?', we wondered. 'What are the constraints of including community voices in health planning?' *were* there productive outreach opportunities with communities through a myriad of provincial agencies and whether communities took advantage of these opportunities was out of their purview. But that was not what we were hearing from communities. So, we set out to learn why there was a disconnect, going straight to the (rural) source, in the form of a pan-provincial survey (Appendix B).

We recognized early on that participants interested in a survey about engagement in health planning would be a niche group: 'health planning' generally ranks below environmental concerns, the current cost of living crisis, unstable housing, and the more immediate downstream effects of the *lack* of health care planning including constricted access to health care. Although this may be true for urban settings, the immediacy of – and lack of recourse for – access to health care is different for many rural communities. Distance to alternative options and lack of specialist care due to low population densities bump healthcare challenges to the top of

the list for many rural residents. It is one of the pillars of the urban-rural divide. Despite this, however, we did not anticipate the 707 responses that we captured. However, we know from research *about* surveys that there are sometimes systematic errors ("survey response bias") that occur due to things like difficulty remembering past experiences ("recall bias"), cultural and language bias or the propensity of most respondents to provide answers that they believe are socially acceptable or favourable. Most important in this instance, however, is the potential for "nonresponse bias" (the attitudes and opinions of those who do *not* respond to the survey) and the potential that the responses that are tabulated do not correspond to the general population ("sampling bias"). This is where one of the benefits of the academic–community collaboration was most useful: through combined, multiple, and community-engaged recruitment, we were able to saturate recruitment opportunities through key stakeholders across the province, with effectiveness increased based on accrued trust and credibility of both organizations. This is not to say that we convinced potential respondents with no interest in health planning to participate, but we did present (and incent) the opportunity. However, we do acknowledge that those who responded to the survey would likely have had very positive or negative experiences, thus leading to over-representation of extreme views. It is with this understanding that we present the findings.

Our Approach

The research team developed a draft survey, which was presented to the BC Rural Health Network's Implementation Committee for feedback. The revised version was posted and tested on UBC's Qualtrics server. The survey asked 22 questions, including a combination of short answers, Likert scales, and multiple-choice questions. The survey consisted of 12 Likert scale or yes/no questions and 11 open-text responses for further explanation, if desired. The latter resulted in rich qualitative data and description to augment the quantitative data that was presented, allowing us to capture unanticipated insights and provide a context to interpret responses, thereby enhancing validity. Ultimately, the mixed-methods approach allowed the *flexibility* for us to explore themes and patterns that emerged from the data, leading to a more comprehensive understanding of rural community involvement in healthcare decision-making.

A poster invitation to participate in the survey was sent electronically through the community databases and communication channels at both the Centre for Rural Health Research and the BC Rural Health Network (see Appendix C). The BC Rural Health Network also issued a media release, prompting several provincial media outlets to write about the study and provide a link to the survey, expanding our reach to rural residents across BC. Please see Appendix F for a list of media coverage.

Survey participants self-identified as rural community members, and participants were not required to answer all questions. The survey was hosted on a UBC Qualtrics server. All responses were collected anonymously, and survey respondents were given the opportunity to enter a draw for one of three $100 gift cards. Two reminder messages were sent after the first invitation. To increase response rates, we ensured that the purpose of the survey was clear, questions were plainly worded and there was a clear pathway to the utilization of the findings (to present to healthcare decision-makers as evidence for amending engagement strategies, if necessary).

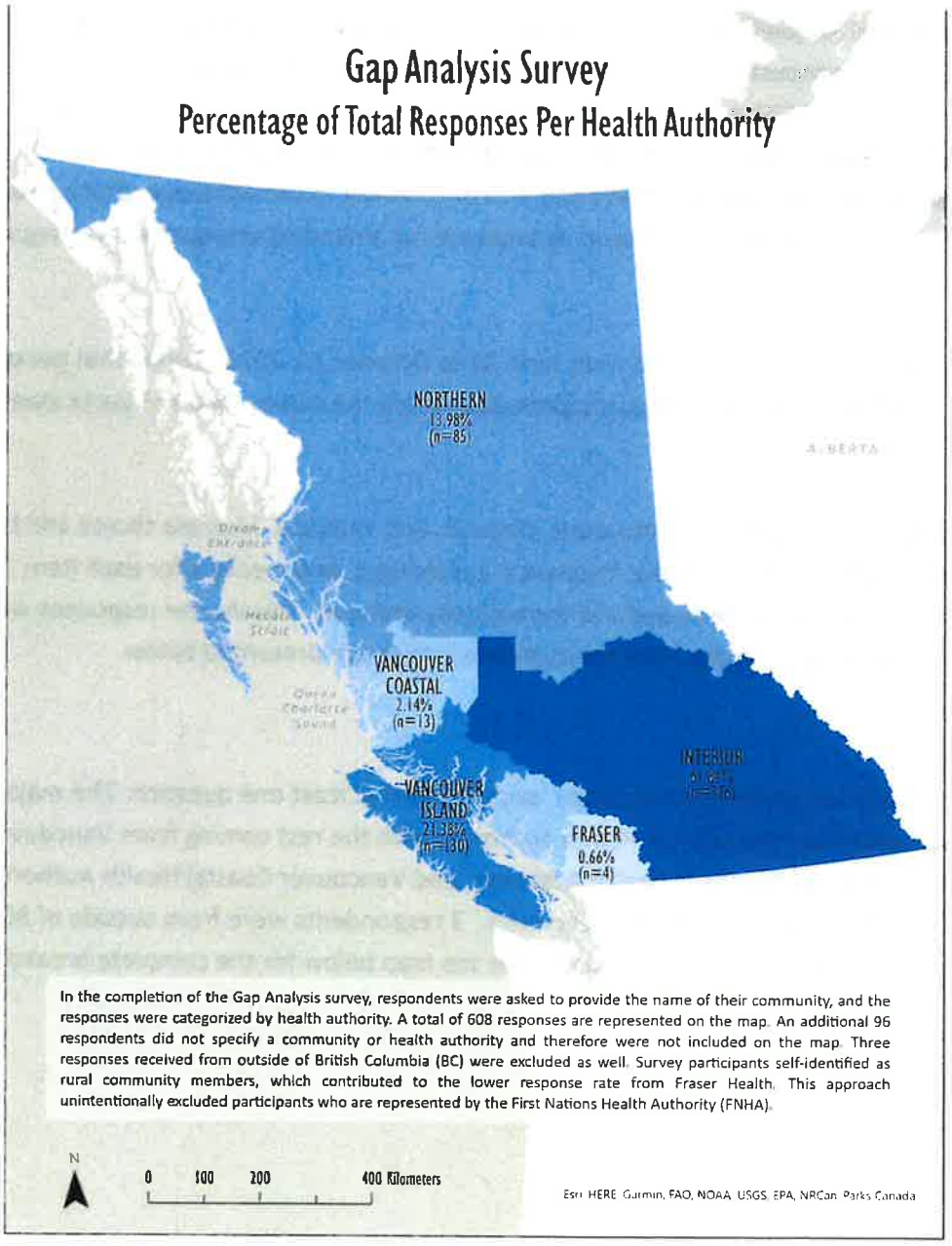
The survey was open for four months from June 20 to October 20, 2023. During that period, 707 participants started the survey, 699 participants submitted the survey, and 413 participants completed the entire survey.

The survey response data was put into Excel, cleaned, and analysed. Multiple choice and Likert scale responses were analysed by the frequency, percentage, and medians for each item. Short answer survey responses were coded and thematically analyzed. The shorter responses were amenable to clustering. Findings from the complete survey are presented below.

Findings

707 people responded to the survey, each filling in at least one question. The majority of respondents came from the Interior Health Authority, with the rest coming from Vancouver Island Health Authority, Northern Health Authority, and Vancouver Coastal Health Authority respectively, with 4 responses from Fraser Health. 3 respondents were from outside of BC and 96 respondents did not specify a community. See the map below for the complete breakdown.

Figure 1: Respondent Map



Open-text responses in the survey explicated, in most instances, the quantitative findings. Quantitative and qualitative findings are thus presented below, sequentially.

Do you feel that your community's healthcare needs are adequately represented in the planning process?

The first question was binary and asked whether respondents felt their community's healthcare needs were adequately represented in the planning process. 90% of respondents said they were not adequately represented, with the remaining 10% replying affirmatively. None of the respondents who felt their needs were adequately represented left open-text responses and the responses of those who felt they were *not* represented were aligned with three themes: a lack of mechanisms for engagement, the urban orientation of health planning and lack of accountability to rural communities. Each is explicated below.

Lack of mechanisms for engagement

Most respondents reflected simply that there was "absolutely no input into the health planning process", that "the community is not included in any aspect of local health care planning" and there is "not much opportunity to work together with the health authority". One respondent summarized the feelings of many when they said,

> *"Most of us feel completely left out of any decision-making processes that affect the state of our local healthcare. There is very little contact or community involvement on the part of [the] Health Authority who own and operate our facility."*

Others asked, *"What planning process? How/where are citizens [able] to find out? Who is involved?" Others were definitive that members of the community had "never been contacted by [the] Health Authority"* to either gather or provide information despite, in some cases, a letter writing campaign, resident surveys and the intervention of their area director. This led many to feel an *"unacceptable disrespect of [the] community".*

Many others, however, spoke directly to the lack of *structure* for such engagements ("the public lacks a mechanism for interface with Health Care Planners for our community"; "there is no way of communicating problems when they arise"). For most, this meant a disconnect between the planning process and the needs of the community. As one person noted:

"Often the planning process for health initiatives is carried out by individuals with limited knowledge [of our community]. Health policies/programs are sometimes implemented by individuals who do not permanently reside in the community or are new to the community. With no opportunity for interface, healthcare needs identified by the community are not met."

Others focused on the way the community was engaged, namely the lack of representation from those 'on the ground':

"There are volunteer groups that could be consulted, instead of limiting discussions with village council and the Health and Wellness Society... community forums are few and far between."

The experience of selective engagement was endemic across respondents, with others emphasizing that although community-level professions may understand the health needs of the community, lay community members also had much to offer based on their lived and living experiences of receiving care. This selectivity was sometimes described as "so-called consultations" that were, ultimately, "really not at all helpful or effective".

Urban orientation of health planning

Most respondents felt that rural communities were "an afterthought" in health planning and that consequently, programs were not targeted to meet the specific needs of rural settings, due to the centralist tendency of health planning. As one respondent said:

"Health planning at the provincial level is very urban-oriented and there is little understanding about the difficulties experienced by rural communities. The attitude is often, "Well, they chose to live there"."

Another noted, "We are rural, not urban and it seems to me that IHA has no interest in a flexible model for rural Healthcare". This led to the observation by many of urban-centric planning ("a lot of planning decisions are based on what is happening in Vancouver"), one consequence being a lack of appreciation for rural community needs ("decision makers in urban areas have no concept of rural needs"). One respondent summarized the corollary to this being the need for policymakers "to listen to the needs of rural communities and enact their recommendations". An additional consequence of urban-based health care planning noted by many was the lack of

capacity to address local issues in a timely, efficient way due to lack of local autonomy. As one respondent noted.

> *"Decisions are made at larger facilities that affect the daily routines of our local hospital. We are not the same as large facilities and have to be able to manage our own daily routines and problems that may arise. Some situations have to be dealt with immediately, but we are faced with having to await decisions made at another facility that has very little understanding of our local situation."*

For some respondents, consequent to the need for rural-specific planning, or perhaps as an antecedent to it, was the need for rural-specific data that addressed the challenge of registering the needs of low population density outcomes. As one respondent clearly described,

> *"The data about the needs of our residents routinely gets subsumed into the data generated by our larger neighbour. Making decisions based on statistics is tricky in a population of under 1,000 but being lumped into the data of a nearby town of 10,000 doesn't always tell our story."*

Lack of accountability

Many respondents observed that not only is there no mechanism of accountability by the RHA or the province to act on the direction of local communities ("The system seems too fractured and unstable to have any accountability"), but there is also no provincial standard for engagement. This has led to "a disconnect...between the everyday resident and their healthcare system". This same lack of accountability led, for some, to a "top-down approach" by the Health Authorities ("I have not been asked what I need; I feel I must take what they provide and have no voice"). Interestingly, many respondents deemed their health authority as being particularly inadequate in working with local communities, despite respondents being from different health authorities.

Others saw accountability as resting in action, particularly in instances when health planners acknowledged and seemed to understand what was required but did not follow through. As one participant succinctly said, "They need to act on recommendations" (made by the community). Many saw the lack of action being due to the lack of political oversite of the engagement process.

Do you agree that your community's needs are met through the health planning process?

When asked about needs being met through the planning process, 76% of respondents disagreed that their community needs were met, 13% neither agreed or disagreed and 11% agreed.

Have you been engaged in healthcare planning in BC?

When asked if they had been engaged in health care planning in BC through community meetings, special interest groups or participating in surveys, 54% responded negatively while 46% said they had been engaged. The level of engagement ranged from "inadequately informed" (42%) to "collaborating" (3%). 23% of respondents felt they were "informed" (provided with balanced and objective information to understand the problem, alternatives, opportunities, and solutions) (International Association for Public Participation, n.d.); 17% felt they were "involved" (asked to actively participate in the process, with concerns and aspirations being understood and considered) (International Association for Public Participation, n.d.); 10% felt they were "consulted" (asked to provide feedback on analysis, alternatives, and decisions) (International Association for Public Participation, n.d.); and 5% felt they were "empowered" (asked to be part of the decision-making itself) (International Association for Public Participation, n.d.).

Open-text responses detailing *how* respondents were engaged ranged from participation in public meetings, workshops and forums and letter writing to advocate for community needs, to participation as elected officials on community health boards or town councils. Although some respondents reflected a performative engagement ("When asked to plan, we hear of that which is already planned"), others reported a more community-driven process where local residents met with the Health Authority and "set the agenda".

When asked what could have been done to improve the engagement process, many participants recursed back to the fact that currently there is *no* engagement process, so the first step is to establish one that includes local, regional, and provincial participation.

There was a thematic awareness of the need to approach engagement through a diversity lens. According to respondents, this begins with recognizing the contribution equivalence of all involved: "Treat everyone as equals, for example, don't [treat] MLAs, mayors or those with more status as being more informed or having better lived experiences". This need to correct power imbalance was noted by others, specifically regarding the lack of recourse of community members when faced with decision-makers who "appear to have all of the clout". Respondents

also noted the importance of creating forms for participation that *everyone* could participate in, including face-to-face encounters to avoid disadvantaging those without access to a computer for virtual engagement opportunities. Others specifically identified the need to be aware of creating opportunities for including those of different ages, cultures, languages, and educational levels to ensure engagement truly represents the needs of the whole community.

Additionally, many respondents identified the need for authenticity in engagement, demonstrated through active listening, repeated engagement and responsive actions based on the engagement. Ideally for many, was decision-maker exposure to small towns ("[Have]... some of them live in a small community when they have medical issues, especially in the winter"). Others identified the need for an alignment of values between communities and decision-makers:

> *"[Decision-makers] main purpose it seems is a business model in which "the bottom line" or providing the cheapest service is their priority, not what will meet the health needs of the members of each community."*

For some, authenticity included the involvement of regional planners, while for others it was contingent on decision-makers truly listening to and acting on the direction of communities, as opposed to having a pre-determined agenda:

> *"I have found there is often already a plan in place before the consultation, they are using the consultation to validate the plan rather than listen to the needs of the community to inform the development of a plan or service."*

Many respondents expressed frustration with time being wasted in meetings that did not lead to change and suggested a clear articulation of "when we are getting help and how".

Solutions offered by respondents ranged from system solutions to cultural ones, the former being largely pragmatic and including suggestions of increasing community meetings and forums to bring people together "to share stories and ideas", and having decision-makers offer solutions to problems ("I feel that there are lots of surveys and studies done, but nothing is being done to fix the problems of health care for rural residents") and involving local leaders and "less from those leaders located on the other side of the province". Summatively, participants recognized the need to "open the doors to the inclusion of rural communities as part of the health care system". As above, accessibility and inclusivity of disparate voices were highly regarded, as one respondent suggested the need to

"Create more accessible ways for community members to be part of the feedback process. Maybe using simple language and paper/pen methods with a few questions. Other surveys, or public meetings, are often presented above the capacity of the most vulnerable community members."

Practical solutions also involved restructuring services to allow local governments to oversee and deliver health services which would allow for "more local knowledge of care needed and delivered" which would most importantly, allow for an iterative approach to system-wide improvements. Finally, practical adjustments suggested by several participants included extending engagement to include an effective communication process "for the two-way flow of information". For many, this necessitated reciprocal information flow sharing policy development and capturing community feedback. As one respondent noted, "Provincial policy has a tremendous impact locally, yet a mechanism to provide feedback is not apparent".

Other participants alluded to the need for a change in culture in how healthcare challenges are handled, including a

"...more proactive approach to issues rather than responsive. Many of our issues are likely preventable with forward thinking and prioritizing provincial funding, projects, and training."

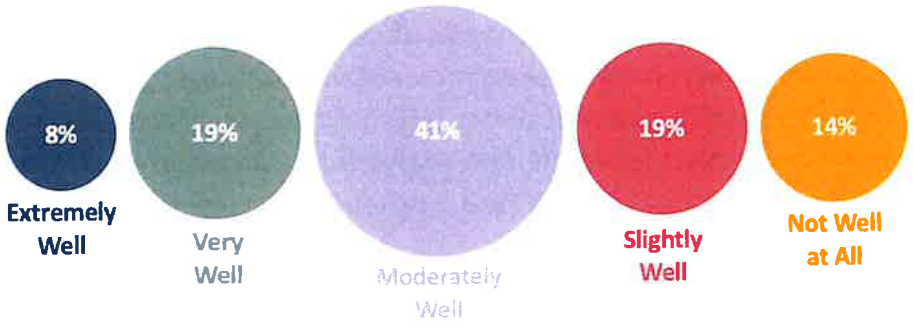
Culture changes also extended to reversing the lack of transparency of health authority decision-making that many respondents identified ("stop the closed-door policy") and resisting the 'tick box' exercise that many experienced.

Some respondents described examples of productive engagement with decision-makers, but offered additional suggestions for improvement, such as ensuring diversity of opinions was captured and having follow-up mechanisms to ensure that the engagement led to actual change in rural health planning.

How well-equipped are you to engage in healthcare decision-making about issues that concern your community?

Most respondents to this survey reported they felt at least moderately well-equipped to engage in health care decision-making, while more felt slightly/not well equipped to engage (33%) than those who reported feeling well/extremely well equipped to engage (27%).

Figure 2



How much confidence do you have in healthcare decision-makers making decisions that will be best for your community?

When asked about their level of confidence that decisions made would reflect what is best for their community, most respondents reported the had 'a little' confidence (36%), while 34% reported no confidence at all. However, 34% also reported having a moderate amount of confidence while 6% reported "a lot of confidence. One respondent said that had "a great deal" of confidence.

Figure 3

As reported above, most respondents (86%) felt that their needs and concerns were not genuinely acted upon, with 14% reporting that they were. In open-text explanations, several respondents attributed this to the "multiple layers of rotating-door infrastructure" in the health authorities while others noted an abject lack of opportunity to *express* their needs and concerns. Most respondents, however, reflected on the lack of opportunities for engagement ("How can my needs and concerns be acted upon if I wasn't asked for input?") or lack of visible

consequence to input given ("[We] have been giving input for years, and nothing is getting better", "It's a lot of talk, but actions say otherwise").

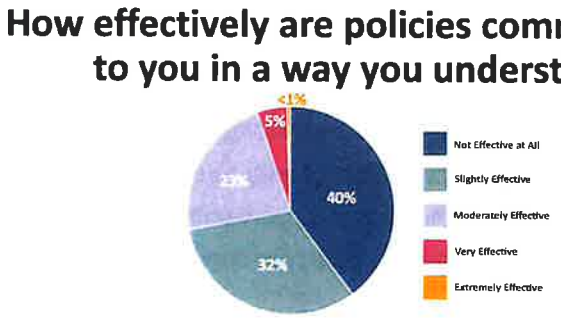
Several respondents expressed difficulties with engagement, mostly in the form of either lack of an engagement process ("There is no transparency in any consultation or planning process. How would one even get involved?"), or lack of acknowledgement for communication when it occurs ("To the best of my knowledge, the current Health Minister, nor anyone in his office has *ever* answered a call or responded to a letter"). These experiences precipitated, for many, a sense of cynicism in health planning.

Others acknowledged that although people on the "front lines" of health care were doing their best to attend to the needs of the population, they were constricted due to infrastructure challenges such as lack of government funding. A minority of respondents conveyed positive experiences with engagement, as noted in the quantitative findings above. A few participants felt validated and appreciated in their role as those with lived and living experiences while others observed more generally that there was "excellent" work being done. As one participant noted:

> *"I think all my engagements have taken my opinions into consideration as most on the committees our business people and not lived experience so I have that to offer as being with chronic pain for 44 years gives me an advantage to what would serve the patient to its fullest but as far as being involved with my community of Vernon there is definitely more work to be done.*

When asked **how effectively policies were communicated to respondents**, most felt they were "not effective at all" (40%), while 32% felt they were "slightly effective". 23% reported moderate effectiveness while only 6% reported they were "very" or "extremely" effective (5% and <1%, respectively).

Figure 4



Most respondents (89%) felt there were no language or cultural barriers impeding effectiveness and 85% of respondents felt that communication with communities regarding health policies was not effective. Many respondents who elaborated on their responses through open text felt there was "no experience of open communication" with their Health Authority, or if there was, they were not aware of it. Others saw communication as being unidirectional from decision-makers, almost always when reduction in local services was being communicated. Still, others lamented the loss of communication channels that previously existed, such as "Health News" websites that were rescinded due to lack of funding.

Many of those who responded that there was adequate communication from health planners further explained that the communication usually occurred after policies were made, prompting one participant to say "This is too late. We need more transparency and communication". Another respondent noted, "I don't think they have trouble communicating policy, it's more [about] being responsive to community in the creation of policy". For others, the *way* information is communicated was a top concern, recognizing that, for example, online communication will disadvantage those without computer access or proficiency. This underscored the contention of one respondent who noted, "The community is too diverse [for one form of communication]; those most in need are too often also those least able to access or interpret the information".

Others recursed back to the theme of "action", suggesting that communication in and of itself will not provide solutions to health care challenges ("The communication provided does not rectify anything"). Several respondents expressed skepticism about *what* was being communicated with some contending that it was all "political in nature" and not fact-based. One respondent noted that it should not be the communities' responsibility to facilitate communication with decision-makers, but instead that communication to constituents is part of their governance responsibility, while others observed the difficulty of effective communication due to "information overload".

Several respondents reported positive instances of communication, expressed that there were "advised as needed", and that the health authority kept the community "well informed".

When participants were asked, through an open-text question, if they **knew of any effective structures or organizations that engage their community in healthcare planning,** the majority replied they did not. Of those who did identify structures or organizations, approximately half

were community-based while the others were pan-provincial and included the BC Rural Health Network (through which recruitment for the survey occurred), Divisions of Family Practice, Health Data Coalition, and the Rural Coordination Centre of BC. Others alluded to informal groups that knew of but that lacked transparency so "unless you are in the loop, you would not know about [them] at all".

The final question was, "**Is there anything you would like to add?",** which elicited responses from 157 of the survey respondents, some expressing opinions in detail. The main themes reflected opinions on the *political structure of health care* (including regionalization and associated reflections on Regional Health Authorities, privatization, and system-level accountability), *models of care* (health centres) and *geographically specific comments* (care in the North and perceptions of an urban bias in health care). Each are described in more detail below.

Political structure of Health Care

Most of the open-text responses focused on the system of regionalized health care that BC implemented in the early 2000s, like other jurisdictions across Canada (Church & Barker, 1998),[†] with most respondents offering critical commentary. Some felt regionalization was the antecedent to current challenges with the health care system:

> *"The centralization/regionalization policies of the last 20 years have been a complete and total failure and are largely responsible for bringing about the state of healthcare not only in rural BC but now it has spilled over into urban centres as well."*

Several respondents noted the centralizing tendencies brought by regionalization and the need to course-correct with a distributed model of health services, while others focused more on the impact of regionalization on local communities, namely a top-down organization that does not allow for regional variation in response to local conditions ("Regionalization has taken away local decision-making regarding health and does not allow for differences, especially in rural communities, each of which are unique"). Others noted that regionalization appears to privilege

[†] Church and Barker (1998) defined regionalization as the creation of a new organizational structure that involves the introduction of an additional layer of governance that assumes responsibility for devolved functions. Typically, programs that were formerly directed by a single body are decentralized as they are taken over by new, regionally defined governing bodies. Regionalization in the Canadian context has typically involved transferring a measure of authority from a ministry of health to a local governing authority. The area administered by this governing authority is usually determined by factors including geography, population distribution and patient flows.

urban settings over rural or, at the least, not understand the realities of rural health care needs ("[RHAs] see, so disconnected from the reality that is rural living").

Closely related to comments on regionalized health care where observations on the nature of regional health authorities themselves including their urban-focus and the attendant loss of structures of communication that existed prior to their implementation. Some felt that the regional structure expunged mechanisms of communication, including local hospital boards with many suggesting their reinstatement. Others focused more on their observations of the urban-centric nature of RHAs ("We are a rural /remote community with unique health needs located in a health authority designed to delivery to an urban population"), while still others were skeptical about the corporate influence ("I believe that the health authorities should be managed by the province, not by corporations whose primary concern is profit").

Alongside concerns about the system structure of health care delivery within a regionalized context were comments reflecting concerns about privatization ("It comes down to dollars. Privatization scares me in that we would simply duplicate the American system"). A key theme among respondents was concern regarding the prioritization of "profit rather than good care".

Comments on accountability, as noted above, focused on the disconnect between input given and actions taken, from both a contextual and system perspective. This coalesced around issues of transparency (in decision-making and resource allocation), as well as the lack of governance and oversite structures. Several respondents also alluded to political decisions trumping evidenced-based health planning that meets community needs. As one respondent noted,

> *"If you ask for input listen to that input. So many different branches of government ask and then do the complete opposite of what had been suggested."*

Models of Care

The championing of Primary Care Networks[‡] by the provincial government gave rise to optimism for meaningful community engagement for several respondents. However, experiences did not match expectations as respondents reported a lack of overall engagement and the engagement that did occur was "slow and fraught with uncertainty". As one respondent succinctly noted, "There is no Primary Care Network collaboration per se".

[‡] A PCN is a clinical network of local primary care service providers located in a geographical area, with patient medical homes (PMHs) as the foundation. A PCN is enabled by a partnership between the local division of family practice and health authority, along with local First Nations and Indigenous partners (Family Practice Services Committee, n.d.).

A few respondents referenced the desire for community health centres, a model of care based on principles of team-based care, health equity and community-driven services *(BCACHC*, n.d.). As one respondent said, "I just know [services] could be provided in a better way using an effective healthcare centre [model]". Others saw the potential for Community Health Centres to gain the trust of rural community members through responsivity to local needs.

Geography

Several respondents provided comments on local conditions (mostly the North) and the perception, as noted above, of an urban bias in health care planning and delivery. In the first instances, survey participants conveyed observations of the North being overlooked in healthcare planning, a harbinger of the more general devaluation of rural healthcare compared to urban health. Examples such as disadvantaged access to cell phones or internet services, resulting in constricted access to virtual care was cited as evidence of a lack of understanding or prioritization of rural health care. Likewise, the example of challenges associated with accessing rural public transportation to access care was also presented as evidence of an urban-centric planning bias.

Some respondents linked urban-centered healthcare funding to further disadvantaging rural communities while others saw the urban focus as the root of health system failure. As one respondent said:

> *"The entire model of centralized healthcare, relying on an expensive hierarchy of bureaucratic managers, mini-managers, and micro-managers, has proven itself an abject failure. Time and again, local medical needs are forced to fit into a one-size-fits-all, primarily urban mentality that has no clue how rural communities work or what their needs are, nor do they seem to care."*

Several respondents saw the best recourse being a reset of the perceived urban planning bias lying in consulting rural community members when designing and implementing health policies.

Despite the majority of comments focusing on critical aspects of health service planning and engagement, some respondents did acknowledge that "[t]here are some good things happening within the healthcare system and money being spent", the same respondent also suggesting that although criticism is generally focused on the current government, it was the *previous* governments that "derailed progress". Many others expressed a desire to be more involved, with one respondent noting:

"Great topic! This leads to the next question regarding the 'how' and 'when' to genuinely engage communities in health services planning and the actual impact/influence such input will have on decision and policy-making, i.e., not just token input. This is more than patient voices; it's community voices."

Others expressed appreciation for the opportunity to voice their concerns through the survey while a handful of participants expressed the need for action over discourse:

"Please stop engaging in planning studies, engagement exercises, etc. etc. The problem of access to primary care in the interior of this province is not new. There are models of primary care, physician recruitment that have been shown to succeed. Act now."

The experiences of engagement in health planning for survey respondents were largely focused on the lack of engagement opportunities and structural barriers to health system improvement. To understand the complete picture of community engagement more fulsomely in rural health planning, however, we needed to understand the experiences of community leaders in the process and, ultimately, the experience of decision-makers. Results from the interviews with each group, respectively, are detailed in the next two sections.

Rural Community Leaders' Experiences of Engagement in Health Planning in British Columbia

The Importance of Local Leadership in Community Engagement and Development

The effectiveness of 'community voices' is enhanced when there is an organizing structure to consolidate otherwise disparate contributions. From this vantage point, however, it is essential to recognize the heterogeneity of communities and the tendency for voices expressing the views of socially marginalized communities to be silent. With good leadership, however, these voices can not only be amplified, but also used to an advantage to understand the composite needs of communities. Understanding and meeting the needs of vulnerable populations is critical not only to improve population-level health outcomes, but also as a way of refining system responsiveness for *all* citizens. Effective leadership is key to this endeavour, both through formal and informal means.

Formal community leadership positions are those that typically occur within community structures, namely elected positions, or organizations with pan-community responsibilities (e.g., director of a local Food Bank). In contrast, *informal* leaders emerge based on their accrued influence in the community, usually over a period of sustained contribution (e.g., members of Hospital Foundations). The differences between the two are mainly in the areas of authority and accountability; that is, formal leaders are vested with the power to make decisions, such as the allocation of resources or the creation of local policies, whereas informal leaders rely on *relational* influence and the attendant capacity to inspire the community around specific causes (Pielstick, 2000; Van De Mieroop et al., 2019). As a corollary, formal leaders are held accountable by higher authorities (or the constituents that elected them) while informal leaders may not have defined accountability structures (although often feel a strong sense of responsibility).

Regardless of the level of formality of a leadership designation – whether by intention or de facto - they play an essential role in community advocacy due to their clear understanding of local needs, the relational trust they have developed over time, their capacity to facilitate productive discussion and participation, and their potential to mobilize resources. It is also often the case that the community leaders are the interface between community dialogue and external partners who can action community intention. For these reasons, and to explicate further the findings from the pan-provincial survey of rural residents, we interviewed community leaders.

Our approach

Policy and decision-makers at regional and provincial levels received an invitation (Appendix G) to participate in the study through email and direct contact. The research team reached out directly to 30 policy and decision-makers: 17 regional and 13 provincial. Snowball sampling was employed to identify additional participants involved in rural health planning, including a participant distributing an email about the study to the Ministry of Health employees. Participants representing either the Ministry of Health, Health Authorities, or other provincial agencies.

Rural community leaders were recruited by distributing posters (Appendix D) and a one-pager (Appendix E) through the BC Rural Health Network communication channels, including newsletters, their website, social media, and a media release. Snowball sampling was used to recruit other rural community leaders to participate in the study. 14 rural community leaders contacted the research team to participate in the study. Participants were included based on their self-identified leadership role in their community, either municipal leaders or directors of community-based organizations. No one who responded to the request for participation was excluded from the study.

Once recruited, policy leaders and rural community leaders participated in in-depth virtual interviews with Dr. Jude Kornelsen (PhD) and Kate Wills, lasting approximately 60 minutes. The interviews were structured around questions such as:

> Do you see a role for community voices in health planning? How valuable is this input, from a practical perspective?
> Are there preferred frameworks for hearing this voice (e.g., existing health and social service agencies)?
> Do you face barriers to including community voices in decision-making? What are they?
> Do you see any downside to community-informed health planning?
> Do you have established ways of reaching out to communities?
> How does the yield of community consultation influence decision-making?
> How do you weigh community perspectives with other policy-making influences?
> How do you build and maintain trust with communities?

Although the questions reflected an open-ended approach, we followed the participants in the direction they felt most important. This approach was used as there is a breadth of knowledge

on this topic and we wanted to ensure comprehensiveness in our understanding of participants' experiences. The interviews were recorded and transcribed with the participant's permission.

The research team thematically analyzed the transcripts by cohort (policy leader and rural community leaders) and transcripts were inductively coded (Fereday & Muir-Cochrane, 2006). Three research team members independently reviewed three transcripts from each cohort respectively, developing codes and grouping ideas and trends in the data relevant to the research questions. The codebooks were compared to determine the level of congruence. There was a high level of congruence between the codes and minimal adjustment was needed. The research team reconciled their codes and developed a codebook to ensure consistency with coding the rest of the transcripts, which was done using a qualitative coding software program, NVivo14. The themes identified in the policymaker and community leader interviews were closely aligned.

Findings

We interviewed 14 participants from across BC and analyzed 12 transcripts, with representation from Interior, Northern, and Vancouver Coastal Health Authorities along with two participants occupying a more pan-provincial role. Participants were included based on their self-identified leadership role in their community, either municipal leaders or directors of community-based organizations. Those involved at a provincial level were engaged in programming that had relevance to rural communities locally or pan-provincially. Our interviews with community leaders revealed the following main themes: *the need for accountability*, *community advocacy*, engagement, and *experiences of urban-centric planning*. Each is described in more detail, below.

Accountability

For most respondents, 'accountability' was the cornerstone of a well-functioning healthcare system and referred to a series of "checks and balances" that ensure the capacity for course correction, should new or contradictory planning information arise. It does not eliminate the potential for errors in decision making, but instead encourages addressing such errors. As one participant said,

> "Hold people accountable. Let them make the decisions they think [are] right. [A]re they gonna make mistakes? Of course, we all make mistakes and there's nothing wrong with making a mistake as long as you learn from them. And as long as we have checks and balances in there through the health authority, say, 'okay, well, you know, you don't get too far down the road, you know, making a mistake,

but you get it... How do we fix it?'"

Others were more terse, observing the current *lack* of accountability: "We have no mechanisms of accountability for the decision makers" or "[t]here's no follow-up". For many, the discussion of accountability necessarily involved the involvement of communities to "offset the negligence at the federal, provincial and ministry level". But some also suggested that accountability also involved compensation to local communities when they fill the service gap that the province is responsible for, in terms of remuneration for costs incurred. One participant provided the following example:

> "[T]here is specific downloading that can be accounted for by your fire departments to say 'we responded to say a hundred calls, and 90 of those calls should have been and ought to have been paramedics'. So, there's a cost to that, to the municipality, so therefore that cost now should be allocated [from] the province."

Others focused more on the challenges of accountability due to the bureaucratic organization of healthcare decision-making that resulted in those who engaged with communities being unable to make decisions until they talked with "somebody else higher up". For many participants, an additional consequence of engaging with a large bureaucracy was the lack of consistency in the individuals occupying the positions, with many observing high turnover ("When they do come, it's different people each time"). This made enforcing accountability difficult.

This was closely related to the observation by others that bureaucratic norms are aligned with protocols like attention to seniority ("Once you get in the big bureaucracy and you are needing to hire the person who's got the most seniority even though they don't like the job and they don't wanna be there...) which made accountability very difficult due to the inherent dysfunction of the position. Others pointed to the larger challenge of health authorities as institutions noting the inefficiencies of bureaucratization itself, in this case with the example of middle managers ("Get rid of about four layers of [Health Authority] managers or, at the very least, redeploy more of them to a site level"). This contrasts with what some saw as the recourse of Health Authorities in response to system challenges: to create new positions ("Their solution is to create a new position and make them a vice president... I can't understand what the job must entail. It's just it's gotten ridiculous").

Relatedly, several other participants noted that the very nature of a large institution makes clear communication (this accountability) difficult. As one participant commented:

> "I feel like the structure itself is probably the biggest [challenge], the many layers and the

> disjointedness of the layers of [the] health authority have probably led to a lot of that... I haven't talked to people at any one level that really knew what the other level was doing and could answer any questions.... That's not helpful, right? ... [I]t doesn't address issues and find solutions. So, I think more it's the structure being as fractured as it is that makes it hard for anybody... even people who really want to make it different..."

Others were more pointed in identifying the importance of an antecedent to system accountability, which was ensuring a good fit between the local community and regional and provincial planners and the consequent challenges when this didn't occur:

> "...the regional or local managers they've hired have just been absolutely terrible at being involved with the community, communicating with the community. Any, *any* involvement with the community has either been none or not very pleasant. Health authorities... have been viewed by communities at the local management level as a barrier to any constructive solutions moving up the food chain."

When the needs of local communities cannot be communicated effectively to those who can effect change, there is no potential for responsivity (thus, accountability) to local needs.

Several participants expressed their ideas of the underlying causes of system accountability beyond the bureaucratic hurdles, such as the need for institutional control and ownership of the process. This was seen to be motivated in part by fear of loss of control and the consequent need to take responsibility for decisions that were not entirely theirs, and also due to the lack of solutions. In this way, the health system was seen as being accountable primarily to its governance mandate, to the detriment of innovation. As one participant said,

> "I think it's control. I think it's ownership. I think that they want to control the situation from their end, but also, I honestly think that they don't have solutions."

Like the survey respondents above, several participants identified the system shift to regionalized health care as being a central challenge of accountability to rural communities. Some recalled that prior to regionalization, many parts of the health care system worked to advantage for rural BC but "they threw the baby out with the bathwater." This led to the contention that to increase accountability as a foundation to solving the current health care crisis, a structural overhaul is required. Several participants described a "broken" health care system", with some noting that this is not limited to rural health care, but urban health care as well.

Others noted that although there were less direct lines of accountability within regionalized health care, there were structural advantages to regionalization due to economies of scale (and appropriate distribution of resources) that need to be considered in juxtaposition to the diminished communication:

> "In these really tiny communities...yes, they have hospital infrastructure and yes, they're trying to attract doctors and nurses to come and live in their communities. [T]hey are not close to the nearest regional hospital. At what point is it unrealistic to duplicate all of these services and have all of these specialists – maybe not even specialists...? ... So, I think there's a conversation that needs to be had."

Others specifically recognized the emergence of Primary Care Networks (PCNs) in their geographies as initial cause for optimism that structures of engagement, leading to accountability, would be put in place, but very few saw this come to fruition. Many noted they were not sure what the PCN engagement process or mandate was, because they didn't "think they involve[d] rural communities... because [they] never hear anything". Another said, "I know very little about it, but it shouldn't be like that, right?" However, the theme of project-focused engagement was conveyed by other participants and seen as a conduit to more fulsome relationships between communities and health authorities. One participant, involved in the development of a health centre, noted that the project forced channels of communication with the health authority and observed how the shared focus forged relationships that had not existed previously, with relationship development being a key component of accountability.

Strategies to enforce accountability

Some participants recounted using media channels to garner the attention of and response from policy and decision-makers, most to positive effect (although one respondent noted that "[I]t's been protest, not communication"). Another participant observed that their media strategy was to reflect "all of the Ministry's own statements about community-based decision-making, patient-centred care" as a public accounting of policy directions. Still another participant, when faced with a lack of response from their Health Authority, reported "There is no recourse, but we do keep nagging. We don't give up. And so, we tend to write a lot of letters." Letter-writing was cited by many as a key strategy in their attempts to precipitate communication.

Several respondents acknowledged the value of uniting the voices of rural communities to create a stronger position of advocacy, some referencing the importance of the BC Rural Health Network in filling this vacuum. This was seen as a necessary step to gaining a rural health strategy or, as others referred to it, "a master planning process" as a step to enforcing accountability. These strategies contrasted with existing provincial mechanisms, such as the annual Union of BC Municipalities meeting, which some respondents deemed ineffectual and

lacking accountability ("You make a bunch of recommendations, you put your hand up, you vote on a motion and then it's kind of... stalls there...").

Some local leaders reported progress in engaging with decision-makers, demonstrated for example through regularly scheduled meetings, amendments to Memorandums of Understanding, and adjustments to local budgets ahead of fiscal year-end deadlines. This led to one respondent to observe, "We're not just a rubber stamp". Others acknowledged the value of "informal round tables" that occurred while others recalled participation in regional panels to argue their positions. Even despite these concrete directions, however, most participants acknowledged uncertainty in outcome and impact. As one study participant said:

> "I don't know how successful it was. Like, people were certainly there and interested and engaged. But I don't know if there's any measurable outcomes from that session that we could point to and say, you know, yeah. They took us seriously. I'm not saying that it's not. I just don't know."

Larger Solutions

Solutions addressing the lack of system accountability offered by many of the participants started with a complete system overhaul starting "at the top" with funding for adjustments to the health system. In this way, participants felt that accountability markers could be built in, including engagement mandates that could be set to establish an expected standard, leaving the health authorities to determine the nuances of the engagement in the context of local communities. Underscoring the system refresh for many was the need for robust evidence to inform planning. Other participants suggested accountability for engagement with rural communities should be included in mandate letters from the Premier to the Ministers and the Health Authorities. This would necessarily be accompanied by resource allocation to build infrastructure and enable meaningful activities.

Others saw the value of increasing the role of municipalities in health service planning and delivery to ensure local responsiveness to need (as one participant said, "I think it starts at a community level to take action and [provide] a coordinating role") while still, others referenced returning to the pre-regionalization model of health boards and councils. This direct pathway from communities to decision-makers was seen to be the most effective:

> "I think I'm probably filling the gap that if [we had] the old board model, [we] would have been the representative from that community. And [the representative] would have presented her information to the board and then the board makes decisions from there."

Some advocated for municipally directed health policy ("... they take ownership of it") including the development of a specific health coordination role responsible for liaising local activities with provincial priorities. This would involve bringing forward community-derived solutions to other layers of government, while the municipalities maintain the agency to set direction. More pragmatically, several participants recognized that for municipalities to have a voice, they needed to work through locally elected officials as "[t]hose are who the health authorities and Health Ministry listen to".

Community Advocacy

Many interview participants who participated in this study took on the role of community leaders based on their recognition of the need for *community advocacy,* to take advantage of the wealth of local knowledge that could contribute to solving health system challenges in a way that responds to local conditions. Similarly, to observations made by rural survey respondents, several community leaders observed the reciprocal need for decision-makers to have local knowledge of the community they are making decisions on behalf of. This was closely associated, for some, with the value of the lived and living experience of rural residents:

> "You know what the community is. You're living it. Like nobody can tell my story like I can tell my story, you know, and so you are living that you have a relationship with the people..."

Several respondents expressed exasperation that locally derived solutions had not been listened to in the past, but some sensed the potential for a change:

> "I am [optimistic]. I am, because deep down, they know it's not working. They have to do something and they're willing to listen to... well-organized groups like [The BC Rural Health Network] with evidence-based solutions. A lot of these solutions have been arrived at rurally for the last 20 years but haven't been listened to and now they know they've got to listen."

At the heart of effective community advocacy was the need for widespread community involvement in planning and decision-making, alongside established linkages between sectors. One participant noted the advantage of being a member of a local community social service agency board and transitioning to chairing the regional district, a position which allowed them to engage with government staff. Others emphasized the value of inclusivity and the importance of "bringing everyone into the discussion". As one participant summarized: "So it was really about bringing business, government, our cultures together, our not-for-profits...". The importance of inclusivity was noted mostly by those participants who reported successful community-level

engagement.

Some participants recognize their effectiveness in advocating for their community would be increased if they were elected representatives ("We can't be just one person going to the media slagging our health authority... you need a united community"). Others emphasized the need for self/community education about the issues of concern. Several respondents opined that rural residents have become used to expecting less access to health care than their urban counterparts, with some groups feeling "embarrassed" to advocate for better care. As one participant, referring to seniors, noted, "They don't have that voice, they don't have the social confidence, the vocabulary". The communicative marginalization extended to a lack of digital literacy, which in some instances leads to isolation and the ensuing system of "invisibility".

Other community advocates espoused, after many years with no engagement, the need to be "confrontational" to gain attention, with the hopes that this would quickly change to constructive work with policy and decision-makers. As one participant said, "But most of us... have come from a protest base. Because it's the only step we had left". Although the "unite and fight" approach was evoked by several participants, many also observed that there is a "fine line" with confrontation and that it is essential to maintain the willingness to collaborate:

> "Unite and fight. That's the first step. But it doesn't always have to be that way. Your ultimate goal should be to finally get the respect of the health authority you're dealing with and the health ministry. Get them to come to the table."

Others described it as "a constant fight". Interestingly, some noted that protest and confrontation were not in their nature personally, but they were spurred on by their commitment to advocating for health services in their community. Ultimately for some, local advocacy-based change was clearly a recourse to the lack of change initiated by others in the health care system: "Something has to change, and the change is not coming from the province, it's not coming from the health authority so it's going to come from within us. And so that's what keeps me going".

For others, community advocacy was more productive, as some observed the value of Health Authority participation in regular meetings, signifying a "direct line" to decision-making. Building on this, one participant described playing a coordinating role to bring others to the table as well. As they described:

> "[W]e invite [the health authority], our local MLA, a representative from Emergency Health Services and our local CRD representative to discuss a variety of things, mainly around transportation of people in emergency situations. And so, we do initiate those

connections". "

However, despite the coordinated engagement, the participant went on to note that *action* arising from the engagement has been slow. This was endorsed by several other participants, many of whom provided discrete examples, one noting "[the engagement] just goes into a vacuum somewhere... it falls by the wayside, and I firmly believe that they are just waiting for all of us with skin in the game to retire". Still, others described what one person referred to as "that walk of death" where, after a meeting, appreciation is expressed and "you never hear from them again".

Engagement

Although there were exceptions, the general tone of participants' description of engaging with decision-makers was one of lack of satisfaction, leading to frustration. This is in part due to the lack of availability of decision-making colleagues but also when they were available, the likelihood that they would be new to the position ("revolving door" was a common phrase) in addition to, as noted above, that lack of consequent action. Engagement, for most, was both regional and provincial in focus, with a clear delineation between those who were advocating for changes to local services (the former) and those more focused on policy solutions (the latter). For some, the challenge lay in their process of responding to community need at a practical level, and the lag-time they experienced waiting for policy to catch up. As one respondent said,

> "We did reach out to Ministry of Health four years ago to [ask] 'what is your funding tied to? ...how closely do we need to line up with this?' And nobody knew. We talked to quite a few people, and they said, oh, we're just writing those policy papers, we're not sure."

Several participants cited the lack of any standards for engagement that would provide a benchmark from which to evaluate the success of their activities. For some, this was seen as a provincial role:

> "And there also... needs to be that provincial expectation and mandate that there's a minimum level of engagement happening and maybe set that standard. But then leave it to health authorities to figure out how that engagement is going to work based on the context of those communities."

Other reflections on engagement were more directed toward mechanisms – and challenges – of engagement, particularly with health authorities. One participant noted that the only way to meet with the CEO of their health authority was at the Union of BC Municipalities (UBCM) annual meeting. Interestingly, others relayed experiences of sending resolutions to UBCM and requests

for meetings with the MoH but reported only having success meeting with staff, not the Minister himself. Another participant noted that they

> "Don't even go to UBCM anymore because it's... a total waste of time... we have these heartbreaking stories, and we share them with the premier and minister after minister and nothing would change."

They went on to note that although there is meant to be access to their Health Authority board, this is only possible if they meet in the local community which, for many, happened infrequently. Others did express more access to their RHA boards, however. When another participant was asked if there was cynicism regarding engagement with the health authority, they replied, "I would say that was an understatement".

Some participants specifically spoke to assumptions of Health Authority knowledge of the history and conditions of health care within their community that were misplaced. These assumptions of inherent knowledge and understanding led to significant challenges, for some, in enacting community-based planning.

Other participants turned the lens towards upskilling local elected officials to optimize relationships with the Health Authorities. They observed:

> "I think a lot of times, local government people get elected, and they go in and... they don't understand their job. They have no idea what they're doing, and so they think their job is to be mad at government for not providing the services that they need. I think educating a bunch of politicians when they come in the door that they do have tools that are more effective than, just being upset, like a master planning process, like the hospital district, like the primary care network, like all of these community groups that are doing work, I think is really important. So, education."

Others reported attending Health Authority board meetings as a municipal elected official, mostly in their capacity as a member of the local Division of Family Practice which created the need for an interface, "... because you are meant to be analyzing data and... developing plans that are all going to interface with the [Health Authority].

Reciprocally, however, other community leader respondents detailed how they reached out to their *communities*, emphasizing the need for this same kind of engagement upstream. The outreach described was based on an understanding of the importance of public engagement (one participant described this as "one of our strategic priorities") fulfilling the commitment to

"listen to our community and hear the inputs they have". This participant went on to note that substantial engagement occurs informally, in social settings ("on the ski hill and the soccer field") but also through more deliberatively organized chats over coffee. The capacity to do this hinged on the characteristics of the (small) town and advantage of previous interactions with community members.

Others noted deliberate efforts to create connections between activities at a municipal, regional, and provincial level through cross appointments in leadership positions:

> "We appoint 2 members to that board, and so that [Community Leader] and myself are both on the hospital district and both on the regional district, and so connecting the dots for people. And then I think maybe one of the biggest ones is what [others]] did for our community, which is educate people, educate politicians, educate municipal staff, help people understand what's going on."

Despite this, others noted the inherent challenges of engagement due simply to the expansive geography that many health regions cover ("...we're disconnected from decision makers because *we're disconnected from decision makers*. Like, they live in different places than we do"). Another participant pointed out that "... our staffing is done in [a regional referral centre]" and that this made responsiveness to the conditions of the local community difficult.

Others suggested mitigators to challenging geography, like tools that facilitate virtual communication, such as Zoom. Despite this, many participants noted geographical distance as an impediment to relationship-building.

Other participants articulated the challenge of community representation in engagement, summarized best by the question, 'Who represents community?'. Several people pointed out that it is "the loudest voices that get heard" and strategies were needed to ensure more stratified representation, starting with an awareness of "who we're missing". For others just starting down the path of engagement, "listening and learning and understanding" was the kind of community engagement already underway which was crucial.

For upstream regional and provincial communication, some participants noted the advantage of structures put in place during the COVID-19 pandemic, such as regular virtual meetings with communities, that were subsequently rescinded. Others described the silver lining to the COVID-19 pandemic more extensively, noting the pandemic was "a tremendous benefit to us" in that it was the first time that there was coordinated activity between the municipality and the Health Authority ("those relationships through COVID were very strong, and it became sort of a natural

advocacy point that we were able to make"). The participant went on to note that the need for communication during the pandemic allowed them to

> "... talk to [the decision-maker] whenever I wanted. I was talking to the Minister of Health... it was a very different time. [We] were in regular touch with decision makers and staffers at all levels."

As with comments on engagement, above, several participants identified the lack of action emanating from engagement, not just with policy and decision-makers, but with other agencies and academics. Lack of follow-through from engagement also extended to a lack of follow-through for decisions made at a provincial or regional level that impacted local communities. As one participant said, "I would expect more from the government in terms of decision making and assessing... the impact of their decisions".

Vulnerable populations

Some participants observed the need – and inherent wisdom – of tailoring services to meet the needs of vulnerable communities, as through this we "create something that meets everyone's needs." Several respondents emphasized the importance of different modes of engagement with those parts of the community whose voices are less heard. One participant summarized the challenge this way:

> "And then how do you get those very important voices to the table? And I use bunny ears because that's the problem, I think in itself, is saying to the table. We often want to engage those voices on our terms in our way and that isn't safe. We've done harm. So, I think there's lots that we need to do differently to engage those voices, those communities. And part of what we need to do is get out and away from our tables and get into the community and connect to organizations and associations and groups and community services that have relationships with those folks and have trust there. And start trying to meet them where they're at, where they do feel safe, in a way that feels safe. So that's a big thing that we need to do there."

Urban Centric Health Planning

Many community leaders observed an "urban centric" tendency to health planning, congruent with the findings from the pan-provincial survey. At the core, this was thought to be due to the disconnect between rural communities and decision-makers, as noted above, but also due to the lack of engagement with rural communities and entrenched evaluation of policies for decisions impacting local care. As discussed above, the disconnect was in part seen simply as a lack of

familiarity with the realities of health services in rural communities, including a lack of understanding of context and multiple roles that individuals may have.

There was a further disconnect between what some rural community members described as 'engagement' and how they believed policy and decision makers saw community engagement, with the former prioritizing *relationship building*. As one respondent said, "[they should not] come in with all of the reasons why they haven't or can't or shouldn't or all these answers that don't work, because yes, they were developed for a city system and it's not going to work here." There was overwhelming consensus that "you have to live rural to know rural," with this participant further stating, "We do know what we're talking about. We do have some good solutions". In addition, several participants emphasized the need to ensure an iterative method of system improvement.

> "...so we can continue to learn and understand and then improve what we're doing. Because I think in some context... some of those structures need to look different, and I think we have to create flexibility in being able to adapt."

Health Care Decision and Policy-Makers Experiences of System Change in British Columbia

The Role of Health Policy and Decision Makers in a High-Functioning Health Care System

Policy and decision-makers play a pivotal role in shaping, implementing, and overseeing the strategic direction of health care. They do this through a myriad of activities from goal and priority setting, allocating resources and providing oversight. They also attend to integration of various health care sectors, partner engagement and monitoring and evaluation, ideally through a lens that promotes health care equity and accessibility thereby reducing health disparities (Mitton & Donaldson, 2002). Their role is critical in ensuring effectiveness (quality and safety in patient outcomes), efficiency, equity, and sustainability (Brinkerhoff, 2004).

The decision-making process, however, is multifaceted and involves a range of partners and municipal, regional, and provincial layers of decision-making. The provincial Ministry of Health is the agency responsible for oversight, on the direction of the Minister of Health (BC Ministry of

Health, 2022). Ministry employees are the "stewards of BC's health system", setting the direction and providing a legislative and regulatory framework for decision-making (Province of BC, n.d.). Activities are funded through regional health authorities, who are responsible for the *delivery* of health care (Province of BC, n.d.). Health Authorities in BC have their own decision-making structure, budgets, and responsibilities, although aligned with provincial priorities (Pauly et al., 2013), leading to regional variation. The province is mandated to engage in consultation and collaboration with partners, from healthcare providers and social service organizations to communities and patients (Légaré et al., 2022) alongside a system-wide commitment to evidence-based decision-making. Public engagement ensures that healthcare policies reflect the needs and preferences of the population, although accountabilities for meaningful engagement, as noted by community members and leaders above, are lacking (Berland, 2019).

This multifaceted governance and decision-making system creates challenges for patients and communities wishing to engage: the system itself is also constrained by *how* and *when* engagement with communities occurs and, perhaps most importantly, by resources facilitating engagement. To better understand the real-world challenges of (rural) community engagement in health care decision-making, we interviewed 14 regional and provincial policy and decision-makers to better understand the constraints they face and to document their views on community participation in health care decision-making. The main themes arising from the interviews include *decision-making during a health care crisis, the use of data in decision-making, the importance of leadership, the challenge of rural health service planning* and *the impact of the electoral process on health care reform.* Each is explicated further, below.

Decision-making during a healthcare crisis

All policy leader participants in this study discussed the challenges facing the BC healthcare system. As one described, "We do know the health care system is in full-blown crisis at the moment." Policy leaders commented on the challenges faced by the Ministry of Health including, for example, emergency transportation and transfer and stabilizing maternity and primary care. In the face of increasing challenges, all policy leaders had a desire to make a meaningful change to improve the healthcare system. As one described:

> "We don't want to continually be fighting fires. Right now, we are being very reactionary to the immediate needs or the service interruptions that are happening across our system."

In the face of service delivery challenges, policy leaders described a complicated process involved in making creating the conditions for meaningful changes within the healthcare system. Participants spoke of using evidence-based data and community engagement in their work. One policy leader explained the process of presenting relevant and comprehensive evidence to the Minister and Ministry, emphasizing that the Ministry takes the lead on health care reform. However, several participants noted that ultimately, "decisions are [made by] elected officials."

Participants explained that healthcare reform is often shaped by the "health mandates" set forward by the Minister, following which, the rest of the system aligns with the mandate. One participant explained, "[T]he government sets the path for a lot of our initiatives... We have guardrails on what we need to deliver based on the current government, our mandate, and what our board says." Despite this seemingly simple top-down approach in decision-making, participants in this study often commented on the challenges when implementing healthcare changes due to the many diverse opinions and desires of different groups present in the healthcare system. One participant noted:

> "There is this constant tension between what the minister wants based on the political party, what the ministry needs to have done as the inner workings of the health system, and what the health care providers want to do."

Many participants described BC's healthcare systems as highly fragmented, highlighting the importance of building relationships to improve system function:

> "There are diatribes in this culture: Us and them, community versus provider, or provider versus health authority, health authority versus ministry, or anywhere in between. We are trying to find those alignments and allegiances and build a better system where we understand one another, we have shared values, shared goals, and shared accountability."

Policy leaders often spoke of making a change from both a systems perspective, which includes understanding service needs of a population, and from a health human resources perspective, which is more pragmatically and fiscally oriented. One participant described the challenges that must be considered when advocating for healthcare:

> "How are we going to navigate, negotiate, or even advocate for the services that people need? We aren't a service provider. So, I can't say we now need a birthing center in Masset. Let's go put it there. We're really negotiating or advocating for the entire system based on the needs of our members who are serving the patients."

Another participant provided an example in maternity service planning by explaining how their decisions are shaped not only by the demand for services within communities, but also by consideration of issues of potential litigation for providers. They explained:

> "In some [rural] communities, do they need c section services? Not in every community. They might want a birthing service and they're happy to move out of community if they want to [have a c-section], but it's patient choice and informed decision making. That is also a risk model where patients may be willing to take on more risk in their care, whereas providers are not."

All participants in this study spoke about an overwhelming desire to improve the current healthcare system. However, policy leaders also acknowledged that in addition to challenges in gathering endorsement from the Minister to implement these changes, there is also limited funding and constrained resources. One participant summarized the fiscal limitations constraining meaningful change:

> "The discretionary funding that is available on an annual basis is relatively slim... Even when their budget increases, it's for wage increases and for other kinds of things or other expenses that just keep going up. Reconceptualizing [our healthcare system] seems incredibly difficult."

Some participants described examples of systemic changes within the healthcare system that are currently taking place. However, they explained that these changes require a lot of planning, data collection, and timing where "alignment in political will/interest aligns." The next section will outline the types of evidence and data policy leaders who participated in this study use to plan healthcare services, design the healthcare system, and bring to the Health Minister.

The use of Data in healthcare decision-making

Many participants described the use of quantitative data to evaluate the current state of service delivery and to identify service and resource needs. In other words, they often use quantitative data to identify what *is going on and what is needed*. Most talked about the process of data

gathering as essential in their work. One participant explained that "data-informed decision making is a key point" in their work. Many talked about jurisdictional scans, assessing population data, and working with economists to identify operational impact to the system. Participants in this study talked about the importance of quantitative data in their work, as one participant explained:

> "We look at policy, population demographics, a variety of inputs to shape up some considerations for health service delivery, both in refinement, making it better, and what are we missing. And then truly new services, big gaps in the system where population over time is needing those services."

Another participant noted that using existing data trends allows them to identify resource needs, develop a service-delivery plan, and justify the request for additional funding. The participant elaborated:

> "The team is looking at call volume, acuity, and patient demographics, like age. Is there a community that has [a higher] proportion of elderly patients compared to a younger population? We're looking at common diseases in those areas, to try and get a better handle on what kind of resources do we need in those communities. That's helping populate the information that we're giving back to government..."

At the same time, participants acknowledged the limitations of using quantitative data in developing service delivery plans. One participant explained, "you have health service models, social service models that are very technocratically designed and created in a bureaucracy. They may have been evidence and data informing in their creation, but they can't very effectively absorb the reality of humans in their delivery."

To ensure their plans are easily implemented, policy leaders explained the importance of engaging with the community and service providers. Gathering information mostly involves gathering qualitative data to understand context in identifying *how* services should be delivered. However, this process is not always straightforward. One policy leader expressed their frustration in integrating qualitative data and experiences to bureaucratic processes, for example when applied to emergency transport:

> "I am trying to convince the government - why would I have ambulances driving for 4 or 5 hours on the road? If I break my hip and I'm in Dease Lake, I want a helicopter to swoop in, package me up and get me somewhere. I want to be comfortable, and I don't want to be rumbling around in the back of an ambulance. Plus, when that ambulance leaves the

> community, that leaves that community unsupported because sometimes there's only 1 ambulance or sometimes there's 2, but a lot of communities only have 1 ambulance. I want to get to a policy where we wouldn't leave a community for more than 2 hours. That air [strategy is] based on what other countries are doing around the world. **But we have used some metric to actually drive the data.**" [Emphasis added]"

Many participants discussed the importance of community engagement from the perspective of healthcare providers. However, many noted they often hear about (rural) community planning second-hand from service providers. Several went on to express limited interest in engaging with community (healthcare recipients) to identify service gaps, explaining that they are concerned about hearing directly from the community who may "have a laundry list of things they would like to see done," and fear that engagement would open the "floodgates such that there are so many expectations created that could absolutely never be met." Despite this hesitation, most policy leaders acknowledged the importance of patient engagement. Specifically, policy leaders talked about the desire to ensure that all patients receive high quality care. One explained:

> "We have [a] patient centered measurement [group], which conducts patient surveys of patients who have had an experience of care within various facilities in the province. The purpose of that is to have information on patient reported outcome measures and patient reported experience measures. We collect and use [that] kind of information. I would absolutely consider it a factor that goes into policymaking, but I don't know that I would consider it as evidence."

Participants talked about several engagement strategies used to engage within communities to identify local needs, including patient surveys and patient advisory committees. Challenges noted included identifying how to determine the appropriate standard and quality of care and how to create policies and standards to enforce them. They policy leader explained:

> "I think [patient engagement] has to be a huge influence, because those are the folks that are receiving the care. If we are not listening or understanding what the needs are, how do you know you're delivering the best appropriate care, [that encompass] all the dimensions of quality. It's so important. But it's been challenging to understand or to translate what those needs are and how to translate that into those policy decisions. I think most of the decisions that are made in health care are clinician driven. What do providers need to deliver safe, appropriate care? But, again, what do people need on the ground?"

Although several respondents discussed patient engagement, fewer identified the importance of and mechanisms of community engagement.

The importance of leadership

One of the themes consistently noted by participants in this study was the importance of leadership within the Ministry, specifically the passion and desire of policy leaders to improve the healthcare system. Several participants expressed a keen desire to advocate for and contribute to policy change, one describing their experiences:

> "In quiet corners, I pushed for physician's assistants. They [have] announced they're going to bring them. Now do I think that was cause and effect? No. By no means. There was a bunch of other work that was happening, but I get to have quiet nudging conversations with ministers or deputy ministers that most people don't."

The policy leader further described the type of work they put in over a long period of time to push for a policy change:

> "...lot of personal blood, sweat, and tears for a couple years.... I hadn't had been involved and done the follow-up and the pre-meetings with the associate deputy and the assistant deputy to say, 'you guys need to show up'. These are some of the things the committee needs to hear."

As alluded to by the experience of the policy leader above, participants in this study often demonstrate long-term thinking, especially in the preparatory work they do to lay the foundation for change. This long-term thinking is best described by a policy leader who continued to share a dataset developed 10 years ago with various colleagues:

> "10 years ago, we did target population definitions for women in childbirth and pregnancy and people with chronic illness and mental health and substance use and, people with frailty... I send that document 10 years later, at least once every 6 months to somebody who's talking about something evaluating mental health [saying that] we don't have actually a provincial definition for mental health. Actually, we do. Here it is... I do think that was good work that's thoughtful and well done, is not exactly timeless because things can change, but it still is really important. However, it does depend on someone

> remembering that it was done, or figuring out ways to make sure that it can be accessible to people who look for it. [Emphasis added]"

As highlighted by the participant above, the continuation of evidence over the years "depends on [organizational] memory. Somebody's got to remember." Having a long-term organisational memory is important to not only prevent the duplication or replication of work, but to also build on existing work to gather evidence to determine healthcare need. In addition, sharing data and building relationships is central to the role of policy leaders. Another participant explicated this when they noted:

> "The Ministry of Health, although being big, is very small. People know people. I do have colleagues, friends, tables of similar roles... in other health authorities that are responsible for clinical care. We meet regularly. Text each other problems. We try to kind of learn from each other. So that's kind of just part of my role and necessity to learn."

Participants in this study noted the need to negotiate a space where they learn about and advocate for the needs of Health Authorities who administer healthcare as well as the Ministers who hold decision-making power for policy changes and resource allocation. Participants reported often finding themselves negotiating the immediate needs of the healthcare crisis and the desire to make long-term lasting change. One illustrated the challenge of negotiating both short-term resource needs from Ministers and long-term healthcare planning:

> "I think there's just too many barriers. I just think there's too many levels, and I think squeaky wheel always gets the grease (funding) in health care. I've been part of that, trying to get my share as well, to be honest. But I do think we've got to get rid of all of that and start from the basics. Let's start with our rural and remote because that's where our least resources are."

As alluded to by this Policy leader, there is a desire to redesign the healthcare system starting with rural healthcare. The next section will further discuss some of the challenges participants in this study articulated in working with the current health system.

The challenge of rural health service planning

One of the challenges participants alluded to was the different needs of rural and urban health services. The low volume of patients characteristic of rural sites meant that health centers or hospitals often lacked health human resources, expertise, and technology to support comprehensive healthcare services, recognizing that providing higher levels of care was not prudent, based on low population density. Consequently, the resources are often clustered in larger centers. As one participant explained:

> "Hospitals have set up their centers of excellence based on recruiting the smartest [physicians] from across the world, and they want to set up their program, which is great, but is it in the right place? Is it in the right hospital? Let's look at what the population is."

The same policy leader contended that healthcare expertise in certain specializations, such as for paramedics, should be concentrated in rural centers, noting, "the highest trained paramedics were put in the urban centers, and the lesser trained paramedics were put in the rural remote. It makes no sense. It should be the other way around." They further explain, 'Do we need an IV in Golden? Yes. Do we need paramedics that know how to intubate? Yes. That's the kind of stuff. So, we're trying to flip [the system] on its head.'

Challenges replicating success in rural settings

Given the size of BC, different population needs, and unique geography, many participants remarked that there is no "one size fits all" approach. One participant noted the need for a flexible approach, recognizing they are planning across a wide geography. Another elaborated on what variations in policy can look like, noting "I think it starts with... saying, you know, a policy that we're going to look at for Burnaby, may not be a policy that works in [a rural community]. So how do we allow for there to be some flexibility?"

Participants described situations where rural communities "may stretch the boundaries of a policy or procedure somewhere down or up the chain because it's the right thing for [the] patients." One participant explained that success from such initiatives can receive:

> "... some accolades, some attention, and some resources to scale it up, but then we need to share it with other people who didn't create it but want to be a part of it. And so, there's an inherent sneakiness initially and then humility when you get to share it."

In this way, participants describe how successful initiatives are implemented and replicated across BC. Another cited the success from Haida Gwaii in maintaining a birthing center. However, despite success in maintaining the birthing center, the policy leader continued to puzzle over how to re-create the success in other rural sites. They explained:

> "I think that a whole study should be done on Haida Gwaii. Because, they are a remarkable community and a remarkable site [to have] maintained low risk birthing for a decade, if not more now. And the physician partners, they don't do the birthing there, but they are completely supportive, and they work in a team-based model. They all learn together frequently, to support the community. And there's mutual respect and team-based care and all the things that happen, and all their nurses are trained...**What is it just the secret sauce of the people that that came around and rallied and worked together?** I'd like to know that, what the secret sauce is to be able to replicate that in other places. [Emphasis added]"

The impact of the electoral process on healthcare reform

As mentioned in the first section, the Minister of Health sets the policy mandate that the rest of the system aligns with. Participants noted there is a "lack of appetite" from Ministers to implement changes to the healthcare system to be "an inevitable product of our politics." One participant described their ability to continue with their initiative due to their capacity to demonstrate it "does not produce any political risks." Another explained this constraint in the context of the electoral cycle:

> "The 4-year political calendar creates the conditions where decision makers... are inevitably focused on their own political well-being and to that often will dispense (omit) long term investments or the willingness to make the kinds of changes that are necessary. "

Most policy leaders in this study described a general feeling of frustration as policymaking often "collides with politics, where the politics wins." The four-year political calendar means that Ministers/politicians favour solutions that appeals to the public for the next election cycle. As this requires the minister/politicians to respond to public sentiments, one participant explained that considering the healthcare crisis, there is the pressure to respond to individually expressed needs, noted that system change must be based on aggregate need. They further explained:

> "[People will write in to say] '...my mom did not have transportation to her health service. Therefore, we need transportation for our health services'. When I do the analysis, and

> it's 1 person in 10 weeks that need it, it doesn't make sense to start that [service]. People are trying to move from personal experience to a system view, which is hard. It's not their role. That's not what they do every day. It's their personal lives... The health system can't be everywhere for everyone. You have to have some rules in what's available."

Participants alluded to a variety of situations where the public/constituents advocate for policy and healthcare changes. Politicians' decisions are often impacted by these voices. Despite the best practices noted above, in some instances, these pressures can cause decision-makers to ignore data-driven evidence in favour of the political realities of a situation:

> "Governments are choosing to ignore good evidence, data, the coroner, the public health bodies, in what they indicate... to reduce the impact of a health crisis and choose instead kind of a nonevidence based, non-data-informed, and probably more expensive [course], which is an ironic approach to addressing a problem, because that's more politically...feasible for them."

Another Policy Leader explained in detail how the political cycle leads to a general reluctance to make extensive changes to the healthcare system, which has led to a shift in the relationship between the elected government and the healthcare bureaucracy. The policy leader explains:

> "We have a lack of a real sense of the role of a minister in a government. A minister is there as the representation of the public and the public interest. On the other hand, you've got this government machinery that operates all along. It doesn't matter what government [the] political party is in, but that machine is going. Your job as the minister is to be relentless, you are pulling that machinery to be oriented towards public interest... What I think we see more of is that the ministers have become spokespeople for the machinery."

They go on to note:

> "And the irony of this is that we get these political changeovers in BC, and it doesn't matter which [party] is on either side of the house, the language is the same. So as soon as one party is in government, they are there defending how great the whole government machinery is and what a superior job they're doing delivering it... And I think that we don't have a kind of political willingness to wrestle with what is the role of

> elected people and elected ministers in this government machinery. We've fallen more and more to where Ministers become spokespeople on behalf of the of the machinery."

Despite referring to rigorous governance structures and parliamentary processes, this policy leader alluded to a breakdown in the political process where elected politicians are not taking steps to change the healthcare system, based on evidence. The participant further explains the lack of willingness to stems partially from the complexity of dismantling the system:

> "I don't pretend to think that this is an easy thing to address, but I worry that as the machinery, the bureaucracies and the health authorities has become so dense, it's very hard to unravel the ways in which its operating, and it doesn't really matter which government is in place. We see decade over decade, the outcomes have not been terrific on the health delivery and the social services delivery. **We have a somewhat unsophisticated kind of way of, like, pointing at one individual or saying, this party is responsible for all these things."**

Policy Leaders are placed in a precarious position as individuals advocating for change within limited and somewhat static healthcare resources. However, as non-elected officials, their capacity to advocate for change remains limited. Building relationships across the healthcare system and with elected officials remains crucial. As one policy leader pointed out, "I have no qualms about whether you're a liberal, conservative, or NDP, but he (the Premier/Prime Minister) is the most powerful person in the country when it comes to resource allocation." As such, policy leaders must identify health service needs, gather financial resources, and build relationships to the implement change they advocate for. Another participant summarized their approach to making meaningful healthcare changes within this disparate system:

> "My answer is going to be courage. This is what it takes to have a different system: courage and graciousness concurrently. I'm going to have to call people out in the ministry to say that this is the going on. Be tough on issues, and still again soft on people so I am able to look them in the eye the next day."

Project Audience

By setting out to understand and address the gaps in the consideration and inclusion of rural community voices in health care policy and decision-making, this project serves residents and

leaders of rural communities, health care providers, as well as regional health authorities and the ministry of health.

Residents of rural communities in BC have unique healthcare needs and challenges compared to their urban counterparts and a lack of community engagement has led to the perception of urban-centric healthcare planning and decision making, resulting in feelings of alienation and distrust towards policy leaders and a lack of ownership in health care decision making.

Rural community leaders, including those working in health or social services, elected officials, and rural healthcare providers are able to observe and acknowledge how current healthcare systems and policies fail to address the needs of rural communities. Thus, engagement with these leaders, as well as rural residents, is vital in developing solutions that respond to these needs through services, policies, and programs. By more fulsomely understanding the perceived gap between community members and decision-makers, this study impacts and informs the potential to strengthen communication and process between the partners. Ultimately, this will lead to improved access to health care services and consequently, improved health outcomes.

Findings from this initiative provides tentative first steps to understand the lack of information flow between planners and community members, with the potential of using it to improve health planning processes. As this study analyzes the existing gaps in the use of rural community output in policy, it will help inform what resources and actions are needed from policy leaders, at both the provincial/ministerial level and the regional level through health authorities. If findings are taken up, they could lead to the development of mechanisms for engagement with rural communities and the implementation of rural community-driven solutions through policy and decision-making.

Limitations

The efficacy of this work rested in the willingness of regional and provincial policy and decision-makers to participate in interviews and share their experiences. However, our interview numbers in this category are low. Although we were persistent in our recruitment strategies, leaned on third-party contacts to assist and employed multiple avenues of contact, regional health authority representatives did not take up the opportunity. We acknowledge that this is a difficult time in healthcare operations with health human resource shortages, transportation challenges and inadequate physical infrastructure to meet the growing needs of the population, we also believe lack of uptake validates the issue at hand of challenging engagement. We do, however,

feel confident in the veracity and insight of the data collected, analyzed, and presented, and believe we have taken tentative first steps to understand the gap in community evidence to policy in BC.

Recommendations

The recommendations below are aimed at improving community involvement and engagement in health care planning, particularly in rural and remote areas of BC. They are derived from the wisdom of the participants in this study and address the challenges of entrenched bureaucracy, political influences, and the need for effective communication with diverse communities, as reported. These recommendations are directed towards the Ministry of Health (MoH) and Regional Health Authorities (RHAs) but must also involve the direct collaboration and cooperation of rural communities. *They are loosely presented under four thematic areas: community engagement and transparency, Inter-RHA collaboration and knowledge sharing, overcoming political and bureaucratic challenges and effective communication with rural and remote communities.

The recommendations are purposively underdeveloped out of the recognition of the importance of co-creation with policy and decision-makers. That is, although we present tentative directions, we need engagement of all key partners to create an effective path forward. Regional and provincial working groups will be held in the spring (2024) to actualize this agenda.

1. *Community Engagement and Transparency*

1.1 Establishing Community Engagement Units (CEUs)**: Each RHA should create a Community Engagement Unit to facilitate dialogue between the RHA and its communities. These CEUs should be staffed with existing senior executive management within each RHA and should include representation from RHA governance.

1.2 Implementing Transparent Reporting Systems: Develop publicly accessible platforms for updating and receiving feedback on healthcare initiatives.

1.3 Forming Community Advisory Boards (CABs): Create boards with diverse community members to regularly meet with RHA CEU officials. These boards could be created to include communities within a focused geographic area to ensure that small communities voices are not lost in the process.

1.4 Organizing Annual Community Health Forums: Facilitate direct interaction between community members, healthcare policymakers, and service providers.

1.5 Implementing Feedback Loops and Storytelling: Ensure community suggestions are acknowledged, reviewed, and responded to in a transparent manner.

2. *Inter-RHA Collaboration and Knowledge Sharing*

2.1 **Inter-RHA Knowledge Exchange Portal:** (1) Develop a digital platform for RHAs to share and access information on successful healthcare strategies. (2) Provide a public access point to this platform that shows and tracks the information being exchanged and allows the public to see that their concerns and solutions are being addressed at the RHA level.

2.2 **Regular Inter-RHA Conferences and Workshops:** Organize events for RHAs to present and learn from each other's initiatives and challenges. Ensure that stakeholders can also interact and attend these events to network and inform their own groups on the information provided to the RHA representatives.

2.3 **Transparent Implementation Roadmaps:** Publish detailed plans for the adoption of strategies from other RHAs, including customization for local contexts. Provide these plans to all communities engaged and disseminate them broadly within the communities through known and reliable channels.

3. *Overcoming Political and Bureaucratic Challenges*

3.1 Policy Sandbox Approach: Test innovative healthcare solutions in controlled environments, free from usual bureaucratic constraints.

3.2 Independent Health System Review Board: Set up a board to periodically review the healthcare system's effectiveness and political neutrality.

3.3 Public Accountability Measures: Implement regular public reporting, community feedback sessions, and performance audits.

4. *Effective Communication with Rural and Remote Communities*

4.1 **Dedicated Rural Outreach Teams:** (1) Establish teams within RHAs focused on maintaining communication channels with rural and remote communities (CEUs). (2) Appoint local health communication representatives in rural and remote areas. These individuals or organizations, from the communities themselves, can act as liaisons between the RHAs/MoH and the community, ensuring that communication is relevant and culturally sensitive.

4.2 **Utilization of Local Media and Community Channels:** Disseminate health-related information and gather feedback through local media channels and non-profit organizations.

4.3 **Regular Community Consultation Tours:** Have healthcare officials visit rural and remote communities for open forums and discussions.

4.4 **Enhanced Digital Infrastructure:** Improve digital access in rural areas to facilitate telehealth services and online health resources. Covid-19 has created awareness and the ability to use video platforms for communication. In-person exchanges are important and should be enhanced but digital infrastructure is essential to ensure that everyone can participate in a better public system that is inclusive and accountable to the people it should serve (everyone.) The technology now exists to ensure every community has high speed internet access in at least one location.

Conclusion

The implementation of these recommendations requires a collaborative effort from the MoH, RHAs, and community stakeholders. By adopting these strategies, we aim to create a more inclusive, transparent, and responsive healthcare system that addresses the unique needs of rural and remote communities in BC.

* Rural communities are not limited to Rural Subsidy Agreement communities (RSAs) and must include organized unincorporated communities, Indigenous communities, and any group or community within a community.
** An example of a Community Engagement Unit model is being used in North Dakota with success and more information can be viewed here.

Leveraged Funding

A further intersection of values between CRHR, BCRHN and SPARC is the commitment to engagement integrity. For the project team, this demanded our accountability through attention to sharing findings with communities not only with integrity (non-partisan transparency), but also with the intent to co-develop an implementation plan for the findings. We were determined to not contribute to the post-engagement 'vacuum' identified by so many of the research participants. To this end, we sought and have received (UBC, $9953.84) additional resources to build on the SPARC-funded knowledge translation plan to actualize a virtual space for rural and marginalized voices to participate in guided discussion regarding how we can utilize the data for further rural health engagement. Again, we will work, through synergistic advantage, through both organizations to establish key rural community partners in each health authority to participate in regional consultations based on the findings from this project.

Beyond community members, however, the target audience also includes municipal, regional, and provincial policy and decision-makers. The rural vulnerabilities noted above emphasize the need for those affected by health planning decisions to be involved in creating solutions. Our

mechanism of research mobilization will be based on a framework for Integrated Knowledge Translation (iKT), which refers to the process of early onset collaboration of knowledge users to ensure the product yields resources of use to the decision-making process, as described above. We anticipate the success of this approach due to the relationships we (re)established during the data collection for this project and the keen interest participants had in follow-up.

Knowledge mobilization will occur through the process of virtual workshops involving the regional and provincial decision makers; that is, they will participate in the development of a framework for community-to-decision-maker knowledge transfer by providing feedback on feasibility (desirability has already been determined through stated policy objectives). The primary knowledge mobilization audience, therefore, are policy and decision-makers positioned to effect change. The secondary audience will be rural communities across BC and to this end, we will develop community-facing reports summarizing the combined output of each workshop and the provincial workshop. To increase the credibility of the findings, we will also develop a manuscript to submit for peer-reviewed publication. **Ultimately, however, our prioritized output will be a community-generated strategic plan for addressing the 'gaps' in community-to-decision-maker knowledge uptake to influence policy and planning.**

Additional funding applied for again by CRHR and BCRHN to build on the SPARC-funded activities which is still under adjudication (UBC $25,000) will, if we are successful, be applied to developing a 'Rural Community Bill of Rights.' This initiative will enable rural voices to articulate their unique health needs and values, ensuring more responsive and accountable health planning. Building on our past successful collaboration, we'll work closely with rural communities to define engagement standards, accountability mechanisms, and practical applications within BC's healthcare framework. This partnership seeks to restore agency to rural communities, fostering improved health outcomes through genuine engagement and tailored health strategies. Through this approach, we will address the alienation rural communities have experienced from healthcare decision-making and planning. Ownership of the co-created product will be shared with participating communities and available through both organizations' websites. We will also use "snowball-sampling" to regionally identify marginalized communities that may require separate engagement sessions. In this way, we actualize our openness to learn from the wisdom of communities. Channels of knowledge translation will include regional and provincial meetings, a peer-reviewed publication, and, if appropriate media engagement.

The primary social benefit of this project, if funded, will be in the area of public and civic engagement as we actualize our collective responsibility to contribute to the needs of the wider community. That is, through a rigorous approach to engagement, data gathering, and report writing, we anticipate a product with a high degree of utility for rural communities currently

advocating for improved access to health services. This is due in part to the level of collaboration shared between the applicant organizations. The strength of the relationship between CRHR and BCRHN further emphasises best practices of engagement with communities in healthcare planning and in research more broadly.

In this project, *knowledge exchange* is not an end product but instead, a determining process characteristic that embeds community feedback into the development of the Bill of Rights. In this way, we are integrating knowledge exchange throughout the proposed work, culminating in the engagement with regional and provincial decision-makers. Based on our experience of the SPARC-funded Gap Analysis Project, we are confident that the relationship have been built will allow this approach.

Appendices

Appendix A: Search Strategy

We took a systematic approach to searching the literature. A search strategy was developed in consultation with a research librarian to optimize search term relevance, using both primary and secondary sources. The search query was run using MEDLINE (Ovid) using four search terms, including *health policy, decision-making, rural, and community voice*, with associated concepts. The geographic focus was refined to include developed countries with similar healthcare systems. The search and review of literature was done between June and September 2023. In the initial search, 2370 articles were identified. The researchers narrowed down the results and reviewed 30 articles discussing the role of community engagement in healthcare planning. There was limited literature on rural community engagement in healthcare planning in British Columbia and in other developed countries. Additionally, the research team reviewed current British Columbian policies and mandates relevant to the research to provide a region-specific understanding of current approaches and attitudes in the province. To ensure academic rigour, the reviewers used an adapted version of the PRISMA 2020 Checklist (Page et al., 2021)

Appendix B: Pan-Provincial Survey

Gap Analysis Survey

Study team

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Sponsor

The Social Planning and Research Council of British Columbia (SPARC BC).

Survey purpose

The purpose of this survey is to understand and document rural residents' and communities' experiences of input into or engagement with health care decision-making.

Your voice will help us understand what we hear from policy makers and rural community leaders. This research project is the first step to bridge the gap between centralized, urban-based health planning and the needs and priorities of rural communities in BC. Understanding and addressing this disconnect is a step towards fostering a more inclusive, representative, and effective health policy-making process in BC.

Your perspective as a rural resident is essential and will contribute to more equitable healthcare policies and practices across BC's diverse communities.

Risks and Benefits

We do not anticipate any harm will be caused to you by completing the survey. You do not have to answer a question in the survey if you do not want to. There will be no direct benefits from participating in the survey; however, we anticipate system level benefits, which include gaining a clearer understanding of the constraints to including community voice in healthcare planning. Participation in

this survey cannot be withdrawn after submission since responses will be anonymous and unidentifiable. You are encouraged to review your responses prior to submission to ensure accuracy and confidentiality.

Privacy and Confidentiality

Your privacy and confidentiality will be respected at all times. You will not able to be identified by your survey responses. All analyses of survey responses will be reported together to ensure participant confidentiality.

Data Access and Storage

The platform used to collect survey data are fully compliant with the BC Freedom of Information and Protection to Privacy Act (FIPPA). The survey data is kept secure and is stored and backed up in Canada. The survey data will be safely stored within the secure computer network at UBC. After survey data is downloaded, it will be encrypted to protect the information. Access to survey data will be strictly limited to the research team.

Study Results

The results of this study will be shared in various ways including journal articles, reports, oral presentations, and posters. A summary will be provide to participants. If you would like to information about the study results, please provide your email. At the end of the survey, you will be prompted to click on a link where you can opt receive a study summary.

In current best practices in research, electronic data is to be preserved for future use in open access initiatives. Open access initiatives allow researchers from different universities to share their data upon completion of studies, in an effort to stimulate further use and exploration of existing data sets. Data from this study will be uploaded to an online repository and these files will be stripped of any information that could identify participants (e.g., names, email addresses), to ensure confidentiality.

Remuneration/compensation

Survey participants can enter a draw to win one of three $100 gift cards. At the end of the survey, there will be link that will take you to another page where you will be asked to provide your email to enter the draw. This is to preserve survey response anonymity.

Contact for information about the study

If you have any questions or would like more information about this survey, you may contact Kate Wills at Kate.Wills@ubc.ca.

Contact for information about the rights of research participants

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this survey contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll free 1-877-822-8598. The Ethics ID for this study is # H23-01773.

Consent

Participating in this survey is optional. By completing the survey, you agree that consent has been given.

Click on the right arrow to continue.

Default Question Block

Which community do you live in?

Do you feel that your community's healthcare needs are adequately represented in the planning process?

- ○ Yes
- ○ No

Please elaborate on why you feel your needs are not adequately represented.

Do you agree that your community's needs are met through the health planning process?

- ○ Strongly Disagree
- ○ Somewhat disagree
- ○ Neither agree nor disagree
- ○ Somewhat agree
- ○ Strongly agree

Have you been engaged in healthcare planning in BC (i.e., through community meetings with your Health Authority, participation on special interest groups, participating in surveys)?

- ○ Yes
- ○ No

Please specify how you were engaged: surveys, public meetings or workshops, forums, etc.

Please, indicate the level at which you were engaged:

- ○ Inform: Provided with balanced and objective information to understand the problem, alternatives, opportunities, and solutions.
- ○ Inadequately informed: Provided with information but not adequately to understand the problem, alternatives, opportunities, and solutions.
- ○ Consult: Asked to provide feedback on analysis, alternatives, and decisions.
- ○ Involve: Asked to actively participate in the process, with concerns and aspirations being understood and considered.
- ○ Collaborate: Asked to be a partner in each aspect of the decision-making process, including the development of alternatives and identification of the preferred solution.
- ○ Empower: Asked to be part of the decision-making itself.

Which healthcare-related topics were you engaged in?

What aspects of this engagement process worked well?

In your opinion, what could have been done differently to improve the engagement process?

How well-equipped are you to engage in health care decision-making about issues that concern your community?

- ○ Not well at all
- ○ Slightly well
- ○ Moderately well
- ○ Very well
- ○ Extremely well

How much confidence do you have in health care decision-makers making decisions that will be best for your community?

- None at all
- A little
- A moderate amount
- A lot
- A great deal

Do you feel that your needs and concerns are genuinely considered and acted upon?

- No
- Yes

Please explain.

How aware are you of provincial or regional policies that directly affect health care in your community?

- Very aware
- Somewhat aware
- Neither aware nor unaware
- Somewhat unaware
- Very unaware

How effectively are policies communicated to you in a way you understand?

- Not effective at all
- Slightly effective
- Moderately effective
- Very effective
- Extremely effective

Are there any language or cultural barriers that might hinder this communication?

- O Yes
- O No

Please explain.

Do you think communication to the community about these policies is effective?

- O Yes
- O No

Please explain.

Do you know of any effective structures or organizations that engage your community in healthcare planning (e.g., govTogetherBC)? If so, what are they?

Is there anything else you would like to add?

Block 2

Thank you for taking the time to respond to this survey.

To enter the draw to win one of three $100 gift cards, complete this form

The link will bring you to another page where you can enter your email for the draw and/ or opt-in to receive information about the study results. This is to maintain survey response anonymity.

References

Abelson, J., Forest, P. G., Eyles, J., Casebeer, A., Mackean, G., Gauvin, F. P., Kouri, D., Martin, E., Pennock, M., & Smith, P. (2004). Will it make a difference if I show up and share? A citizens' perspective on improving public involvement processes for health system decision-making. *Http://Dx.Doi.Org/10.1258/1355819042250203*, *9*(4), 205–212. https://doi.org/10.1258/1355819042250203

Anton, S., McKee, L., Harrison, S., & Farrar, S. (2007). Involving the public in NHS service planning. *Journal of Health, Organisation and Management*, *21*(4–5), 470–483. https://doi.org/10.1108/14777260710778989/FULL/XML

Aronson, J. (1993). Giving consumers a say in policy development: influencing policy or just being heard? *Canadian Public Policy/Analyse de Politique*, *19*(4), 367–378. https://doi.org/10.2307/3551384

BC Ministry of Health. (2022). *Ministerial Mandate for Honourable Adrian Dix*. https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/premier-cabinet-mlas/minister-letter/hlth_-_dix.pdf

BC Ministry of Health, & Eby, D. (2023). *Jennifer Rice Mandate Letter*.https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/premier-cabinet-mlas/minister-letter/hlth_-_rural_health_-_rice.pdf

Beiser, M., & Stewart, M. (2005). Reducing Health Disparities: A priority for Canada. *Canadian Journal of Public Health*, *96*(2). www.igh.ualberta.ca/

Berland, A. (2019). Lessons from the field for community engagement and accountability. *International Journal of Health Governance*, *24*(4), 261–266. https://doi.org/10.1108/IJHG-05-2019-0030/FULL/XML

Boivin, A., Lehoux, P., Burgers, J., & Grol, R. (2014). What Are the Key Ingredients for Effective Public Involvement in Health Care Improvement and Policy Decisions? A Randomized Trial Process Evaluation. *The Milbank Quarterly*, *92*(2), 319–350. https://doi.org/10.1111/1468-0009.12060

Braveman, P. A., Kumanyika, S., Fielding, J., LaVeist, T., Borrell, L. N., Manderscheid, R., & Troutman, A. (2011). Health Disparities and Health Equity: The Issue Is Justice. *American Journal of Public Health*, *101*(Suppl 1), S149. https://doi.org/10.2105/AJPH.2010.300062

Brinkerhoff, D. W. (2004). Accountability and health systems: toward conceptual clarity and policy relevance. *Health Policy and Planning*, *19*(6), 371–379. https://doi.org/10.1093/heapol/czh052

British Columbia Ministry of Health. (2015). *The British Columbia Patient-Centered Care Framework*.

Charles, C., & DeMaio, S. (1993). Lay Participation in Health Care Decision Making: A Conceptual Framework. *Journal of Health Politics, Policy and Law*, *18*(4), 881–904. https://doi.org/10.1215/03616878-18-4-881

Church, J., & Barker, P. (1998). Regionalization of Health Services in Canada: A Critical Perspective. *Https://Doi.Org/10.2190/UFPT-7XPW-794C-VJ52*, *28*(3), 467–486. https://doi.org/10.2190/UFPT-7XPW-794C-VJ52

Fagnan, L. J., & Dolor, R. (2015). From the North American Primary Care Research Group: PBRN CONFERENCE HIGHLIGHTS STAKEHOLDER ENGAGEMENT AND DANGEROUS IDEAS. *Annals of Family Medicine*, *13*(5), 496. https://doi.org/10.1370/AFM.1861

Farmer, J., Taylor, J., Stewart, E., & Kenny, A. (2018). Citizen participation in health services co-production: a roadmap for navigating participation types and outcomes. *Australian Journal of Primary Health*, *23*(6), 509–515. https://doi.org/10.1071/PY16133

Family Practice Services Committee. (n.d.). Primary Care Networks . Retrieved January 9, 2024, from https://fpscbc.ca/what-we-do/system-change/primary-care-networks

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development. *International Journal of Qualitative Methods*, *5*(1). http://www.ualberta.ca/~iiqm/backissues/5_1/pdf/fereday.pdf

Gaston, M. H. (2001). 100% access and 0 health disparities: Changing the health paradigm for rural women in the 21st century. *Women's Health Issues*, *11*(1), 7–16. https://doi.org/10.1016/S1049-3867(00)00090-6

Greig, M. (1990). The psycho-social perspective on social inequalities in health. *Sociology of Health and Illness*, *20*(5), 598–618.

Grzybowski, S., Fahey, J., Lai, B., Zhang, S., Aelicks, N., Leung, B. M., Stoll, K., & Attenborough, R. (2015). The safety of Canadian rural maternity services: A multi-jurisdictional cohort analysis. *BMC Health Services Research*, *15*(1), 1–7. https://doi.org/10.1186/S12913-015-1034-6/TABLES/7

Grzybowski, S., Stoll, K., & Kornelsen, J. (2011). Distance matters: A population based study examining access to maternity services for rural women. *BMC Health Services Research*, *11*(1), 1–8. https://doi.org/10.1186/1472-6963-11-147/TABLES/6

Hogg, C., Soc Admin Studies, D., & Williamson, C. M. (2001). Whose interests do lay people represent? Towards an understanding of the role of lay people as members of committees. *Health Expectations*, *4*(1), 2–9. https://doi.org/10.1046/J.1369-6513.2001.00106.X

BCACHC. (n.d.). Retrieved January 9, 2024, from https://bcachc.org/

International Association for Public Participation. (n.d.). *IAP2 Spectrum*. Retrieved January 9, 2024, from https://iap2canada.ca/Resources/Documents/0702-Foundations-Spectrum-MW-rev2%20(1).pdf

Johnston, C. S., Belanger, E., Wong, K., & Snadden, D. (2021). How can rural community-engaged health services planning achieve sustainable healthcare system changes? *BMJ Open*, *11*(10), e047165. https://doi.org/10.1136/BMJOPEN-2020-047165

Kenny, A., Hyett, N., & Dickson-Swift, V. (2018). Reconceptualising community participation in primary health. *Australian Journal of Primary Health*, *23*(6), i–ii. https://doi.org/10.1071/PYV23N6_ED

Kilshaw, M. (2002). *Rural health in British Columbia: The determinants.*

Kirby, M. J. L., & Le Breton, M. (2002). *The Health of Canadians – The Federal Role. Volume Two: Current Trends and Future Challenges.*

Koch, T. (2003). *9 months later: Changes to the BC public health care system. BC Health Care Infrastructure Changes: A preliminary assessment of proposed changes to the BC health care system.*

Kornelsen, J., Carthew, C., & Lloyd-Kuzik, N. (2022). Optimizing Community Participation in Healthcare Planning, Decision Making and Delivery through Rural Health Councils. Healthcare Policy, 18(2), 27. https://doi.org/10.12927/HCPOL.2022.26972

Kornelsen, J., Carthew, C., Míguez, K., Taylor, M., Bodroghy, C., Petrunia, K., & Roberts, D. (2021). Rural citizen-patient priorities for healthcare in British Columbia, Canada: findings from a mixed methods study. *BMC Health Services Research*, *21*(1), 1–12. https://doi.org/10.1186/S12913-021-06933-Z/TABLES/2

Légaré, F., Stacey, D., Forest, P. G., Archambault, P., Boland, L., Coutu, M. F., Giguère, A. M. C., LeBlanc, A., Lewis, K. B., & Witteman, H. O. (2022). Shared decision-making in Canada: Update on integration of evidence in health decisions and patient-centred care government mandates. *Zeitschrift Fur Evidenz, Fortbildung Und Qualitat Im Gesundheitswesen*, *171*, 22–29. https://doi.org/10.1016/j.zefq.2022.04.006

Legislative Assembly of BC. (2023). *Report on the Budget 2024 Consultation. Second Report.*

Leipert, B. D., & Reutter, L. (2005). Developing Resilience: How Women Maintain Their Health in Northern Geographically Isolated Settings. *15*(1), 49–65. https://doi.org/10.1177/1049732304269671

McClean, J., & Trigger, K. (2018). Not just tea and biscuits; the Gold Coast Primary Health Network process of designing, implementing and operating a Community Advisory Council. *Australian Journal of Primary Health*, *23*(6), 504–508. https://doi.org/10.1071/PY16157

Mitton, C., & Donaldson, C. (2002). Setting priorities in Canadian regional health authorities: a survey of key decision makers. *Health Policy*, *60*(1), 39–58. https://doi.org/10.1016/S0168-8510(01)00190-7

Mitura, V., & Bollman, R. (2003). The health of rural Canadians: A rural-urban comparison of health indicators. *Rural and Small Town Analysis Bulletin | Statistics Canada*.

Montesanti, S. R., Abelson, J., Lavis, J. N., & Dunn, J. R. (2017). Enabling the participation of marginalized populations: case studies from a health service organization in Ontario, Canada. *Health Promotion International*, *32*(4), 636–649. https://doi.org/10.1093/HEAPRO/DAV118

Nagarajan, K. V. (2004). Rural and remote community health care in Canada: beyond the Kirby Panel Report, the Romanow Report and the federal budget of 2003. *Canadian Journal of Rural Medicine*, *9*(4), 245–251.

Northern Secretariat of the BC Centre of Excellence for Women's Health. (2001). *The Determinants of Women's Health in Northern Rural and Remote Regions | Examples and Recommendations from Northern British Columbia*.

O'Neil, J. D., & Gilbert, P. (1990). *Childbirth in the Canadian North: Epidemiological, Clinical and Cultural Perspectives*. University of Manitoba. Department of Community Health Sciences. Northern Health Research Unit.

Pagatpatan, C. P., & Ward, P. R. (2017). Understanding the factors that make public participation effective in health policy and planning: a realist synthesis. *Australian Journal of Primary Health*, *23*(6), 516–530. https://doi.org/10.1071/PY16129

Page, M., McKenzie, J., Bossuyt, P., Boutron, I., Hoffmann, T., Mulrow, C., & et al. (2021). *PRISMA 2020 Statement: an updated guideline for reporting systemic reviews*. https://doi.org/10.1136/bmj.n71

Pauly, B., Macdonald, M., Hancock, T., Martin, W., & Perkin, K. (2013). Reducing health inequities: The contribution of core public health services in BC. *BMC Public Health*, *13*(1), 1–11. https://doi.org/10.1186/1471-2458-13-550/PEER-REVIEW

Pielstick, C. D. (2000). Formal vs. Informal Leading: A Comparative Analysis. *7*(3), 99–114. https://doi.org/10.1177/107179190000700307

Pitblado, J. R., Pong, R. W., Irvine, A., Nagarajan, K. V., Sahai, Vlc., Zelmer, J., Dunikowski, L., & Pearson, D. (1999). *Assessing Rural Health: Toward developing health indicators for rural Canada*. Laurentian University, Centre for Rural and Northern Health Research.

Province of BC. (n.d.). *For the Public | How is the Public Health System Organized in BC?* Retrieved January 9, 2024, from https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/about-public-health/for-the-public

Public Health Agency of Canada, & Pan-Canadian Public Health Network. (2018). *Key Health Inequalities in Canada*.

Reimer, B. (2010). Rural and Urban: Differences and Common Ground. In Harry H. Hiller (Ed.), *Urban Canada: Sociological Perspectives* (2nd ed., p. 87). Oxford University Press.

Report of the Royal Commission on Aboriginal Peoples. Volume 3: Gathering strength. (1996). https://publications.gc.ca/collections/collection_2016/bcp-pco/Z1-1991-1-3-eng.pdf

Ryan-Nicholls, K. (2003). Health and Sustainability of Rural Communities. *Rural and Remote Health*, *4*.

Safaei, J. (2015). Deliberative democracy in health care: current challenges and future prospects. *Journal of Healthcare Leadership*, *7*, 123. https://doi.org/10.2147/JHL.S70021

Shields, M., & Tremblay, S. (2002). The Health of Canada's Communities. *Supplement to Health Reports | Statistics Canada*, *13*(Catalogue no. 82-003-ZIE).

Smith, K. B., Humphreys, J. S., & Wilson, M. G. A. (2008). Addressing the health disadvantage of rural populations: How does epidemiological evidence inform rural health policies and research? *Australian Journal of Rural Health*, *16*(2), 56–66. https://doi.org/10.1111/J.1440-1584.2008.00953.X

Smith, W. C., & Benavot, A. (2019). Improving accountability in education: the importance of structured democratic voice. *Asia Pacific Education Review*, *20*(2), 193–205. https://doi.org/10.1007/S12564-019-09599-9/FIGURES/2

Sparc BC. (n.d.). *Mission and Values*. Retrieved January 9, 2024, from https://www.sparc.bc.ca/about-us/mission-and-values/

Statistics Canada. (2022). *Population growth in Canada's rural areas, 2016 to 2021*. 2021 Census. https://www12.statcan.gc.ca/census-recensement/2021/as-sa/98-200-x/2021002/98-200-x2021002-eng.cfm

Strasser, R. (2003). Rural health around the world: challenges and solutions. *Family Practice*, *20*(4), 457–463. https://doi.org/10.1093/FAMPRA/CMG422

Van De Mieroop, D., Clifton, J., & Verhelst, A. (2019). Investigating the interplay between formal and informal leaders in a shared leadership configuration: A multimodal conversation analytical study. *Https://Doi.Org/10.1177/0018726719895077*, *73*(4), 490–515. https://doi.org/10.1177/0018726719895077

BCRHN
British Columbia
Rural Health Network

May 2024 Edition

A Letter from our President

Dear Readers;

May 1st! I can hardly believe it! Looking forward to May flowers and even some more showers as at least in our area it still is pretty dry!

Lots happened for the BCRHN in April!

Exciting things are happening with the Transplant Committee, in that Premier Eby met with Christine and Paul to discuss the hardships faced by those who live rurally and need transplants in our province. Christine's courage to come forward and shine the light on difficulties people face with lack of service coordination, transportation, and cost.

We are also hopeful that looking at solutions to these issues that surround rural residents needing transplants, will also provide solutions to the challenges that rural and remote residents face who must travel for health services.

I am constantly learning new things by being a member of the BCRHN. I was recently introduced to the UBC Run and Ride for Rural Medicine. The 20th annual event was held on April 27th and April 28th and is an annual fundraiser organized by medical students to raise money for charity. I was so impressed that one of the members of one of the other groups I am involved with, the Rural Citizens Perspective Group, participated in the run. Thank you, Irina! Hope Air, as you know, is one of our partners here at the BCRHN and was the recipient of this year's fundraising event. I am so pleased that the difference that Hope Air makes in rural and remote residents' lives is recognized and honoured in this way.

Thank you to all involved in the organization, who participated in the run, and to those who donated!

Speaking of learning, the position paper on Agency Nursing that was initiated by the Implementation Committee will be released soon. I'm sure you will find it an informative and thoughtful look at this complicated topic.

and provide information on these important topics to our board. Their most recent presentation was on micro-aggressions...so interesting! see the video here

If you haven't had a chance to look at the **Gap Analysis Report** that was recently completed by Dr Jude Kornelsen's team in partnership with the BCRHN, please take a bit of your time to have a look. The survey was pan-provincial and looked at "the gap that occurs between rural community into health care planning and decision makers using the wisdom gained from lived and living experience."

Rural and remote residents indicated that they felt a lack of engagement in the health planning process. We have received additional support to follow through with regional consultations to hear about what next steps should be taken to address these gaps.

The Executive resumed our regular quarterly meetings with Interior Health in April. We believe it's so important to have the Regional Health Authorities hear the difficulties being faced by rural residents directly from us. We are very pleased that this is important to Interior Health as well. We appreciate their time and commitment and we hope to engage the other Regional Health Authorities in regular meetings as well.

I also feel the need to mention the continued issues surrounding transportation. So frustrating to hear of people not being able to go to their appointments as they have no way to get there! Locally, I am aware of a situation where a person needed to travel 2 hours each way to get to their consult for surgery, relying on friends or volunteers to get there. Then again for their surgery, (thankfully **Hope Air** covered hotel costs for the night before surgery) and now for follow-up appointments. The person is not only very stressed about whether anyone can take her to her appointments but also feels so bad for "being a burden "to friends and volunteers for always having to ask them. Certainly, extra stress is not conducive to a restful recovery!

I am aware of the difficulties surrounding getting to ongoing treatments like dialysis in the Nelson area. People are having to make arrangements to travel to Trail, several times a week for their treatments. Travelling for Dialysis, Chemotherapy, and of course, just for routine appointments is a challenge when there is no transportation.

The "**Bus of the North**" is an initiative that has started in the North. It is set up to help an individual organize their transportation to appointments by providing contact information for transportation services in each of the communities it serves, from Haida Gwaii to Prince George and from Fort St. John to Williams Lake, and the communities between. This initiative is a great step in the right direction but more work on accessible and reliable transportation in rural and remote BC is needed.

Before I sign off, I want to acknowledge that it was National Volunteer Week in Canada April 14 -20th. I want to send a thank you to all volunteers who give so much of their time to make life better for all!

And a special shout out to Paul and Phoebe who work so hard and volunteer so much of their time in addition to their paid hours to the BCRHN, our Board of Directors, and

Please enjoy the rest of the newsletter!

Only my best,

Peggy

From the Desk of the Executive Director

Greetings Members and Supporters,

April has been a month of meaningful progress and advocacy for the BC Rural Health Network, marked by significant milestones and strategic engagements aimed at advancing our mission to improve health equity across British Columbia. We have focused on our transplant patients and the financial hardship faced by them, but this work is leading to broader and more comprehensive work in travel, housing and assistance for those needing to leave their community for care.

Here's an overview of our activities and what's next for our network:

Newsletter Subscription
If you are receiving this newsletter for the first time and you are a member of the BC Rural Health Network, I apologize! I thought that all members of the Network were automatically enrolled in our newsletter subscription, but this was not the case. If you are now receiving this newsletter and don't want to, please unsubscribe and you will not be re-added. From now on though, all new members will be subscribed to the newsletter, and I apologize if you have not received these updates on a regular basis, you can always view past editions by visiting the newsletter archives **here**.

Housing, Travel and Transplants
As reported in the mid-month news, this month, I travelled to Victoria alongside Jacqueline Podewils from the Lung Transplant Housing Support Group where we accompanied Christina Derksen-Unrau, a lung transplant patient and Arlen Unrau, her husband and care provider. We met with key political leaders, including the BC Conservatives, BC United, BC Greens, and the Premier of British Columbia. Our discussions focused on the challenges faced by transplant patients, particularly those travelling long distances for care. We were hosted for lunch by Parliamentary Secretary for Rural Health, Jennifer Rice, and Parliamentary Secretary for Rural Development, Roly Russell, and had some great discussions with all we engaged with. We were all recognized in the Legislature by the Premier and Roly Russell which was both moving and appreciated. This visit has set the stage to ensure transplant

Jacqueline Podewils taking over Victoria and celebrating our future win on "Housing is Healthcare"!

The work has just begun on creating equity in access for this niche group of patients who face egregious inequity in seeking the life-saving surgery they need. Following the meetings in Victoria, our work continued with a variety of meetings with many key stakeholders as well as philanthropists who have a desire to help those in need.

Post Victoria, I met virtually with Eric Lun, who is the Executive Director of the BC Transplant team and was most generous in providing his time and his ear to our concerns. We wanted to ensure that BC Transplant and all key stakeholders know that our concerns are not with the amazing work of the transplant teams, and the amazing support of many charities and non-profit organizations that help patients, but with the gaps in coverage and the system-wide lack of assistance in navigating the complex and scattered resources that could be and should be available to all those in their care. Eric has been appreciative of the feedback and input and has assured working with us in providing better solutions moving forward. We are not a group that starts a project without moving forward with solutions and we intend to continue our work until we have a comprehensive support system in place for all those who need our help.

Some amazing people have come to light in this process. Christina found her “earth angel” in the generous donation from Gary Johal who has provided the financial support she will need following her surgery. Likewise, at least 3 other people have been given financial support and housing support to allow them to have a less

heroes, and we appreciate you. One such hero is working on bringing investors into the picture to purchase real estate for long-term utilization as medical housing. This presents yet another amazing opportunity for those needing to stay close to Vancouver for care and presents challenges in ensuring that such a facility remains as intended (housing for healthcare), has operational funding and can provide a much-needed long-term solution to this ever-increasing challenge.

As you also know, we have many existing groups that provide services to help rural and remote residents reach the care they need. We partner with Hope Air and recognize them for their amazing service and continue to promote their services pan-provincially. We also support the work of many other organizations that provide niche services and are sometimes overlooked in the bigger picture but I do want to thank the amazing work of Angel Flight East Kootenay, Angel Flight, Helicopters without Borders, Wheels of Hope, Canadian Cancer Society, United Way, Ronald McDonald House BC and Yukon, Shriners Care for Kids, Canuck Place, Living Kidney Donor Expense Reimbursement Program, Lung Transplant Housing Support, Heart Transplant Home Society, The Kidney Foundation, Happy Liver Society, Burn Fund Centre, The Right Fit, David Foster Foundation and the many government and indigenous programs that do assist many people in reaching care and providing mobility options for those in care outside of their home community. Thank you all! (I apologize to the many who I have likely missed.)

Health Authorities

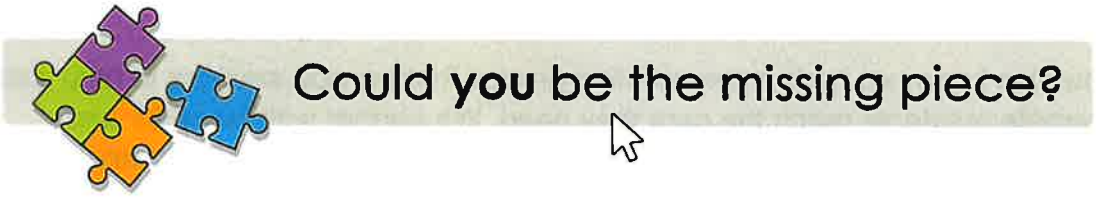
As mentioned by Peggy, our meetings with the Interior Health Authority Executive and supporting staff have resumed. These meetings provide the opportunity for direct engagement and provision of the community experience at the highest level. In our latest meeting, we covered a variety of topics and set the stage for more productive and action-oriented conversations moving forward.

We have also engaged with the Northern Health Authority Executive and I was informed today that a meeting is now being set to establish an initial meeting with the NH Executive and Peggy and I. The meeting date will be provided soon and we hope to establish regular meetings moving forward as a means to enhance the community engagement process with Northern Health as well as the Interior Health Authority.

It is our sincere hope that the work we continue to do in partnership with UBC Centre for Rural Health Research and the Gap Analysis will lead to providing insights into new pathways to community engagement and processes that are not driven by our view on how this should occur but from the viewpoint of the communities we champion. You will have received and been given the opportunity to engage in the next round of community consultation on this project and these regional working groups will provide the foundational work in presenting solutions and options to the Health Authorities and to the Ministry to effectively engage with those who currently feel invisible. If you missed this invite please reach out to us at info@bcruralhealth.org

Media Engagement

publicity and political engagement. We recently shared insights on CBC Radio North regarding our Gap Analysis and other local media and radio spots we have engaged with in April. Our active media strategy ensures that rural health issues remain a focal point as we advocate for solutions.



Fundraising Initiatives
Post-Victoria, I met with marketing specialists in Vancouver to refine our fundraising strategies. A personal friend and amazing human has also generously offered his services and is helping connect us with potential supporters. We are exploring new fundraising avenues, including a dedicated donation page and targeted marketing campaigns, to sustain and amplify our impact. We are limited in our ability to network, travel and work with others simply due to the lack of funding streams available to us. We appreciate all our existing supporters which include HopeAir, the Ministry of Health, the RCCbc, UBC Centre for Rural Health Research and the travel support we have been provided by hosts of meetings and conferences to which we have been invited without the financial means to attend. Thank you all! We do need more money to do our work in a meaningful way and have the ability to pay our existing employees a living wage and to further expand our team. We are not there yet but we will overcome this challenge too!

Collaborations and Community Engagement
Our network is expanding, with new members such as the Nuu-chah-nulth Tribal Council, Mackenzie Social Services, Williston Lake Elders Society and the Canadian Cancer Society joining us. Our outreach efforts, led by Phoebe, continue to strengthen our community ties. Thank you, Phoebe, I cannot say enough good things about the work you do and the time you give to make life better for rural residents in BC.

Looking Ahead
In the coming month, our focus will shift towards enhancing our fundraising efforts and preparing for a presentation to the Select Standing Committee on Finance. We are also planning a town hall session with the **British Columbia Association of Community Health Centres**. With the provincial election season approaching, we anticipate increased media interest and public engagement.

Thank you for your unwavering support and commitment to the BC Rural Health Network. Together, we are making strides towards a healthier, more equitable British Columbia.

Yours in health and wellness,

Community Connect: An Update on Our Outreach Initiatives

Hi everyone!

For those I haven't had the pleasure of connecting with yet, please allow me to extend a warm introduction. My name is Phoebe and I am the Community Outreach Coordinator with the BC Rural Health Network.

As many of you know, in my role with the BCRHN as the community outreach coordinator, I have been engaged in a Community Outreach Initiative in collaboration with the **BC Association of Community Health Centres (BCACHC)** and the Innovations Solutions Unit (ISU) at UBC, **Hope Air** and **United Way BC (UWBC)** over the past few months.

As I continue with outreach work, I am immensely grateful for everyone who has taken the time to speak with me and share their insights and personal experiences related to accessing care in their community. We sure have some incredible individuals across the province working tirelessly to make positive change!

In our last newsletter, we did a callout for stories from rural residents on their experiences in travelling to access care in larger centres. The response we received was incredible. Over the past few weeks, my inbox has been full of stories from rural residents such as yourselves, taking the time to share their stories with me. I can't thank you enough for your care and courage in trusting me with your stories. Although these stories were coming from all over the province and were unique in their experiences, the sentiments remained the same: more support is needed for rural residents in accessing care and navigating BC's healthcare system. These stories further highlight the importance of the support services that do exist, including but not

As we move into the warmer months, I know that many of us are worried about what the summer will hold, with many areas already in a drought, the prospect of record-breaking heat and forest fires already sparking across the province. It is important to stay up-to-date on current events in your area and relevant information on how to stay safe. You can check out the Emergency Response and Preparedness Page on our website for resources and information. I urge you to have an emergency bag ready with enough essentials to last you at least 72 hours, and your important documents. Please visit FireSmart BC for further information and resources to help you prepare yourselves and your homes. During these times, make sure to check on your neighbours!

Thank you for reading! As always, I am continuing my community outreach work and would love to hear from you. Please feel free to send me an email at phoebe.lazier@bcruralhealth.org.

Best,
Phoebe

Everyone has questions about sex. Ask Options for Sexual Health!

Sex Sense is a free, pro-choice, sex-positive, and confidential service. Their team of registered nurses, counsellors, and sex educators offer information and resources on sex, sexuality and sexual health, for people living in British Columbia and the Yukon.

Their hours of operation are Monday to Friday 9 a.m. to 9 p.m. Pacific Time. They are closed on weekends and public holidays.

How to get in touch:

- Call at 1-800-739-7367 throughout BC or 604-731-7803 in the Lower Mainland
- Submit your question through the email form here.

Visit the Sex Sense Website

OPTIONS FOR SEXUAL HEALTH

RHSRNbc Youth Symposium 2024

The Rural Health Services Research Network of BC is holding a virtual symposium with a focus on engaging with and empowering rural youth leaders in the face of climate change and ecosystem disruption. A big theme for this symposium is the term solastalgia, which refers to the distress that individuals feel when they witness environmental changes impacting them directly in their home environment.

Participants will have an opportunity to connect with like-minded individuals, hear directly from youth who are already making an impact in their communities, and learn actionable items that they can take back to their local contexts as leaders.

This event is open to all ages, but with a particular focus on youth (age 15 – 30), as we discuss the need for bottom-up approaches driven by the cumulative effects of grassroots and local initiatives, in addressing the climate crisis.

Learn more and register

RHSRNbc is running a photography contest alongside the symposium! Submit up to three of your favourite photos to describe what solastalgia and climate change look like to you, and be entered in a draw to win a $75 gift card to a place of your choosing! More details can be found here.

The deadline for photo submissions is May 14, 2024, 11:59 pm PDT

BRITISH COLUMBIA RHC Rural Health CONFERENCE

May 24 - 26, 2024

Whistler Conference Centre
On the ancestral and traditional territory of the Sḵwx̱wú7mesh and Líl̓wat7úl peoples

There's something special about the BC Rural Health Conference. It's not just the knowledge you gain, but also the friendships you form. Embrace the excitement, the learning, and the camaraderie that makes this event so exceptional!

We are thrilled to feature an amazing line-up of speakers and topics in our program that is packed with opportunities to network and interact with individuals who can share and learn the unique benefits of rural practice. Highlights include:

- Social and networking events to connect with rural peers, including locums
- Interactive breakout sessions and hands-on skills workshops to discover current and emerging trends in rural medicine
- Pre-conference courses include: The CARE Course Goes WILDE and the Rural POCUS Congress
- Presentation of the BC Rural Health Awards on Friday afternoon
- Wellness opportunities, including stretching and yoga sessions, complimentary chair massages, guided hikes and other excursions
- Free (and fun) childcare during conference hours

Register now!


JUNE 17TH IS
HOPE AIR
DAY
Join us on June 17 as we shine a light on the medical travel needs of people living in B.C., and our commitment to equitable access to health care regardless of distance or cost.
HOPE AIR
Pledge your support at hopeair.ca/bc

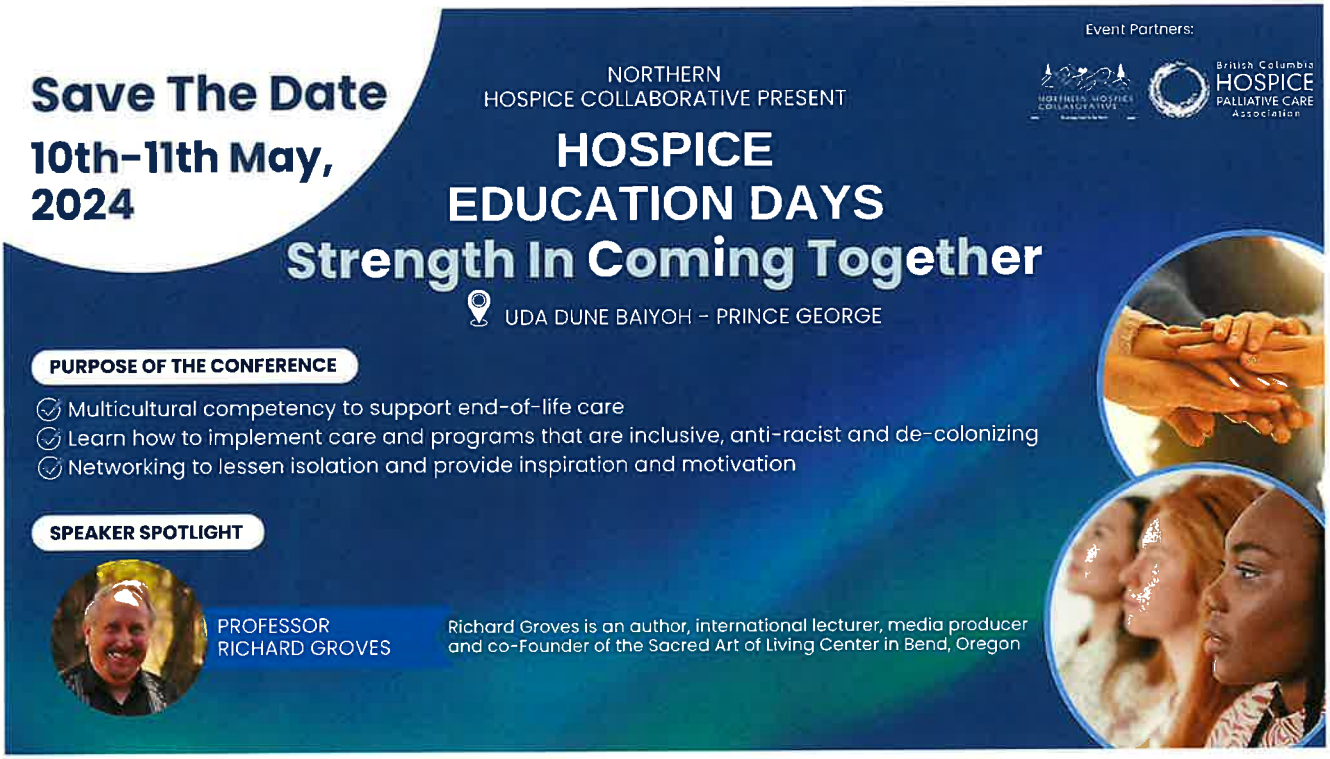
The BC Rural Health Network and the Centre for Rural Health Research at UBC have just completed a project, funded by the Social Planning and Research Council of BC, on the gap that occurs between rural community input into health planning and decision-makers using the wisdom gained from lived and living experience. You can find a copy of the report here. We heard that most rural residents experienced a lack of engagement in the health planning process, that there was not a clear line to decision makers and that community needs were not well understood.

We have received additional funding to follow up through regional consultations to hear from rural residents about what the next steps should be. To action this, we are holding a series of virtual regional engagements over the next few months. If you would like to attend, you will be provided with a link to the report, a one-page overview and an executive summary. During the engagement session, we will work through a series of questions and allow time for open discussion.

If you are interested in the role of community voice in provincial decision-making, we welcome your participation. Please reach out to Phoebe Lazier (Phoebe.Lazier@bcruralhealth.org), BC Rural Health Network Community Outreach Coordinator.

Advancing Community Engagement in Healthcare in Rural BC

Northern Hospice Collaborative - Strength in Coming Together -



This year's Hospice Education Days event promises to be a unique and informative experience focusing on the specific needs of Northern Hospice Collaborative and the communities they support. The two-day in-person event will feature various engaging sessions and workshops addressing the challenges and opportunities of delivering hospice care in northern regions. We have curated a program centred around the theme of "Northern Hospice Collaborative - Strength in Coming Together."

Topics such as multicultural competency to support end-of-life care, community outreach, and the practicality of virtual grief support will be covered in depth, providing attendees with practical tools and insights to better serve the hospice and palliative care communities. Additionally, the event will offer opportunities for networking and collaboration with allied professionals and community members.

The event is an excellent opportunity for hospice care industry professionals to stay updated, connected, and motivated while gaining valuable insight into the specific needs of northern communities.

Learn more & register

Working Caregivers Connect: BC Virtual Support Group

This support group fosters a supportive environment where you can freely share your experiences, seek valuable advice, and connect with others who are also navigating the delicate balance between caregiving and work. This support group is offered on the 4th Tuesday of each month from 7:00 pm - 8:30 pm.

Register in Advance Here!

Please join us for a virtual event about the Community Health Centre (CHC) model of care and the benefits of team-based care. Hear from CHCs and ask questions about CHCs in the community.

Featured CHCs:

STEPS

Supporting Team Excellence with Patients Society

(Kamloops and Sun Peaks)

Bowen Island Community Health Centre

(Bowen Island)

Umbrella Multicultural Health Co-op

(New Westminster and the Fraser Valley)

When: June 19th, 2024 from 1:00-3:00 PM PDT

Where: This is a virtual event held over Microsoft Teams

Please reach out to Phoebe at phoebe.lazier@bcruralhealth.org with any questions you may have

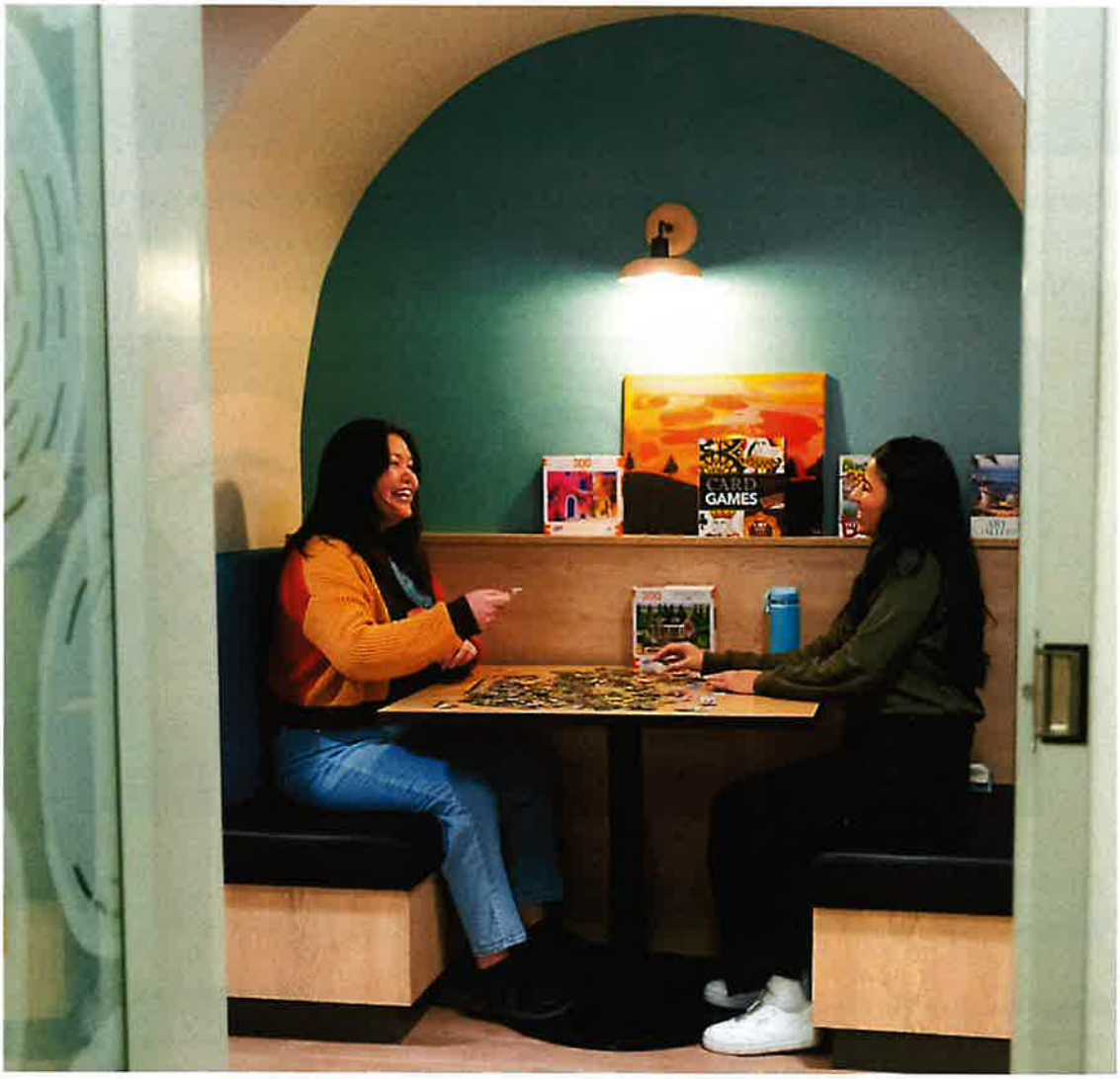
Click here to register!

BCACHC
BRITISH COLUMBIA ASSOCIATION OF COMMUNITY HEALTH CENTRES

BCRHN
British Columbia Rural Health Network

Register Here!

May Member of the Month: Foundry



Foundry is a province-wide network of integrated health and wellness services for young people ages 12-24 and their caregivers. Integrated Youth Service (IYS) allow young people access to five core services in one convenient location: mental health care, substance use services, physical and sexual health care, youth and family peer supports, and social services.

Foundry's beginnings can be traced back to 2007 when a small team of psychiatrists at St. Paul's Hospital – an academic health sciences centre operated by Providence Health Care in downtown Vancouver – decided to take a completely different approach to helping young people. They knew that young people needed better access to mental health and substance use care, and primary health care. Also,

launched the Inner City Youth (ICY) program, which soon transitioned into the Granville Youth Health Centre. Since 2015, Foundry has expanded across the province, with 16 operating centres (in addition to Foundry Virtual BC) including centres in several rural communities. There are 9 more centres currently in development, and an additional 10 to come with the recent Foundry expansion announcement that was shared in March 2024.

Recognizing the continued need for mental health and wellness services across BC, several teams at Foundry are focusing on how to make services more accessible and expand to youth living in rural communities. One of our primary goals is to work with and alongside community members to learn, adapt and evolve our services and better support the needs of rural and remote youth and families. Acknowledging we still have work to do in bringing this vision to reality, we hope to highlight the current and future direction for Foundry to increase accessibility for communities like yours.

Virtual Services for Youth and Caregivers Across BC

Foundry Virtual BC offers free same-day and scheduled services to youth aged 12-24 and their caregivers anywhere across BC, through the Foundry BC app. All services a young person can access at their local centre are available through the Foundry BC app. Based on youth engagement and feedback, one unique element of Foundry's virtual services is the modality of which appointments are accessed. Youth and caregivers can choose whether they want to access services by video, audio or chat options. We also offer phone appointments and a web portal (accessed through desktop devices) for those without a smart device and where internet is not available.

work collaboratively with providers in rural and remote communities, where it is identified by the community that virtual services could play a supportive role—together with local services and providers—in helping fill service gaps. Open 7 days a week, all services accessed through the Foundry BC app free, and no referrals are required. When supportive, our team can bridge support between community providers and Foundry Virtual BC, through our Intake Coordinator. Please email online@foundrybc.ca to get connected!

Attending various wellness fairs, conferences and local events — including most recently the All Native Basketball Tournament in Prince Rupert — Foundry Virtual BC has had the opportunity to build relationships, make connections and increase awareness and uptake of virtual services for young people and families in rural and remote communities. If you would like to learn more about virtual services and explore if/how they can support your community, please email Foundry's Communications Officer, Sierra Turner at sturner@foundrybc.ca.

Community Development at Foundry

Our Community Development team has been working with several communities to build capacity and reduce barriers to services. This past winter, we partnered with the Kaxla Heiltsuk Society to bring young people from Bella Bella to visit Foundry Port Hardy. Our hopes of having youth see and experience a Foundry centre were successfully met, and allowed our team to hear directly the wants, needs and feedback. Youth noted it was important for them to see a space and meet service providers in person, encouraging our team to explore further planning for future trips.

We also recently piloted an Access Point project in partnership with the Kootenay Columbia Learning Centre in Castlegar, where students co-designed a wellness room where they could comfortably and safely connect with Foundry Virtual BC. They taught us how we can be creative in relationship building and tested out a hybrid approach to

We are continuing to build partnerships with rural, remote and Indigenous stakeholders across the province and are thrilled to join on as a member of the BCRHN. Foundry recently joined Northern Health as a key partner in the community-based substance use prevention project (Planet Youth), which aims to build capacity in the North, implementing the Icelandic Prevention Model.

Foundry is Expanding

The March 4th expansion announcement of 10 new centres continued to push us to hear rural voices. This expansion process brought more applicants from rural communities than ever before, further highlighting the need for youth mental health and substance use resourcing. We will continue to learn from these communities in our goal to understand and deliver appropriate services in a meaningful way in non-urban communities. While the expansion of 10 centres was great news, it also meant many rural communities who applied did not receive a Foundry Centre. Our rural and remote community development team is continuing to work with these communities and hopes that we can find creative ways to fill any gaps, when appropriate.

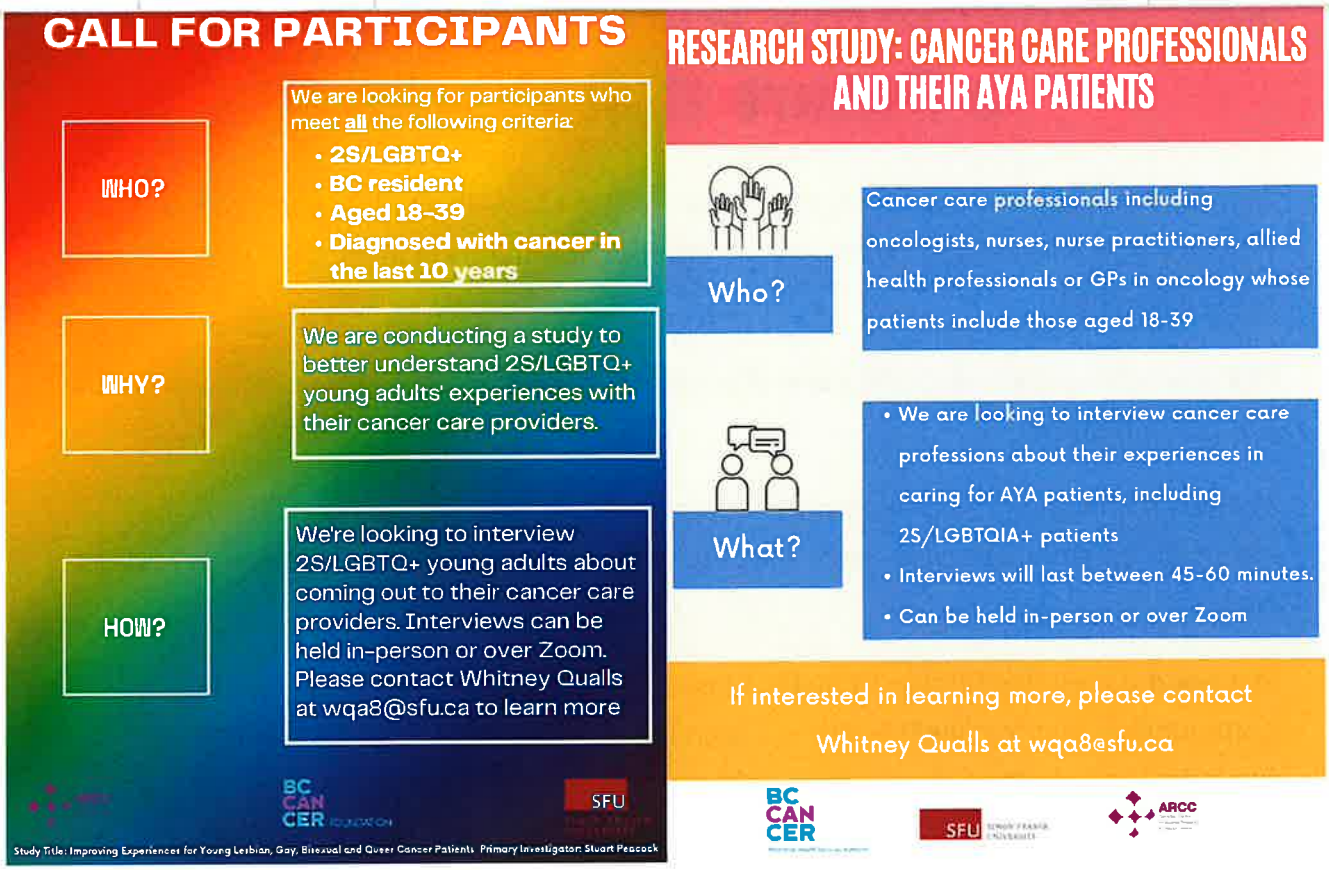
Next Steps

In the spirit of learning from one another, Foundry offers a monthly Rural and Remote community of practice to bring together champions of youth (service providers, clinicians, educators) in rural communities. If you are looking to create connections, inspire hope and stay up to date on Foundry's Rural and Remote projects, email Raelene Hodgson, at rhodgson@foundrybc.ca

To learn more, please visit www.foundrybc.ca or email info@foundrybc.ca. If you have questions about our provincial virtual services, please visit www.foundrybc.ca/virtual or email online@foundrybc.ca. If your organization would like a presentation on Foundry Virtual BC's services, please email Sierra Turner at sturner@foundrybc.ca

- Click here to download posters and promotional materials
- Click here to find your local Foundry centre
- Click here to learn more about Foundry's approach to supporting youth across BC

See more members of the month here.



Are you a cancer care provider or a 2S/LGBTQ+ young adult cancer survivor/ patient? We're seeking participants to share their experiences during a 60-90 minute interview. The interviews are part of a PhD research project and information gathered will be used to understand how cancer care professionals can better support their 2S/LGBTQ+ patients. **Email Whitney at wqa8@sfu.ca for more info or to sign up.**

Cancer care provider eligibility criteria:

- Works in BC
- Any cancer care professional whose patients include those aged 18-39

Patient/Survivor eligibility criteria:

- BC resident
- Aged 18-39
- Cancer diagnosis within the last 10 years
- 2S/LGBTQ+

BC Community Discussions to Build a Future that Works

The BC Federation of Labour coming to a community near you this spring for a province-wide discussion hosted by the BCFED, member unions and your local Labour Council.

Our environment and economy are changing. Our jobs and the communities we live in are being hit hard.

Nobody's immune from the impacts: workplace closures, wildfire evacuations, cold stress on construction sites, heat stress in schools and restaurant kitchens, and much more.

We need a meaningful plan to tackle these urgent issues affecting our families, our communities and our livelihoods — a plan that puts workers front and centre, and leaves nobody behind. And to do it right, we need to hear from you.

Please come to a community discussion near you, to help develop a worker and community-centred Climate Justice and Jobs Plan for BC. Join us to build a future that works for you, your community and future generations. More information here.

Community Town Halls

5:30 - 8:00 pm, with a light dinner at 5:30

Northern BC
Register by May 9th

- Prince George — 21 May
- Terrace — 22 May
- Prince Rupert — 23 May

Vancouver Island/Sunshine Coast
Register by May 10

- Nanaimo — 3 June
- Campbell River — 4 June
- Gibsons — 5 June

Southern BC
Register by May 17

- Abbotsford — 9 June
- Kamloops — 10 June
- Kelowna — 11 June
- Trail — 12 June
- Cranbrook — 13 June

Attention energy and resource workers

We know that energy and resource workers are bearing the brunt of these changes, so we invite you to attend a small focus group or interview in your community if you work in these sectors. Please contact Trish at tgarner@bcfed.ca to sign up.
As well as the communities listed above, we'll be coming to Burns Lake, Cumberland, Duncan, Elk Valley, Fort St. John, Fraser Lake, Houston, Kitimat, Merritt, Port Alberni, Princeton, Sparwood, Vanderhoof and Vernon — and we'll wrap up in Chilliwack for our Regional Conference in mid-June.

Register for your nearest town hall

Travel Assistance with Kindness and Compassion!

Hope Air is doing more than many know to help people reach medical treatment and appointments In BC and across Canada. Their "no patient left behind" policy is inspiring and greatly needed by many rural residents in our province. Hope Air provides not only air travel where needed but also helps many with out-of-pocket costs associated with accessing the care they need. Hotels, meals and ground transportation are all aspects of service that Hope Air not only provides but coordinates for those in need. **Visit Hope Air!**

Popular Posts and News from April 2024

[FIRST READING: B.C. Tells Nurses To Ignore Rising Phenomenon Of Armed Patients Doing Drugs In Hospitals]

[BCEHS Expands Paramedic Services For 21 Interior Communities]

[Fire Bans Announced In B.C. And Alberta As More Than 170 Wildfires Burn]

[B.C. Rural Health Network Seeking Stories From Rural Residents]

[Overdoses Prompt B.C. First Nation To Declare State Of Emergency]

[From Crisis To Care: How BC Can Transform Transplant Access For Rural Residents]

We look forward to connecting with you.

BCRHN
British Columbia Rural Health Network

District of
100 MILE HOUSE

COUNCIL REPORT
File No. 570-01

Regular Council – May 28th, 2024

REPORT DATE: May 21st, 2024

TITLE: Community Services Fleet – RFQ Terrain Mower Award
RFQ Front Mower Award

PREPARED BY: S. Elias, Director of Finance

PURPOSE:

The purpose of this Council report is to provide information on the Community Services Fleet RFQ submissions and award the supply of a new commercial terrain mower and a new commercial front mower.

RECOMMENDATION:

Recommended Resolution

BE IT RESOLVED THAT the report from Administration dated May 21st, 2024 regarding the RFQ for the supply of two commercial mowers be received; and further

BE IT RESOLVED THAT the RFQ to supply the District of 100 Mile House with a new Commercial Terrain Mower be awarded to Prairie Coast Equipment for the stated price of $123,562 plus applicable taxes.

BE IT RESOLVED THAT the RFQ to supply the District of 100 Mile House with a new Commercial Front Mower be awarded to Prairie Coast Equipment for the stated price of $64,126 plus applicable taxes.

BACKGROUND INFORMATION / DISCUSSION:

The District of 100 Mile House issued two (2) RFQ's for the supply and delivery of one (1) Commercial Terrain Mower and one (1) Commercial Front Mower. Due to supply timelines, both mowers have expected delivery dates of 2025.

Commercial Terrain Mower

Two (2) submissions were received by the deadline. Submissions were opened in the presence of Director of Community Services T. Conway. and Director of Finance S. Elias. The budget for this piece of equipment was approved at $100,000.

The submissions were received as follows:

Submission	Quoted Amount Prior to Taxes	Taxes (GST)	Taxes (PST)	Total Amount of Quote
Prairie Coast Equipment	**$ 123,562.00**	**$ 6,178.10**	**$ 8,649.34**	**$ 138,389.44**
Oakcreek Golf & Turf	**$ 117,285.00**	**$ 5,862.95**	**$ 8,209.43**	**$ 131,357.38**

Trade in value of $10,000 is estimated when the new mower is delivered in 2025.

Commercial Front Mower

Three (3) submissions were received by the deadline. Submissions were opened in the presence of Director of Community Services T. Conway. and Director of Finance S. Elias. The budget for this piece of equipment was approved at $65,000.

The submissions were received as follows:

Submission	Quoted Amount Prior to Taxes	Taxes (GST)	Taxes (PST)	Total Amount of Quote
Prairie Coast Equipment	**$ 64,126.00**	**$ 3,206.30**	**$ 4,488.82**	**$ 71,821.12**
Oakcreek Golf & Turf	**$ 68,020.00**	**$ 3,401.00**	**$ 4,759.58**	**$ 76,180.58**

**** The third submission did not meet the requirements of the RFQ.**

Trade in value of $15,000 is estimated for when the new mower is delivered in 2025.

OPTIONS: Council may choose to award to one of the other alternate bids.

BUDGETARY IMPACT:

The 2024 Capital Budget for these Community Services fleet upgrades were approved for a combined value of $165,000.

There is an estimated trade in value for the two current mowers of $25,000.

The purchase prices minus trade in value exceeds the budgeted amount by approximately $10,000 - $15,000 (Trade in value is estimated).

An amendment to the budgeted values can be included in the 2025 Capital budget.

LEGISLATIVE CONSIDERATIONS (Applicable Policies and/or Bylaws): *N/A*

ATTACHMENTS:

RFQ Submissions

2024-08 Commercial Terrain Mower
2024-09 Commercial Front Mower

Prepared By: S. Elias — **Date:** May 23/24
S. Elias, Director of Finance

Reviewed By: T. Boulanger — **Date:** May 23, 2024
T. Boulanger, CAO

2024 PROJECT SUBSTATION CS-02

Project Title: E330 - 2010 John Deere Terrain Mower Replacement

Department: Community Services

Date: January 17, 2024

Fiscal Year:	Prior	2024	2025	2026	2027	2028	Future
Capital Costs: (Budgeted)		$100,000					
O&M Costs:							

BACKGROUND (WHY)

The District adopted an aggressive equipment replacement philosophy over the past 10 years. In doing so global maintenance costs were significantly reduced. Those savings offset the purchase of new equipment. The 2010 John Deere Terrain Mower is now scheduled for replacement. This units primary use is for mowing our high profile areas, Soccer Field, Ball Diamonds, Centennial Park, etc.

SCOPE OF WORK (WHAT/ WHERE)

A Request for Proposal (RFP) is planned to be released for the acquisition of a new John Deere Terrain Mower of equivalent with an expected delivery date in 2024.

OR

Parts will be acquired to complete necessary repairs to existing mower.

CAPITAL REQUIREMENTS (HOW MUCH/WHEN)

Year 1 $ 100,000 / Equipment Reserve (NEW)

OR

Year 1 $15,000. / Increase to Operational Parts & Maintenance Budget (Repairs)

ADDITIONAL COMPONENTS TO CONSIDER:

In 2021 and 2022 a total of $11,662.52 was expensed towards the repair and maintenance of the mower unit E330. It was in the best interest of the District to limit additional part replacement in 2023 as this unit was scheduled for replacement. To keep this unit in good, safe, running condition an additional $12,939.87 in parts is required, with approximately 40 hours of labour ($1,555.60 / plus 29% benefits $451.12) for an estimated total of $14,946.59. These replacement parts and repairs do not guarantee additional repairs may be necessary in the future.

The mower was purchased in 2010 for $42,800 and has been fully depreciated with a remaining salvage value of $5,000. The maximum trade-in allowance is estimated at $10,000.

OPTIONS

Replace existing unit with the acquisition of a new John Deere Mower or equivalent

Repair unit with the estimated value of $14,946.59 in parts and labour.

ATTACHMENTS

PrairieCoast Equipment Parts Quote

John Deere Equipment Quote

- ✓ **ENDORSED BY COMMITTEE OF THE WHOLE FEBRUARY 27th, 2024**

PREPARED BY: _____ **DATE:** _____

T. Conway, Director of Community Services

REVIEWED BY: _____ **DATE:** _____

S.Elias, Director of Finance

District of 100 Mile House

REQUEST FOR QUOTATION
RFQ Number 2024-08

The District of 100 Mile House is requesting quotations for:

One (1) – NEW Terrain Mower

This is a Request for Quotation only. By requesting quotations, the District does not intend to enter into, and shall not be considered to have entered into, contractual relations upon the submission of a quotation by any person and no "Contract A" shall be formed between the District and any supplier upon the submission of a quotation. Without limiting the foregoing, the District shall not be obligated in any manner whatsoever to any supplier until a written agreement for the performance of the work herein contemplated has been duly executed.

Inquiries regarding this Request for Quotation may be directed to Todd Conway, Director of Community Services, 250-706-2217, e-mail: tconway@100milehouse.com.

A quotation shall be prepared and submitted at the sole expense of the proponent and without cost to the District of 100 Mile House. All quotations received by the District of 100 Mile House become the property of the District of 100 Mile House and as such are subject to the Municipal Freedom of Information and Protection of Privacy Act.

Quotations sealed in an envelope, clearly marked with the supplier's name and the product and/or service name will be accepted up to 2:00 p.m. (local time), April 18th, 2024 and will be received by:

Sheena Elias
Director of Finance
District of 100 Mile House
#1-385 Birch Avenue
selias@100milehouse.com

DISTRICT OF 100 MILE HOUSE
TERMS AND CONDITIONS – QUOTATIONS

GENERAL

1. **THE LOWEST OR ANY QUOTATION NOT NECESSARILY ACCEPTED.** The District of 100 Mile House may accept any quotation in whole or in part, unless otherwise stipulated.

2. Bidders will be advised of acceptance or rejection within a reasonable time following receipt of bid.

3. Quotations received after the specified closing time & date, will be rejected and returned.

4. The District shall not be obliged to purchase any goods or services from any bidder until a Purchase Order has been issued. Any discussions, inspections or meetings with District staff will not constitute an expressed approval to purchase.

QUOTATION REQUIREMENTS

1. **Acceptance:** Quotations must remain valid for thirty (30) days after the closing date.

2. **Errors:** Quotations as received shall be considered final and no quotation shall be altered, amended or withdrawn after the specified closing date.

3. **Form:** Quotations will not be accepted unless properly signed and submitted on this form.

4. **Taxes:** Quotations must show appropriate taxes as indicated on the form attached.

5. **Quotes for Services:** In the event this quotation is for contracted services, the successful bidder will be required to provide

    - A copy of your current WorkSafeBC Clearance Letter
    - A copy of your current District of 100 Mile House Business Licence (IF applicable)
    - A copy of your insurance acceptable to the District of 100 Mile House

6. **Submissions of Bids:** The District shall not be bound and the Bidder agrees not to rely upon any written or verbal statements or representations of any other persons, whether employed by the District or not, in the preparation and submission of their bid.

7. **Quantities:** The District reserves the right to increase or decrease quantities related herein to meet operational or budget requirements.

8. **Delivery Requirements:** The product must be delivered by August 30th, 2024. Notification will be given post Council approval and will accompany the issuance of a purchase order.

CONDITIONS OF PURCHASE

1. **Acknowledgement/Acceptance:** The District intends to award a contract through the issuance of a letter of award to the selected bidder.

2. **FOB Point:** All goods shall be quoted F.O.B. at the District specified site or unless otherwise specified.

3. **Shipments:** The District reserves the right to cancel this order, if the contract delivery date shown herein, is not met. All materials must be transported based on the conditions herein.

4. **Indemnity:** Notwithstanding the providing of insurance coverage by the Bidder, the Bidder hereby agrees to indemnify and save harmless the District, its officers, agents, servants and employees and each of them from and against all claims, demands, losses, costs, damages, actions, suites or proceedings by whomever made, brought or prosecuted and in any manner based upon, arising out, related to, occasioned by or attributable to the activities of the Bidders, its servants, agents, subcontractors and sub-subcontractors, in providing the services and performing the work of this Contract, excepting always liability arising solely out of the negligent act or omission of the District.

SPECIFICATIONS

A. GENERAL

8800A Turbo TerrainCut Commercial Wide-Area Mower with 4-Post ROPS Canopy

Breakaway LED Beacon Light Kit

Slow Moving Vehicle Sign Kit

Alternative specifications may be provided which will be evaluated to determine the suitability of the alternatives. The District reserves the right to reject any and all alternatives.

DISTRICT OF
100 Mile House

ANNUAL REPORT
2023

250-395-2434 | district@100milehouse.com | 100milehouse.com

TABLE OF CONTENTS

Introduction

Departmental Services

PHOTO CREDIT

Thank you to all who have contributed photos in this report!

Special Thanks To:

Mandy McLelland
Micheal Bednar
Robert Brunet
Allan Jones


CCM
John
CCM
CCM

100 MILE HOUSE

YESTERDAY TO TODAY

During the 1860's gold rush to the Barkerville area, roadhouses offered a way-side resting place for prospectors and pioneers.
Located 100 miles from the start of the Cariboo Waggon Road in Lillooet, 100 Mile House originated as a roadhouse, welcoming travelers, and it continues to do so today!

100 Mile House is a thriving community with an economy based in forestry, ranching, log home building and tourism. The District of 100 Mile House is located within the Tsq̓escencúl̓ecw. The area population experiences significant growth each year as travelers from around the world come to 100 Mile House as it is well known for it's outdoor recreational activities.

100 MILE HOUSE

YESTERDAY TO TODAY

The District of 100 Mile House is now recognized as the “Handcrafted Log Home Capital of North America” and is also home to the worlds largest cross country skis. 100 Mile House has a population of approximately 1930, is the commercial hub of the South Cariboo and the main service centre for many outlying communities. The South Cariboo service area has a population roughly ten times the size of the District, and includes the communities of Lac La Hache, Forest Grove, Lone Butte, Horse Lake, Bridge Lake, 70 Mile House, Canim Lake and 108 Mile Ranch. The South Cariboo is the largest residential centre between Kamloops and Williams Lake.

DISTRICT COUNCIL

In 2023 District Council gathered to develop a strategic plan for the 2023-2026 term. The Strategic Plan pledged to the community that Council will work tirelessly in implementing strategies and forge a bright future for the community.

Core Services - What We Do

Core services are the foundation of the work of the District and the focus of the vast majority of the District's resources. The Strategic Priorities do not include the ongoing core work of the District but rather identify those specific initiatives Council identifies as priorities over and above core work during the term.
The District of 100 Mile strives to deliver our core services including:

- Public works and infrastructure
- Parks, recreation, arts and culture
- Community Planning and economic development
- Public safety and emergency management; and
- Good governance and administration

Mission Statement

Consistent with the Community Charter the mission of the District of 100 Mile is to provide good governance for the community, services for community benefit, stewardship of community public assets, and fostering the economic, social and environmental well-being of the community

DISTRICT COUNCIL

Mayor Maureen Pinkney

- Administration Liaison
- Budget Committee
- CRD Representative
- Collective Bargaining
- Community Forest
- Emergency Executive Committee
- Hospital Liaison
- NDI Regional Advisory Committee
- Northern Medical Program Trust
- RCMP Liaison
- South Cariboo Joint Committee
- Treaty Advisory Committee
- Woodlot Management
- And other community boards as invited

Council Values

The District of 100 Mile Council values guide our decision making and our work:

- Respect
- Integrity
- Accountability
- Leadership & Collaboration

Councillor Ralph Fossum

- Acting Mayor Dec 2023 - Feb 2024
- Age Friendly Liaison
- Budget Committee
- South Cariboo Joint Committee

DISTRICT COUNCIL

Councillor Donna Barnett

- Acting Mayor Dec 2024 - Nov 2025
- Age Friendly Liaison
- Budget Committee
- Community Volunteer Development
- Hospital Liaison
- RCMP Liaison
- Safety Committee
- South Cariboo Joint Committee

Councillor Dave Mingo

- Acting Mayor Feb 2024 - Nov 2024
- Administrative Liaison
- Budget Committee
- CRD Representative
- NDI Regional Advisory Committee
- Treaty Advisory Committee
- South Cariboo Joint Committee

Councillor Jenni Guimond

- Acting Mayor Dec 2025 - Nov 2026
- Chamber of Commerce Representative
- Budget Committee
- South Cariboo Joint Committee

MESSAGE FROM THE MAYOR

Dear Residents of 100 Mile House,

It is my great honor and privilege, on behalf of the 100 Mile House Council, to present the 2023 Annual Report for our beloved District. We are profoundly grateful to live, work, and play on Tsq̓escencúĺecw (The land of the Tsq̓ésceń people) and deeply value our relationship with our neighboring community, including our partnerships with First Nations, and Provincial and Federal Governments. Together, we are stronger. Our community has shown remarkable resilience through unprecedented times over the past five years, maintaining a strong fiscal position despite local and global challenges. We continue to face significant concerns like wildfires and the economic impact on our forestry and tourism industries. Additionally, new drought conditions, climate change, and other challenges are pressing issues that we must address.

Historically, the District of 100 Mile House has operated with a 'pay as you go' philosophy. However, the evolving world we live in now poses challenges to our budgets. Aging infrastructure, repairs, and new constructions are becoming increasingly expensive. For instance, the cost of replacing the Sawmill Creek Bridge has doubled since 2021. While funding that was once sufficient is now inadequate, our staff and Council are actively seeking matching funds for both minor and major projects. These grants are essential for our community's progress, and we continuously advocate for their reliable and steady delivery.

Our community is a beautiful place to live, work, and play. We remain committed to replacing aging infrastructure and essential assets like fire trucks and water storage tanks as needed. However, budget constraints mean we might not be able to replace failing sidewalks or add new amenities like benches and lighting as quickly as we'd like.

The District of 100 Mile House is located on the traditional territories of the Tsq̓escencúĺecw.

The District of 100 Mile House Mayor, Council, and staff recognize the importance of building respectful relationships that contribute to stewarding the land and waters in the community with integrity and consideration for future generations.

MESSAGE FROM THE MAYOR

One of our major projects is the replacement of the Sawmill Creek Bridge on Horse Lake Road. This crucial infrastructure connects residents, supports emergency services, and facilitates daily commutes for about 4,000 people. We are working diligently to secure the necessary permits and additional funding to complete this project by spring 2025.

Our water supply transition from Bridge Creek to new wells in 2017/18 has created some challenges, particularly with hard water. While our water is safe, the hard water affects our pipes and machinery. We are exploring solutions and hope to secure the necessary approvals and funding soon. We appreciate your patience as we work to ensure a reliable water source.

In 2023, Council and Staff completed a new Strategic Plan outlining priorities and actions to enhance the quality of life in 100 Mile House. This plan addresses infrastructure, parks, recreation, public safety, planning, governance, and administration, serving as a roadmap for our community's future.
Our core services, which consume the majority of our resources, include:

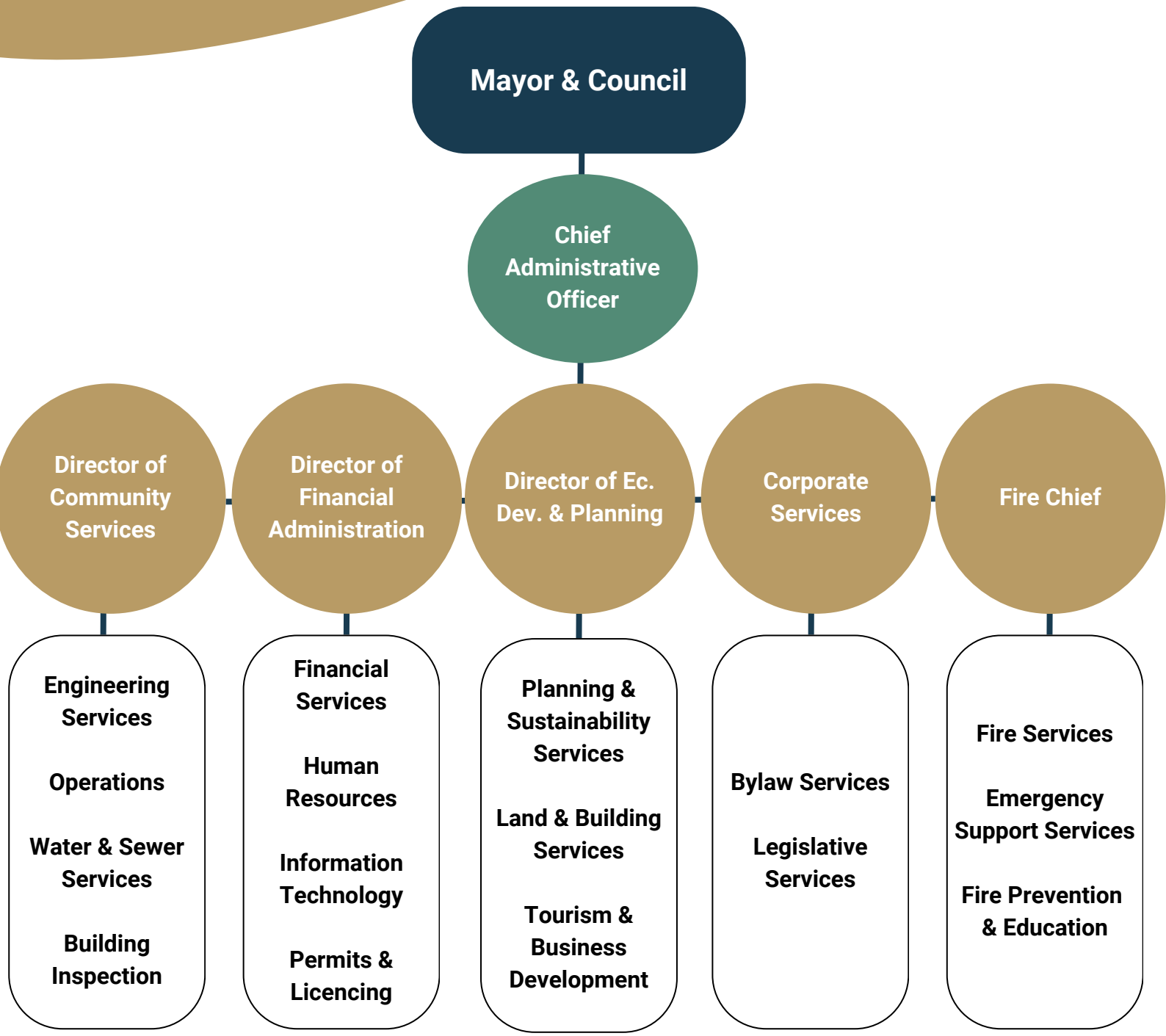
- Public Works and Infrastructure: Maintaining water, sewer, roads, and sidewalks.
- Parks, Recreation, Arts & Culture: Managing facilities like Centennial Park, Martin Exeter Hall, and recreational fields. We are excited about our new management contract for the South Cariboo Recreation Center, aiming to enhance local activities and events.
- Community Planning and Economic Development: Attracting developers, encouraging growth, and updating our official community plan with public input.
- Public Safety and Emergency Management: Our dedicated 100 Mile Fire Department, mostly volunteers, plays a crucial role in keeping us safe.
- Good Governance and Administration: Our Council and District Staff are committed to serving you with excellence and transparency.

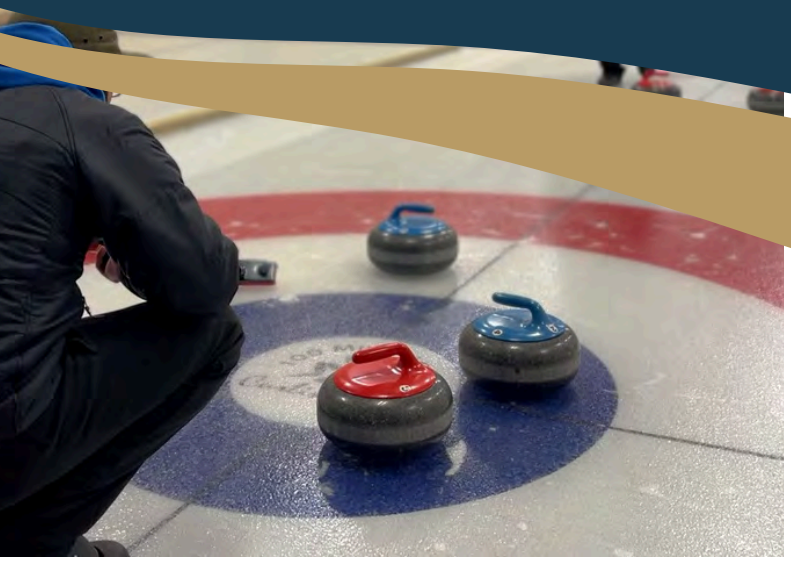
We are incredibly fortunate to have beautiful parks, superb recreational facilities, and a vibrant collection of stores and services. It's easy to focus on what we lack, but let's also appreciate what we have. Volunteer-driven initiatives like the new outdoor skating rink and improved skateboard park are testaments to our community spirit.

What makes a community? It's all of us, working together to create a strong and vibrant place to live. Our countless volunteers tirelessly make so many things happen in our community. Thank you to everyone for your dedication and effort in making 100 Mile House our cherished home.

Warm regards,
Maureen Pinkney
Mayor of 100 Mile House

ORGANIZATION CHART





CORPORATE SERVICES

The Chief Administrative Officer (CAO) is statutorily appointed under the Community Charter and is responsible for the overall management of the District operations and programs providing guidance and direction to Senior Managers.

The CAO assists Council in establishing and implementing policies through municipal staff and ensures that all departments are working towards the same goals and objectives as Council.

This department is responsible for:

- Bylaws, Policies and Procedures
- Human Resource Management
- Council Meeting Agendas & Minutes
- Records & Information Management
- Public Relations
- Legal and Administrative Services

In 2023 the District of 100 Mile House developed a Strategic Plan for our beloved 100 Mile House. This plan, developed by our dedicated council and staff, outlines the District priorities for this term of office.

Key focus areas 2023 - 2026

In this term Council will focus on five key service areas as illustrated below and detailed in the Strategic Plan.

CORPORATE SERVICES

2023 Achievements

- Launched a news subscription service - amount of subscribers has grown to 251!
- Established a Council Code of Conduct
- Developed Strategic Plan
- Transitioned new Chief Administrative Officer and Director of Finance
- Facilitated “Coffee with Council” events

In 2023 The District of 100 Mile House established a Accessibility Committee. The committee is comprised of volunteers who stepped up to help identify areas to improve accessibility relating to municipal services, facilities and natural built environments. The District will continue to gather information through public feedback and committee input and will work towards becoming a municipality where every person is able to participate fully and equally and is empowered to pursue the life they wish to live.

In spring of 2023 we invited the entire community to get out and explore in our “March into Spring” event where grant funding allowed to us to offer a multitude of free events for the community to try! We hope you got out and enjoyed one of the many activities hosted by businesses and **volunteers!**

CORPORATE SERVICES

2024 Goals

- Continue to implement accessibility requirements and work with the committee to identify areas the District and Community can improve.
- Hold a C2C forum with the Tsq̓éscen̓ First Nations & continue to build working relationships with regional government
- Implement Green Municipal Building & Infrastructure Improvements
- Continue to encourage professional development and cross training
- Develop an asset management plan and seek funding for support
- Continue to work with Commissionaires to improve service delivery of Bylaw Enforcement
- Facilitate cultural safety training for staff, council and volunteers
- Facilitate additional “Coffee with Council” events
- Work in partnership with the Cariboo Regional District to obtain the management of the South Cariboo Recreation Centre under the 100 Mile Development Corporation

CORPORATE SERVICES

Connect with Us!

Website: www.100milehouse.com
Email: district@100milehouse.com
Phone: 250-395-2434
Office: #1-385 Birch Ave., 100 Mile House

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facebook.com/districtof100milehouse

RIDE TRANSIT!

In 2023 We saw ridership continue to increase :)

PLANNING & DEVELOPMENT

This department is responsible for the administration of the District's Official Community Plan, review and approvals of development and subdivision application, land use planning and economic development.

The planning department has been very successful in securing grant funding, which has meant another busy year in terms of project management. Housing pressures remain significant, and new Provincial housing mandates will require additional Planning resources toward the housing file in 2024.

Long range planning and sustainability are part of this department's role and include development and implementation of strategies and policies related to:

- Climate change adaptation and mitigation
- Recreation
- Housing
- Transportation
- Trails network planning

Land use planning and development applications also involve review of development proposals and processing of applications for:

- Development Permits, Development Variance Permits & Sign Permits
- Amendments to Zoning Bylaw

Planning services manage the subdivision review process for:

- Fee-Simple, Bare Land Strata and Strata conversions
- Administration of subdivision related agreements such as:
    - Statutory right-of-way, Covenants & Servicing Agreements

Speed board Launch in 2023

PLANNING & DEVELOPMENT

2023 Accomplishments & Goals

Projects Completed in 2023

- ALR Exclusion Policy
- Finalize public washroom project
- Completed Active Transportation Plan
- Implementation of Wayfinding Strategy
- Completed Active Living Guide
- Participation in Solid Waste Management Committee
- March into Spring Event
- Shopping Survey
- Business Opportunity Scan
- Award winning **Path Forward** document is being shared province-wide and adapted for use in the mining sector.

Ongoing projects & goals for 2024

- Secondary Suite Policy
- Implementation of Ec Dev Strategies
- Review Housing needs assessment and identify implementation priorities
- Transition love100milehouse.com
- DCC Bylaw Review
- *Make the Move* labour recruitment and explore Cariboo partnership with the CRD
- Presentation of the OCP & Zoning to Council for Consideration of updates
- Mobile Home Parks Bylaw initiated and adopted
- Complete Community Tourism Plan & initiate at least one project
- Conclude Community Transition Capacity Project
- Continued grant administration to support District projects
- Ongoing initiatives - Business Façade Improvement Program, BC PNP Entrepreneur Immigration Pilot Program
- Airport Master Plan
- Engineering - Community Hall Upgrades
- Complete Forest Employment Program & Projects

DEVELOPMENT COST CHARGES

New development typically triggers need for expansion of services like roads, sewer, drainage and water systems. The level of investment needed to support new development is significant and one of the mechanisms available to municipalities to help finance this investment is Development Cost Charges (DCCs)

DCCs are monies collected from developers to help offset the costs of the infrastructure investments needed to service new development. They are imposed by bylaw, pursuant to the Local Government Act, and provide the municipality with a way to finance capital investment related to roads, sewer, drainage, water and parks.

In 2023 there were some new residential lots created as a result of subdivision, triggering DCCs, and several industrial construction projects where DCCs were collected at the building permit stage. This resulted in stronger than usual DCC collection. 2023 remained active with single family and duplex residential building permits, for which DCCs are paid at the time of subdivision.

2024 should see continued strong trends in single family residential construction, for which DCCs are already paid. Commercial, industrial and multi-family residential development is expected to be modest; and therefore, modest DCCs are anticipated

2024 Building Permit Stats

- Total Construction Value: $5,032,165.
- Total of 38 Permits Issued
  - Residential: 18
  - Industrial: 1
  - Commercial: 19

DEVELOPMENT COST CHARGES

The following table provides information about DCC collections and expenditures from 2023 for each of the infrastructure types.

	Sewer	Water	Drainage	Roads	TOTAL
Opening Balance	$136,800.60	$216,011.73	$14,776.61	$95,861.94	$463,450.87
Collections	-	$6,887.55	-	$40,851.00	$47,738.55
Interest	$3,065.66	$4,802.86	$306.57	$2,043.77	$10,218.85
Expenditures	-	-	-	-	-
TOTAL	$139,866.25	$227,702.14	$15,083.17	$138,753.71	$521,408.27
Waivers & Reductions	-	-	-	-	-

Note: Collections are reported net of Waivers and Reductions. In some instances, a developer will undertake work that would otherwise be done by the Municipality and funded by DCC's. When this occurs, the amount of DCC's related to those works may be forgiven. The amounts forgiven are reported as Waivers & Reductions.

Sheena Elias
Director of Finance

COMMUNITY SERVICES

The role of the department is to ensure that pro-active planning, renewal and maintenance of the District's capital works programs maximize benefits to the community. The department seeks to foster good communications with the community, with a view to working together to achieve the best balance between cost and benefit.

The department is responsible for roads, transportation infrastructure, recreation, cemetery, airport, water & sewer facilities, vehicle and equipment fleet and municipal buildings.
Community Services also oversees road and utility construction and design, transportation planning (including traffic, pedestrian and cycling planning, parking and road construction, utility planning, and environmental programs. The department plays an integral role in the long-term planning of infrastructure design and costing, and managing the District's infrastructure to promote sustainability.

The department is staffed with the Director of Community Services/Chief Building Inspector, eight full time, and casual/summer students as needed.

COMMUNITY SERVICES

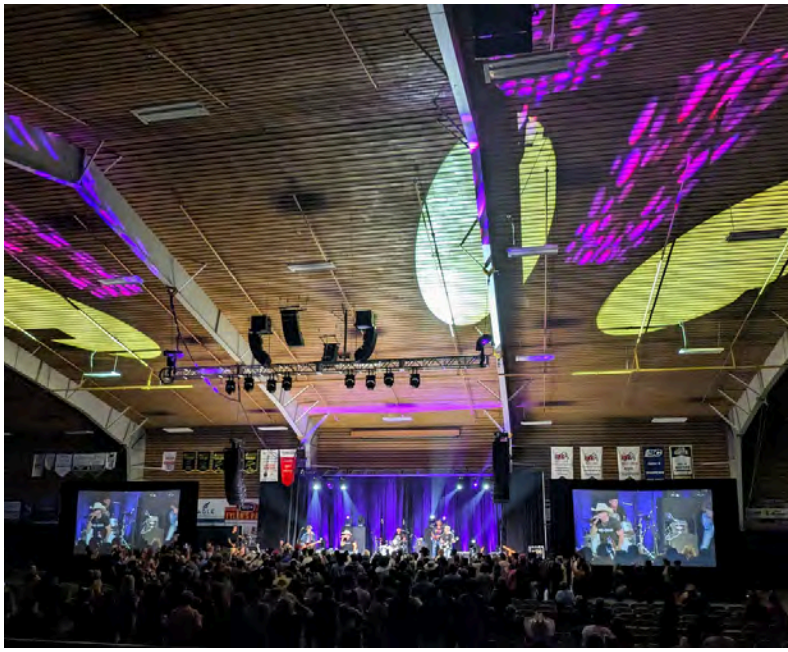
2023 Achievements

- Demolition & rebuild of tennis courts and basketball court
- Water & Sewer service truck & Gardener truck
- Municipal Office Roof Replacement & LED Lighting upgrades in Fire Hall/Public Works Complex
- Paving completed on Birch Ave from First St to Aspen St
- Completed Birch Ave & Fifth Street watermain loop upgrades with the assistance of **Community Works Fund!**

2024 Goals

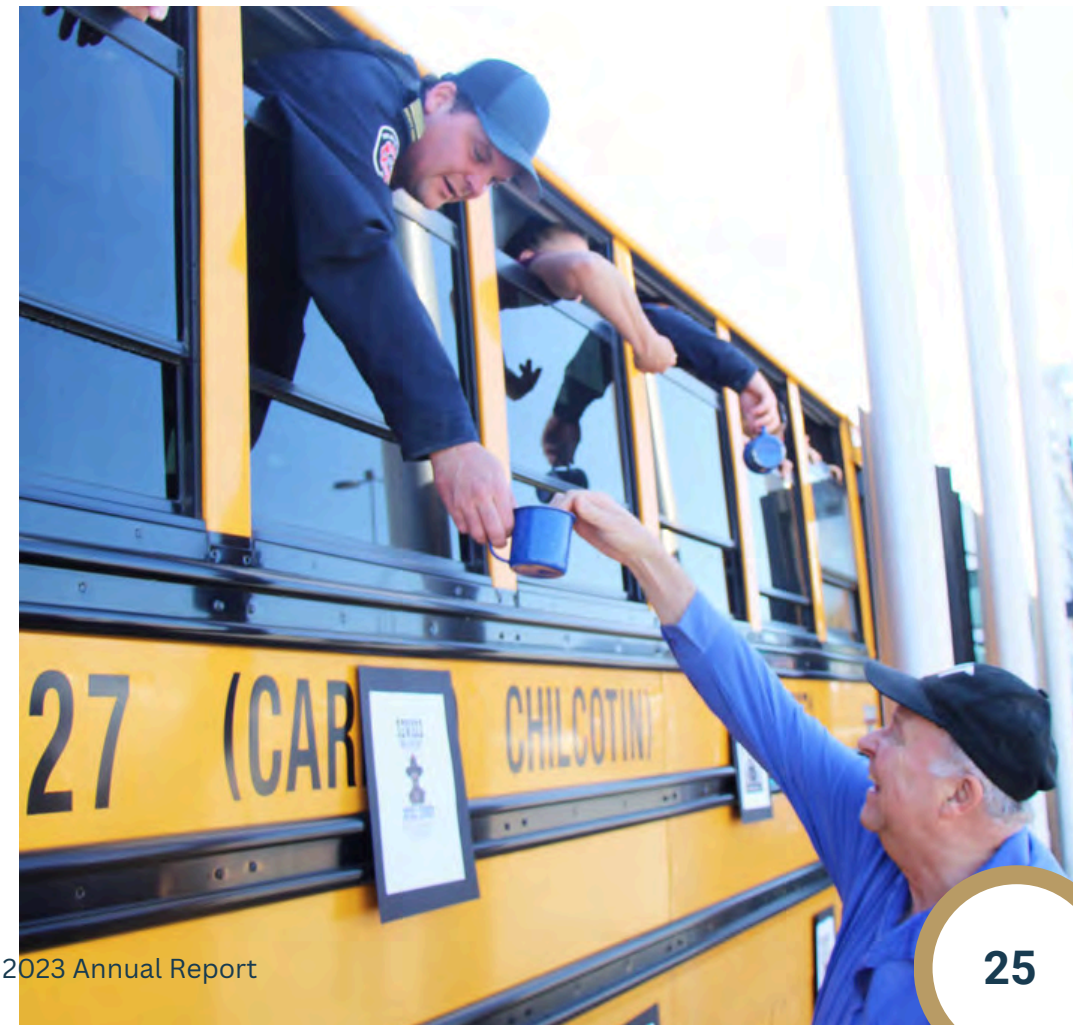
- Staff Training & Development
- Water Quality & Quantity Upgrades Planning
- Horse Lake Bridge Project (2025 Build)
- Community Hall Renovation Planning
- Paving - Horse Lake Road & Cedar Ave
- Demolition of Valley Room - Historical Lodge Preservation
- Refinish Municipal Office Building
- Install wayfinding sign kiosks
- Install new Centennial Park Entryway & path for accessible picnic area
- Fleet Upgrades. Mower Replacement & Shop improvements
- Complete Sewage WWTP Upgrades & main lift station control panels
- Begin construction on Exeter Sewer Lift Station
- Purchase & Install new columbaria
- Upgrade stage lighting in Martin Exeter Hall
- Implement Green initiatives using LGCAP funds
- BC Hydro re-greening upgrades to 100 Mile Marsh picnic area
- Asset Management Planning
- New Centennial Park Washroom Engineering


Yellow Peril



100 MILE FIRE RESCUE

Fire Hall 1961



100 MILE FIRE RESCUE

The 100 Mile House Fire Rescue department has been serving 100 Mile House and the surrounding area since 1956. Comprising of 25 Paid-On-Call members alongside a career Fire Chief and Deputy Chief, the department is committed to providing fire suppression, road rescue services, medical aid, and public education. Additionally, the Emergency Services Training Centre under their operation offers training opportunities to the region.

In 2023 100 Mile Fire Rescue welcomed David Bissat as the new Fire Chief who took over for Roger Hollander who assumed a new position with the Cariboo Regional District.

Fire Chief David Bissat welcomed the new career Deputy Fire Chief Cole Sparreboom to his position. Deputy Chief Sparreboom is no stranger to the department or the community of 100 Mile House. Cole grew up in 100 Mile House and has over seven years experience as a paid-on call member including the rank of Firefighter and Lieutenant. Deputy Chief Sparreboom will continue to improve the department as he focuses on training as well as operational duties.

100 MILE FIRE RESCUE

Goals Achieved in 2023

CRD Fire Protection Agreement

- Continued collaboration with the CRD, renewing the fire protection agreement to provide fire protection services to the surrounding communities.

Training

- Continuous training efforts were upheld to maintain the department's "full service" fire designation, including medical, auto extrication, embankment rescue, and public safety programs.
- 2 members completed the JIBC Officer 1 Program with Safety Officer Certification.
- 2 members obtained the First Responder Train the Trainer Certification, aimed at reducing the cost of training for new recruits.
- 5 members became First Responder certified.
- 3 members completed the NFPA 1006 Vehicle Extrication Course.
- 11 Members successfully completed the NFPA 1006 Rope Rescue Embankment Course.

Recruitment

- The department successfully recruited ten new members. Two of them have already trained in Firefighter 1 and 2, further strengthening our operational capacity.

Equipment & Fleet Upgrades

We have acquired a new structure protection trailer through a UBCM grant. Continued to work with Hub International with the construction of our new fire engine apparatus, expected to be delivered by June 2024.

100 MILE FIRE-RESCUE

2024 Goals

Training Continuation

- Ongoing training efforts will be prioritized to uphold the department's "full service" fire designation and other specialized services. The department aims to recruit up to five new members in spring to bolster its operational capabilities.
- Successful 2024 Recruitment Drive

Equipment & Apparatus Upgrades

- Pursue grant funding for the Emergency Services Training Centre Burn Building replacement and burn props maintenance.
- Welcome the delivery of the new engine and acquire a new brush truck for expected delivery in 2024.
- Pursue grant opportunities to outfit the Sprinkler Protection Unit Trailer

100 Mile Fire Rescue actively participated in various community initiatives such as Safe Ride Home, Grad Ceremonies, Fill the Truck Day, and Fire Prevention programs with local schools and daycares.

The Department aims to recruit up to five new members annually to bolster its operational capabilities. If you are interested in joining please contact us today!

100 Mile Fire Rescue
#1-385 Horse Lake Road
100 Mile House, BC

www.100milefire.com
Ph: (250) 395-2152

Emergency Calls in 2023

93
Fire & Alarm

119
MVI & Rescue

193
Medical Calls

67
Admin

EMERGENCY SUPPORT SERVICES

ESS volunteers are under the direction of the Fire Chief and prepare year-round in case they are called upon. ESS provides short term assistance to British Columbians who are forced out of their homes due to fires, floods, earthquakes or other emergencies. The 100 Mile House ESS Team is committed to helping those affected by emergencies throughout the South Cariboo and other neighbouring communities. Our role is to help people during a very difficult and stressful time in their lives.
The ESS team attended three house fires and hosted approximately 268 evacuees from around the Province and Territories in 2023.

WE ARE THE "PEOPLE" PART OF EMERGENCY RESPONSES.

Do you want to be an ESS volunteer? ESS volunteers are people committed to the wellbeing of others. There are many roles that volunteers can help fill within our team. If you are interested in volunteering please reach out to us today!

EMERGENCY SUPPORT SERVICES

In 2023 we lost a valued member of the ESS team, Betsy Herring (Hoff) who worked tirelessly to help people in need. You will be missed!

EMERGENCY SUPPORT SERVICES

2023 Accomplishments

In 2023 members of the ESS were invited to a variety of community events to participate as guest speakers. These events included the Better at Home Seniors Preparedness, Prepared Not Scared, Preparedness Week, Farm Life Chicken Workshop, Markets and Fairs.

The team attended multiple training opportunities, including the Network of Emergency Support Services Team (NESST) conference in Prince George, Intro to ESS/Level I, Reception Centre Training, Intro to Meet and Greet and working with Disabilities.

2024 Goals

- Continue Evacuation Registration & Assistance (ERA) portal training.
- Work in partnership with the Cariboo Regional District to promote and launch the new emergency alert system *Voyent Alert!*
- *Participate in community events to promote emergency preparedness.*
- *Plan and practice for real time events*

COMMUNITY FOREST

2023 SILVICULTURE OPERATIONS

161,990 seedlings were planted within the Community Forest in 2023 over 164 ha.

A mix of Douglas-Fir, Lodgepole Pine and Hybrid Spruce were planted.

Seven of the blocks planted were recently harvested, and one was a low density replant to bump up stocking after some seedling losses.

Silviculture surveys were completed on 26 blocks (485 ha)

Manual brushing was completed on 3 blocks (117 ha). This was done in high deciduous competition where crop trees were being suppressed.

The 100 Mile Development Corporation manages the Community Forest on a multi-use basis with the primary focus on good environmental stewardship, guaranteed recreational and public use opportunities and the continued enhancement of the forest resources.

COMMUNITY FOREST

2023 OPERATIONS & PLANNING

Recce and initial layout on next permits are being developed

Pile burning was completed on the 2 blocks with remaining obligations

2024

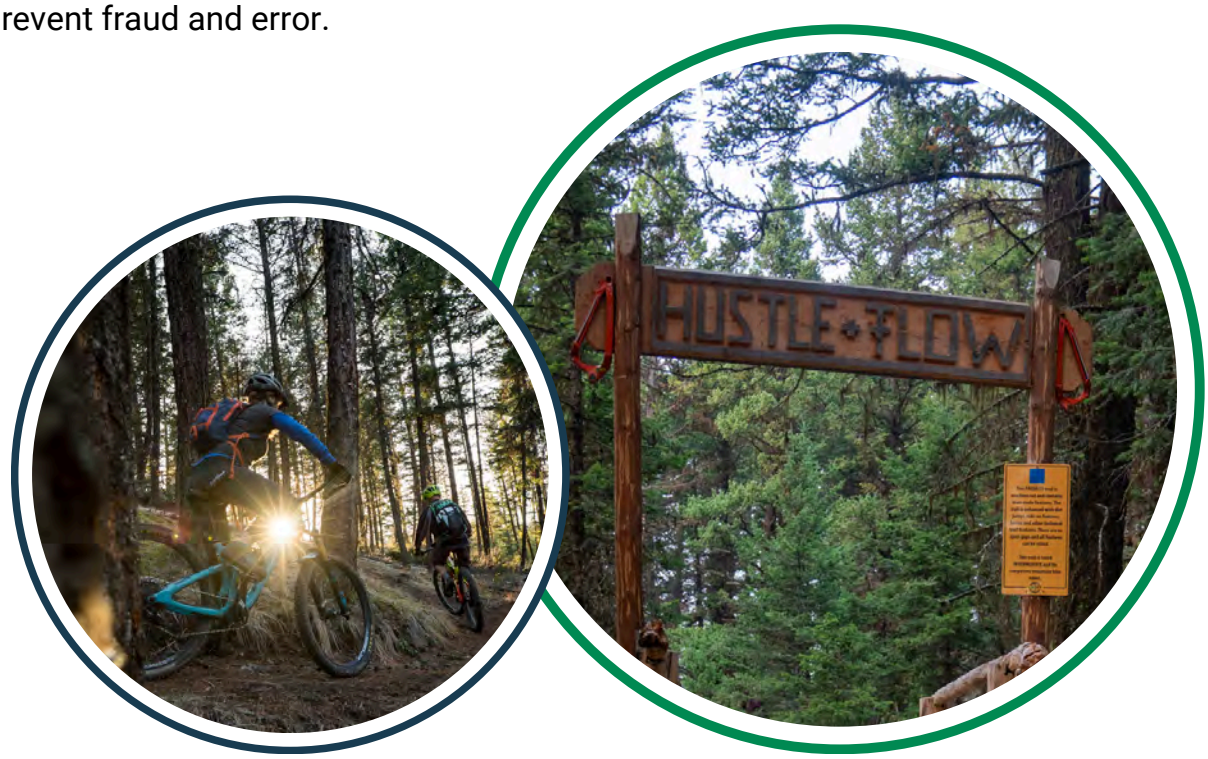
In 2024 the 100 Mile Development Corporation in partnership with West Fraser will continue to develop future cutting permits within the Community Forest potentially harvesting in late fall/early winter.

FINANCIAL SERVICES

The primary purpose of the Annual Report is to provide residents with a clear representation of the financial position and financial activities of the District. Finance staff provides accurate and full disclosure on the financial affairs of the District as set out in the Community Charter and the Local Government Act. This information includes annual municipal reporting forms, operational and capital budgets, setting of annual property tax, water and sewer rates, annual financial statements, long term financial plans, investments, statement of financial information report and grant reporting.

A strong financial position with adequate reserves will allow the District to work towards its strategic priorities and ensure ongoing financial viability. It is essential that local governments maintain adequate levels of reserve balances to mitigate current and future risks, ensure stable tax rates and demonstrate a financial commitment to long range infrastructure planning.

Service to our client base remains our number one priority. The department ensures financial and information technology controls are in place to safeguard District assets and prevent fraud and error.



FINANCIAL SERVICES

2023 Achievements

- Over $1.9 Million invested in District infrastructure.
- Staff training & cross-training
- Upgrades to Fire Departments and Community Services Fleet
- Continued to enhance communication to residents with a new email subscription service.
- Incorporated new financial reporting requirements for Asset Retirement Obligations.

Many of the projects staff are working on in one year can spill over into multiple years, our project list is a living document that can grow with grant funding opportunities. With direction and support of Council, the Finance Department strives to build fiscal capacity that supports future equipment and capital projects with a focus on debt avoidance, thus reducing or eliminating any negative impact to rate payers. First and foremost, our priority is to continue contributions to reserves, with a view of reducing our infrastructure deficit. This has been and will continue to be our number one goal.

2024 Goals

- Continue to build reserves
- Fire Department & Community Services fleet upgrades
- Staff Training & Development
- Begin working on a long-term asset management plan
- Continue to source grant opportunities to support community projects

CONSOLIDATED REVENUE BY SOURCE

	2023	2022	2021
Property Tax & GIL	$3,138,613	$3,015,002	$3,157,660
Government Transfers	$2,989,878	$2,677,246*	$1,635,703
Sales of Service	$1,244,154	$1,168,318	$1,230,930
Other Revenue	$328,044	$261,047	$213,649
Investment Income	$1,004,644	$368,348*	$109,557
100 Mile Dev Corp Earnings	-	$665,340	$1,196,737
Developer Contributions	-	$389,400	-
Gain on Disposal	($17,618)	$184,109	$14,666

* Denotes Restated Amounts

The municipal portion of property taxes fund items like parts & recreation, fire protection , road maintenance, sidewalks, water, sewer, capital projects and much more! The remainder of the taxation is collected on behalf of the Provincial School and Police Tax, BC Assessment Authority, Municipal Finance Authority, Cariboo Regional District and Cariboo-Chilcotin Regional Hospital District

CONSOLIDATED EXPENSES BY CATEGORY

	2023	2022	2021
General Government	$1,062,263	$1,153,291	$973,551
Protective Services	$868,925	$864,627	$926,318
Solid Waste Management	$127,752	$112,199*	$108,774
Public Health	$32,527	$34,981	$39,096
Planning & Development	$616,960	$594,746	$631,863
Transportation	$2,405,752	$2,303,108	$1,985,273
Parks, Recreation & Culture	$255,888	$211,765	$207,862
Water Services	$922,779	$823,976*	$725,118
Sewer Services	$437,724	$481,019	$438,746
Debt Financing	$5,278	$5,278	$5,278
Loss-Sale/Write down of TCA's	$17,618	-	-

PERMISSIVE TAX EXEMPTIONS

Organization	Property Value	Tax Class	Tax Exemption
100 Mile House Nordic Ski Society	$253,000	8	$627
100 Mile House Sikh Society	$247,700	8	$614
100 Mile House Snowmobile Club	$153,400	8	$380
100 Mile House United Church	$224,800	8	$557
Hillside Community Church	$2,148,900	8	$5,323
Hillside Community Church	$41,800	6	$310
Canadian Red Cross	$35,600	6	$264
Cariboo Elders Building & Rec Society	$409,000	6	$3,030
Cedar Crest Society for Community Living	$197,300	1	$480
Cedar Crest Society for Community Living	$287,200	8	$711
Cedar Crest Society for Community Living	$1,136,000	1	$2,763
Christ the King Lutheran Church	$204,200	8	$506
Emissaries of Divine Light - Leasee	$8,631	6	$64
Evangelical Free Church of America	$297,500	8	$737
Fraser Basin Property Society	$239,200	8	$593
Nature Trust of BC	$312,300	6	$2,314

FINANCIAL STATEMENTS

District of 100 Mile House
Financial Statements
For the year ended December 31st, 2023

District of 100 Mile House
Financial Statements
For the year ended December 31, 2023

Contents

Management's Responsibility for Financial Reporting

The accompanying financial statements of the District of 100 Mile House (the "District") are the responsibility of management and have been approved by the Mayor and Council of the District.

The financial statements have been prepared by management in accordance with Canadian public sector accounting standards. Financial statements are not precise since they include certain amounts based on estimates and judgments. When alternative accounting methods exist, management has chosen those it deems most appropriate in the circumstances, in order to ensure that the financial statements are presented fairly, in all material respects.

The District of 100 Mile House maintains systems of internal accounting and administrative controls of reasonable quality, consistent with reasonable cost. Such systems are designed to provide reasonable assurance that the financial information is relevant, reliable and accurate and the District's assets are appropriately accounted for and adequately safeguarded.

The Mayor and Council are responsible for ensuring that management fulfills its responsibilities for financial reporting and is ultimately responsible for reviewing and approving the financial statements.

The Mayor and Council review the District's financial statements and recommend their approval. The Mayor and Council meet periodically with management, as well as the external auditors, to discuss internal controls over the financial reporting issues, to satisfy themselves that each party is properly discharging their responsibilities, and to review the annual report, the financial statements and the external auditor's report. The Mayor and Council take this information into consideration when approving the financial statements for issuance to the taxpayers. The Mayor and Council also appoint the engagement of the external auditors.

The financial statements have been audited by BDO Canada LLP in accordance with Canadian generally accepted auditing standards on behalf of the taxpayers. BDO Canada LLP has full access to the Council and management.

Director of Finance

Tel: 250-372-9505
Fax: 250-374-6323
www.bdo.ca

BDO Canada LLP
300 – 275 Lansdowne Street
Kamloops, BC V2C 6J3

Independent Auditor's Report

To the Members of Council, Inhabitants and Taxpayers of the District of 100 Mile House

Opinion

We have audited the financial statements of the District of 100 Mile House (the "District"), which comprise of the statement of financial position as at December 31, 2023, and the statement of change in net financial assets, statement of operations, and statement of cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the District as at December 31, 2023, and the results of its operations, change in net financial assets, and cash flow for the year then ended in accordance with Canadian public sector accounting standards.

Other Matters

We have not audited, reviewed or otherwise attempted to verify the accuracy or completeness of Schedule 1 on page 34 and Schedule 2 on page 35 of these financial statements.

The financial statements for the year ended December 31, 2022 were audited by another auditor who expressed an unqualified opinion on those financial statements on May 4, 2023.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are independent of the District in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is responsible for assessing the District's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the District or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the District's financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the District's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the District to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.
- Obtain sufficient appropriate audit evidence regarding the financial information of the entities or business activities with the District to express an opinion on the financial statements. We are responsible for the direction, supervision and performance of the audit. We remain solely responsible for our audit opinion.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Chartered Professional Accountants

Kamloops, British Columbia
April 25, 2023

District of 100 Mile House
Statement of Financial Position

As at December 31	2023	2022
		(Restated - Note 10,16)
Financial assets		
Cash (Note 2)	$ 8,317,681	$ 16,505,739
Short-term investments (Note 2)	10,838,914	463,481
Accounts receivable (Note 3)	751,284	1,331,733
Investment in 100 Mile Development Corporation (Note 6)	518,982	518,982
Municipal Finance Authority deposits (Note 7)	8,401	8,306
	20,435,262	18,828,241
Liabilities		
Accounts payable and accrued liabilities (Note 5)	802,917	578,215
Deferred revenue (Note 8)	277,641	553,817
Development cost charges (Note 8)	521,408	463,451
Municipal Finance Authority debt reserve (Note 7)	8,401	8,306
Long-term debt (Note 9)	13,337	26,038
Asset retirement obligation liability (Note 16)	880,462	838,775
	2,504,166	2,468,602
Net financial assets	17,931,096	16,359,639
Non-financial assets		
Tangible capital assets (Note 11)	40,958,043	40,678,176
Supply inventory	163,900	61,744
Prepaid expenses and deposits	491,479	487,814
	41,613,422	41,227,734
Accumulated surplus (Note 12)	$59,544,518	$ 57,587,373

Contingent Liabilities and Commitments (Note 15)

Director of Finance

Mayor

District of 100 Mile House
Statement of Operations

For the year ended December 31	Fiscal Plan	2023	2022
	(Note 17)		(Restated - Note 10,16)
Revenue			
Property taxation & grants in lieu (Note 13)	$ 3,091,970	$ 3,138,613	$ 3,015,002
Government transfers (Note 14)	1,484,880	2,989,878	2,677,246
Sales of services	1,201,568	1,244,154	1,168,318
Income of 100 Mile Development Corporation (Note 6)	-	-	665,340
Developer contributions	4,090	-	389,400
Other revenue	312,585	328,044	261,047
Investment income	-	1,004,644	368,348
Gain (loss) on sale of tangible capital assets	-	(17,618)	184,109
	6,095,093	8,687,715	8,728,810
Expenses			
General government	1,039,952	1,062,263	1,153,291
Protective services	880,907	868,925	864,627
Solid waste management and recycling	80,740	127,752	112,199
Public Health	135,130	32,527	34,981
Planning and development	648,510	616,960	594,746
Transportation	2,259,465	2,405,752	2,303,108
Parks, recreation and culture	293,325	255,888	211,765
Water services	904,438	922,779	823,976
Sewer services	508,037	437,724	481,019
	6,750,504	6,730,570	6,579,712
Annual surplus (deficit)	(655,411)	1,957,145	2,149,098
Accumulated surplus, beginning of year	58,222,030	57,587,373	55,438,275
Accumulated surplus, end of year	$57,566,619	$59,544,518	$ 57,587,373

The accompanying notes are an integral part of these financial statements.

District of 100 Mile House
Statement of Change in Net Financial Assets

For the year ended December 31	Fiscal Plan	2023	2022
			(Restated - Note 10,16)
Annual surplus (deficit)	$ (655,411)	$ 1,957,145	$ 2,149,098
Acquisition of tangible capital assets	(5,619,275)	(2,126,824)	(3,957,800)
Amortization of tangible capital assets	1,467,655	1,846,957	1,648,835
Loss (gain) on sale of tangible capital assets	-	17,618	(184,109)
Proceeds on sale of tangible capital assets	-	(17,618)	250,000
Change in supply inventory	-	(102,156)	4,712
Change in prepaid expenses	-	(3,665)	(433,171)
	(4,807,031)	1,571,457	(522,435)
Net change in net financial assets	(4,807,031)	1,571,457	(522,435)
Net financial assets, beginning of year	16,359,639	16,359,639	16,882,074
Net financial assets, end of year	$11,552,608	$17,931,096	$ 16,359,639

The accompanying notes are an integral part of these financial statements.

District of 100 Mile House
Statement of Cash Flows

For the year ended December 31	2023	2022
		(Restated - Note 10,16)
Operating transactions		
Annual surplus	$ 1,957,145	$ 2,149,098
Items not involving cash		
Income (loss) from 100 Mile Development Corporation	-	(665,340)
Amortization	1,846,957	1,648,835
Gain (loss) on disposal of tangible capital assets	17,618	(184,109)
Actuarial adjustment on debt	(7,424)	(6,819)
Changes in non-cash operating balances		
Accounts receivable	580,456	(642,727)
Inventories for resale	(102,156)	4,711
Asset retirement obligation liability	41,687	39,714
Accounts payable and accrued liabilities	217,549	(86,067)
Deferred revenue and development cost charges	(218,220)	(205,346)
Prepaid expenses	(3,665)	(433,171)
Other liabilities	7,148	4,435
	4,337,095	1,623,214
Capital transactions		
Acquisition of tangible capital assets	(2,126,824)	(3,957,800)
Proceeds on sale of tangible capital assets	(17,618)	250,000
	(2,144,442)	(3,707,800)
Investing transactions		
Purchase of short-term investments	(10,375,433)	(463,481)
Dividend paid from 100 Mile Development Corporation	-	1,000,000
	(10,375,433)	536,519
Financing transactions		
Principal payment on long-term debt	(5,278)	(5,278)
Net decrease in cash	(8,188,058)	(1,553,345)
Cash, beginning of year	16,505,739	18,059,084
Cash, end of year	$ 8,317,681	$ 16,505,739

The accompanying notes are an integral part of these financial statements.

1. Significant Accounting Policies

Government Reporting Entity

The District of 100 Mile House (the "District") was incorporated in 1965 and operates under the statute of the Province of British Columbia and operates under the provisions of the Local Government Act and the Community Charter of British Columbia. The District provides municipal services including administrative, protective, transportation, environmental, recreational, water, sewer and fiscal management.

Reporting Entity

The reporting entity is comprised of all organizations, committees and local boards accountable for the administration of their financial affairs and resources to the District and which are owned or controlled by the District except for the District's government business enterprise, 100 Mile Development Corporation which is accounted for on the modified equity basis of accounting.

The Perpetual Care Fund is excluded from the financial statements.

Basis of Accounting

The District follows the accrual method of accounting for revenues and expenses. Revenues are normally recognized in the year in which they are earned and measurable. Expenses are recognized as they are incurred and measurable as a result of receipt of goods or services and/or the creation of a legal obligation to pay.

The financial statements of the District have been prepared in accordance with Canadian Public Sector Accounting Standards.

Asset Retirement Obligation

A liability for an asset retirement obligation is recognized when there is a legal obligation to incur retirement costs in relation to a tangible capital asset; the past transaction or event giving rise to the liability has occurred; it is expected that future economic benefits will be given up; and a reasonable estimate of the amount can be made. The liability is recorded at an amount that is the best estimate of the expenditure required to retire a tangible capital asset at the financial statement date. This liability is subsequently reviewed at each financial reporting date and adjusted for the passage of time and for any revisions to the timing, amount required to settle the obligation or the discount rate. Upon the initial measurement of an asset retirement obligation, a corresponding asset retirement cost is added to the carrying value of the related tangible capital asset if it is still in productive use. This cost is amortized over the useful life of the tangible capital asset. If the related tangible capital asset is unrecognized or no longer in productive use, the asset retirement costs are expensed.

1. Significant Accounting Policies (continued)

Cash and Cash Equivalents

Cash and cash equivalents consist of cash on hand less outstanding cheques and deposits with a maturity of less than three months at the time of purchase.

Investment in Government Business Enterprise

The investment in 100 Mile Development Corporation (the "Corporation"), a government business enterprise, is accounted for on a modified equity basis. Under the modified equity basis, the Corporation's accounting policies are not adjusted to conform with those of the municipality and inter-organizational transactions and balances are not eliminated. The District recognizes its equity interest in the annual income or loss of the Corporation in its statement of operations with a corresponding increase or decrease in its investment asset account. Any dividends that the District may receive from the Corporation will be reflected as reductions in the investment asset account.

Revenue Recognition

Taxes are recorded at estimated amounts when they meet the definition of an asset, have been authorized and the taxable event occurs. For property taxes, the taxable event is the period for which the tax is levied. As taxes recorded are initially based on management's best estimate of the taxes that will be received, it is possible that changes in future conditions, such as reassessments due to audits, appeals and court decisions, could result in a change in the amount of tax revenue recognized. Taxes receivable are recognized net of an allowance for anticipated uncollectable amounts.

Charges for sewer and water usage are recorded as user fees when the service is provided. Connection fee revenues are recognized when the connection has been established.

Conditional non-government grant revenue is recognized to the extent the conditions imposed on it have been fulfilled. Unconditional non-government grant revenue is recognized when monies are receivable.

Grants for the acquisition of tangible capital assets are recognized in the period in which eligible expenditures are made.

Sales of service and other revenue is recognized when the service is provided.

Government Transfers

Government transfers, which include legislative grants, are recognized in the financial statements in the period in which events giving rise to the transfers occur, providing the transfers are authorized, any eligibility criteria have been met, and reasonable estimates of the amount can be made.

1. Significant Accounting Policies (continued)

Collection of Taxes on Behalf of Other Taxation Authorities

The District collects taxation revenue on behalf of other entities. Such levies, other revenues, expenses, assets and liabilities with respect to the operations of entities are not reflected in these financial statements.

Tangible Capital Assets

Tangible capital assets are recorded at cost which includes amounts that are directly attributable to acquisition, construction, development, or betterment of the asset. The cost, less residual value, of the tangible capital assets, excluding land, are amortized on a straight-line basis over their estimated useful lives as set out in the Capital Asset Policy. Estimated useful lives are as follows:

Buildings	40 to 75 years
Building Improvements	10 to 40 years
Furniture, Equipment & IT Technology	4 to 20 years
Machinery, Equipment & Vehicles	5 to 20 years
Roads	10 to 100 years
Underground & Other Engineered Structures	10 to 100 years

Tangible capital assets are written down when conditions indicate that they no longer contribute to the District's ability to provide goods and services, or when the value of future economic benefits associated with the tangible capital assets are less than their net book value. The net write-downs are accounted for as expenses in the statement of operations.

Tangible capital assets acquired during the year but not placed into use are not amortized until they are placed into use.

Contributions of Tangible Capital Assets

Tangible capital assets received as contributions are recorded at their fair value at the date of receipt and recorded as revenue.

Leased Assets

Leased assets which transfer substantially all the benefits and risk incidental to ownership of property, are accounted for as leased tangible capital assets. All other leases are accounted for as operating leases and the related payments are included in expenses as incurred.

Supply Inventory

Inventories are valued at the lower of cost and replacement cost. Cost is determined using average costing.

1. Significant Accounting Policies (continued)

Employee Future Benefits	The District's contributions due during the period to its multi-employer defined benefit plan are expensed as incurred.
Investment Income	The District follows the practice of investing individually significant unspent funds within individual funds. Interest earned is allocated on the basis of actual earnings from the specific instruments. Excess funds or temporary borrowings of all functions and capital projects are pooled and interest income or expense is allocated to the individual function on a monthly basis.
Long-term Debt	Long term debt is recorded net of any related sinking fund balances. Debt service charges, including principal and interest, are charged against current revenue in the period in which they occur.
Measurement Uncertainty	The preparation of financial statements in conformity with PSAB requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure on contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenditures during the reporting period. Significant areas requiring use of management estimates relate to amortization of capital assets and measurement of asset retirement obligations. Actual results could differ from those estimates.
Reserve Funds	Reserves represent amounts set aside for specific or future expenditures. Statutory reserves require the passing of a by-law before funds can be expended. Reserve accounts require an approved council budget and resolution.
Budget Reporting	Unaudited budget figures shown represent the Financial Plan Bylaw adopted by Council on April 4, 2023. These figures do not reflect subsequent amendments made by mayor and council to reflect changes in the budget throughout the year.

1. Significant Accounting Policies (continued)

Financial Instruments

Cash and equity instruments quoted in an active market are measured at fair value (hierarchy level one – quoted market prices). All other financial instruments, are measured at cost or amortized cost. The carrying amount of each of these financial instruments is presented on the statement of financial position.

Unrealized gains and losses from changes in the fair value of financial instruments are recognized in the statement of remeasurement gains and losses. Upon settlement, the cumulative gain or loss is reclassified from the statement of remeasurement gains and losses and recognized in the statement of operations. Interest and dividends attributable to financial instruments are reported in the statement of operations.

When investment income and realized and unrealized gains and losses from changes in the fair value of financial instruments are externally restricted, the investment income and fair value changes are recognized as revenue in the period in which the resources are used for the purpose specified.

For financial instruments measured using amortized cost, the effective interest rate method is used to determine interest revenue or expense.

For portfolio measurements measured at cost, the cost method records the initial investment at cost and earnings from such investments are recognized only to the extent received or receivable. When an investment is written down to recognize an impairment loss, the new carrying value is deemed to be the new cost basis for subsequent accounting purposes.

All financial assets are tested annually for impairment. When financial assets are impaired, impairment losses are recorded in the statement of operations.

Transaction costs are added to the carrying value for financial instruments measured using cost or amortized cost. Transaction costs are expensed for financial instruments measured at fair value.

2. Cash and Short-term Investments

	2023	2022
Bank	$ 8,317,681	$ 16,505,739
Municipal Finance Authority Money Market Fund	408,549	388,883
Municipal Finance Authority Short Term Bond Fund	78,541	74,598
Royal Bank of Canada GIC, interest at 5.16% per annum, maturing April 2024	5,178,082	-
Royal Bank of Canada GIC, interest at 4.95% per annum, maturing October 2024	5,173,742	-
	$19,156,595	$ 16,969,220

Short Term Investments are held with the Municipal Finance Authority of BC in a pooled money market fund at a market value of $408,606 and an annual rate of return of approximately 2.95% (2022 – 1.93%). A short term bond is held with the Municipal Finance Authority of BC at a market value of $191,674 and an annual rate of return of approximately 5.33%.

3. Accounts Receivable

	2023	2022
Property Taxes and Utilities	$ 529,311	$ 379,069
Other Governments	68,684	87,110
100 Mile Development Corporation	315	272
Trade and Other	152,974	865,282
	$ 751,284	$ 1,331,733

As of December 31, 2023, 99% of trade accounts receivable are aged less than 60 days.

4. Related Party transactions

During the year, the District provided operational funding of $75,000 (2022 - $112,910) to the 100 Mile Development Corporation, a wholly owned subsidiary. The District also charged rent of $17,985 (2022 - $17,985) to the 100 Mile Development Corporation for the Visitor Information Centre.

The District and the Cariboo Regional District signed a 3-year agreement commencing January 1, 2020 to support the operation of the Martin Exeter Hall Complex through the District up to a maximum of $60,000 annually. This complex is owned by the District but operated by the 100 Mile Development Corporation. This contribution is recognized in the subsidiary's revenue.

The 100 Mile Development Corporation declared a dividend payable of $nil (2022 - $1,000,000). Included in accounts receivable on December 31, 2023 is $511 (2022 - $272) due from the 100 Mile Development Corporation. Included in accounts payable on December 31, 2023 is $88,062 (2022 - $62,910) due to the 100 Mile Development Corporation.

5. Accounts Payable & Accrued Liabilities

	2023	2022
Other Government	$ 12,740	$ 11,513
Accrued Wages & Benefits	67,544	99,689
Trade & Other	722,633	467,015
	$ 802,917	$ 578,217

As of December 31, 2023, 99% of trade accounts payable are aged less than 60 days.

6. Investment in 100 Mile Development Corporation

The Corporation is owned and controlled by the District and is considered a Government Business Enterprise. As such, the Corporation is accounted for on the modified equity basis in these financial statements. The Corporation is charged with responsibility for economic development activities, operation of the Visitor Information Centre and management of the Community Forest.

The following provides condensed supplementary financial information for the Corporation for the year ended December 31:

Financial Position	2023	2022
Assets:		
Current	$ 536,925	$ 540,903
Tangible Capital Assets	445	577
Total Assets	$ 537,370	$ 541,480
Liabilities:		
Accounts Payable	$ 17,877	$ 22,226
District of 100 Mile House	511	272
Total Liabilities	$ 18,388	$ 22,498
Equity:		
Share Capital	$ 100	$ 100
Retained Earnings	518,882	518,882
Total Equity	518,982	518,982
Total Liabilities and Equity	$ 537,370	$ 541,480
Operations:		
Revenue	$ 324,350	$ 1,026,869
Expenses	324,350	361,529
Net Income (loss)	-	665,340
Dividend	-	1,000,000
Change in equity	$ -	$ (334,660)

7. Deposit and Reserve Municipal Finance Authority

The Municipal Finance Authority of British Columbia (MFA) provides capital financing for regional districts and their member municipalities. MFA is required to establish a Debt Reserve Fund. Each regional district, through its member municipalities who share in the proceeds of a debt issue, is required to pay into the Debt Reserve Fund certain amounts set out in the debt agreements. MFA pays into the Debt Reserve Fund these monies from which interest earned thereon less administration expenses becomes an obligation to the regional districts. It must then use this Fund, if at any time there are insufficient funds, to meet payments on its obligations. If this occurs, the regional districts may be called upon to restore the Fund.

As of December 31, 2023 the total of the Debt reserve fund was comprised of cash deposits of $3,144 (2022 – $3,049) and deposit notes of $5,257 (2022 - $5,257).

8. Deferred Revenue

	December 31, 2022 (Restated - Note 10)	Collected	Interest	Recognized	December 31, 2023
Deferred revenue					
Taxes	$ 175,405	$ 195,720	$ -	$ (175,405)	$ 195,720
Other	378,412	81,920	-	(378,411)	81,921
	553,817	277,640	-	(553,816)	277,641
Development cost charges	463,451	47,739	10,218	-	521,408
	$ 1,017,268	$ 325,379	$ 10,218	$ (553,816)	$ 799,049

Development cost charges are restricted revenue liabilities representing funds received from developers and deposited into a separate reserve fund for capital expenses. In accordance with generally accepted accounting principles, the District records these funds as restricted revenue which is then recognized as revenue when the related costs are incurred.

9. Long-term Debt

Regular payments are made in accordance with the loan terms. Final payment amounts are based on actuarial calculations. Interest paid on long-term debt is included in the Sewer Revenue Fund $3,927 (2022 - $3,927).

	Balance Beginning of Year	Principal Amount	Actuarial Adjustment	Balance End of Year
Sewer Fund				
MFA Issue 85	$ 26,038	$ 5,277	$ 7,424	$ 13,337

MFA 85 matures in 2024, bearing interest at 4.575%.

10. Community Works Fund

During the year, management determined that the funding received under the Community Works Fund (CWF) Agreement with the Union of British Columbia Municipalities (UBCM) did not contain stipulations that would create a liability that would allow for the funds to be recognized as a liability. This determination requires retroactive restatement of the previously deferred CWF revenues. The unspent CWF revenues have been recognized as revenue, as per the below and transferred to the Community Works Fund Reserve (Note 12). The impact of this restatement on the December 31, 2023 financial statements is as follows:

Statement of Financial Position:	As Previously Stated	Increase (Decrease)	Restated*
Deferred revenue	2,396,701	(1,842,884)	553,817

Statement of Operations:	As Previously Stated	Increase (Decrease)	Restated
Revenue	8,564,549	164,261	8,728,810
Accumulated surplus, beginning of year	54,342,220	1,678,623	56,020,843
Annual Surplus	2,036,926	164,261	2,201,187
Accumulated surplus, end of year	56,379,146	1,842,884	58,222,030

* Restated balance before the adoption of PS 3280 Asset Retirement Obligations (Note 16).

11. Tangible Capital Assets

	2023								
	Land	Buildings	Vehicles, Furniture & Equipment	Transportation	Recreation Facilities	Water	Sewer	Assets under construction	Total
Cost, beginning of year	$ 2,114,120	$ 4,253,148	$ 5,438,037	$ 27,492,874	$ 2,097,546	$ 16,646,732	$ 8,325,015	$ 2,573,063	$ 68,940,535
Additions	-	361,488	519,326	772,915	216,832	964,956	-	565,997	3,401,514
Disposals	-	-	-	(94,762)	(13,344)	-	-	-	(108,106)
Transfers	-	-	-	-	-	-	-	(1,274,690)	(1,274,690)
Cost, end of year	2,114,120	4,614,636	5,957,363	28,171,027	2,301,034	17,611,688	8,325,015	1,864,370	70,959,253
Accumulated amortization, beginning of year	-	2,744,727	3,082,072	11,755,121	1,070,779	5,278,907	4,330,753	-	28,262,359
Amortization	-	138,319	369,319	693,710	114,320	357,060	174,229	-	1,846,957
Disposals	-	-	-	(94,762)	(13,344)	-	-	-	(108,106)
Accumulated amortization, end of year	-	2,883,046	3,451,391	12,354,069	1,171,755	5,635,967	4,504,982	-	30,001,210
Net carrying amount, end of year	$ 2,114,120	$ 1,731,590	$ 2,505,972	$ 15,816,958	$ 1,129,279	$ 11,975,721	$ 3,820,033	$ 1,864,370	$ 40,958,043

11. Tangible Capital Assets (continued)

2022
(Restated - Note 16)

	Land	Buildings	Vehicles, Furniture & Equipment	Transportation	Recreation Facilities	Water	Sewer	Assets under construction	Total
Cost, beginning of year	$ 2,088,611	$ 3,751,116	$ 5,353,574	$ 24,612,720	$ 2,120,823	$ 16,646,732	$ 8,298,042	$ 2,213,056	$ 65,084,674
Additions	91,400	502,032	97,234	2,880,154	-	-	26,973	3,471,167	7,068,960
Disposals	(65,891)	-	(12,771)	-	-	-	-	-	(78,662)
Transfers	-	-	-	-	-	-	-	(3,111,160)	(3,111,160)
Write-downs	-	-	-	-	(23,277)	-	-	-	(23,277)
Cost, end of year	2,114,120	4,253,148	5,438,037	27,492,874	2,097,546	16,646,732	8,325,015	2,573,063	68,940,535
Accumulated amortization, beginning of year	-	2,627,899	2,833,708	11,085,578	1,008,434	4,941,147	4,152,806	-	26,649,572
Amortization	-	116,828	261,135	669,543	85,622	337,760	177,947	-	1,648,835
Disposals	-	-	(12,771)	-	-	-	-	-	(12,771)
Write-downs		-	-	-	(23,277)	-	-	-	(23,277)
Accumulated amortization, end of year	-	2,744,727	3,082,072	11,755,121	1,070,779	5,278,907	4,330,753	-	28,262,359
Net carrying amount, end of year	$ 2,114,120	$ 1,508,421	$ 2,355,965	$ 15,737,753	$ 1,026,767	$ 11,367,825	$ 3,994,262	$ 2,573,063	$ 40,678,176

Contributed tangible capital assets have been recognized at fair value at the date of contribution. The value received during the year is $nil (2022 -$389,400).

12. Accumulated Surplus

Accumulated surplus consists of individual fund surplus and reserve funds as follows:

	2023	2022 (Restated - Note 10,16)
Operating Surplus:		
General operating fund	$ 1,816,687	$ 457,737
Sewer operating fund	308,942	264,849
Water operating fund	451,340	(152,996)
	2,576,969	569,590

	2023	2022
Investment in tangible capital assets	40,064,245	39,813,363

	2023	2022
Reserves:		
Municipal infrastructure	2,388,868	2,695,691
Utility infrastructure	3,287,072	2,991,019
Parkland	6,279	6,208
Machinery & equipment	2,867,790	3,117,028
Covid-19 (Schedule 1)	27,408	38,304
Woodlot	358,170	370,942
Community Forest	6,290,111	6,142,345
Growing communities (Schedule 2)	1,275,857	-
Community works fund	401,747	1,842,883
	16,903,302	17,204,420
Accumulated surplus	$59,544,516	$ 57,587,373

a) Included in the General Operating Fund are internally restricted funds of $100,000 (2022 - $100,000) for the purposes of planning.

b) Included in the General Operating Fund are internally restricted funds of $nil (2022 - $1,170) to be used to fund Interior Health Transit expense.

13. Property Taxation and Grants in Lieu

	2023	2022
Taxes Collected		
Property taxes	$ 5,391,027	$ 5,065,845
Special assessments	223,913	212,124
1% Utility tax	64,872	62,753
Grants in Lieu of taxes	84,898	83,097
Penalties and interest on taxes	57,454	20,932
	5,822,164	5,444,751
Transfers to other governments		
School District	1,297,974	1,173,712
Regional District	693,052	685,474
Regional Hospital District	490,950	397,912
Joint Boards & Commissions	34,145	31,867
Other	167,430	140,784
	2,683,551	2,429,749
Available for municipal purposes	$ 3,138,613	$ 3,015,002

14. Government Grants and Transfers

	2023	2022 (Restated - Note 10)
Provincial transfers		
IBA-ICIP	$ 35,852	$ 631,047
ICIP - Rural and Northern Communities Project	92,287	-
BC Active Transportation Infrastructure	-	179,925
Community Transition Capacity project	84,401	91,565
Community Support Grant	-	38,498
Growing Communities Fund	1,265,000	-
Ministry of Forests - Forestry Employment Program	20,266	32,996
Ministry of Tourism - Tourism Dependent Community Fund	-	143,277
Small Community Protection	387,000	488,000
Community Works	151,754	145,024
Other	188,663	347,976
	2,225,223	2,098,308
Federal transfers		
Tourism Relief Fund	-	40,778
Tourism Development	207,500	-
	207,500	40,778
Regional transfers		
Cariboo Regional District	437,195	453,546
NDI Trust	15,000	50,000
UBCM	104,960	34,614
	557,155	538,160
	$ 2,989,878	$ 2,677,246

15. Contingent Liabilities and Commitments

a) Municipal Pension Plan

The District of 100 Mile House and its employees contribute to the Municipal Pension Plan (a jointly trusteed pension plan). The Board of Trustees, representing plan members and employers, is responsible for administering the plan, including investment of the assets and administration of benefits. The Plan is a multi-employer defined benefit pension plan. Basic pension benefits are based on a formula. As at December 31, 2022, the Plan has about 240,000 active members and approximately 118,000 retired members. Active members include approximately 43,000 contributors from local governments.

Every three years, an actuarial valuation is performed to assess the financial position of the plan and adequacy of plan funding. The actuary determines an appropriate combined employer and member contribution rate to fund the plan. The actuary's calculated contribution rate is based on the entry-age normal cost method, which produces the long-term rate of member and employer contributions sufficient to provide benefits for average future entrants to the plan. This rate may be adjusted for the amortization of any actuarial funding surplus and will be adjusted for the amortization of any unfunded actuarial liability.

The most recent actuarial valuation for the Municipal Pension Plan as of December 31, 2021 indicated a $3,761 million funding surplus for basic pension benefits on a going concern basis.

The District of 100 Mile House paid $113,032 (2022 - $102,998) for employer contributions while employees contributed $99,915 (2022 - $91,082) to the Plan in fiscal 2023.

The next valuation will be as at December 31, 2024.

Employers participating in the Plan record their pension expense as the amount of employer contributions made during the fiscal year (defined contribution pension plan accounting). This is because the Plan records accrued liabilities and accrued assets for the Plan in aggregate, resulting in no consistent and reliable basis for allocating the obligation, assets and cost to individual employers participating in the Plan.

b) Joint and Several Liability

The District of 100 Mile House, as a member of the Cariboo Regional District, is jointly and severally liable under the provisions of Sections 815 and 816 of the Local Government Act for any default on monies borrowed by the Cariboo Regional District.

c) Potential Litigation

From time to time the District is brought forth as a defendant in various lawsuits. The District reviews its exposure to any potential litigation for which it would not be covered by insurance and assesses whether a successful claim against would materially affect the financial statements. The District is currently not aware of any claims brought against it that if not defended successfully would result in a material change to the financial statements of the District.

15. Contingent Liabilities and Commitments (continued)

d) Municipal Insurance Association

The District is a participant in the Municipal Insurance Association of British Columbia. Should the Association pay out claims in excess of premiums received, it is possible the District, along with the other participants, would be required to contribute towards the deficit.

e) Tangible Capital Assets

The District entered into a contract with Hub Fire Engines & Equipment Ltd. on December 21, 2021 for a Fire Engine Apparatus costing $880,394 plus tax. The Fire Engine Apparatus is expected to be delivered in June 2024.

16. Asset Retirement Obligations

Effective January 1, 2023, the District of 100 Mile House adopted the new Public Sector Accounting Handbook Standard, PS 3280 Asset Retirement Obligations. The standard requires the reporting of legal obligations associated with the retirement of tangible capital assets by public sector entities. The standard was adopted on the modified retroactive basis at the date of adoption. Under the modified retroactive method, the discount rate and assumptions used on initial recognition are those as of the date of adoption of the standard. The impact of adoption of this standard was as follows:

December 31, 2022	As Previously Stated*	Increase (Decrease)	Restated
Tangible capital assets - cost	68,577,976	362,559	68,940,535
Accumulated amortization - tangible capital assets	28,103,918	158,441	28,262,359
Asset retirement obligation	-	838,774	838,774
Accumulated surplus	58,222,030	(52,089)	58,169,941
Annual surplus	2,201,187	(52,088)	2,149,099
Amortization of tangible capital assets	1,636,460	12,375	1,648,835
Accretion expense	-	39,713	39,713

*Accumulated surplus and annual surplus as restated for the Community Works Fund prior period adjustment (Note 10).

a) Asbestos abatement obligation
The District owns buildings that are known to contain asbestos. Following the adoption of PS 3280 – Asset Retirement Obligations, the District recognized an obligation relating to the removal and post-removal care of the asbestos in these buildings as estimated at January 1, 2023. The buildings all have an estimated useful life of between 40 and 75 years from the date of completion of construction, of which various numbers of years remain. Estimated costs of $1,255,216 have been discounted to the present value using a discount rate of 4.97% per annum (2022 – 4.97%).

b) Wells decommissioning obligation
The District owns water wells which will require decommissioning at the end of their useful lives under BC Regulations. Following the adoption of PS 3280 – Asset Retirement Obligations, the District recognized an obligation relating to the decommissioning of the wells at January 1, 2023. The wells are estimated to have 60 year useful lives, of which various numbers of years remain. Estimated costs of $63,000 have been discounted to the present value using a discount rate of 4.97% per annum (2022 – 4.97%).

16. Asset Retirement Obligations (continued)

Changes in the asset retirement obligation in the year are as follows:

Asset Retirement Obligation	Asbestos remediation	Well decommissioning	2023
Opening balance	$ 809,170	$ 29,605	$ 838,775
Accretion expense	40,216	1,471	41,687
Closing balance	$ 849,386	$ 31,076	$ 880,462

Asset Retirement Obligation	Asbestos remediation	Well decommissioning	2022
Adjustment on adoption of PS3280	$ 770,858	$ 28,202	$ 799,060
Accretion expense	38,312	1,402	39,714
Closing balance	$ 809,170	$ 29,604	$ 838,774

The asset retirement liability has been estimated using a net present value technique using the assumptions as described above. The related asset retirement costs are being amortized on a straight-line basis over the remaining useful lives of the assets.

Significant estimates and assumptions are made in determining the asset retirement costs as there are numerous factors that will affect the amount ultimately payable. Those uncertainties may result in future actual expenditures that are different than the amounts currently recorded. At each reporting date, as more information and experience is obtained as it relates to these asset retirement obligations, the estimates of the timing, the undiscounted cash flows and the discount rates may change. Adjustments to these factors are accounted for as an adjustment to the asset retirement obligation and the related tangible capital asset in the current period on a retrospective basis.

17. Budget

The budget data presented in these financial statements is based upon the 2023 operating and capital budgets approved as the 2023 to 2027 Financial Plan by Council on April 4, 2023. The legislative requirements for the Financial Plan are that the cash inflows for the period must equal planned cash outflows.

Cash inflows and outflows budgeted for include such items as transfers to and from reserves, transfers to and from operating surpluses and proceeds on sale of assets. These items are not recognized as revenues and expenses in the Statement of Operations as they do not meet the definition of such under public sector accounting standards. PSAB requires that budget figures be presented on the same basis of accounting as actual figures.

The chart below reconciles the budget figures reported in these financial statements.

	2023
Budget surplus per Statement of Financial Activities	$ (655,411)
Adjust for budgeted items not included in Statement of Financial Activities:	
Transfers from reserve funds	4,807,031
Acquisition of tangible capital assets	(5,619,275)
Non-cash items - amortization	1,467,655
Financial Plan (Budget) Bylaw surplus for the year	$ -

18. Comparative Figures

Certain of the comparative figures have been restated to conform with the current year financial statement presentation.

19. Financial Instruments

The District is potentially exposed to credit risk, market and interest rate risk, and liquidity risk from the District's financial instruments. Qualitative and quantitative analysis of the significant risks from the District's financial instruments is provided below by type of risk.

There have not been any changes from the prior year in the District's exposure to above risks or the policies, procedures and methods it uses to manage and measure the risks.

Credit risk

Credit risk is the risk that one party to a financial instrument will cause a financial loss for the other party by failing to discharge an obligation. The District is exposed to credit risk through its cash, accounts receivable, and short-term investments.

The District manages it credit risk by manages it credit risk by:
- Ensuring receivables are primarily government organizations
- Having legislated collateral over taxes receivable from highly diversified nature of residents of the District
- Holding cash and guaranteed investment certificates at federally regulated chartered banks with cash accounts insured

The District measures its exposure to credit risk based on:
- By how long amounts have been outstanding from government organizations regarding capital projects and other
- Based on historical experience regarding collections

The maximum exposure to credit risk at the financial statement date is the carrying value of its cash and accounts receivable as outlined in Note 3. Accounts receivable arise primarily as a result of utilities, and grants receivable. Based on this knowledge, credit risk of cash and accounts receivable are assessed as low.

The District manages exposure to credit risk for short-term investments by ensuring adequate diversification and by maintaining its investments in the Ministry of Finance Authority which meets the investment requirements of Section 183 of the Community Charter of the Province of BC. As a result, the District has reduced exposure to market or value risk. The maximum exposure to credit risk on short-term investments is outlined in Note 2.

Liquidity risk

Liquidity risk is the risk that the District will encounter difficulty in meeting obligations associated with financial liabilities. The District is exposed to liquidity risk through its accounts payable, long-term debt, and investments.

The District manages this risk by staggering maturity dates of investments based on cash flow needs. Also to help manage the risk, the District has in place a planning, budgeting and forecasting process to help determine the funds required to support the normal operating requirements. The District's five-year financial plan is approved by the Mayor and Council, which includes operational activities and capital investments. The District measures its exposure to liquidity risk based on cash flow needs versus available cash.

18. Financial Instruments (continued)

Interest rate risk

Interest rate risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market interest rates. The District is exposed to interest rate risk through its long-term debt and the value of short-term investments.

The District manages interest rate risk on its long-term debt by holding all debt through MFA at a fixed rate, with refinancing typically being completed at the ten or fifteen year mark. Therefore, fluctuations in market interest rates would not impact future cash flows and operations relating to long-term debt. See Note 9 for interest rates and maturity dates for long term debt.

Investments that are subject to interest rate risk are MFA pooled investment funds (see Note 2). The risk is caused by changes in interest rates. As interest rates rise, the fair value of the MFA pooled investment funds notes decrease and, as interest rates fall, the fair value of these investments increase.

As a result of diversification by security type, only a portion of the overall investment portfolio is exposed to interest rate risk. As at December 31, 2023 the amount of the investment portfolio exposed was $10,838,914 (2022 - $463,481) per Note 2.

To mitigate interest rate risk and market risk on its short-term investments, the District holds its MFA long term pooled investment funds for 10 years or longer.

20. Segmented Information

The District is a diversified municipal government institution that provides a wide range of services to its citizens such as transit, public housing, police, fire and water. Distinguishable functional segments have been separately disclosed in the segmented information. The nature of the segments and the activities they encompass are as follows:

General government
General government operations provide the functions of corporate administration, finance, human resources, legislative services, building services and maintenance, and any other functions not categorized to a specific department.

Protective services
Protective services is comprised of bylaw enforcement, and the fire department.

Solid waste management and recycling
Solid waste management and recycling comprises of the collection, disposal and recycling of solid waste.

Public Health
Public health services comprises of cemetery services.

20. Segmented Information (continued)

Planning and development
Planning and development includes services related to planning and zoning, Woodlot #577, logging, weed control and 100 Mile Development Corporation.

Transportation services
Transportation services includes the municipal public works services related to the planning, development, and maintenance of roadway systems, street lighting, airport, snow removal, parking and transit services.

Parks, recreation and culture
Parks, recreation and culture provides for the delivery of municipal recreation programs and the services related to the planning, development and maintenance of parklands and park infrastructure, and the maintenance of open space and other recreation space and facilities.

Water and sewer utilities
The District is responsible for environmental programs including the engineering and operation of the potable water and wastewater systems.

Certain allocation methodologies are employed in the preparation of segmented financial information. Taxation and payments-in-lieu of taxes are allocated to the segments based on the segment's budget net expenditure. The various user charges and other revenues have been allocated to the segments based upon the segment that generated the revenue. Government transfers have been allocated to the segment based upon the purpose for which the transfer is made. Development charges earned and developer contributions received are allocated to the segment for which the charge was collected.

The accounting policies used in these segments are consistent with those followed in the preparation of the financial statements as disclosed in Note 1.

20. Segmented Information (continued)

2023

	General government	Protective services	Solid waste management and recycling	Public health	Planning and development	Transportation	Parks, recreation and culture	Water services	Sewer services	Total
Revenue										
Property taxation & grants in lieu	$ 2,914,700	$ -	$ -	$ -	$ -	$ -	$ -	$ 116,615	$ 107,298	$ 3,138,613
Government transfers	2,427,967	244,815	49,772	3,000	-	188,324	76,000	-	-	2,989,878
Sale of services	133,849	-	28,634	22,878	5,000	-	-	585,157	468,636	1,244,154
Other revenue	208,605	86,981	-	3,380	-	19,583	9,495	-	-	328,044
Investment income	997,220	-	-	-	-	-	-	-	7,424	1,004,644
Loss on disposal of assets	(17,618)	-	-	-	-	-	-	-	-	(17,618)
	6,664,723	331,796	78,406	29,258	5,000	207,907	85,495	701,772	583,358	8,687,715
Expenditures										
Goods and services	490,630	324,695	78,406	10,382	394,145	855,040	87,615	396,492	125,982	2,763,387
Salary, wages and benefits	490,546	421,847	49,346	22,145	222,815	512,678	53,893	167,756	133,586	2,074,612
Amortization	40,871	122,383	-	-	-	1,038,034	114,380	357,060	174,229	1,846,957
Interest and finance charges	40,216	-	-	-	-	-	-	1,471	3,927	45,614
	1,062,263	868,925	127,752	32,527	616,960	2,405,752	255,888	922,779	437,724	6,730,570
Surplus (deficit)	$ 5,602,460	$ (537,129)	$ (49,346)	$ (3,269)	$ (611,960)	$ (2,197,845)	$ (170,393)	$ (221,007)	$ 145,634	$ 1,957,145

20. Segmented Information (continued)

2022

	General government	Protective services	Solid waste management and recycling	Public health	Planning and development	Transportation	Parks, recreation and culture	Water services	Sewer services	Total
Revenue										
Property taxation & grants in lieu	$ 2,802,878	$ -	$ -	$ -	$ -	$ -	$ -	$ 110,149	$ 101,975	$ 3,015,002
Government transfers	2,118,624	240,799	50,995	7,000	-	183,828	76,000	-	-	2,677,246
Sale of services	128,338	-	26,861	10,745	6,950	-	-	562,022	433,402	1,168,318
Earnings of 100 Mile Development Corporation	665,340	-	-	-	-	-	-	-	-	665,340
Developer Contributions	389,400	-	-	-	-	-	-	-	-	389,400
Other revenue	144,761	74,604	-	3,803	-	15,937	9,845	-	12,097	261,047
Investment income	368,348	-	-	-	-	-	-	-	-	368,348
Gain on disposal of assets	184,109	-	-	-	-	-	-	-	-	184,109
	6,801,798	315,403	77,856	21,548	6,950	199,765	85,845	672,171	547,474	8,728,810
Expenditures										
Goods and services	322,937	345,706	77,856	22,701	398,278	927,930	62,858	348,603	197,117	2,703,986
Salary, wages and benefits	758,520	417,591	34,343	12,280	196,468	462,524	63,285	136,211	102,028	2,183,250
Amortization	33,522	101,330	-	-	-	912,654	85,622	337,760	177,947	1,648,835
Interest and finance charges	38,312	-	-	-	-	-	-	1,402	3,927	43,641
	1,153,291	864,627	112,199	34,981	594,746	2,303,108	211,765	823,976	481,019	6,579,712
Surplus (deficit)	$ 5,648,507	$ (549,224)	$ (34,343)	$ (13,433)	$ (587,796)	$ (2,103,343)	$ (125,920)	$ (151,805)	$ 66,455	$ 2,149,098

District of 100 Mile House
Schedule 1: COVID-19 Safe Restart Grant
(Unaudited)

December 31, 2023

	2023	2022
Eligible costs incurred		
Computer & IT Costs - Virtual Communications	$ 10,896	$ 16,974
Emergency Planning & Response Cost	-	4,648
Revenue Shortfalls	-	61,807
	10,896	83,429
Reserve balance, beginning of year	38,304	121,733
Reserve balance, end of year	$ 27,408	$ 38,304

District of 100 Mile House
Schedule 2: Growing Communities Fund
(Unaudited)

December 31, 2023

	2023
Revenue	
Grant funding	$ 1,265,000
Interest income	10,857
Reserve balance, end of year	$ 1,275,857

Thank you for reading the District of 100 Mile House 2023 Annual Report

J1

DISTRICT OF 100 MILE HOUSE

Bylaw No. 1421

A bylaw to amend the District of 100 Mile House Zoning Bylaw No. 1290, 2016

This bylaw may be cited for all purposes as ***"Zoning Amendment Bylaw No. 1421, 2024"***.

The Council of the District of 100 Mile House, in open meeting assembled, enacts as follows:

(1) That Section 7.3 Resource Area Zone (A-3), Subsection 7.3.3 Accessory Permitted Uses is amended by adding:

"secondary suite"

(2) That Section 1.0 Administration, Subsection 1.12 Public Hearing be amended to read:

1.12.1 Unless waived or prohibited in accordance with Section 464 (2), (3), (4) of the *Local Government Act*, a public hearing must be held for any amendment to this Bylaw.

READ A FIRST, SECOND and THIRD TIME this 23rd day of April, 2024.

NOTICE OF PUBLIC HEARING NOT HELD GIVEN this 11th and 18th day of April, 2024.

RECEIVED MINISTRY OF TRANSPORTATION AND INFRASTRUCTURE APPROVAL

this 1ST day of May, 2024 _____
Ministry of Transportation and Infrastructure

ADOPTED this _____ day of _____, 2024.

_____ _____

Mayor Corporate Officer

DISTRICT OF 100 MILE HOUSE

Cheque Register-Summary-Bank

AP5090 Page : 1

Date : May 23, 2024 Time : 3

K1

Supplier : 079850 To ZZ9950

Pay Date : 16-Apr-2024 To 15-May-2024

Bank : 0099 - CASH CLEARING/SUSPENSE "BANK" To 6 - 10(

Seq : Cheque No. Status : All

Medium : M=Manual C=Computer E=EFT-PA

Cheque #	Cheque Date	Supplier	Supplier Name	Status	Batch	Medium	Amount
29589	26-Apr-2024	1MDE50	100 MILE DEVELOPMENT CORPORATION	Issued	159	C	63,062.07
29590	26-Apr-2024	1MFI50	100 MILE FIREMEN'S SOCIETY	Issued	159	C	1,400.00
29591	26-Apr-2024	1MLA50	100 MILE LAUNDROMAT	Issued	159	C	105.00
29592	26-Apr-2024	1MTC50	100 MILE TRAFFIC CONTROL	Issued	159	C	840.29
29593	26-Apr-2024	ACEC50	ACE COURIER SERVICES	Issued	159	C	424.76
29594	26-Apr-2024	ASSO50	ASSOCIATED FIRE SAFETY	Issued	159	C	20,817.00
29595	26-Apr-2024	ATST50	ATS TRAFFIC LTD	Issued	159	C	3,590.72
29596	26-Apr-2024	BARD50	BARNETT, DONNA	Cleared	159	C	45.13
29597	26-Apr-2024	BCTR50	BC TRANSIT	Issued	159	C	23,206.33
29598	26-Apr-2024	BERJ50	BEREZIAK, JULIE K	Cleared	159	C	500.00
29599	26-Apr-2024	BREE50	BREE CONTRACTING LTD	Cleared	159	C	60,137.17
29600	26-Apr-2024	BUCK50	BUCKIN' HORSE CONTRACTING	Issued	159	C	500.00
29601	26-Apr-2024	CAGE50	CARIBOO GEOGRAPHIC SYSTEMS	Issued	159	C	866.78
29602	26-Apr-2024	CARN50	CARO ANALYTICAL SERVICES	Issued	159	C	3,571.58
29603	26-Apr-2024	CENC50	CENTRIX CONTROL SOLUTIONS LP	Issued	159	C	5,875.33
29604	26-Apr-2024	CINT50	CINTAS CANADA LIMITED	Issued	159	C	533.16
29605	26-Apr-2024	CITN50	CITY OF NANAIMO	Issued	159	C	105.00
29606	26-Apr-2024	COMI50	COMMISSIONAIRES BRITISH COLUMBIA	Issued	159	C	2,162.74
29607	26-Apr-2024	DHLE50	LOOMIS EXPRESS	Issued	159	C	352.58
29608	26-Apr-2024	DONP50	DONNELLY, PAUL	Cleared	159	C	1,278.07
29609	26-Apr-2024	EXEC50	EXETER COUNTRY TIRE	Issued	159	C	128.86
29610	26-Apr-2024	GART50	GARTH'S ELECTRIC CO LTD - INC NO. 248102	Issued	159	C	164.61
29611	26-Apr-2024	INLA50	INLAND KENWORTH PARTNERSHIP	Issued	159	C	310.59
29612	26-Apr-2024	INNO50	INNOV8 DIGITAL SOLUTIONS	Issued	159	C	864.78
29613	26-Apr-2024	INTO50	INTERIOR LOCKSMITH	Issued	159	C	168.00
29614	26-Apr-2024	INTU50	INTERNATIONAL UNION OF OPERATING ENG	Issued	159	C	963.16
29615	26-Apr-2024	IRLT50	DAWSON INTERNATIONAL TRUCK CENTRES	Issued	159	C	1,024.39
29616	26-Apr-2024	MTSM50	MTS MAINTENANCE TRAINING SYSTEMS INC	Issued	159	C	432.60
29617	26-Apr-2024	NORM50	NORTHERN COMPUTER	Issued	159	C	2,807.84
29618	26-Apr-2024	NOWE50	NORWEST	Issued	159	C	2,226.00
29619	26-Apr-2024	PATE50	PATERSON SEPTIC SERVICE	Issued	159	C	1,572.50
29620	26-Apr-2024	PERF50	PERFORMANCE ALL TERRAIN & RENTALS LT	Issued	159	C	63.84
29621	26-Apr-2024	PINM50	PINKNEY, MAUREEN	Issued	159	C	3,705.74
29622	26-Apr-2024	PRAR50	PRAIRIECOAST EQUIPMENT	Issued	159	C	680.34
29623	26-Apr-2024	RISJ50	RISLUND, JOEY	Issued	159	C	936.34
29624	26-Apr-2024	SAVE50	SAVE ON FOODS	Issued	159	C	126.38
29625	26-Apr-2024	SMIT50	SMITTY'S JANITORIAL SERVICES (1993)	Cleared	159	C	2,352.00
29626	26-Apr-2024	SOUC50	SOUTH CARIBOO CHAMBER OF COMMERCE	Cleared	159	C	435.00
29627	26-Apr-2024	SUNM50	SUNSET MEMORIAL AND STONE LTD	Issued	159	C	27,126.00
29628	26-Apr-2024	SUNR50	SUNRISE FORD SALES LTD	Issued	159	C	429.11
29629	26-Apr-2024	WILO50	WILLIAM LOVE	Cleared	159	C	1,611.75
29630	26-Apr-2024	WURT50	WURTH CANADA LTD	Issued	159	C	194.26
04509-0001	18-Apr-2024	POST50	POSTAGE BY PHONE	Cleared	143	E	820.00
04510-0001	19-Apr-2024	PENS50	PENSION CORPORATION	Cleared	144	E	7,844.01
04511-0001	19-Apr-2024	TELU50	TELUS COMMUNICATIONS COMPANY	Cleared	145	E	17.01
04512-0001	19-Apr-2024	TELU50	TELUS COMMUNICATIONS COMPANY	Cleared	146	E	17.35
04513-0001	19-Apr-2024	TELU50	TELUS COMMUNICATIONS COMPANY	Cleared	147	E	17.70
04514-0001	19-Apr-2024	RECE50	RECEIVER GENERAL OF CANADA	Cleared	148	E	12,392.91
04515-0001	19-Apr-2024	RECE50	RECEIVER GENERAL OF CANADA	Cleared	149	E	15,658.24
04516-0001	19-Apr-2024	PITN50	PITNEY BOWES GLOBAL CREDIT SERVICES	Cleared	150	E	433.40
04517-0001	23-Apr-2024	SHAW50	SHAW CABLE	Cleared	151	E	254.19
04518-0001	23-Apr-2024	SHAW50	SHAW CABLE	Cleared	152	E	305.54
04519-0001	24-Apr-2024	FORT50	FORTIS BC - NATURAL GAS	Cleared	153	E	315.00
04520-0001	29-Apr-2024	PENS50	PENSION CORPORATION	Cleared	154	E	8,728.54

Supplier : 079850 To ZZ9950
Pay Date : 16-Apr-2024 To 15-May-2024
Bank : 0099 - CASH CLEARING/SUSPENSE "BANK" To 6 - 10(

Seq : Cheque No. **Status :** All
Medium : M=Manual C=Computer E=EFT-PA

Cheque #	Cheque Date	Supplier	Supplier Name	Status	Batch	Medium	Amount
Bank : 4	**ROYAL BANK - CURRENT ACCOUNT**						
04521-0001	29-Apr-2024	RECE50	RECEIVER GENERAL OF CANADA	Cleared	155	E	3,577.59
04522-0001	29-Apr-2024	RECE50	RECEIVER GENERAL OF CANADA	Cleared	156	E	16,100.02
04524-0001	26-Apr-2024	BCHY50	BC HYDRO & POWER AUTHORITY	Cleared	158	E	256.22
04525-0001	30-Apr-2024	PITN50	PITNEY BOWES GLOBAL CREDIT SERVICES	Cleared	160	E	153.43
04526-0001	30-Apr-2024	PITN50	PITNEY BOWES GLOBAL CREDIT SERVICES	Cleared	161	E	144.46
04527-0001	01-May-2024	XPLO50	XPLORE INC.	Issued	162	E	111.99
04528-0001	01-May-2024	FRCO50	FOUR RIVERS CO-OPERATIVE	Issued	163	E	9,934.74
04529-0001	02-May-2024	SHAW50	SHAW CABLE	Issued	164	E	190.40
04530-0001	02-May-2024	SHAW50	SHAW CABLE	Issued	165	E	107.47
04531-0001	02-May-2024	SHAW50	SHAW CABLE	Issued	166	E	151.20
04532-0001	07-May-2024	BCHY50	BC HYDRO & POWER AUTHORITY	Issued	167	E	123.78
04533-0001	07-May-2024	FORT50	FORTIS BC - NATURAL GAS	Issued	168	E	134.29
04534-0001	08-May-2024	FORT50	FORTIS BC - NATURAL GAS	Issued	170	E	1,443.28
04535-0001	13-May-2024	PENS50	PENSION CORPORATION	Issued	171	E	8,863.02
04536-0001	13-May-2024	RECE50	RECEIVER GENERAL OF CANADA	Issued	172	E	19,691.53
04537-0001	13-May-2024	RECE50	RECEIVER GENERAL OF CANADA	Issued	173	E	3,373.58
04538-0001	09-May-2024	BDOC50	BDO CANADA LLP	Issued	174	E	1,958.25
04539-0001	09-May-2024	BDOC50	BDO CANADA LLP	Issued	175	E	6,179.25
04540-0001	03-May-2024	SCOO50	SCOTT, ROY	Issued	176	E	7,350.00
04541-0001	13-May-2024	TELU50	TELUS COMMUNICATIONS COMPANY	Issued	177	E	17.01
04542-0001	14-May-2024	ROYL50	ROYAL BANK VISA	Issued	178	E	10,447.67
04543-0001	14-May-2024	SHAW50	SHAW CABLE	Issued	179	E	395.14
04545-0001	07-May-2024	ROYL50	ROYAL BANK VISA	Issued	181	E	7,095.98
04546-0001	07-May-2024	ROYL50	ROYAL BANK VISA	Issued	182	E	2,090.18
04547-0001	01-May-2024	CLIF50	CANADA LIFE	Issued	183	E	11,390.54
04549-0001	07-May-2024	ROYL50	ROYAL BANK VISA	Issued	185	E	926.91

Total Computer Paid :	**237,697.80**	**Total EFT PAP :**	**159,011.82**	**Total Paid :**	**396,709.62**
Total Manually Paid :	**0.00**	**Total EFT File :**	**0.00**		

80 Total No. Of Cheque(s) ...

CAPITAL: $87,263.17