East Kootenay
Division of Family Practice
A GPSC initiative

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About Us

Divisions of family practice are community-based groups of family physicians working together to achieve common health care goals. Divisions work collaboratively with community and health care partners to enhance local patient care and improve professional satisfaction for physicians.

Beginning in 2009 in three prototype communities, the Divisions of Family Practice initiative has expanded to include 35 divisions representing more than 230 communities, including a division that targets physicians in remote and rural areas of the province.

The Divisions of Family Practice initiative is funded by the General Practice Service Committee (GPSC), one of four joint committees that represent a partnership of the provincial government and Doctors of BC.

History

A decade ago, primary health care in BC was in decline. Family doctors were disillusioned and disengaged, and increasing numbers of medical students were opting out of family medicine. Recognizing a need for change, Doctors of BC and the provincial government embarked on a journey together to improve primary care. This process began in 2002, with the formation of the GPSC.

As a first step to improving patient care and physician satisfaction, the GPSC listened to the stories of over 1000 doctors across BC during a two-year consultation process. The message they heard was clear: doctors wanted to be valued, trained, supported, and compensated appropriately within the health care system. Responding to these needs meant finding new ways of empowering doctors to build relationships in their communities, promote leadership, and inspire health care change. A grassroots approach was needed, and the Divisions of Family Practice initiative enabled this.

Structure and funding

Divisions are community-based non-profit groups that bring family doctors together and provide the infrastructure to support them in addressing common needs and health care priorities in their regions.

Through their local division, physicians have been able to:

- Connect and share ideas.
- Overcome the obstacles to collegiality created by geography and busy work schedules.
- Come together to address common issues in their practices, organize educational events, discuss health issues faced by local residents, and make decisions about health care in their communities.
- Work with other health care stakeholders and government partners, and refine a framework for collaborative health care decision-making.
- Have a powerful voice, and, for the first time in many years, feel capable of influencing change.

Collaborative work

Perhaps the greatest success of divisions has been in building relationships and fostering collaboration between physicians and other stakeholders within the health care system. Much of this collaboration happens through the Collaborative Services Committees (CSCs), which include representatives from divisions, regional health authorities, the GPSC, and Ministry of Health.

Through CSCs, these partners work collectively to identify and address local health care challenges, as well as to engage the broader community (e.g., representatives from municipalities, other nonprofits, and patients). This new collaborative landscape has revitalized interest in primary care, and helped to reverse the trend of physicians and students opting out of family practice. Divisions have also created a supportive physician work environment, helping to ensure that doctors don't experience the kind of isolation they felt in the past.

Evolution of care

The expansion of the Divisions of Family Practice initiative is driven by the interest and commitment of family physicians. Divisions are engaged in both community-based projects and province-wide initiatives to meet the needs of specific patient populations and improve access to primary care.

In seven years, the Divisions of Family Practice initiative has become a cornerstone of BC's primary health care system. In a field as large and complex as health care, the speed and growth of change that has been achieved through divisions is revolutionary.

With over 90% of family physicians in the province engaged in a division of family practice, this movement is shifting the culture of primary health care in British Columbia and supporting the next generation of family doctors to enter the health care system in an exciting environment of collaborative change.

GPSC
General Practice Services Committee

GENERAL PRACTICE SERVICES COMMITTEE

Divisions of Family Practice

FAQs for Family Practitioners

The General Practice Services Committee (GPSC), a joint BC Medical Association-Ministry of Health Services initiative, has launched *Divisions of Family Practice* – affiliations of family physicians (FPs) with common health care goals and/or in the same geographic area of BC. The initiative will give physicians a stronger collective voice and more impact in their community while helping them work together to improve their clinical practices, offer comprehensive patient services, and influence health service decision-making in their community.

The following frequently asked questions are provided for family physicians interested in learning more about what a Division of Family Practice is and how they are developed.

Who is eligible to form a Division of Family Practice?

Membership in any Division of Family Practice will be open to all FPs with common goals and/or in the same geographic area. To form a Division, family physicians must:

- currently be discussing common issues impacting patient care in the community
- be interested in working as partners with their health authority (HA) and the GPSC
- have a practice or participate in a network that provides comprehensive care.

Each Division should have as a goal the participation of the majority of family practitioners in its community. Through the GPSC, Divisions will have access to a facilitator to assist in the development and implementation stages.

What kind of governance structure will Divisions have?

Each Division will be a society. This involves a relatively simple and straightforward development process which will be heavily supported by the GPSC. A prime benefit of the society structure is that it allows Divisions to hold service contracts.

How will the Divisions of Family Practice be funded?

Annual funding for basic facilities and the operation of each Division will be provided by the GPSC and is calculated based upon the number of physicians in the Division. These funds can also be used to cover physician attendance at planning meetings. Additional funding for special clinical programs or other initiatives undertaken may be available separately from the Ministry of Health Services (MoHS) and/or from the HAs, as agreed upon by the Division partners.

GPSC
General Practice Services Committee

Why would I want to be part of a Division of Family Practice?

Participating in a Division in your community offers a number of benefits, including:

- enhanced provision of full spectrum primary care as a collective responsibility
- greater impact on the organization of local/regional health services around your practice
- improved access to health authority and specialist services
- increased ability to advocate for the needs of patients and for yourself and your colleagues
- on-going support from peer networks as well as physician health and wellness programs
- shared efforts for recruitment, retention and locums
- more support from colleagues in caring for complex or unattached patients
- reliable assistance with duties historically falling to call groups, e.g. scheduling, meeting organization
- strong financial and practice support for information technology and pilot projects.

How does a Division of Family Practice work?

A group of family physicians will negotiate and sign a Document of Intent (DOI) with the GPSC, their local HA and the MoHS Medical Services Division (the partners) that will outline how each partner will support the Division of Family Practice and each other. The partners also will negotiate which important issue will be addressed first. The Ministry and HA will provide the Division with community data (demographics, community health status, percentage of patients receiving recommended care) to assist in identifying health service gaps and developing plans to address them. A Division may take advantage of existing GPSC/ health authority programs – such as maternity care networks, integrated health networks, the enhanced access primary health care services network or the residential care network – or to develop new ones.

Although there will be some basic, common elements to all Divisions, others – such as family physician involvement in the local hospital – will be determined by a Division's members to reflect local issues.

As Divisions mature, they will take on additional responsibilities that could include:

- ensuring comprehensive primary health care for community residents
- facilitating administration for Division members
- facilitating integrated care with specialists
- exploring integration with mental health
- addiction services, palliative care and residential services as well as with community organizations.

How does a Division integrate with other health services?

A Division of Family Practice will work with its local health authority and community agencies through a Collaborative Services Committee (CSC), co-chaired by both a Division and an HA representative. The CSC will develop and implement solutions to issues facing the delivery of health services at the community level across the continuum of care. Any initiatives requiring additional funding will require the support of the Division, local HA and the MoHS.

For example, the CSC members may identify that the largest issue facing the partners is unattached patients. Data will be used to understand the scope of the problem and to determine which patients are the highest priorities, and how the partners will assign care providers to them. Costs of the proposed solution will be examined by the partners. The HA may agree to provide physicians with access to nurse practitioners and the MoHS may agree to provide the Division with a contract to offset the additional costs associated with attaching additional patients to Division members' practices. Over time the CSC will track the progress towards the Division's goal.

GPSC
General Practice Services Committee

Why would a health authority support a Division of Family Practice?

The major reasons for HAs to support Divisions in their area are:

- improved ability to connect and partner with family physicians, who have the greatest clinical influence over the health of the population
- enhanced coordination across the continuum of care
- ability to partner on solving regional problems e.g. hospital coverage, unattached patients
- enhanced ability to provide inter-disciplinary clinical support to family physicians.

Why does BCMA and the Society of GPs support Divisions of Family Practice?

The two organizations recognize that the Divisions can:

- revive the professional community of family practitioners
- enhance the profile of family practice to the public and to medical students
- provide a regional infrastructure for clinical teaching of family medicine to medical students and family practice residents
- provide an infrastructure for FPs to interact with HAs, community resources and others.

Why would the Ministry of Health Services support a Division of Family Practice?

The goals of the Division support the Ministry's commitment to:

- ensure each British Columbian has easy access to good primary health care
- better understand, plan and provide integrated, coordinated care
- connect community supports with professional services in family practice
- accelerate integration of health authority services with primary health care
- improve the transfer of patients between hospitals and the community
- de-congest emergency rooms and reduce hospitalizations and re-hospitalizations
- better attend to the needs of patients in hospital and residential facilities
- improve GP recruitment, retention and engagement.

What is the role of the regional health authority?

The health authority's role is to:

- co-chair the CSC (VP or executive director)
- remove systemic barriers to improved care and system sustainability
- provide regional, in-hospital and emergency department data while respecting patient privacy
- provide practice and change management support
- provide evaluation support.

What is the role of the Ministry of Health Services?

The Ministry will provide:

- funding to prototype new models of care
- data including individual practice profiles and overall Division profiles.

What is the role of the GPSC?

As well as providing oversight through the Executive Lead position, the GPSC will provide:

- annual infrastructure funding
- clear guidance on the Division of Family Practice structure and policies
- access to additional GPSC initiatives
- support through family practice initiatives including the Practice Support Program
- funding for multidisciplinary care and improved specialist interface.

Are there similar models in use in Canada or other parts of the world?

Yes, there are Divisions of Family Practice in the United Kingdom, Australia and New Zealand. Their evaluations identified a number of policy decisions that weakened their effectiveness:

- the FP organizations did not include improved patient access, health outcomes and physician professional satisfaction among its ultimate goals
- they operated in competition, rather than in alignment, with the regional health authority delivery system
- they did not consider their community and local government as partners.

BC's approach is somewhat influenced by the UK and Australia experiences, but more closely parallels current BC collaborative projects such as the BC Maternity Care Networks. The Division concept is grounded in the following principles:

- The Divisions of Family Practice are a response to FP requests for quality improvement/practice change support, and are supplemented by existing incentive payments, professional development opportunities, peer and professional support, specialist access, and physician recruitment activities
- The Divisions do not duplicate roles and responsibilities of a regional health authority.

East Kootenay Division of Family Practice
A GPSC initiative

BRITISH COLUMBIA | GPSC General Practice Services Committee | doctors of bc British Columbia Medical Association

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From: "engagement@doctorsofbc.ca" <engagement@doctorsofbc.ca>
Date: Thursday, October 29, 2020 at 5:14 PM
Subject: AMENDED UPDATE: Doctors of BC Engagement Partner Staff Role

Dear East Kootenay Division of Family Practice and Dr. Todd Loewen, Shannon Statham, Dr. Mike Walsh, Megan Purcell:

I am writing to provide an update on the development of the role of the Engagement Partner to better support the divisions of family practice and the Medical Staff Associations (MSAs) in their important work across BC.

In June, Doctors of BC announced that staff supporting divisions (GPSC Community Liaisons) and MSAs (Facility Engagement Liaisons) were joining together into one team led by Cindy Myles, Director of Facility & Community Engagement. The Liaisons took on a new title of **Engagement Partner** (EP).

The EPs are the key contact in a geographical region to help divisions and MSAs access the support and services of the Joint Collaborative Committees (JCCs). By working with divisions and MSAs in a region, the EPs will be better able to collaborate and strategize with you on how best to support doctors in community practices and within facilities to address similar challenges and opportunities.

You will benefit from more streamlined services and program administration processes, shared knowledge, and stronger connections between MSAs and divisions in your region. By being on the same team and working closely with the primary care team, EPs will be able to better collaborate and strategize on how best to support doctors within community practices and facilities to address similar challenges and opportunities.

Also, as we announced in June, the former GPSC Regional Liaisons now have the new title of **Primary Care Transformation Partner** (PCTP) and are led by Alana Godin, Director of Primary and Community Care Transformation. By becoming part of this team, the PCTPs will have a stronger connection with the people who do the strategic and program work in support of primary care networks, regional and provincial activities and policy.

What's new?

- We have now identified the lead EP for each division and MSA. I'm pleased to let you know that Patti King will be working with you as your EP.
- Your EP is your key contact for support related to the JCCs, working in partnership with Doctors of BC staff including the PCTPs, the Regional Advisors and Advocates (RAAs), and external teams in the Ministry of Health and health authorities.
- Your EP will support you with strategic capacity building, relationship management, and managing specific issues.
- Your regional Primary Care Transformation Partner is Robin Watt, available to support deeper local primary care network planning, and regional and provincial initiatives and meetings (e.g., interdivisional strategic tables, regional Division leadership meetings, regional primary care network planning).

What's not changing

- There are no changes to the Joint Collaborative Committee structures nor the General Practice Services Committee and the Specialist Services Committee funding processes.
- No jobs were lost in this service improvement change.
- The Regional Advisors and Advocates (RAA) continue to support and advocate for physicians on matters such as contracts, agreements, complaints, disciplinary matters, and issues. They are available to answer questions on all other Doctors of BC matters not related to the JCCs.

Transition plan

- For some divisions and MSAs, this change means building a relationship with your new EP. All of our EPs and PCTPs are working to ensure a smooth transition. Our team is holding comprehensive training sessions and we look forward to learning from you and your communities.
- Where applicable, your former Liaison will spend the next few months supporting your new EP in learning about your division or your MSA. Your EP, Patti King, will reach out to you over the next few weeks for an introductory conversation.
- The transition will be an iterative process in the next several months as the EPs learn how to better support new and existing relationships in their new roles.

As we continue to work together during the pandemic, all our meetings and connections will continue to take place virtually. To protect the health and safety of our staff and our members, it is Doctors of BC policy that staff are not permitted to travel for work during the COVID-19 pandemic.

Our team members are looking forward to working closely with you and furthering the strong relationships we have built together. If you have any questions or feedback, please reach out to your Engagement Partner at pking@doctorsofbc.ca or contact engagement@doctorsofbc.ca.

Sincerely,

Linda Lemke

Vice President, Engagement & Quality Improvement

Supporting the Joint Collaborative Committees

T 604 638 7836 TF 1 800 665 2262 C 604 992 5107

Happy with the service you received today? Have a suggestion? I'd appreciate your feedback here.

Physicians: Our COVID-19 resource page is updated regularly. Find it here.

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Interior Health

VISION:

To set new standards of excellence in the delivery of health services in the Province of British Columbia.

MISSION:

Promote healthy lifestyles and provide needed health services in a timely, caring and efficient manner to the highest professional and quality standards.

⊶ Key Strategy

GOAL 1

Improve Health and Wellness

1.1 Implement health promotion, health protection, and prevention initiatives

1.2 Work with First Nations and Aboriginal partners to plan and deliver culturally sensitive health-care services ⊶ *Aboriginal Health*

1.3 Assess, recommend, and implement actions to improve the health of Interior Health's population

1.4 Deliver patient and family centred care

GOAL 2

Deliver High Quality Care

2.1 With partners, deliver primary and community care to meet population and individual health-care needs ⊶ *Primary and Community Care Transformation*

2.2 Implement health improvement strategies for targeted populations across the continuum of care ⊶ *Seniors Care* ⊶ *Mental Health and Substance Use*

2.3 Provide efficient, effective acute services that are linked across a coordinated system of care ⊶ *Surgical Access*

2.4 Deliver evidence informed quality and safety initiatives

GOAL 3

Ensure Sustainable Health Care by Improving Innovation, Productivity, and Efficiency

3.1 Implement innovative service delivery models

3.2 Develop priority plans and implement transparent decision making processes

3.3 Enhance IMIT solutions

3.4 Build research and education capacity

3.5 Develop and enhance relationships with key external stakeholders

GOAL 4

Cultivate an Engaged Workforce and a Healthy Workplace

4.1 Enhance health and safety in the work environment ⊶ *Health & Safety in the Workplace*

4.2 Ensure effective health human resource planning and management

4.3 Build leadership capacity

Every person matters

Quality · Integrity · Respect · Trust

KTUNAXA NATION

Health & Wellness Plan
2018 – 2022

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Ktunaxa Nation Health Strategic Direction

Priority #1 Mental Health and Substance Use

Priority #2 Improved Access to Medical Health Professionals & Benefits

Priority #3 Culture in All Social Investment Programs/Services

Priority #4 Recreation/Exercise for All Ages

Priority #5 Integrate Person-Centered Practice Framework Throughout Social Investment Sector (SIS)

Priority #6 Integrated Programs and Services

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Yakɬ·ki
(Yellowhead Pass)
Kunanuqɬi?it
(Kootenay Plains)
Kinbasket Reservoir
?aknuqɬuk
Golden
Kootenay River
Alberta
?aknuqtap¢ik
Calgary
Ktunwakanmituk
Mi¢qaqas
Revelstoke
Kyaknuqɬi?it
Invermere
?akisqnuk
(Columbia Lake)
British Columbia
Ȼaɬnu ?akuqnuk
Nakusp
Yaqa ·n Nukiy
Canal Flats
Kakaminnuqɬi?it
(Elkford)
kuk¢aknana
?amak?is
Burton
Qasɬu
Kaslo
Kootenay Lake
?aqam
(St. Marys)
Kaqawakanmituk
Sparwood
?akwum
Lethbridge
?aqyamɬup
Nelson
?akiskaqɬi?it
Cranbrook
Ȼaqahak
Fernie
Kiksiɬuk
Castlegar
Kunama?nam
Creston
?akinkumɬasnuqɬi?it
Grasmere
CANADA
U.S.A.
Yaqan Nu?kiy
(Lower Kootenay)
?akinkumɬasnuqɬi?it
(Tobacco Plains)
Columbia River
?aqanqmi
(Kootenai Tribe
of Idaho)
Flathead River
Montana
Kamanqukuɬ
Sandpoint
Washington
Lake Pend
Oreille
Clark Fork River
Kqaya·qawa·kɬu?nam
Kalispell
Flathead lake
Kupawi¢qnuk
Elmo
Spuqin
Spokane
Idaho
Kupawi¢qnuk
(Confederated Salish
and Kootenai Tribes)
Tuhuɬnana
Missoula

?aqam (St. Marys) — Ktunaxa Communities
Kwataqnuk Athalmere — Ktunaxa Placenames
Kootenay River — Water Features
Provincial/International Boundary
?amak?is Ktunaxa

0 50 100 200 300
Kilometers

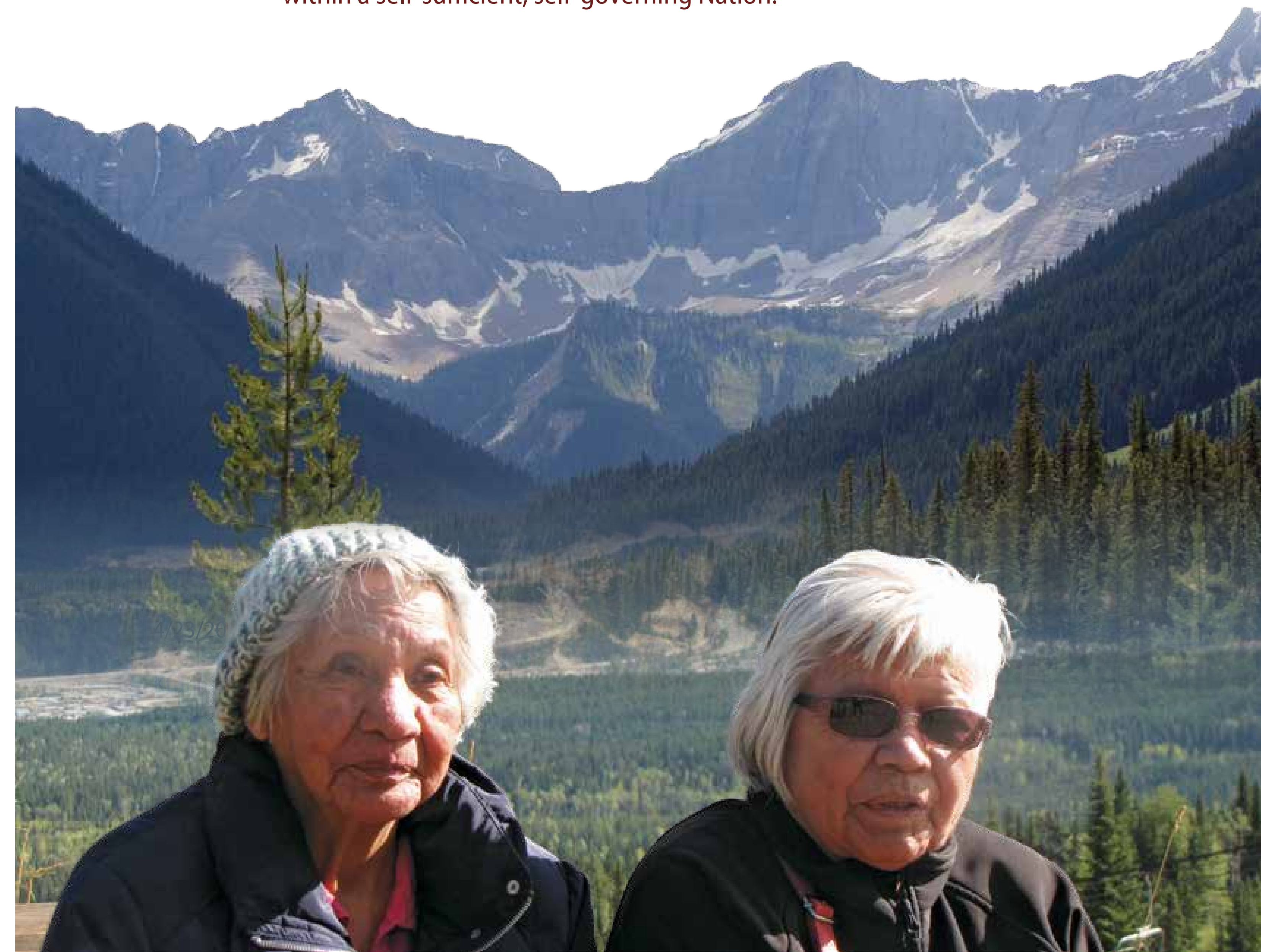
Date: 06/09/2018
Map produced by: Ktunaxa Lands and Resources
For information purposed only. ?amak?is Ktunaxa and placenames by Ktunaxa Nation Council.

KTUNAXA NATION

Health & Wellness Plan
2018 – 2022

Vision Statement

Strong, healthy citizens and communities, speaking our languages and celebrating who we are and our history in our ancestral homelands, working together, managing our lands and resources, within a self-sufficient, self-governing Nation.



Health & Wellness Planning Background

Why the Ktunaxa Nation Health & Wellness Plan was Created

The Ktunaxa Nation continuously strives to build and improve its Holistic Wellness Service Delivery Model.
The Ktunaxa view health with a holistic lens recognizing that wellness is not solely about health care and social services but about lands and resources, traditional knowledge and language, education and employment and the economy. Our Ktunaxa Health & Wellness Plan reflects that holistic view of wellness.

The purpose of the Health & Wellness Plan is to outline strategies that will guide the Nation towards improving health and wellness of Ktunaxa and other Aboriginal individuals and families within the Ktunaxa ʔamakʔis.

Throughout the year, to ensure the Nation is working towards each community's current health priorities, community collaboration takes place through Community engagement. This plan captures Community health priorities and will guide leadership leadership with the development of the Ktunaxa Nation's Health and Wellness Service Delivery model. This Plan belongs to the Citizens of the Ktunaxa Nation.

This Plan belongs to the Citizens of the Ktunaxa Nation.

How the Ktunaxa Nation Health & Wellness Plan was Created

LEADERSHIP

The Ktunaxa Nation is comprised of 5 Sectors including the Social Investment Sector (SIS) under which health services and governance are mandated. The Ktunaxa Nation Social Investment Sector Council (SISC) directs the work of the Social Investment Sector (SIS). The SISC hires and oversees the work of the Sector Director. The SISC is made up of one elected council member from each of the 4 Ktunaxa communities: ʔaq̓am, ʔakisq̓nuk First Nation, ʔakink̓umǂasnuqǂiʔit (Tobacco Plains Indian Band) and Yaqan Nukiy (Lower Kootenay Band).

In addition to the SIS Director, the Sector's health and wellness mandate is supported by the Community Engagement Transformation Manager who facilitates collaboration between Ktunaxa communities to "provide proactive capacity for groups of First Nations communities to communicate, collaborate and plan around health." This engagement with communities, staff and citizens ensures leadership is collaborative and not a top down approach.

COMMUNITY HEALTH & WELLNESS PLANS

Health & Wellness Plans were developed for each of the 4 Ktunaxa Communities which were principal informants of the Ktunaxa Nation Health & Wellness Plan. Community Health & Wellness Plans were developed using a variety of methods including:

- Community Engagement Sessions (Citizens, Staff and Council)
- Urban Engagement Sessions (Ktunaxa and other Aboriginal people)
- HUB Communication, Collaboration and Planning
- IHA LOU Committee Collaboration
- Health Manager & Director Input
- Community Nurse Input
- Nurse Practitioner Input
- Health Staff Questionnaire
- Community Strategic Plans
- Community Asset Mapping
- One to One Discussions

INTERIOR HEALTH AUTHORITY (IHA) COMMUNITY ENGAGEMENT SESSIONS

IHA Managers and Coordinators throughout the Ktunaxa Territory met with Citizens, Staff and Council in each of the 4 Communities as well as with Urban Aboriginal individuals both to share and learn. IHA shared their available services and learned about the health gaps, successes and priorities in each Community. These engagements were a catalyst for relationship building as well as deeper conversations around health priorities and their solutions.

PARTNERSHIPS

The Ktunaxa Nation's partnerships help to deliver strong programs, build bridges for individuals and families accessing its services and integrate into the community at large. Ktunaxa Nation Council (KNC)'s formal partnerships include Cranbrook Restorative Justice, College of the Rockies, IHA, East Kootenay Divisions of Family Practice, Métis Nation BC, CLBC, Ktunaxa/Kinbasket Child & Family Services (KKCFS) and Industry. The Ktunaxa Nation has also developed many informal partnerships with key partners being ANKORS, RCMP, Community Connections, Probation, Poverty Initiative, East Kootenay Addictions Services, Victims Services, Community Outreach Worker, Kootenay Transition House, Haven Gardens 2nd Stage Housing, CMHA, Columbia Basin Alliance for Literacy, Columbia Basin Trust, Summit Community Services Society, Homeless Outreach & Prevention Program, Interior Health Association, Health Outreach Team and East Kootenay and Kootenay Boundary Collaborative Services Committees. Additionally and of significant importance, the Social Investment Sector works collaboratively with all 4 Ktunaxa Communities and with the other KNC Sectors.

FIRST NATIONS HEALTH AUTHORITY (FNHA)

FNHA is governed by BC's First Nations. Ktunaxa Nation's governance role within FNHA creates vast opportunities to build capacity and access resources in line with the Ktunaxa Nation Vision Statement and community priorities. The Nation's intricate understanding and involvement with FNHA is advantageous for moving the Nation's health planning work forward in a cohesive and timely manner.

GUIDING VISION AND OTHER MEANINGFUL DOCUMENTS

The Ktunaxa Nation Vision Statement is a holistic overarching vision of wellness and it is from this statement that all Ktunaxa Nation work is developed:

Ktunaxa Nation's Vision Statement:

Strong, healthy citizens and communities, speaking our languages and celebrating who we are and our history in our ancestral homelands, working together, managing our lands and resources, within a self-sufficient, self-governing Nation.

In addition to the Ktunaxa Nation Vision Statement, the following Social Investment Sector documents helped to guide the Ktunaxa Nation's Health & Wellness Plan:

- Values and Principles
- Indicators of a Strong, Healthy Ktunaxa Citizen (written and poster illustrations)
- Service Delivery Principles
- Community Priorities and Asset Mapping 2013
- A Path Forward: Ktunaxa Nation Assembly 2013.

Nation Health Work Resulting from 2013 and 2016 Community Health Priorities

- Health Priorities Focus Groups: Ktunaxa Communities and Urban
- Continuum of Care Expansion:
  - « Scotty's House: Assisted Living for Aboriginal youth aging out of foster care, Elders and other vulnerable adults
  - « Mary Basil Recovery House: residential program for individuals recovering from substance use addictions or waiting for treatment following Detox
  - « Aftercare Housing Program Development
  - « 7 Nations Treatment Centre Development
  - « Aboriginal Detox Centre Development
- IHA/Community Engagement: Ktunaxa Communities and Urban
- KNC/MIRR Vulnerable Adult Charter Development and Implementation
- Suicide Protocol Development
- CLBC Contract: FASD, Community Based Inclusion, Supported Living/ Outreach and Skill Development
- MNBC/KNC Health Services Letter of Understanding Development and Working Committee
- Nation SIS Mental Health Clinician
- Nation SIS Traditional Wellness Coordinator
- In-Community Opioid Harm Reduction Activities
- Crisis Response Protocol Development
- KNC Staff Gladue Report Training
- Program Policies and Procedures Development and Implementation
- Electronic Health Record Training and Implementation.
- Increased Nurse Practitioner Outreach to Communities.
- Urban Service Partnerships
- RCMP Engagement/Partnerships
- First Responders Cultural Exchange
- Social Investment Sector Governance Framework.
- Aboriginal Community Based Justice Needs Assessment and Strategic Plan

Community Health & Wellness Priorities

The following Community Health & Wellness Priorities were identified through Ktunaxa Community engagement.

For a list of engagement methodologies, refer to the *Health & Wellness Planning Background: Community Health & Wellness Plans* section on page 9 of this document.

ʔakinkʼumǂasnuqǂiʔit (Tobacco Plains Indian Band) Health Priorities

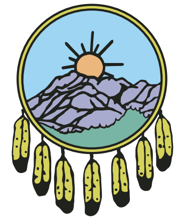
In 2018 Ktunaxa Nation Council (KNC) facilitated a Health Priorities Focus Group in ʔakinkʼumǂasnuqǂiʔit. In attendance were ʔakinkʼumǂasnuqǂiʔit community members, community Staff, KNC Staff and Interior Health Authority Staff. ʔakinkʼumǂasnuqǂiʔit community members and ʔakinkʼumǂasnuqǂiʔit Staff identified their community's top health priorities as follows:

1. **Elders**: Qualified home support and medical equipment
2. **Extended Benefit Coverage**: Improved coverage including dental, vision and co-payments
3. **Interior Health Program Community Outreach**: Dietician, Mental Health and home support for all
4. **Youth**: Improved support for youth including, workshops, youth groups, camps and mentoring and
5. **Mental Health**: Timely access to Mental Health and Addictions Counselling and Mental Health First Aid Training.

Additional ʔakinkʼumǂasnuqǂiʔit Health & Wellness Areas for Improvement

In addition to ʔakinkʼumǂasnuqǂiʔit's health priorities outlined above, the following additional Health & Wellness Areas for Improvement were identified through both the Health Priorities Focus Group and a KNC Health Questionnaire completed by ʔakinkʼumǂasnuqǂiʔit and KNC Staff who work directly with ʔakinkʼumǂasnuqǂiʔit community members:

a. Early Years Education and Activities for Parents and Children
b. Internal Communication
c. Community Social Worker
d. Transportation
e. Housing
f. Education
g. Employment
h. Community Cohesiveness
i. Social Isolation
j. Stress Reduction Techniques



ʔakisq̓nuk First Nation Health Priorities

In 2018 Ktunaxa Nation Council (KNC) facilitated a Health Priorities Focus Group in ʔakisq̓nuk. In attendance were ʔakisq̓nuk community members and staff, KNC Staff and Interior Health Authority Staff. ʔakisq̓nuk community members and ʔakisq̓nuk staff identified their community's top health priorities as follows:

1. **On Reserve Mental Health Services**: For community members with special attention to Elders who are not ambulatory. Billing to First Nations Health Authority needs improvement both in terms of process and reimbursement time.
2. **Communication**: Increased flow through of information from Social Investment Sector Council (ʔakisq̓nuk Representative) to ʔakisq̓nuk Chief and Council, Community Members and Staff
3. **House Safety**: Air quality (radon, mold), water quality
4. **FNHA Coverage Criteria**: Too strict
5. **Updated Opioid Overdose Training**: Recurring training for existing and new techniques.

Additional ʔakisq̓nuk Health & Wellness Areas for Improvement

In addition to ʔakisq̓nuk's health priorities outlined above, the following additional Health & Wellness Areas for Improvement were identified through both the Health Priorities Focus Group and a KNC Health Questionnaire completed by ʔakisq̓nuk and KNC Staff who work directly with ʔakisq̓nuk community members:

a. Youth Interested in Health Careers
b. Jordan's Principle Coverage for all
c. Hospital providing services not covered by MSP and FNHA (i.e. air cast)
d. Staff Training including Mental Health First Aid
e. FASD Prevention, Support and Education with revitalization of Community Healing and Intervention Program (CHIP)
f. Additional Health Professional Resources
g. Lateral Violence
h. Mental Wellness Partnerships and Collaboration
i. Extended Benefits including partial funding and long reimbursement waiting periods
j. Home Care Support
k. Intergenerational Trauma Healing
l. Nutrition
m. Substance Use
n. Early Childhood Development
o. Seamless Care for Off-reserve Members
p. Aboriginal Medicine and Healing Practice Service Integration
q. On-reserve Housing and
r. Transportation to Work/school.

Horse and Elders photo courtesy of Dusty Dehart

ʔaqˈam Health Priorities

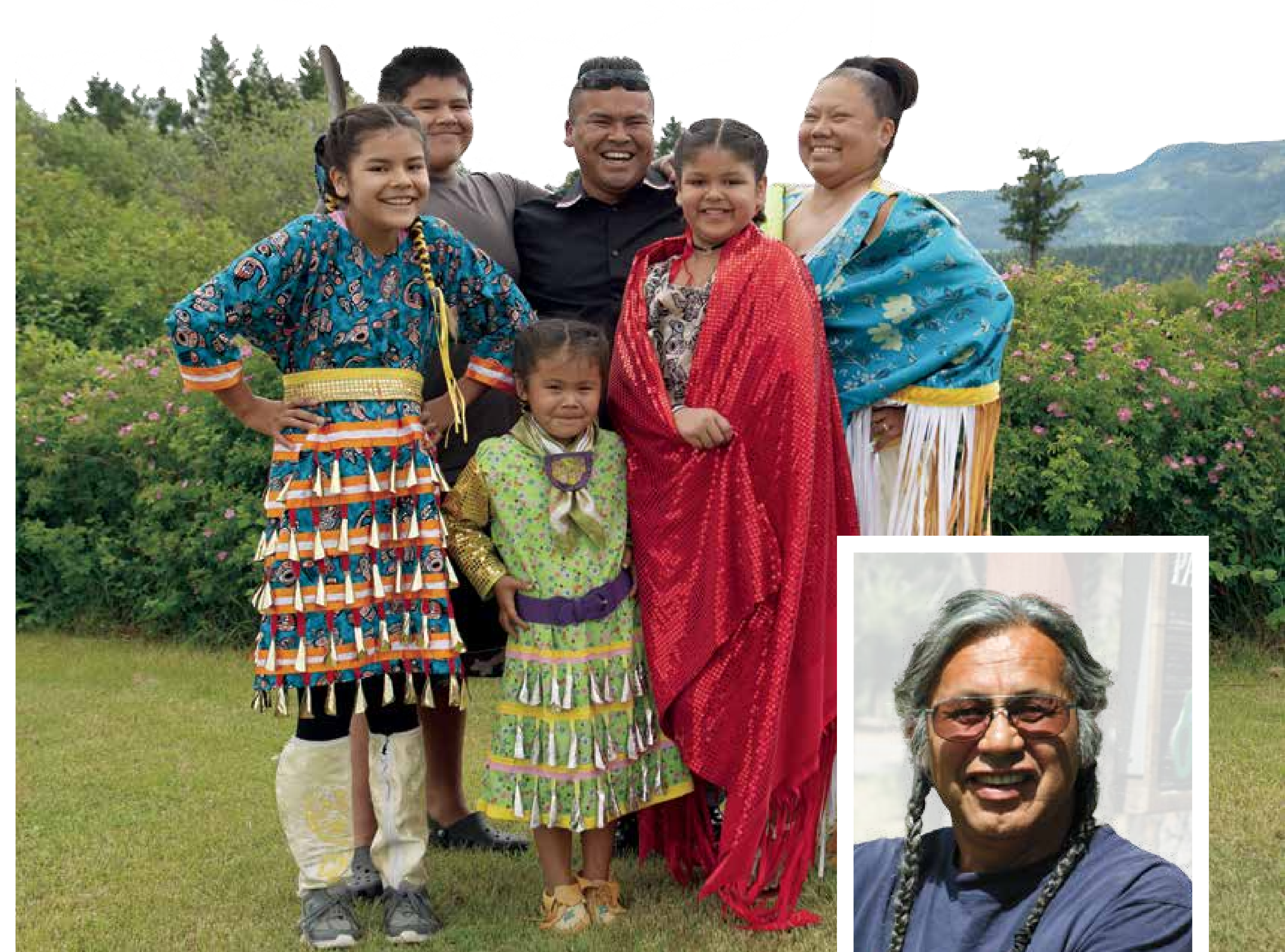
ʔaqˈam has an internal process for developing its Strategic Health Plan which includes community member engagement sessions and tracking of needs/requests that come through providing care and programming. Below are ʔaqˈam's top health priorities:

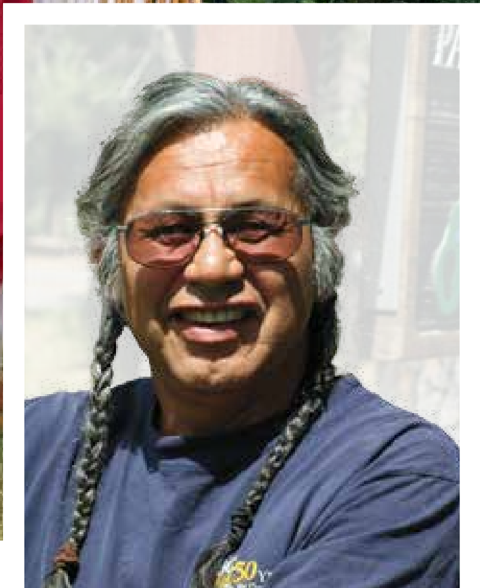
1. **Health Care Building**: Completion of Health Care Building that includes everything required for optimal care provisions for community members of all ages
2. **Implementation of a Mental Health and Addictions Community Intervention Plan**: Resulting in timely support services, community capacity development, collaborations and partnerships
3. **Recreation & Culture Wellness Program**: Implementation providing cultural, physical, art and other forms of wellness activities. Identification of sustainable funding sources
4. **Daycare And School Inclusion**: Increased integration of ʔaqˈam health services in its daycare and school, enhancing support to children, prevention and early detection of health and developmental issues

Additional ʔaqˈam Health & Wellness Areas for Improvement

In addition to ʔaqˈam's top health priorities outlined above, the following health goals and objectives were identified through ʔaqˈam Staff Work Plans and a KNC Health Questionnaire completed by ʔaqˈam and KNC Staff who work directly with ʔaqˈam community members:

a. Awareness of Community Health Services
b. Efficient, meaningful and timely direct services and professional referrals
c. Embedded Culture in all programs and services, including education
d. Culture and Language: Immersion – Support and honour fluent speakers, learners and teachers – Continue to record and document language – Rejuvenate and honour traditional practices – Traditional Medicine and Healing Practice Service Integration –Cultural connections through arts, dancing, singing, drumming, and other activities
e. Cultural Centre
f. Increased Elder support, program participation and satisfaction within Elder's groups
g. Physical Health: Diabetes, Heart Disease, Nutrition with more traditional diet
h. Family and Community Holistic Wellness Programs, strategies and outcomes





i. Communication and Conflict Resolution
j. Education and Learning using Ktunaxa methods
k. Stress, anxiety and depression reduction/coping mechanisms
l. Rape education & prevention
m. Safety and security for all community environments: community laws, emergencies and natural disasters
n. Prevent, heal from and raise awareness of abuse in all its forms
o. Housing
p. Transportation to/from work & school
q. Education participation and completion including grade level and program expansion
r. Employment Opportunities
s. Develop and use individual and family health plans. Participate in and celebrate community health initiatives
t. Celebrate and foster as a community, as families and as individuals
u. Internal Mentorship

Yaqan Nukiy

Lower Kootenay Band Health Priorities

In 2018 Ktunaxa Nation Council (KNC) facilitated a Health Priorities Focus Group in Yaqan Nukiy. In attendance were Yaqan Nukiy community members, KNC Staff and Interior Health Authority Staff. Yaqan Nukiy community members identified their community's top health priorities as follows:

1. **Health Advocacy**: Someone to attend Doctors and other health appointments alongside community members
2. **Community Safety**: Feel physically safe on-reserve
3. **Medical Professionals**: Respect towards community members
4. **Extended Benefit Coverage**: Improved coverage including dental, vision and co-payments and
5. **Ktunaxa Culture**: More opportunities/ activities to experience and learn about Ktunaxa knowledge, language, traditions and spirituality.

Additional Yaqan Nukiy Health & Wellness Areas for Improvement

In addition to Yaqan Nukiy's health priorities outlined above, the following additional Health & Wellness Areas for Improvement were identified through both the Health Priorities Focus Group and a KNC Health Questionnaire completed by KNC Staff who work directly with Yaqan Nukiy community members:

a. Nurse Practitioner access and communication
b. Hospital services including friendliness and access to Aboriginal Patient Navigator
c. Substance Use
d. Aboriginal Medicine and Healing Practices Service Integration
e. Mental Wellness Partnerships and Collaborations
f. Addictions and Trauma Counselling
g. Water System
h. Community Unity
i. Male Empowerment
j. Housing
k. Communication from Leadership and within Health Services
l. Employment
m. Education
n. School Health – Culturally appropriate discussions on puberty and reproductive health
o. Attachment to GP Doctor
p. Lateral Violence
q. Red Tape for health services, medications and equipment
r. Community Health Centre
s. Early Childhood Development
t. Physical Health: Nutrition, Physical Activity, Diabetes and Obesity

Ktunaxa and Other Urban Aboriginal Health Priorities

In 2017 Ktunaxa Nation Council (KNC) facilitated a Health Priorities Focus Group in Cranbrook, BC. In attendance were Ktunaxa Citizens, Métis and other Aboriginal individuals, KNC Staff, and Interior HealthAuthority Staff. Focus Group participants identified their top health priorities as follows:

1. Housing
2. Access to Health Professionals in culturally safe environments and after hours
3. High Medical Costs
4. Transportation

Additional Urban Health & Wellness Areas for Improvement

In addition to the Urban health priorities outlined above, the following additional Health & Wellness Areas for Improvement were identified through both the Health Priorities Focus Group and a KNC Health Questionnaire completed by KNC Staff who work directly with the Ktunaxa and other Urban Aboriginal community members:

a. Child Care
b. Education
c. Employment
d. Substance Use
e. Hep C & Aids
f. Safe Sexual Relationships
g. Safe and Clean Living Conditions
h. Social Isolation
i. Stress Reduction/Coping Techniques
j. Access to Resources/Health Needs for non-status

Métis Nation BC – Kootenay Region Health Priorities

The Ktunaxa Nation Council and Métis Nation BC hold a Health Services Letter of Understanding (MOU). The MOU Working Committee meets several times annually which provides opportunities to update and collaborate on health issues affecting both Ktunaxa and Métis people.

The following are health priorities for Métis people living in the Kootenay Region:

1. Mental Health Substance Use – support, counselling, treatment. Specific to mental wellness and substance withdrawal treatments
2. Timely/quick access to local health care services, diagnostic and treatments
3. Funded Home Support for Elders and disabled as needed
4. Family physicians access for all
5. Funded transportation for out of town/region appointments for essential treatments and timely diagnostic testing
6. Hot/Healthy Lunch options for school children

Ktunaxa Nation Health & Wellness Priorities

Strategic Direction, Goals, Objectives, Actions and Indicators of Success

Ktunaxa Nation Health Strategic Direction

Spiritual, emotional, physical and mental wellness for Ktunaxa individuals, families and communities regardless of where they live is the overarching strategic health direction of the Ktunaxa Nation Social Investment Sector. Below are the top priorities for the Ktunaxa Nation including Health Goals, Objectives, Actions and Indicators of Success.

Health Priority #1: Mental Health & Substance Use

Goal A: Significantly Increase Access to Mental Health & Substance Use (MHSU) Professionals & Programs

Objective	Action	Indicators of Success
Full time on-reserve professional MHSU clinicians for each of the four Ktunaxa communities.	Funding advocacy: FNHA, IHA & Historical Grievances Working Group	Timely access to MHSU counselling. Improved on-reserve citizen, family and community MHSU health and wellness on reserve.
Objective	**Action**	**Indicators of Success**
Full time urban professional MHSU clinician servicing Ktunaxa urban programs/services, individuals and families (Cranbrook based).	Funding advocacy: FNHA, IHA & Historical Grievances Working Group	Timely access to MHSU counselling. Improved urban citizen, family and community MHSU health and wellness.
Objective	**Action**	**Indicators of Success**
Relocate our addictions recovery beds to centralized location (on Cranbrook city bus route).	Feasibility assessment to move recovery beds from Mary Basil House to Scotty's House. **Action** If feasible prepare Scotty's House to accommodate 4 recovery beds. **Action** Move residents from Mary Basil House to Scotty's House.	Residents independently access community services/activities. Staff have more time to plan and implement health and wellness activities: recreational, cultural, life skills and addiction/ harm reduction strategies. Improved resident independence, life skills and overall health and wellness.
Objective	**Action**	**Indicators of Success**
Increased access to cultural, land-based, trauma informed addictions healing.	Develop and implement a Healing Centre **Action** Develop and implement a Mobile Treatment Program. **Action** Ensure community Professional MHSU Clinicians provide cultural based and trauma informed programs/services.	Timely access to culturally relevant and trauma informed healing including MHSU counselling. Empowered individuals, families and communities

Health Priority #1: Mental Health & Substance Use, *continued*

Goal A: Significantly Increase Access to Mental Health & Substance Use (MHSU) Professionals & Programs, *continued*

Objective	Action	Indicators of Success
Increased access to substance use detoxification.	Develop and implement a four-bed detoxification facility in the Cranbrook.	Timely access to culturally meaningful detoxification treatment. Increased number of detoxed adults with access to culturally relevant continuum of care programs/services. Improved citizen, family and community MHSU health and wellness.

Objective	Action	Indicators of Success
Reestablish Fetal Alcohol Spectrum Disorder (FASD) program - Community Healing Intervention Program (CHIP).	Research current individual, family and community needs related to FASD and prenatal drug-exposure. **Action** Develop and implement FASD Program/Service. **Action** Program/Service implementation	Increase in healthy pregnancies resulting from FASD education and prevention. Supported individuals, families and communities living with FASD and other disorders related to prenatal drug disorders. Free access to FASD resources including diagnostic testing.

Objective	Action	Indicators of Success
Secure operational funding for Scotty's House (supported residential living for youth aging out of foster care with developmental challenges, Elders and other vulnerable Aboriginal adults).	Funding Advocacy: FNHA, IHA & Historical Grievances Working Group Relocate Recovery House beds to Scotty's House. **Action** Apply for after recovery care funding. **Action** Secure 24/7 multi-year funding.	Scotty's House is fully funded. Culturally appropriate supported housing for Aboriginal youth aging out of foster care with developmental challenges, Elders and other vulnerable Aboriginal adults.

Goal B: Develop and Implement Opioid Education/Harm Reduction Strategies

Objective	Action	Indicators of Success
Opioid and harm reduction educated KNC and community staff.	Develop and deliver opioid and harm reduction education workshops for community and KNC staff.	Decreased overdoses. Increased harm reduction strategies by staff. Clients initiate their own harm reduction strategies.

Objective	Action	Indicators of Success
Harm reduction education and support for opioid users.	Create & distribute culturally appropriate opioid education and harm reduction printed and digital materials to opioid users. **Action** Educate about and provide sterile drug use paraphernalia to opioid users.	Decreased overdoses. Increased use of harm reduction strategies (i.e. use marijuana instead of opioids). Citizens implementing harm reduction strategies reducing overdoses and disease spreading.

Objective	Action	Indicators of Success
Facilitate pathways for opioid users to access health and wellness programs/services.	Work with KNC health Professionals to ensure continuum of care including detoxification and harm reduction. **Action** Work with Education and Employment Sector to provide opportunities for personal growth and development	Culturally relevant, trauma informed continuum of care programs/services used by opioid users. Decreased number of Ktunaxa and other Aboriginal opioid users. Recovering opioid users engaged in health and wellness services, programs and other activities.

Objective	Action	Indicators of Success
Opioid User Peer Mentors	Educate, train and support recovering opioid users as peer mentors	Empowered peer mentors regularly engaged with active users and those working towards recovery. Active users have support, eduction and information when choosing recovery Increased number of recovered community opioid users on and off reserve Support Cohort of recovering opioid users.

Health Priority #2: Improved Access to Medical Health Professionals & Benefits

Goal A: Significantly Increase Access to Culturally Safe, Trauma Informed Medical Health Professionals

Objective	Action	Indicators of Success
Ktunaxa and other Aboriginal people in the Ktunaxa service area are attached to a General Physician (GP) or a Nurse Practitioner (NP).	Through advocacy, collaborations and partnerships, SIS Staff support clients in securing attachment to a NP or GP.	Improved health and wellness resulting from attachment to a NP or a GP who provide clients with timely appointments in a culturally safe, trauma informed environment.
Objective	**Action**	**Indicators of Success**
Improve Citizen access to on-reserve medical health professionals.	SIS staff advocate to secure funding for on reserve medical health professionals in podiatry, hearing, speech, psychology, FASD assessments and other areas.	Improved health and wellness resulting from timely access to on reserve medical professional services offered in culturally safe, trauma informed environments.
Objective	**Action**	**Indicators of Success**
Improve access to Health Professionals for off reserve Ktunaxa and other Aboriginal people..	SIS staff advocate to secure funding for off reserve medical health professionals in podiatry, hearing, speech, psychology, FASD assessments and other areas.	Improved health and wellness resulting from timely access to off reserve medical professional services offered in culturally safe, trauma informed environments.
Objective	**Action**	**Indicators of Success**
Collaborate with regional medical Health Professionals.	Work to improve access to Health Professionals through participation in local and regional health and wellness committees/tables.	Improved health and wellness resulting from timely access to Medical Professionals offered in culturally safe, trauma informed environments.
Objective	**Action**	**Indicators of Success**
Ktunaxa and other Aboriginal people in the Ktunaxa service area are culturally safe and supported, before, during and after GP appointments.	Create partnership between the KNC and the East Kootenay Divisions of Family Practice for a shared service initiative where Physician's Offices in each urban centre share a Social Worker with each corresponding Ktunaxa community.	Signed Partnership agreement Patients are culturally safe/ supported before, during and after GP appointments Implemented Jordan's Principle.

Goal B: Culturally Safe, Trauma Informed and Harm Reduction Trained Medical Health Professionals

Objective	Action	Indicators of Success
Increase number of Medical Professionals with cultural safety, trauma informed and harm reduction training.	Develop and deliver Ktunaxa Cultural Safety Education Training Program for partner Health Professionals.	Increased number of Medical Professionals with cultural safety training. Clients feel culturally safe with Medical Professionals. Improved health and wellness of Ktunaxa and other Aboriginal people in Ktunaxa ʔamakʔis.

Health Priority #3: Culture in all Social Investment Sector Program/Services

Goal A: Improve Citizen Access to Ktunaxa Cultural Activities, Traditions and Language

Objective	Action	Indicators of Success
Integrate Traditional Activities, Medicine & Healing Practices into all SIS Programs/Services.	Review SIS's programs/services for cultural integration. **Action** Guided by SIS Traditional Wellness Coordinator, modify programs/ services if necessary.	Traditional Activities, Medicine & Healing Practices integrate into all SIS Sector programs/services. Clients/Patients choose to engage in cultural activities/traditions within SIS programs/services. Clients/Patients reconnect with their culture and engage in cultural activities outside of SIS programs/services.

Goal B: Identify Traditional Knowledge Holders (Ktunaxa and Aboriginal people)

Objective	Action	Indicators of Success
Develop SIS Protocol for Traditional Knowledge Holders to work within the SIS and its programs/services.	Identify criteria for employing Traditional Knowledge Holders. **Action** Identify Remuneration for employing Traditional Knowledge Holders.	Protocol for Traditional Knowledge holders working within SIS programs/services. Traditional knowledge holders confirm protocol both honours and fairly remunerates their knowledge.
Objective	**Action**	**Indicators of Success**
Collaboratively work with Traditional Knowledge and Language Sector (TKL) to create a user friendly system for accessing Traditional Knowledge Holders, their expertise as well as other Ktunaxa cultural resources.	Contact TKL, communities, urban services and MNBC to identify Traditional Knowledge Holders, their expertise and their interest in employment and/or participating in SIS and its programs/services. Identify TKL's resources (curriculums, books, videos, photographs) that will support the integration of cultural activities and traditions into SIS's programs/services.	Comprehensive List of Traditional Knowledge Holders, their expertise, experience and interest in working within SIS programs/services. Traditional Knowledge Holders and their expertise are easily identified. Honoured and employed Traditional Knowledge Holders.

Health Priority #4: Recreation/Exercise for All Ages

Goal A: Opportunity and Access to On and Off Reserve Age Appropriate Recreation/Exercise Supports and Programs

Objective	Action	Indicators of Success
Age specific, off reserve recreation/ exercise programs/services	Consultation with off reserve families, family workers, Elders, Elder family and caretakers and recreational professionals.	Increased activity and support programs for off reserve Elders and families resulting in increased Elder and family participation, mobility and overall health and wellness.
	Action	
	Funding advocacy: FNHA , IHA & other funding sources.	
	Action	
	Develop and implement off reserve recreation/exercise programming activities and support programs for off reserve families and Elders.	
Objective	**Action**	**Indicators of Success**
Age specific on reserve recreation/ exercise programs/services	Funding advocacy: FNHA , IHA & other funding sources acknowledging that on reserve recreation/ exercise programs/services are a responsibility of each Community.	Increased activity and support programs for on reserve Elders and families resulting in increased Elder and family participation, mobility and overall health and wellness.

Health Priority #5: Integrate Person-Centered Practice Framework Throughout Social Investment Sector (SIS)

Goal A: Develop Person-Centered Practice Framework (values, principles, approaches, practices, policies and procedures)

Objective	Action	Indicators of Success
Research and develop SIS Practice Framework.	Research and Interview SIS Staff, SIS Council, SIS clients/patients, Elders and Traditional Knowledge Holders.	Completed Draft SIS Practice Framework. SIS Staff and Council have sense of ownership and pride in the Practice Framework and its implementation.
	Action	
	Create Draft SIS Practice Framework.	
Objective	**Action**	**Indicators of Success**
Approved Practice Framework for SIS integration	Present Practice Framework to SIS Council for approval.	Approved SIS Practice Framework.
Objective	**Action**	**Indicators of Success**
Trained SIS Staff and Council.	Practice Framework training provided to all SIS Staff and Council.	Informed and trained SIS Staff with ability to work within the framework and its approaches within all SIS programs/services. SIS Council leadership's work is grounded in the SIS Practice Framework. Improved health and wellness for all clients/patients of SIS programs/services.
Objective	**Action**	**Indicators of Success**
Nation and Community leadership and staff informed of SIS Practice Framework.	SIS Staff and leadership share framework, offering information sessions if requested.	Informed Nation and community leadership and staff.
Objective	**Action**	**Indicators of Success**
Framework integrated into all SIS programs/services.	SIS Management oversees framework implementation within all SIS programs/services.	SIS Staff perform all employment duties within framework parameters. Client/Patient's health and wellness improves as a result of practice approaches.

Health Priority #5: Integrate Person-Centered Practice Framework Throughout Social Investment Sector (SIS), *continued*

Goal A: Develop Person-Centered Practice Framework (values, principles, approaches, practices, policies and procedures), *continued*

Objective	Action	Indicators of Success
Identify correlation between Practice Framework and client/patient individual support plans.	Review client/patient support plans to determine framework alignment.	Individual Support plans are achieved within practice framework parameters. Improved client/patient health and wellness.
Objective	**Action**	**Indicators of Success**
Identify correlation between Practice Framework approaches and client/patient experiences.	Interview clients/patients who have received supports from SIS to determine framework alignment.	Clients identify positive impact resulting from framework implementation. Improved client/patient health and wellness.
Objective	**Action**	**Indicators of Success**
Feedback from SIS Staff and Council on framework implementation.	Interview staff who delivered framework aligned with SIS programs/services.	Indicators of Success Improved client/patient health and wellness as a result of successful framework implementation.

Health Priority #6: Integrated Programs and Services

Goal A: Create systems to monitor, review and evaluate programs/services.

Objective	Action	Indicators of Success
Programs/services complement one another and do not stand alone.	Review SIS work and strategic plans and desired outcomes and identify gaps in programs/services.	SIS programs/services offer continuum of care. Client/Patient health and wellness journeys are supported through culturally appropriate continuum of care programs/services. Improved client/patient health and wellness.
Objective	**Action**	**Indicators of Success**
Programs/services are directly linked to Nation and Community Health & Wellness Plans.	Review programs/services for links to Nation and Community Health & Wellness Plans.	Programs/services are aligned with community and Nation Health and Wellness Plans and vice versa. Outcomes of Health and Wellness Plan are achieved resulting in improved client/patient wellness.
Objective	**Action**	**Indicators of Success**
Meaningful Data Systems	Identify meaningful data categories to measure against desired health and wellness outcomes	Meaningful data collected, analyzed and reported.
	Action	
	Develop data system to collect and channel data for aggregation into relevant indicators for program management, outcome assessment and reporting.	
Objective	**Action**	**Indicators of Success**
Filled Capacity Gaps	Identify capacity gaps, corresponding strengthening measures and resources to implement modified and/or additional programs/services.	Programs/services modified or developed based on data analysis and its alignment with desired outcomes. Improved client/patient health and wellness.

Health & Wellness Priority Summary

The Ktunaxa Nation's health and wellness priorities are interlinked which presents opportunities to fulfill multiple deliverables in one program or service.

The Nation's health and wellness priorities are garnered in large part from the health and wellness priorities identified by the 4 Ktunaxa Communities. Below are a few statistics that exemplify the interconnectedness between the Nation Health Plan and the Community Health Plans:

- All 4 Ktunaxa Communities (members and staff) and Urban Aboriginal (clients and staff) identified **Mental Health and Substance Use** as a priority health concern.
- All 4 Ktunaxa Communities and Urban Aboriginal identified improved **Access to Medical Health Professionals and Benefits** as a priority health concern.
- 3 of the 4 Communities identified **Culture/Spirituality/Language** as a priority with 2 of the 3 identifying it as a top priority.
- All 4 Ktunaxa Communities identified **Recreation/Exercise for all Ages** as a priority with 2 of the 4 identifying it as a top priority.

Additional health priority input comes from our Social Sector Council, Staff, Clients, and ultimately, from our program/services which quickly reveal existing service gaps.

The Nation's health and wellness priorities are interlinked which presents opportunities to fulfill multiple deliverables in one program or service. For example, culture and exercise are interlinked within the Seven Nations Healing Centre's programming. When residents of the Centre are on the land picking berries, building tipis and paddling the rivers, they are exercising physically.

Communication: Health & Wellness Plan

The Ktunaxa Nation Social Investment Sector (SIS) Staff & Council will ensure citizens, leadership and staff are kept up to date on the Ktunaxa Health & Wellness Plan including deliverables and outcomes. FNHA, IHA, MNBC and other external organizations and agencies will also be kept apprised of the plan. The communication tools used to update will depend on the readers and their literacy levels. Communication tools include:

- HUB Community Engagement Activities
- SIS Council Meetings
- Ktunaxa Leadership Briefings
- Nurse Manager (Nurses and NP's)
- Community Focus Groups
- Ktunaxa Nation Website & Social Media
- Social Media
- Newsletters
- FNHA Communication
- IHA LOU and other Meetings
- Métis LOU and other Meetings
- Internal Meetings (SIS Managers, Nurse/NP, KNEC)
- Conferences and Gatherings (Community, Nation and external)
- Collaborative Services Committees (physicians)

Evaluation

The Ktunaxa Health & Wellness Plan will be reviewed in its entirety every 2 years.

The Ktunaxa Health & Wellness Plan is guided by the Ktunaxa Nation Vision Statement and other relevant Ktunaxa documents. Likewise, the evaluation of this plan will be guided by the same documents. Specifically, the actions attached to each health and wellness priority will be evaluated against the "Indicators of a Strong, Healthy Ktunaxa Citizen" document which was created for Ktunaxa Citizens by Ktunaxa Citizens. (see Health and Wellness Plan Section "Guiding Vision and other Meaningful Documents" for list of documents).

The Ktunaxa Health and Wellness Plan will be evaluated both internally and externally. Internally, examination of programs/services is completed on an ongoing basis allowing for time sensitive Social Investment Sector program and service modifications. Externally, required reporting provides funders and others opportunity for clear insight into the work of the Sector. Funders and others with an interest in the health and wellness of Ktunaxa citizens are welcome to visit our programs and services anytime!

The Ktunaxa Health & Wellness plan will be reviewed in its entirety every 2 years.

Next Steps/ Conclusion

Strong Healthy Ktunaxa Citizens

The Ktunaxa Health & Wellness Plan is a living document that will be revisited parallel to the changes in the health and wellness needs of Ktunaxa Citizens. This plan is based on both the Ktunaxa way of knowing and contemporary views of wellness providing a solid foundation for making key contributions to Nation's vision of "Strong Healthy Citizens". Using the Ktunaxa Nation Vision Statement as well as Nation and Sector principles, values and indicators of strong, healthy Ktunaxa citizens to develop this plan, ensures high quality and consistent programs/services in line both with one another, and with the work of the Ktunaxa Nation's other Sectors: Education and Employment, Traditional Knowledge and Language, Economic and Lands and Resources.

Outcomes will be shared and celebrated!

Ktunaxa Nation Health Strategic Direction

Spiritual, emotional, physical and mental wellness for Ktunaxa individuals, families and communities regardless of where they live.

SharedCare
Partners for Patients

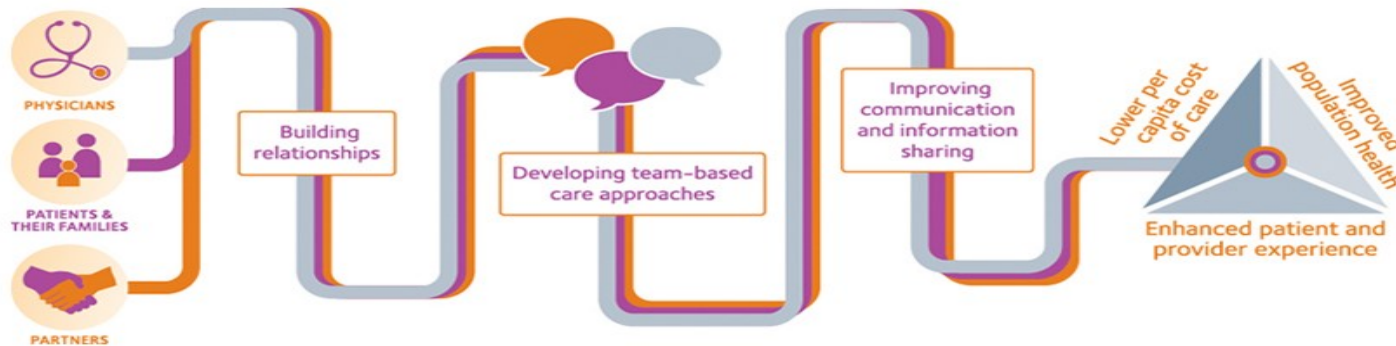
Since 2006, the Shared Care Committee has supported GPs, specialists, and partners, to work together on over 240 projects across BC. The mandate of this collaborative committee is to provide funding and project support to family and specialist physicians to improve the coordination of care from primary to specialist services.

COORDINATED SENIORS CARE INITIATIVE

Supports communities to improve coordination of care for older adults with complex medical conditions, as they move between providers and care settings.

PARTNERS IN CARE/TRANSITION IN CARE PROGRAM supports GP/specialist-led improvement projects focused on local, regional and in some cases provincial issues.

PHYSICAN LEADERSHIP TRAINING offers financial support with tuition, travel and accommodation for family physicians for leadership and quality improvement training through accredit training organizations



POLYPHARMACY RISK REDUCTION supports GP's, pharmacist and other health care providers to reduce risk of multiple medications for seniors and the frail, that may impact their safety and quality of life

RAPID ACCESS TO CONSULTATIVE EXPERTISE (RACE) increasing access to specialist advice for primary care providers through the RACE telephone line, mobile app and secure messaging.

SPREAD NETWORKS of successful work that will link communities interested in:

- **CYMHSU community of practice**
- **Chronic pain**
- **Maternity**

TELEDERMATOLOGY utilizes a secure web-based platform to provide electronic access to dermatology consultation for primary care providers – reducing long wait times.

British Columbia

doctors of bc
British Columbia Medical Association

GPSC
General Practice Services Committee

The Big Picture

TRANSFORMING BC'S HEALTH CARE SYSTEM

From a traditional system that is episodic and siloed.

Many people in BC can't get a family doctor or timely access to the full range of care they need. GPs are under stress and the threat of burnout is real. Meanwhile, hospitals are facing unsustainable pressures.

To a new system that is robust and integrated.

It's why doctors, divisions of family practice, health authorities and provincial partners are working to create an integrated system of care across BC, where patients have access to quality primary health care that effectively meets their needs.

THE FOUNDATION

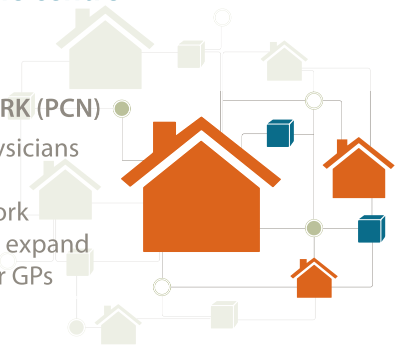
Together, PMHs and PCNs position primary care at the centre of an integrated health care system.

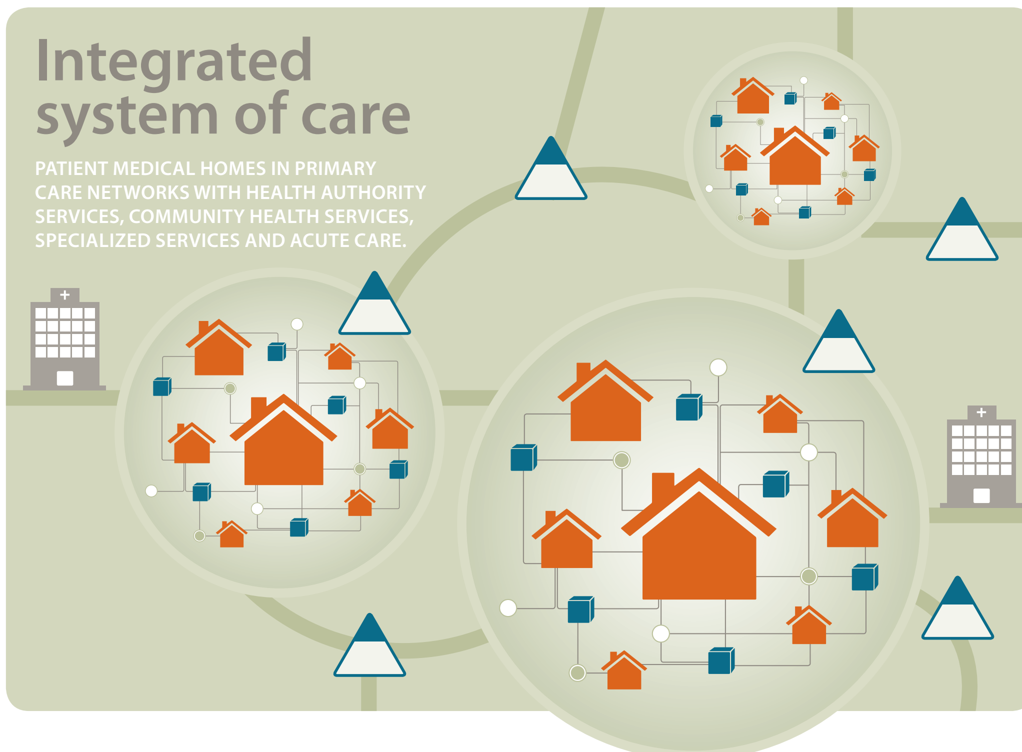
PATIENT MEDICAL HOME (PMH)

A team-based family practice operating at an ideal level where patients get the majority of their care and GPs focus on diagnoses, patient relationships and longitudinal care.

PRIMARY CARE NETWORK (PCN)

A clinical network of physicians and other providers in a geographic area who work together in new ways to expand team-based supports for GPs and patients.





BETTER FOR PHYSICIANS

- Shifts focus to diagnoses and patient relationships.
- Brings services together around GPs and patients.
- Eases the burden of doing it alone.
- Attracts and retains GPs.

BETTER FOR PATIENTS

- Increases attachment to a primary care provider.
- Increases access to a broad range of services.
- Coordinates care and services.

BETTER FOR THE SYSTEM

- Maximizes health care roles and resources.
- Reduces hospital visits.
- Builds sustainable, quality health care.

GPSC
General Practice Services Committee

Primary Care Networks

I need support for a patient.
Where can I send her?
How will I know what happens to my patient?

As part of a primary care network, you have access to a supportive team of health care providers and services outside of the practice to expand care for your patients.

A primary care network (PCN) is a clinical network of providers in a geographic area where patients receive expanded, comprehensive care and improved access to primary care. PCNs include GPs in patient medical homes (PMHs), allied health care providers, health authority services and community health services. Everyone works together to provide all of the primary care services for the local population.

PATIENTS

Get timely, comprehensive, coordinated care outside of the doctor's office when needed, arranged by the GP.

PCNs reorganize the way everyone works together by:

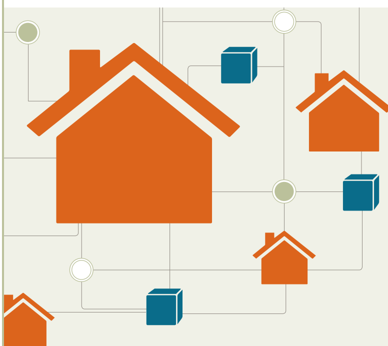
- Strengthening teamwork, communication and links.
- Bringing services together around GPs and patients.
- Creating capacity in a community to increase access.

FAMILY DOCTORS

Have convenient access to a supportive network of people and services for expanded patient care.

You get more support to do your job, including:

- Direct access to an array of clinical services.
- Team-based care supports for patients.
- Connections with other parts of the system.



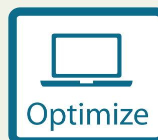
THE BIG PICTURE

Makes the whole community stronger, which in turn supports GPs to care for patients and create patient medical homes.

Get Involved

Divisions of family practice and health authority and community partners have started the work to create PCNs in some BC communities. Other communities will follow.

Participate in a supportive network of local primary care services to increase comprehensive care



Use EMR data to know and plan for your patients' needs.

Work with other GPs and use collective data to identify team-based needs.

Work with divisions and CSCs to plan community supports.

gpscbc.ca

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General Practice Services Committee

Patient Medical Homes

How can I give the best care to my patients?
Where can I get some help?
How can I make my practice run better?

A patient medical home brings more supports into a family practice to increase your ability to care for patients.

A patient medical home (PMH) is a family physician practice where patients get the majority of their care. It builds on what GPs are already doing, and takes the practice to the next level. GPs get more consistent support from teams, networks, and clinical services in the community and use data to inform decisions.

PATIENTS
Have a relationship with a GP and access to the best care.

FAMILY DOCTORS
Spend time on diagnoses, patient relationships and longitudinal care.

A PMH helps GPs to get relief from caring for patients alone, which can help avoid burnout, and make the most of practice resources, time, and capacity.

Four key changes create a patient medical home:

1. Greater use of EMR data to plan care and supports.
2. Team support from allied health professionals and other providers.
3. Physician networks for peer and patient support.
4. Being part of a primary care network.

THE BIG PICTURE

Helps a practice operate at an ideal level, which in turn creates a strong foundation for primary care networks in the community.

Get Involved

The creation of patient medical homes is an emerging area of work in BC. You and your practice team can get started by identifying supports you need for your patients through the process of panel management.

Frees you up to do the work you love to do, and for what brought you into the medical profession in the first place.

Use EMR data to know and plan for your patients' needs.

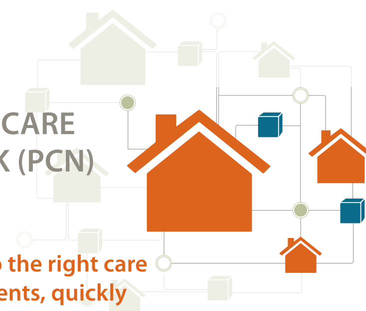
Identify team-based supports that would help you.

Connect with other GPs to plan for mutual patient supports.

GPSC
General Practice Services Committee

The Difference

PATIENT MEDICAL HOMES and PRIMARY CARE NETWORKS

	PATIENT MEDICAL HOME (PMH) **Frees you up to do the work you love to do, and for what brought you into the medical profession in the first place.**	PRIMARY CARE NETWORK (PCN)  **Get access to the right care for your patients, quickly and conveniently.**
PATIENT CARE	Patients get the majority of their care and have an ongoing relationship with a GP.	Patients receive expanded, comprehensive care and improved access to primary care.
WHERE	A family physician practice, or community health centre or health authority clinic.	A clinical network of primary care providers in a geographic area.
PROVIDER	The most responsible provider, usually a family doctor who is supported by a team, directs care in the practice and into the community.	Includes all primary care providers: GPs or NPs in PMHs, allied health providers, health authority services and community health services.
PROVIDER FOCUS	GPs focus on diagnoses, patient relationships, and longitudinal care, with expanded support from teams and networks as needed.	Providers bring team-based services together around GPs and patients in PMHs to enable access, and to better support complex care and vulnerable patient needs.
ROLE IN PATIENT ACCESS	GPs manage patient practice panels and take on new patients when there is capacity to do so.	Networks provide primary care services for the local population and build capacity in the community.
KEY CHANGE	A practice operates with greater use of EMR data, more teams and networks, and better access to clinical services in a community.	Primary care providers work together in new ways and to their strengths, through increased teamwork, communication and linkages.
RESPONSIBILTY	Family doctor(s) with their practice teams.	Divisions of family practices, health authority and community partners.
BETTER FOR PATIENTS	Access to timely, coordinated and comprehensive care that meets patients' range of needs.	
BETTER FOR FAMILY DOCTORS	• Be relieved of caring for all patient needs alone. • Avoid burnout. • Make the most of practice resources, time and capacity.	• Access an array of clinical supports and services outside of the practice. • Be connected to other parts of the system. • Provide better access to care for patients.

THE BIG PICTURE

Helps a practice operate at an ideal level, which in turn creates a strong foundation for primary care networks in the community.	Makes the whole community stronger, which in turn supports GPs to care for patients and create patient medical homes.

Ministry of Health Policy Instrument

Type:	General Policy Direction
Policy Name	Integrated Health System for Primary and Community Care

Version	1.0
Effective Date:	
Division/Branch:	Primary and Community Care Policy Division
Ministry Contact:	ADM Primary and Community Care
Document Number:	
Date:	September 15, 2017

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BRITISH COLUMBIA

INTEGRATED HEALTH SYSTEM FOR PRIMARY AND COMMUNITY CARE

POLICY OBJECTIVE

Create a quality, integrated and coordinated delivery system for primary and community care that is person-centred, effective in meeting population and patient needs, delivers a quality service experience for patients in terms of access, appropriateness, acceptability, safety and efficiency – a system that is easy to understand for those who use it and those who work in it.

Provide a set of policies to improve outcomes and the service experience for primary care patients; mental health and substance use patients; surgical patients; cancer care patients; complex medical patients and/or frail patients. These policies focus on a large sub-set of patients where significant changes in health needs and demand for services are occurring requiring increased integration and coordination of services.

Expected Impact on Health Outcomes and Service Attributes

The Integrated Primary and Community Health Care System will achieve meaningful health outcomes (effectiveness) and service attributes (accessibility, appropriateness, acceptability, safety, efficiency). Measurable expected impacts include:

1. *Effectiveness:* Care achieves meaningful health outcomes for the individuals based on evidence-informed clinical and service assessment of needs and delivery of evidence informed services. Patients receive the majority of care in the community and there is reduced utilization of emergency departments, hospitals and residential care services by those patients.
2. *Accessibility:* Timely access to services based on best-practice clinical standards.
3. *Appropriateness:* Care meets the unique clinical service needs (scheduled, unscheduled and urgent) of the patient based on informed choices of the client in consultation with family/caregiver, using evidence-informed assessment and care planning processes, treatments and services as measured by outcomes.
4. *Acceptability:* Deliver respectful, compassionate and competent care that is designed around, and responds to, the needs, values, beliefs, language, culture and preferences of people seeking care, as well as their family members and caregivers, to ensure a quality patient/family and provider experience with care and service delivery.
5. *Safety:* Care provided is evidence-based, ethical and enables safe and competent care delivery that includes physical, emotional and cultural safety.

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6. *Efficiency:* Services are streamlined to enable the flow of services to meet the needs of clients; deliver the required cross-sector service delivery, information flow and collaborative care and includes formally established linkages to local community-based seniors services.

DEFINITIONS

See glossary for common definitions.

SCOPE

This policy applies to health authorities, publicly funded health care providers and community-based health and social service organizations funded through the Ministry of Health.

POLICY DIRECTION

Implement a standard system of health care delivery at the Local Health Service Delivery Area level and their component communities to achieve improved outcomes and service experience focused on implementing an integrated and coordinated service design, which makes optimal use of health human resources and digital technology, across four key parts of the health system:

- primary care services
- specialized community care services
- a sub-set of hospital and diagnostic, regional and provincial health services
- supportive funding and compensation

Health authorities, publicly funded health care providers and community-based health and social service organizations funded through the Ministry of Health will collaborate to deliver an integrated primary and community care health system that is person-centred, co-ordinated, seamless and easy to understand for patients, family members and care providers. An integrated primary and community care system that has appropriate access and support from hospital and diagnostic services. This whole system of care will help people maintain their health, recover from illness or surgery, improve their quality of life, stay independent longer and avoid unnecessary hospital visits.

Primary Care Services

The foundation of the integrated system of care is the delivery of person-centred primary care services by interdisciplinary teams. The objective is to transform family physician practices and health authority primary care clinics into team-based patient medical homes and link them together in a a team-based **primary care network.** The primary care network will include **patient medical homes** and primary care services delivered or contracted by a health authority (including First Nations Health Authority) and community-based health and social service organizations (e.g. walk-in clinics, First Nations and Aboriginal agencies).

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Our vision is that every individual and family who a regular primary care provider – a family physician or nurse practitioner – will be attached to one in a patient medical home. Patients will have an ongoing care relationship with their regular primary care provider who is most responsible for the overall coordination and continuity of the individual's care throughout their life. The regular primary care provider maintains this key role regardless of whether the required care is provided elsewhere in the healthcare system.

The regular primary care provider will work in a team-based patient medical home, including nurses and other health professionals, that provides primary care services supported by a network of other patient medical homes and the broader primary care network to ensure access to comprehensive primary care services. The services delivered in a primary care network will be designed to be person-centred, culturally-safe and to meet individual and population health care needs. This work will involve practice optimization, service redesign, team work, increased use of digital technology, and different business and compensation models.

Individuals, families and caregivers will be able to access or contact their regular primary care provider, or patient medical home team, in a timely fashion using a variety of channels, including in-person face-to-face visits, group visits, telephone and email consultations, and online and video calls. They will know how to access advice and care from their patient medical home and the broader primary care network and get access to urgent care 24 hours a day, 7 days a week.

Specialized Community Care Services

The second building block of the integrated system of care is to redesign and link a range of what are currently disconnected or fragmented service delivery systems into three integrated and coordinated **Specialized Community Services Programs** and the **Surgical Services Program** linked to Primary Care Networks focused on Adults with Complex Medical Conditions and/or Frailty; Moderate to Severe Mental Health and Substance Use; Cancer Care; and Surgery. These programs will provide effective and holistic care planning; comprehensive and coordinated service delivery wrapped around the needs of the individual needs of patients and providing a quality service experience. Services will be delivered by an inter-disciplinary team.

Once referred to a specialized services or the surgical services program, patients will have access to the care services and management they need. Any referrals and appointments will be coordinated for them, along with education and self- management support and round the clock access to care or advice. Whether they live in a rural area, small town, or big city – specialized and primary care providers will communicate with patients and each other – providing citizens with an understandable, patient-centred system of care.

Supportive Hospital and Diagnostic, Regional and Provincial Health Services

The third building block of the integrated of the integrated system of care is for **hospitals and more specialized tertiary regional and provincial services t**o provide expedited access to diagnostics, care and consults to patients from the Specialized Community Services Programs to enhance the quality of care to these patients and reduce pressure on Emergency Departments.

Supportive Funding and Compensation

The fourth building block is to establish targeted and sustained **funding** and implementing a **value-based compensation model** that supports the delivery of high-quality integrated and coordinated health services that are team based, cost effective and align with health system priorities.

POLICY FRAMEWORK

The Ministry sets out the expectations for the Integrated System of Care in a comprehensive policy framework. This framework includes a range of general policy directions and supportive policy directions categorized into five sections:

1. Requirements for an Integrated Primary and Community Health Care System
    a. Integrated Health System for Primary and Community Care
        i. Interdisciplinary Team-Based Care
        ii. Continuity of Care
        iii. Digital Care
        iv. Information Sharing
        v. Geographic Boundaries in B.C.

2. Requirements for Primary Care
    a. Primary Care Networks
    b. Patient Medical Home

3. Requirements for Specialized Community and Surgical Services Programs
    a. Mental Health and Substance Use
    b. Complex Medical Conditions and/or Frailty
    c. Surgery
    d. Cancer Care

4. Requirements for linked Hospital, Diagnostic, Regional and Provincial Services
    a. Direct Hospital and Diagnostic Access and Effective Discharging
    b. Direct Access to Regional and Provincial Health Services

5. Compensation Models
    a. Value Based Compensation Models

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MONITORING AND EVALUATION

The Integrated Primary and Community Care System general policy direction acts as an enabling policy for the entire suite of policies representing Ministry Strategic Initiatives. Enabling policies lay the foundation for overall health system transformation to take place, and help to address structural and systemic issues and enhance the effectiveness, reach and impact of general and supportive policy directions.

REVIEW & QUALITY IMPROVEMENT

1. The policy will be refreshed as needed and reviewed three years from the <insert date of implementation> and following completion of the summative evaluation.
2. The policy may also be reviewed as determined through consultation between Ministry and external stakeholders.
3. Information from the annual evaluation will be used to understand the performance of Primary and Community Care strategic initiative, areas of success and areas for continuous quality improvement.

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Ministry of Health Policy Instrument

Type:	General Policy Direction
Policy Name	Establish Primary Care Networks

Version	14.5 Draft
Effective Date:	
Division/Branch:	Primary and Community Care Policy Division
Ministry Contact:	Executive Director, Primary Care Access
Document Number:	
Date:	September 20, 2017

Deputy Minister
Ministry of Health

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ESTABLISH PRIMARY CARE NETWORKS

POLICY OBJECTIVE

Primary care networks (PCNs) will be established across British Columbia to provide comprehensive, person-centred, culturally safe, quality primary care services to the population of a Community Service Delivery Area (CSDA) and, as required, coordinate patients' access to specialized community services programs (SCSPs), the Surgical Services Program (SSP) and the broader health system.

A PCN is a network of patient medical homes (PMHs) linked with primary care services delivered or contracted by a health authority and community-based social and other health service organizations. PCNs are the foundation of an integrated system of team-based primary and community care. In most instances, an individual's primary care needs will be met by their PMH though some aspects of care may be provided within the broader network.

PCN services will be designed and maintained to meet the needs of individuals, families and caregivers to improve population health at sustainable per capita costs.

Expected Impact on Health Outcomes and Service Attributes

It is expected that establishing PCNs will achieve meaningful health outcomes (effectiveness) and a quality service experience linked to key service attributes (accessibility, appropriateness, acceptability, safety, efficiency). Measurable expected impacts include:

1. *Accessibility:* The population within a CSDA:
    a. Are attached to a regular primary care provider who is most responsible for overall coordination and continuity of care;
    b. Have timely access to appointments (same-day or at a scheduled time, as appropriate) with their regular primary care provider or another in-practice interdisciplinary team member; and
    c. Are able to access (in person or virtually) primary care advice and the provision of, or direction to, needed care 24 hours a day, 7 days a week, as close to home as feasible.

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2. *Appropriateness:* Improved patient, family and caregiver experience outcomes through access to comprehensive, evidence-informed primary care delivered by interdisciplinary teams.
3. *Acceptability:* Improved patient, family and caregiver experience outcomes through access to person-centred and culturally safe care.
4. *Efficiency:* All appropriate ambulatory care needs are met in the community.

DEFINITIONS

See glossary for common definitions.

SCOPE

This policy covers the comprehensive suite of primary care services (see *Appendix A*) needed throughout an individual's life and across health service areas. This policy applies to family practices, health authority primary care clinics, primary care services delivered or contracted by health authorities (including the First Nations Health Authority) and community-based social and other health service organizations (e.g. community health centres, walk-in clinics).

POLICY DIRECTION

PCN Design

1. PCNs will be designed to meet the needs of individuals and ensure the comprehensive suite of primary care services (see *Appendix A*) are accessible by the community population they serve. Each PCN will serve approximately 10,000 to 50,000 people in rural and remote areas, and 50,000 to 100,000 people in urban areas of British Columbia.
2. Ministry of Health will work with each local PCN steering committee to determine the PCN's size, scope and service composition based on a number of design principles including: person- and family-centredness; comprehensive primary care will be delivered as close to home as possible; stable and professional inter-personal working relationships can be built among providers; and financial and other resources are distributed in an equitable and optimal manner.
3. In rural and remote communities, a smaller PCN may be able to provide comprehensive primary care services through a single PMH linked with health authority primary care services.
4. Consideration will be given for physical accessibility (e.g. rural and remote travel distances, public transportation, and limited mobility) and significant efforts will be made to reduce and mitigate access issues through the use of a variety of models, including virtual care, mobile services, group visits and other design elements.

5. PCN service design will consider both existing patients and those without access. PCNs will identify unattached individuals and families in the community and have a centralized primary care waitlist and protocols for patient-provider attachment.
6. PCN design will align with regional and provincial guidelines that will be co-created with health system partners, including patients, families and caregivers, to ensure comprehensive services are available on a human scale while taking into consideration local context (geography, population, Aboriginal Self Identification, etc.).
7. Within a CSDA a PCN will provide the community population with:
    a. An explicit, ongoing care relationship (i.e. attachment/relational continuity) with a regular primary care provider who is most responsible for their care for all people who want one;
    b. Comprehensive primary care services (see *Appendix A)* ensuring that services and care plans are holistic, person-centred, culturally safe and responsive to individual needs (including consideration of the social determinants of health);
    c. Timely access to appointments (same-day or at a scheduled time, as appropriate) with their regular primary care provider or another in-practice interdisciplinary team member;
    d. Access to primary care advice and provision of, or direction to, needed care 24 hours a day, 7 days a week through a variety of mechanisms, e.g. 811, email access, call networks;
    f. Extended hours of care (including evenings and weekends) possibly through PMHs and/or linkages with walk-in clinics, urgent care centres, and community health centres;
    g. Coordinated service delivery including timely appointments for investigations, treatments and consultations in other health service areas;
    h. When more specialized care is required by a patient, ensure effective transitions of care as appropriate to the local or nearest SCSP (cancer care, mental health and addictions, and complex medical/frail) or Surgical Services Program, diagnostic facilities, medical specialists, hospital services, community-based service organizations and agencies (including on- and off-reserve First Nations and Aboriginal); and,
    i. Clear mechanisms and protocols for the patient's regular primary care provider to maintain continuity of care (relational, informational, and management) through contributing to care planning delivered through SCSPs or SSP, hospitals, and regional and provincial programs;
    j. Regular opportunities for patients, families and caregivers to be engaged and give feedback for quality improvement activities.
8. PCN design will include implementation and sustainment of the following functions:
    a. Interdisciplinary team care (in-practice and network) to optimal scope of practice;

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b. Technology-enabled solutions with virtual care embedded into daily operations to link patients and providers (e.g. home health monitoring);
c. Informational continuity (e.g. appropriate information sharing, single patient health record) and management continuity (e.g. longitudinal care planning, integrated team planning, team-based case management), including working towards linked electronic medical records;
d. Case finding to identify individuals requiring care prior to crisis or hospitalization, including consistent use of upstream assessment tools (e.g. frailty scales);
e. Provider access to rapid and optimal consultation services from SCSP or SSP, and regional and provincial services, to support the primary care team to appropriately and effectively meet mild to moderate needs of patients, address problems as they arise, and avoid the need for specialized care where possible.
f. Partnership with the local community including school-based health promotion programs, community health centres, and community initiatives with citizens, local government, and other organizations focused on areas such as:
    i. healthy eating, food security and healthy weights,
    ii. physical activity and non-sedentary living,
    iii. tobacco and vapour product use prevention, cessation and enforcement,
    iv. social/emotional health and resiliency,
    v. culture of moderation of alcohol use, and
    vi. injury prevention.

Patient Medical Home <see Patient Medical Home Supportive Policy Directive>

1. Within a PCN, all family practices and health authority primary care clinics will be supported to become a PMH as defined by the attributes of the BC PMH model.
2. All practices and clinics within a CSDA are considered a part of the PCN, both before and after they have attained PMH attributes.
3. In a PMH, individuals are attached to a regular primary care provider, a family physician or nurse practitioner, who is most responsible for the overall coordination and continuity of the individual's care across the life course. The regular primary care provider maintains this key role regardless of health service area or whether the required care is provided within the PMH or by other health professionals (e.g. specialists) in the system.
4. Primary care services delivered in a PMH will meet the majority of the populations' primary care needs. The balance of comprehensive primary care services required by a geographic population will be met through PMH being networked with each other and with other primary care services being delivered or contracted by health authority as part of a PCN.
5. Coordinated and consistent PMH indicators and metrics will be applied across PCNs.

PCN Administration

1. PCN steering committees will be established, building on existing local structures (e.g. collaborative services committees) or sub-groups (e.g. local action teams) with a clearly defined local governance model including: joint planning, decision making, and accountability to regional and provincial governance structures for reporting and monitoring.
2. A PCN steering committee will start with a core membership representing the health authority and practices (i.e. division of family practice). Steering committee membership will expand as the network develops in the community to include patients/families/caregivers and additional community organizations in the PCN, for example the First Nations Health Authority, walk-in clinics, community health centres, urgent care centres, and community-based social and other health service organizations (on- and off-reserve).
3. PCN steering committees will have effective communication with municipal bodies, including First Nations councils, to inform planning for primary care services to address community needs.
4. PCN steering committees will design and maintain primary care services that meet the needs of individuals and improve population health at sustainable per capita costs through joint planning, implementation, resource management, quality improvement and reporting.
5. Locally developed PCN implementation plans will be reviewed and finalized regionally and provincially, in alignment with PMH, SCSP and SSP implementation.
6. PCN steering committees will implement plans in a sustainable, incremental process within and across geographic areas, leveraging existing assets and services, new innovations and local or regional opportunities as they occur.
7. PCN steering committees will consistently use data and evidence to inform planning and quality improvement activities at a professional, practice, community and system level. The necessary information sharing agreements will be in place to support quality improvement and evaluation work.

LINKAGES

Health Human Resources

PCN interdisciplinary care teams will provide wrap-around, person-centered care using available HHR resources, optimized scopes of practice and where necessary and appropriate virtual care to achieve service objectives. Based on the population served, interdisciplinary care teams may be comprised of, but are not limited to, the following health care providers:

1. Audiologists
2. Counsellors
3. Dentists
4. Dietitians

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5. Medical laboratory and diagnostics professionals
6. Medical office assistants
7. Midwives
8. Nurses and nurse practitioners
9. Occupational therapists and physiotherapists
10. Optometrists
11. Pharmacists
12. Psychologists
13. Physicians (mainly general practitioners)
14. Respiratory therapists
15. Social workers
16. Complementary and alternative providers (e.g. traditional healers)

Organizational Capacity

Data Analytics and Reporting

Service delivery data collection and submission should be comprehensive, accurate, and timely to support adequate and thorough understanding of population and patient needs and baseline service levels, and to plan for and assess improvements over time.

Data and analysis will be provided by the Ministry of Health to support service delivery planning at both the Local Health Service Delivery Area and CSDA levels. Collaboration and dialogue on these products can be used to inform strategic planning, gap analysis and subsequent roll-out in a range of environments. These tools can also be used to understand the baseline for performance.

Integrated analytics will support performance monitoring, reporting and evaluation in line with the strategy for health system performance management.

PERFORMANCE INDICATORS

Initial performance indicators have been developed in collaboration with the Ministry and external stakeholders to measure the expected outcomes of the service attributes of accessibility, appropriateness, acceptability, efficiency. <Insert Number> performance indicators to report on the Primary and Community Care Strategic Initiative include:

1. TBD

In addition to the above indicators, Ministry and external stakeholders will continue to collaborate to identify additional indicators that provide insight into the performance of both the Establish Primary Care Networks General Policy Directive and the Primary and Community Care Strategic Initiative overall.

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REVIEW & QUALITY IMPROVEMENT

1. The policy will be refreshed as needed and reviewed three years from the date of implementation and following completion of the summative evaluation.
2. The policy may also be reviewed as determined through consultation between Ministry and external stakeholders.
3. Information from the annual evaluation will be used to understand the performance of the strategic initiative, areas of success and areas for continuous quality improvement.
4. The Ministry will work with the program area to develop a quality improvement plan where necessary and will support the program area to manage the review and quality improvement process.
5. The Ministry will lead any monitoring of outcome measures that are identified in the quality improvement plans developed.

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Appendix A – Comprehensive Primary Care Services

Within a PCN, the majority of the comprehensive primary care services will be provided by PMHs. The balance of primary care will be provided in the PCN by primary care services delivered or contracted by health authorities and other community-based health and social service organizations. Comprehensive primary care services include:

POPULATION	PRIMARY CARE SERVICES
Staying Healthy	1. Supports to address health literacy, self-care and self-management 2. Supports to address factors that contribute to health status advocacy for healthy public policy, supportive environments and communities 3. Population health assessment of the PCN population including the identification high risk sub-populations and clinical preventive maneuvers as required 4. Implementation of the Lifetime Prevention Schedule for the general asymptomatic population including: immunizations, screening (e.g., perinatal depression, cancer, etc.), behavioural interventions (e.g., tobacco cessation), preventive medications/devices (e.g. statins) 5. Nutrition counselling 6. ***Reproductive care:*** a. sexual health, including prevention and management of sexually transmitted infections b. health promotion services and supports before, during and after pregnancy (e.g. nutrition, exercise, hypertension, smoking cessation and substance use, birth planning) c. low-risk maternity care d. antepartum and postpartum care e. contraception, safe abortion services and post-abortion care 7. ***Healthy early childhood development:*** a. implementation of guidelines for developmental surveillance and case finding (see the SPD: Healthy Start) b. provision of information about child health, growth and development and parenting c. breastfeeding and child nutrition education and support d. health promotion services (e.g. immunizations and dental services)
Getting Better	1. Assessment and treatment services for minor illnesses 2. Access to diagnostic services, including point-of-care testing where

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	practical 3. Basic in-office emergency services 4. Linkages to community-based resources, including peer and group support
Living with Illness or Disability	1. Outpatient diagnostic imaging and laboratory services, as appropriate 2. Early detection, intervention, education and support for self-care 3. Guideline-based chronic disease management and service coordination 4. Post-cancer treatment care and support 5. Pre- and post- surgical care (e.g. pre-habilitation, optimization and rehabilitation services). 6. Local surgical services, as appropriate 7. Use of existing standardized care pathways (e.g. hip surgery) 8. Ongoing monitoring, including medication 9. Home support for mild to moderate complex and frailty 10. Support for care provided in hospital and long-term care facilities *11.* ***Care for mental health and substance use:*** a. screening, assessment and management of mild to moderate conditions and stable severe or complex disorders including concurrent physical health conditions, b. individual, group and on-line counselling, c. pharmacological treatment and medication monitoring, d. rapid access to crisis intervention services, e. harm reduction resources, f. tools to increase resilience, g. opioid agonist therapy services.
Optimally Coping with End of Life	1. Serious illness and quality of life conversations 2. Palliative approach to care (e.g. pain management) 3. Support for the terminally ill

Ministry of Health
Policy Instrument

Type:	General Policy Direction
Policy Name	Specialized Community Services Program for Adults with Complex Medical Conditions and/or Frailty

Version	6.4
Effective Date:	
Division/Branch:	Primary and Community Care Policy Division
Ministry Contact:	Executive Director, Seniors' Services
Document Number:	1075592
Date:	September 15, 2017

Deputy Minister
Ministry of Health

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SPECIALIZED COMMUNITY SERVICES PROGRAM FOR ADULTS WITH COMPLEX MEDICAL CONDITIONS AND/OR FRAILTY

POLICY OBJECTIVE

This policy requires regional health authorities to establish specialized community services programs (SCSPs) for adults with complex medical conditions and/or frailty to achieve meaningful health outcomes (effectiveness) and a quality service experience linked to key service attributes (accessibility, appropriateness, acceptability, safety, efficiency).

Expected Impact on Health Outcomes and Service Attributes

It is expected that establishing SCSPs for Adults with Complex Medical Conditions and/or Frailty will achieve meaningful health outcomes (effectiveness) and a quality service experience linked to key service attributes (accessibility, appropriateness, acceptability, safety, efficiency). Measurable expected impacts include:

1. *Effectiveness:* Care achieves meaningful health outcomes for individuals based on evidence-informed clinical and service assessment of needs and delivery of services. Clients receive the majority of care in the community and there is reduced utilization of emergency departments, hospitals, and residential care services by those clients.
2. *Accessibility:* Timely access to services based on best-practice clinical standards.
3. *Appropriateness:* Care meets the unique clinical service needs (scheduled, unscheduled and urgent) of the client based on informed choices of the client in consultation with family and caregivers, using evidence-informed assessment and care planning processes and as measured by a client experience and outcomes survey.
4. *Acceptability:* Deliver respectful, compassionate and competent care that is designed around and responds to the needs, values, beliefs, language, culture, and preferences of people seeking care, their family and caregivers, to ensure a quality client, family, and provider experience with care and service delivery.
5. *Safety:* Care provided is evidence-based, ethical, and enables safe and competent care delivery that includes physical, emotional, and cultural safety.
6. *Efficiency:* Services are streamlined to enable the flow of services to meet the needs of clients, deliver the required cross-sector service delivery, information flow and

collaborative care and includes formally established linkages to local community-based seniors' services.

DEFINITIONS

See glossary for common definitions.

Community-Based Seniors Services: A broad definition that includes all non-profit and municipal services that provide programming for older adults (including community centers, multi-service agencies, senior's centres, community coalitions, neighbourhood houses[1]).

SCOPE

The policy applies to health authorities, health professionals, and health authority contracted service providers delivering these specialized services. It includes all services to meet the needs of adults with complex medical conditions and/or frailty.These services include program-based clinical care, community nursing and allied services managed (or contracted) by health authorities, specialist medical care, home support, adult day respite, respite care and short-term residential care, assisted living, long-term residential care, and palliative care and formal linkages to local community-based seniors services.

POLICY DIRECTION

Regional health authorities establish and develop, at minimum, one SCSP for adults with complex medical conditions and/or frailty in each Local Health Service Delivery Area based on population health needs and geography.

Shared SCSP Attributes

Regional health authorities will ensure that each SCSP provides an integrated and comprehensive suite of evidence-based services to address the health care needs of a particular population and has the following attributes built in to its design and functioning:

1. The program will serve one or more primary care networks (PCNs) in a Local Health Service Delivery Area.
2. Services will be designed to maintain or improve health status. The effectiveness and quality of the services provided will result in less need for emergency department services or in-patient care. The services will also minimize the time a client spends in hospital care.
3. A commonly known, single point of contact for SCSP will be available to health care providers in the PCNs for consultation or referral. In addition, clients, families and

[1] Cohen, M., & Kadowaki, L., 2017. *Raising the Profile of the Community-based Seniors' Services Sector in BC.*

caregivers will have web-based access to information and the ability to talk with someone directly to discuss and/or access SCSP services.

4. Multiple related services will be integrated into a single program structure to provide and coordinate seamless interdisciplinary team-based care to meet the client's physical and psychosocial needs. Clients will experience an integrated system of care organized by a single care manager who will ensure care is seamless and coordinated across the program. Clients' needs will be met by an interdisciplinary team, consisting of the most appropriate skill mix. Any referrals and appointments will be coordinated for clients, along with education and self-management support and 24/7 access to care or advice.
5. Access to other specialized services will be coordinated with the client by the SCSP when subsequent to the original referral other services are required from a different SCSP.
6. Interdisciplinary team-based care within the SCSP: promotes collective competence, shared leadership, and the active participation of each care provider and support staff in client care, ensures person-centred goals and values, provides continuous communication among team members, provides opportunities for education and training, enhances participation in clinical decision-making within and across disciplines, and fosters respect for the contributions of all team members.
7. Digital and information technology enables flexible and innovative service delivery options including virtual care. Information sharing across providers informs effective and quality person-centred care and enables quality improvements in client care and practice workflow.
8. Programs will optimize co-location but ensure a single communication network and personal connectivity across all the service elements that make up a specialized program, including program team meetings.
9. Each SCSP will have a single designated leader with fiscal and operational accountability for all aspects of the program and its services.

Specific SCSP Attributes

Each SCSP integrates multiple related services into a single program structure for the provision of community care for adults with complex medical conditions and/or frailty.

Client Population

1. The SCSP will be structured to meet the needs of adults with complex medical conditions as set out in the health system matrix and those assessed as frail.

Services

1. The SCSP will provide timely access to a coordinated and comprehensive suite of services to meet the needs adults with complex medical conditions and/or frailty. These services will be person-centred and accessible through clear, simple and well-understood

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pathways, coordinated and managed on the client's behalf, and designed to optimize client functioning and outcomes.

2. The SCSP services will include, at minimum: clinical and medical care, family/friend informal caregiver supports, community nursing and allied services managed (or contracted) by health authorities, access to specialist medical care, home support, adult day care (through both adult day respite care centres and where available access to services provided by assisted living and residential care such as cafeteria, social activities, bathing, laundry and personal care), respite care and short-term residential care, assisted living, long-term residential care, and palliative care.

Care Coordination, Key Functions and Team-Based Care

1. The SCSP ensures a commonly known, single point of contact is available both to health care providers within the Primary Care Networks for consultation or referral. In addition there is web-based access for clients/families to information and the ability to talk with someone directly to discuss and/or access SCSP services.
2. The SCSP will assign a most responsible clinician (MRC) to each client who is responsible for designing seamless, person-centred, culturally safe care provided by the interdisciplinary team and may include care and services outside of the SCSP, as required.
3. The SCSP will establish team-based care around clients that provides relational continuity with the care team members.
4. The SCSP's MRC will ensure access to direct care and supports for clients and families 24/7, providing care and services as needed to avoid unnecessary emergency department visits and hospital admissions.
5. The SCSP will have efficient and timely access for clients to pharmacy, diagnostic, hospital outpatient, emergency, and inpatient hospital services.
6. The SCSP will reduce and mitigate requirements for long distance travel by clients for diagnostic tests, treatments, and follow-up appointments through the use of virtual care, mobile services and other design elements, where appropriate.
7. The SCSP will work with specialists or networks of sub-specialties to establish mechanisms for coordinating access to appropriate care to meet the needs of clients as required.
8. The SCSP will deliver the following functions:
    a. Urgent Response:
        i. The SCSP will be responsive to urgent needs 24/7, using defined pathways to support individuals in crisis.
    b. Case Finding and Screening:
        i. *Screening:* Initial screening will be completed on contact.
        ii. *Case finding and in-reach services:* These services will be provided on an ongoing basis in partnership with patient medical homes, PCNs, hospitals,

and community based seniors' services to identify people requiring specialized services.

iii. The SCSP will provide general advice and information to people and families who do not require SCSP services. The SCSP will maintain involvement until the person is linked with the most appropriate service for their needs.

c. Consultation to assigned PCNs:

i. The SCSP will provide consultation to primary care providers to assist in clarifying functions necessary to support adults with mild to moderate complex conditions and/or frailty to remain healthy in community.

d. Intake, Initial Assessment and Care Plan Development:

i. At intake, people will be triaged using the RAI Contact Assessment to determine appropriate care and services needed for immediate discharge home, including safety and risk assessments based upon standardized assessment tools. This assessment may be completed in a community setting such as a person's home, physician's office, hospital, emergency department, or community agency, or via virtual care.

ii. RAI-MDS HC assessment will be conducted in a setting that supports engagement of the individual and their family and in the most appropriate environment conducive to an accurate assessment. This will be a community setting, such as a person's home, assisted living site, or via virtual care technologies. RAI-MDS HC assessments will not be completed in hospital as the outcomes may provide inaccurate results.

iii. The assessment will inform the development of an initial care plan, overseen by a MRC.

iv. The initial care plan will include the set of services and interventions required based on individual needs.

e. Immediate and short-term supports:

i. Following the initial assessment, rapid access to urgent response services will be activated for those with high levels of acuity that require immediate stabilization. Consideration will be given to the context of rural and remote communities where the scope of and availability of health providers are limited.

ii. People will be matched with the right service to meet their diverse needs, and receive rapid access to short-term intervention, general guidance, and support to address immediate health needs.

iii. The SCSP will be available 24/7 to address immediate needs.

f. Specialized team-based care:

i. The person will be linked to appropriate SCSP services and supported by an interdisciplinary team with an assigned MRC.

ii. Rapid mobilization of services will address changing, urgent or unscheduled needs. This includes expedited access to pharmacy, hospital outpatient, emergency, and inpatient services, residential respite, home support services, treatment and rehabilitation services, with consideration of cultural preferences as appropriate.

iii. Care management and coordination:
   - Services will be designed around and respond to the unique needs, values, beliefs, language, culture, and preferences of people seeking care, their family and caregivers.
   - Timely access to specialized services will follow a stepped-care approach.
   - All care will be provided and/or coordinated by a MRC through the interdisciplinary team. Management of care is seamless to the person. The logistics of managing services will happen in the background on behalf of the client and in alignment with their decisions for the planning of their care. *<link to Continuity of Care General Policy Direction>*

iv. Consultation support and collaborative care planning:
   - General information, education and advice will be provided to clients, families and caregivers, and PCNs in the prevention, management and treatment of health issues.
   - The interdisciplinary team provides consultation support and collaborative care planning with other SCSPs (e.g. adults with moderate to severe mental health and/or substance use issues, cancer care) and the Surgical Services Program.
   - The interdisciplinary team participates in local collaborative planning tables which design care delivery and linkages between the PCN, provincial specialized services, specialists, community-based seniors' services (i.e. - NGOs and community service partners, municipalities), First Nations organizations and social services provided by other government ministries.
   - Active PCN involvement in planning and delivery of care to improve client experience, enable information flow and support access to specialist consultations and services as required.

v. Transition and ongoing support:
   - Clients who have stabilized and no longer require services of the SCSP will be transitioned to the PCN, as well, clients being managed within the PCN requiring additional care and supports will be supported by the SCSP. The MRC will continue to

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support the PCN when clients require clinical support from the SCSP.
    - When an in-hospital admission is necessary, the MRC remains involved in care and planning, working closely with acute care staff to organize and facilitate an effective and timely transition back to the community setting.
    - The MRC coordinates care to and from regional services or provincial specialized services. Care planning is integrated with shared accountabilities.

9. The SCSP will provide a team-based model of delivery <link to Interdisciplinary Team-Based Care Supportive Policy Direction> ensuring:
    a. Interdisciplinary teams use an integrated care management model to deliver comprehensive care to clients based on an assessment of need and assignment of appropriate care to meet individual health goals.
    b. The roles and functions of team members will be clearly defined and scopes of practice optimized.
    c. Team members will be co-located or linked using technology to facilitate communication and information sharing, and clinical supervision of all services provided by the program.
    d. Interdisciplinary teams will work collaboratively with:
        i. Government services that provide housing, social and financial supports.
        ii. Non-Government Organizations (NGO's), municipality programs and community coalitions to develop community based seniors' services which provide social supports for clients, their families and their care providers.
        iii. Paramedic teams to facilitate assessments in community whenever possible to avoid unnecessary emergency department admissions.
        iv. Service partners, communities, First Nations on and off reserve, and other Aboriginal organizations.
    e. Team-based care will include contracted service providers from home care, adult day care assisted living, and residential care as full members of the SCSP team and the specific client-based care teams. SCSP contracted services will be expected to adhere to the same quality and safety standards as health authority operated services.

LINKAGES

Health Human Resources

Interdisciplinary care teams will provide wrap-around, person-centred care, optimized scopes of practice, and use digital technologies to increase the range and means of service delivery

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(including virtual care) to achieve service objectives. Based on the population served, interdisciplinary care teams may be comprised of, but are not limited to, the following health care providers:

1. Registered nurses
2. Licensed practical nurses
3. Health care assistants
4. Occupational therapists
5. Physiotherapists
6. Rehabilitation assistants
7. Dieticians
8. Social workers
9. Medical specialists
10. Other disciplines may be added to meet the local needs of the population

Organizational Capacity

Data Analytics and Reporting

Service delivery data collection and submission should be comprehensive, accurate, and timely to support adequate and thorough understanding of population and client needs and baseline service levels, and to plan for and assess improvements over time.

Data and analysis will be provided by the Ministry of Health to support service delivery planning at the Local Health Service Delivery Area and Community Service Delivery Area levels. Collaboration and dialogue on these products can be used to inform strategic planning, gap analysis and subsequent roll-out in a range of environments. These tools can also be used to understand the baseline for performance.

Integrated analytics will support performance monitoring, reporting and evaluation in line with the strategy for health system performance management.

PERFORMANCE INDICATORS

Initial performance indicators have been developed in collaboration with the Ministry and external stakeholders to measure the expected outcomes of the service attributes of effectiveness, accessibility, appropriateness, acceptability, safety and efficiency. Eleven performance indicators to report on the Primary and Community Care Strategic Initiative include:

1. Percent of home health clients who received a CTAS score of 4 or 5 for an ED visit
2. % of assessed clients receiving service within accepted standardized response times.
3. # new clients receiving home health care within X days
4. Proportion of Alternative Level of Care (ALC) clients waiting for a home health service
5. % of RAI assessments completed within the appropriate time frames (all HCC services)
6. Maintained or improved performance on QI’s across all HCC health client populations

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7. % of clients with a reassessment within one year of initial assessment
8. Clinicians have electronic access to RAI outputs to make decisions about care for clients at point of care (add for AL and RC)
9. % of res care and AL clients hospitalised for a fall (Prevalence of falls all HCC services)
10. % of HH/AL clients with improved IADL/ADL outcome scores
11. Percent of continuous home health clients with a Method of Assigning Priority Levels (MAPLe) score of 4 or 5

In addition to the above indicators, Ministry and external stakeholders will continue to collaborate to identify additional indicators that provide insight into the performance of both the Specialized Community Services Program for Adults with Complex Medical Conditions and/or Frailty General Policy Direction and the Primary and Community Care Strategic Initiative overall.

REVIEW & QUALITY IMPROVEMENT

1. The policy will be refreshed as needed and reviewed three years from the <insert date of implementation> and following completion of the periodic evaluation.
2. The policy may also be reviewed as determined through consultation between Ministry and external stakeholders.
3. Information from the periodic evaluation will be used to understand the performance of the strategic initiative, areas of success and areas for continuous quality improvement.
4. The Ministry will work with the program area to develop a quality improvement plan where necessary and will support the program area to manage the review and quality improvement process.
5. The Ministry will lead any monitoring of outcome measures that are identified in the quality improvement plans developed.

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Ministry of Health Policy Instrument

Type:	General Policy Direction
Policy Name	Specialized Community Services Program for Mental Health and Substance Use

Version	1.22
Effective Date:	TBD
Division/Branch:	Primary and Community Care Policy Division
Ministry Contact:	Executive Director, Mental Health and Substance Use
Document Number:	
Date:	September 15, 2017

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Deputy Minister
Ministry of Health

BRITISH COLUMBIA

SPECIALIZED COMMUNITY SERVICES PROGRAM FOR MENTAL HEALTH AND SUBSTANCE USE

POLICY OBJECTIVE

This policy requires regional health authorities to establish and develop specialized community services programs (SCSPs) for individuals with moderate to severe mental health, substance use, and concurrent mental health and substance use (MHSU) disorders or conditions to achieve meaningful health outcomes (effectiveness) and a quality service experience linked to key service attributes (accessibility, appropriateness, acceptability, safety, efficiency).

Expected Impact on Health Outcomes and Service Attributes

It is expected that establishing SCSPs for Mental Health and Substance Use will achieve meaningful health outcomes (effectiveness) and a quality service experience linked to key service attributes (accessibility, appropriateness, acceptability, safety, efficiency). Measurable expected impacts include:

1. *Effectiveness:* Care is based on individuals receiving evidence-informed assessment of clinical and service needs, followed by evidence-informed services, leading to more meaningful health outcomes. Clients receive the majority of care in the community and there is reduced utilization of emergency departments, hospitals and residential care services by those clients.
2. *Accessibility:* Timely access to services that meet best-practice clinical standards.
3. *Appropriateness:* Care meets the unique clinical service needs (scheduled, unscheduled and urgent) of the patient based on informed choices of the patient in consultation with family and caregivers, as needed, using evidence-informed assessment and care planning processes and as measured by a patient experience and outcomes survey.
4. *Acceptability:* Deliver respectful, compassionate and competent care that is designed around, and responds to, the needs, values, beliefs, language, culture, and preferences of people seeking care, their family and caregivers, to ensure a quality client/family and provider experience of care and service delivery.
5. *Safety:* Deliver evidence-based, ethical, and competent care that protects clients, keeping them free from physical, emotional and cultural disrespect and/or harm.
6. *Efficiency:* Services are streamlined to enable the flow of services to meet the needs of clients, deliver the required cross-sector service delivery, information flow and collaborative care and includes formally established linkages to local community-based services for mental health, and for substance use.

DEFINITIONS

See glossary for common definitions.

SCOPE

The policy applies to health authorities, publicly funded health care providers, and health authority contracted service providers delivering these specialized services. It covers all MHSU services to individuals (including children, youth, adults and older adults) with moderate to severe mental health, substance use, or concurrent mental health and substance use disorders or conditions. It includes all specialized voluntary mental health and substance use services as well as involuntary mental health services under the *Mental Health Act*. It includes assessment, treatment and support related to specialized interventions and highly specialized care.

POLICY DIRECTION

Regional health authorities establish and develop, at minimum, one SCSP for individuals with moderate to severe mental health, substance use, and concurrent MHSU disorders or conditions in each Local Health Service Delivery Area based on population health needs and geography.

Shared SCSP Attributes

Regional health authorities will ensure that each SCSP provides an integrated and comprehensive suite of evidence-based services to address the health care needs of a particular population and has the following attributes built in to its design and functioning:

1. The program will serve one or more primary care networks (PCNs) in a Local Health Service Delivery Area.
2. Services will be designed to maintain or improve health status. The effectiveness and quality of the services provided will result in less need for emergency department services or in-patient care. The services will also minimize the time a patient spends in hospital care.
3. A commonly known, single point of contact for SCSP is available both to health care providers in the PCNs for consultation or referral. In addition, patients, families and caregivers will have web-based access to information and the ability to talk with someone directly to discuss and/or access SCSP services.
4. Multiple related services are integrated into a single program structure to provide and coordinate seamless interdisciplinary team-based care to meet the patient's physical and psychosocial needs. Patients will experience an integrated system of care organized by a single care manager who will ensure care is seamless and coordinated across the program. Patients' needs will be met by an interdisciplinary team, consisting of the most appropriate skill mix. Any referrals and appointments will be coordinated for them, along with education and self- management support and 24/7 access to care or advice.

5. Patient access to other specialized services will be coordinated by the SCSP with the patient, including when subsequent to the original referral the patient requires services from a different SCSP.
6. Interdisciplinary team-based care within the SCSP: promotes collective competence, shared leadership, and the active participation of each care provider and support staff in patient care; ensures person-centred goals and values; provides continuous communication among team members; provides opportunities for education and training; enhances participation in clinical decision making within and across disciplines; and fosters respect for the contributions of all team members.
7. Digital and information technology enables flexible and innovative service delivery options including virtual care. Information sharing across providers informs effective and quality person-centred care and enables quality improvements in patient care and practice workflow.
8. Programs will optimize co-location but ensure a single communication network and personal connectivity across all the service elements that make up a specialized program, including program team meetings.
9. Each SCSP will have a single designated leader with fiscal and operational accountability for all aspects of the program and its services.

Specific SCSP Attributes

Each SCSP integrates multiple related services into a single program structure for the provision of community mental health and substance use services for individuals with moderate to severe (1) mental health, (2) substance use; and (3) concurrent MHSU disorders or conditions. Coordinated and integrated leadership and service planning is established for both mental health and substance use services for each SCSP.

Patient Population:

1. The SCSP will be structured to meet the distinct health care needs for three groups of patients, providing and coordinating seamless team-based care to meet the person's bio-physical, psychological, and social needs. Needs are based on a person's level of functioning, acuity, behaviour, stage of recovery, legal requirements, and cultural background. The three groups include the following disorders, consistent with the Diagnostic and Statistical Manual of Mental Disorders (DSM):
    a. Mental Health

        Moderate to severe mental health issues are disorders or conditions that may produce psychotic symptoms, such as schizophrenia and schizoaffective disorder, and moderate to severe forms of other disorders, such as major depression, bipolar disorder, eating disorders, conduct disorders, severe anxiety disorders, and concurrent neuro-developmental disorders.

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b. Substance Use
    i. Moderate to severe substance use disorders and conditions associated with the risks and harms of moderate to severe substance use in the form of drugs or alcohol (health related issues, social functioning, overdose) and related behaviours (sharing needles and other drug paraphernalia, unsafe sexual practices).

c. Concurrent
    i. Moderate to severe substance use and mental health disorders occurring at the same time.

Services:

1. The SCSP will provide timely access to a coordinated and comprehensive suite of MHSU services that are responsive to the full range of disorders and conditions experienced by individuals, their families and caregivers faced with managing moderate to severe (1) mental health, (2) substance use; and (3) concurrent MHSU disorders or conditions. These services will be person-centred and accessible through clear, simple, and well-understood pathways that are coordinated and managed on the patient's behalf and designed to optimize patient functioning and outcomes.
2. The SCSP services will include, at minimum, emergency response and triage services, clinic-based services, home-based community outreach services, assertive outreach services and rehabilitation, recovery and residential treatment services based on the needs of the population. It either directly provides, or has linkages to, acute and tertiary care services.
3. The SCSP provides a range of services to meet both the shared and distinct needs of the three populations for people with moderate to severe (1) mental health, (2) substance use and (3) concurrent MHSU disorders or conditions.
    a. Common services for people with moderate to severe mental health issues are a combination of proactive screening and case finding, keeping a person engaged in treatment, emergency response services, counselling, cognitive, behavioural and social learning interventions, pharmacological treatment, intensive day programming, psychosocial rehabilitation support services, and residential care.
    b. Common services for people with moderate to severe substance use disorders and conditions include proactive screening and case finding, keeping a person engaged in treatment, emergency response services, managing a person's intoxication or addiction and associated acute medical problems, counselling, behavioural and social learning interventions, pharmacological treatment including opioid agonist therapy, withdrawal management, intensive day programming, psychosocial support services, supervised injection sites, and short- and medium-term residential treatment and rehabilitation services.

4. The SCSP integrates court-related forensic psychiatric assessment, treatment and community services to individuals with moderate to severe mental health, substance use, and concurrent MHSU disorders or conditions that are in conflict with the law in order to return individuals safely back into their local community.
5. The SCSP ensures services:
    a. Align with the (1) trauma-informed and responsive practice principles <link >; (2) wellness-focused and recovery-oriented practice principles <link>;(3) culturally safe and community-centred practice principles <link>.
    b. Patients and, as appropriate, family and caregiver input into the care planning and design of services and, where possible, patients have a choice of interventions and supports.
    c. Provide holistic bio-physical, psychological, social, and spiritual care and therapies to the patient and family to address both immediate and longitudinal needs as well as providing access to specialist medical care.
    d. Address physical health care needs, including prevention/promotion services, and can be provided by the PCN directly for stable patients or through reverse shared care approaches for patients who are unstable and/or have complex behaviours or conditions.
    e. Are offered in various settings including community-based clinics, a person's home, their community, and assertive outreach services, as well as in residential settings, hospital and specialized inpatient care facilities, and through virtual care and other digital technologies.
    f. Are delivered according to legislation, provincial clinical practice guidelines and program standards, and are informed by current evidence and best practice where possible.

Care Coordination, Key Functions, and Team-Based Care

1. The SCSP ensures a commonly known, single point of contact is available both to health care providers within the PCNs for consultation or referral. In addition, there is web-based access for patients, families and caregivers to information and the ability to talk with someone directly to discuss and/or access SCSP services.
2. The SCSP will assign a most responsible clinician (MRC) to each patient who is responsible for designing seamless, person-centred, culturally safe care provided by the interdisciplinary team and may include care and services outside of the SCSP, as required.
3. The SCSP will establish team-based care around patients that provides relational consistency with the care team members.
4. The SCSP's MRC will ensure the access to direct care and supports for patients and families 24/7, providing care and services as needed to avoid unnecessary emergency department visits and hospital admissions.

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5. The SCSP will have efficient and timely access for patients to pharmacy, diagnostic, hospital outpatient, emergency, and inpatient hospital services.
6. The SCSP will reduce and mitigate requirements for long distance travel by patients for diagnostic tests, treatments and follow-up appointments through the use of virtual care, mobile services and other design elements, where appropriate.
7. The SCSP will work with community MHSU specialists or networks of sub-specialties to establish mechanisms for coordinating patient access to appropriate care to meet the needs of patients as required.
8. The SCSP will establish relationships with local private MHSU community service providers to enable improved quality of services, improved integration and coordination of services between the SCSP and private service providers.
9. The SCSP will deliver the following functions:
    a. Urgent Response:
        i. The SCSP will be responsive to urgent needs 24/7, using defined pathways to support individuals in crisis.
    b. Case Finding and Screening:
        i. *Screening:* Initial screening will be conducted within 24 hours unless the person is experiencing a high level of acuity requiring a minimum response time of one to two hours. Response times will vary depending on geography.
        ii. *Case finding and in-reach services:* These services will be provided on an ongoing basis in partnership with patient medical homes/PCNs, hospitals, community first responders, corrections, and homeless shelters to identify people with moderate to severe mental health and/or substance use issues with unmet MHSU needs.
        iii. Immediately following screening, an intake and initial assessment is conducted for people who meet initial screening requirements for SCSP.
        iv. The SCSP will provide general advice and information such as MHSU health literacy to people and families who do not require SCSP services. The SCSP will maintain involvement until the person is linked with the most appropriate service for their needs.
    c. Consultation to assigned PCNs.
    d. Intake and Initial Assessment:
        i. At intake, people will be triaged to determine appropriate service.
        ii. The initial assessment will be conducted based on standard assessment tools and will address mental health, substance use and physical health care needs.
        iii. Initial psychiatric consultation for assessment is provided as appropriate.
        iv. The assessment will take place in a setting that supports appropriate engagement of the individual. This may be a community setting, a

person's home, hospital, emergency department, community agencies or via virtual care technologies. The assessment will inform the development of an initial care plan overseen by a MRC.

v. The initial care plan will include the set of services and interventions required based on individual needs.

e. Immediate and short-term supports:

i. Following the initial assessment, rapid access to urgent response services will be activated for those with high levels of acuity that require immediate stabilization. Consideration will be given to the context of rural and remote communities where the scope and availability of health providers are limited.

ii. A MRC will be assigned the patient to ensure continuity of care.

iii. People will be matched with the right service to meet their diverse needs and receive rapid access to short-term intervention, general guidance, and support to address immediate psychological distress and issues concerning determinants of health.

iv. The SCSP will be available 24/7 to address immediate needs.

f. Specialized team-based care:

i. The person will be linked to appropriate SCSP services and supported by an interdisciplinary team with an assigned MRC.

ii. Rapid mobilization of services will address changing, urgent or unscheduled needs. This includes expedited access to pharmacy, hospital outpatient, emergency inpatient services, residential treatment, and rehabilitation services with consideration of cultural preferences as appropriate.

iii. Care management and coordination:

- Services will be designed around, and respond to, the unique needs, values, beliefs, language, culture and preferences of people seeking care, their family and caregivers.
- Timely access to specialized MHSU will services follows a stepped-care approach.
- All MHSU care will be provided and/or coordinated by a MRC through the interdisciplinary team. Management of care is seamless to the person. The logistics of managing services will happen in the background on behalf of the patient and in alignment with their decisions for the planning of their care. *<link to Continuity of Care Supportive Policy Direction>*

iv. Consultation support and collaborative care planning:
    - General information, education and advice will be provided to patients, families, and caregivers, and PCNs in the prevention, management and treatment of MHSU issues.
    - The interdisciplinary team provides consultation support and collaborative care planning with other SCSPs (e.g. adults with moderate to severe mental health and/or substance use issues, cancer care) and the Surgical Services Program
    - The interdisciplinary team participates in collaborative planning and delivery of care with the PCN, provincial specialized MHSU services, specialists, non-governmental organizations, and community service providers, First Nations organizations, and social services provided by other government ministries.
    - Active PCN involvement in planning and delivery of care to improve patient experience, enable information flow and support access to specialist consultations and services as required.

v. Transition and ongoing support:
    - Patients with moderate to severe MHSU issues who have stabilized and no longer require services of the SCSP will be transitioned to the PCN. The MRC will continue to support the PCN when patients require clinical support from the SCSP.
    - When an in-hospital admission is necessary, the MRC remains involved in care and planning, working closely with acute care staff to organize and facilitate an effective and timely transition back to the community settings.
    - The MRC coordinates care to and from local acute care in-patient MHSU services, regional MHSU services, and provincial specialized MHSU services. Care planning is integrated with shared accountabilities, and transition protocols align with Regional and Provincial Services.

10. The SCSP will provide a team-based model of delivery <link to Interdisciplinary Team-Based Care Supportive Policy Direction> ensuring:
    a. Interdisciplinary teams use an integrated care management model to deliver comprehensive care to patients based on an assessment of need and assignment of appropriate care to meet individual health goals.
    b. The roles and functions of team members will be clearly defined and scopes of practice optimized.
    c. Team members will be co-located or linked using technology to facilitate communication and information sharing and clinical supervision of all services provided by the program.

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d. Interdisciplinary teams will work collaboratively with:
    i. Government services that provide housing, social, educational and skill training, and financial supports;
    ii. Non-government organizations that provide social supports for patients, families and caregivers;
    iii. Police and paramedic teams to facilitate assessments in community whenever possible to avoid unnecessary emergency department admissions;
    iv. Service partners, communities, First Nations on and off reserve, and other Aboriginal organizations to raise awareness of MHSU issues and services available in the SCSP and support the development and delivery of services and supports for populations with MHSU issues.

e. Team-based care will include contracted MHSU service providers as full members of the interdisciplinary team. SCSP contracted MHSU services will be expected to adhere to the same quality and safety standards as health authority operated services, including medical and clinical oversight.

LINKAGES

Health Human Resources (HHR)

Interdisciplinary care teams will provide wrap-around, person-centred care using available HHR resources, optimized scopes of practice and, where necessary and appropriate, virtual care to achieve service objectives. Based on the population served, interdisciplinary care teams may comprised of, but are not limited to, the following health care providers:

1. Psychiatrist
2. Physician specializing in addiction medicine
3. Family physician or nurse practitioner
4. Registered psychiatric nurse/registered nurse
5. Psychologist
6. Social worker
7. Clinical counsellor
8. Occupational therapist
9. Trained peer support

The interdisciplinary teams include the following allied professionals:

1. Pharmacist
2. Medical specialist (dentist, optometrist, podiatrist, speech and hearing)
3. Nutritionist
4. Naturopathic medicine
5. Recreation therapist
6. Music and art therapists

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7. Physiotherapist
8. Spiritual services
9. Traditional Chinese medicine and acupuncturists
10. Cross-cultural liaison
11. Forensic experts
12. Vocational experts
13. Staff with expertise in public health
14. Staff with expertise in psychosocial rehabilitation, including rehabilitation practitioners with expertise in basic living skills support, supported housing, supported employment, supported education and wellness support (nutrition, weight management, smoking cessation)

Organizational Capacity

Data Analytics and Reporting

Service delivery data collection and submission should be comprehensive, accurate, and timely to support adequate and thorough understanding of population and patient needs and baseline service levels, and to plan for and assess improvements over time.

Data and analysis will be provided by the Ministry of Health to support service delivery planning at both the Local Health Service Delivery Area and Community Service Delivery Area levels. Collaboration and dialogue on these products can be used to inform strategic planning, gap analysis, and subsequent roll-out in a range of environments. These tools can also be used to understand the baseline for performance.

Integrated analytics will support performance monitoring, reporting, and evaluation in line with the strategy for health system performance management.

PERFORMANCE INDICATORS

Initial performance indicators have been developed in collaboration with the Ministry and external stakeholders to measure the expected outcomes of the service attributes of effectiveness, accessibility, appropriateness, acceptability, safety and efficiency. Seven performance indicators to report on the Primary and Community Care Strategic Initiative include:

1. % of MHSU Population Attached to a GP/NP
2. % of people admitted for mental illness and substance use who are readmitted within 30 days
3. Rate of ED visits for people with a mental health and/or substance use diagnosis per capita
4. Average length of stay for people with a mental health and/or substance use diagnosis
5. % of patients receiving follow up care by a primary care physician or specialist within 30 days following hospital discharge for a mental health and/or substance use diagnosis
6. Unplanned ED use for mental health and substance use
7. MHSU Patient Attached to Physician

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In addition to the above indicators, Ministry and external stakeholders will continue to collaborate to identify additional indicators that provide insight into the performance of both the Specialized Community Services Program for Mental Health and Substance Use General Policy Direction and the Primary and Community Care Strategic Initiative overall.

REVIEW & QUALITY IMPROVEMENT

1. The policy will be refreshed as needed and reviewed three years from the <insert date of implementation> and following completion of the periodic evaluation.
2. The policy may also be reviewed as determined through consultation between Ministry and external stakeholders.
3. Information from the periodic evaluation will be used to understand the performance of the strategic initiative, areas of success and areas for continuous quality improvement.
4. The Ministry will work with the program area to develop a quality improvement plan where necessary and will support the program area to manage the review and quality improvement process.
5. The Ministry will lead any monitoring of outcome measures that are identified in the quality improvement plans developed.

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Divisions Funding Summary

GPSC General Practice Services Committee

Funding Stream	Description/Purpose/Eligibility	Restrictions	Funding Amount	Timeline
COVID (Retroactive from April 1, 2020)	(i) to support the Division in active physician planning for the second wave of COVID-19, and for implementation and monitoring of that planning at the local and regional level. (ii)the Division shall use the Funding for the support of both routine and COVID-19 emergency response in primary care, (III)the funds could also be used for 2021 fire emergency implementation	Funds may be used for the following specific activities only: a) active planning and meetings for up to 5 sessional hours per family physician per month; b) staffing needs, limited to 60 percent of Funding; and c) administration needs, limited to 10 percent of Funding.	$170,000	November 2020 – March 31, 2022 Unspent funds as of March 31, 2022 must be returned to the GPSC
Infrastructure (annual, ongoing)	(i) Infrastructure funding comprises of Foundational and Collaboration funds. (ii) The purpose of this funding is to pay infrastructure costs necessary for the ongoing operation of the Division. (iii) All divisions eligible to apply	(i) The cost of Infrastructure that is otherwise available to the Division through an initiative of the GPSC (e.g. technology solutions provided through the Division IT Infrastructure) (ii) Infrastructure costs attributable to an annual year other than the annual year for which the funding is provided (e.g. pre-payment of a lease or any other business expenses attributable to a future fiscal year)	FY 2021-22, three components: (i) Foundational funds per FY 2021-22 + member adjustment if applicable (ii) Collaboration funds (iii) Support to Physician Change Management FY2022-23 – onwards: to be determined.	Annual funding: April 1 – March 31
Long Term Care Initiative (LTC) (one-time planning funding; ongoing monthly payment for implementation)	(i) LTC funding comprises of Planning and Implementation funds. The purpose of this funding is designed to enable divisions of family practice, or self-organizing groups of family physicians in communities where no division exists, to design and implement local solutions that improve the care of patients receiving residential care services (ii) All divisions eligible to apply.	(i) Where a division exists, the request for planning funding will be made through the division. FPs in a community without a division should self-organize and appoint a lead to submit funding request. Only one planning funding request may be submitted per community. (ii) The request for planning funding should be made by divisions/groups when they are ready to start their local planning process.	$400/bed/year	Funding available from April 01, 2015 – onwards

Funding Stream	Description/Purpose/Eligibility	Restrictions	Funding Amount	Timeline
Patient Attachment Mechanism (PAM) (3-year commitment starting 2019) Delayed start of this project due to Provincial HRC system delay. Projected to start in early 2022.	In addition to supporting linkages between Primary Care Networks and the Health Connect Registry (HCR), the funds may be used to boost Divisions' local attachment mechanisms in the following ways; (i) creating a process or system to keep accurate, up-to-date primary care provider information, including attachment capacity (ii) developing referral pathways for unattached patients presenting in emergency/acute care (iii) hiring dedicated attachment personnel who might; • assess patient needs and best placement approach • liaise between HCR and primary care providers who are accepting patients • ensure HCR administrative interface has accurate, complete patient information	At the end of each fiscal year, the Division must submit a report indicating the use of funds and demonstrating the impact in their communities.	$25,000/year	April 1, 2019 – March 31, 2022
Primary Care Network (PCN) (3-year commitment starting 2020)		No Project Admin can be taken from any of the PCN Funds		April 1, 2020 – March 31, 2023
PCN Change Management	Facilitate change management activities to transition from status quo to a fully implemented PCN Service Plan as directed by the PCN Steering Committee.	Change management costs considered out of scope are: (i) GP engagement and GP participation in the implementation of PCN (ii) Division resources, such as Executive Director salary, that are covered by other funding sources	$428,954/year	
PCN Governance	Ensure the governance requirements outlined in the Interim Letter of Intent signed by the Division and Health Authority partner are provided within the Funding envelope.	No additional funds will be made available for the governance functions required by the PCN Steering Committee, including advisory committees and working groups	$40,000/year	

Funding Stream	Description/Purpose/Eligibility	Restrictions	Funding Amount	Timeline
PCN Management	The Division shall hire a PCN Manager and administrative support for the PCN to provide overall project leadership for the implementation of the primary care initiative within the PCN, which includes working with Patient Medical Home (PMH) programs/services, primary care providers, the regional health authority, community agencies, and other stakeholders. While working with the Division and other local groups to facilitate engagement of physicians, nurse practitioners, nurses, allied health and other community member participation in the PCN	Management costs considered out of scope are: (iii) GP engagement and GP participation in the implementation of PCN (iv) Division resources, such as Executive Director salary, that are covered by other funding sources	$246,150/year	
Physician Change Management (3-year commitment starting 2019)	Upon submission of the PCN Service Plan, Divisions will receive this funding component to sustain the active involvement of physicians and physician leaders in local development and implementation of PCNs. Funds may be used for: a) Physician time and travel expenses b) MOA time and travel expenses c) Professional development (training)	Project Admin fee is taken from this fund, but no employee wages are allowed. The Division will submit a report indicating the use of Funds at the end of each fiscal year Which will include how many physicians and how many engagement activities were supported through this funding.	$138,620/year	April 1, 2019 – March 31, 2022
Innovation (ends March 31, 2022)	(i) Innovation funding is for innovative yet practical projects that will focus on a sustainable strategy or promising practice. They will be locally informed and led, and will enhance the health care system, processes, or practices in the community. The use of Innovation funds should advance the goals of the Triple Aim. (ii) All divisions eligible to apply	(i) Funds cannot be used for ongoing Division operating expenses supported by Foundational funding, expenses that pre-date project approval, rent/lease/capital improvements, technology provided by the PDO, events, attendance at conferences/training. They are for strategic initiatives, not work that is of an operational or ongoing nature. (ii) Not for projects eligible for other source of funding (e.g. Shared Care).	(i) Max $100,000/division between November 2016-March 2019). (ii) Up to 3 grants per division within the $100,000 overall cap. (iii) The $100,000 may be increased if more than one division is involved.	Funding available between February 2020-February 2022. Unspent funds must be returned to the GPSC **Team Based Care**

Funding Stream	Description/Purpose/Eligibility	Restrictions	Funding Amount	Timeline
In-patient Care ***funds flow through the MoH*** (ongoing)	To support community-based FPs who deliver in-patient care service. These incentives form part of a comprehensive strategy to support the provision of in-patient care.		(i) Assigned In-patient Care Network Incentive (G14086): A quarterly networking fee of $2,100 per physician is available to community-based FPs for participating in a network to deliver in- patient care for their own patients. (ii) Unassigned In-patient Care Network Incentive (quarterly level II Teleplan adjustment): This incentive varies between $90/day and $600/day with the specific funding level for each hospital outlined in section 5 of the Q&A document referenced below. (iii) Unassigned In-patient Care Fee (G14088): A fee of $150/per unassigned in-patient is available to community-based FPs assuming MRP or delivering the majority of care for a non-admitting diagnosis when a medical or surgical specialist is MRP. This $150/per unassigned in-patient fee is in addition to the Unassigned In-patient Care Network Incentive listed above. (iv) Enhanced clinical fees for select in-patient MRP services (13008 and 00127): The GPSC is providing funding to increase the value of the 13008 and 00127 fee items by an additional 25 per cent through a bonus that has been directly applied to the fees starting on April 1st, 2013. Where applicable for the community, Rural Retention Premiums will be applied to the fee increases.	Funding available from April 01, 2013 – onwards

East Kootenay
Division of Family Practice

PROJECT FUNDING STREAMS

PROJECT	FUNDER	AMOUNT	TIMELINE
COVID (Retroactive from April 1, 2020)	GPSC	$170,000	November 2020 – March 31, 2022
EK CPD (CPD Event costs only) Sessionals for Steering Committee	Rural CME RccBC	$40,935 $17,500	April 1, 2021 – March 31, 2022 Nov 1, 2020 – March 31, 2022
Core Infrastructure Funds	GPSC	$562,196	April 1, 2021 – March 31, 2022
Long Term Care (LTC) (Project Admin only)	GPSC	$7,464	April 1, 2021 – March 31, 2022
Maternity Care Initiative (MCI) Cranbrook/Kimberley Creston Fernie Golden Invermere	GPSC	 $29,000 $23,000 $23,000 $20,000 $20,000	 Nov 1, 2020 – August 31, 2021 Oct 1, 2020 – March 31, 2022 Aug 1, 2020 – March 31, 2022 Sept 1, 2020 – April 30, 2021 Sept 1, 2020 – March 31, 2022
Patient Attachment Mechanism (PAM) (3-year commitment starting 2019)	GPSC	$25,000/year	April 1, 2019 – March 31, 2022
Primary Care Network (PCN) Change Management Governance Management (3-year commitment starting 2020)	MoH	 $428,954/year $ 40,000/year $246,150/year	 April 1, 2020 – March 31, 2023 April 1, 2020 – March 31, 2023 April 1, 2020 – March 31, 2023
Physician Change Management (3-year commitment starting 2019)	GPSC	$138,620/year	April 1, 2019 – March 31, 2022
Project Administration (Estimated and incl carry over)	Projects	$93,935	April 1, 2021 – March 31, 2022
Recruitment and Retention (2-year commitment)	RDEK	$10,000 (2020) $15,000 (2021)	June 1, 2020 – May 31, 2022 August 2021 – August 2022

Shared Care Projects Acute Care Transition EASE (EK) Gender Affirmation (Golden) HealED (Cranbrook) Liver Care Maternity Cranbrook Kimberley Steering Committee (EK)	Shared Care	 $135,000 $30,000 $135,000 $60,000 $135,000 $100,000 $20,000	 January 2022 – January 31, 2023 September 2020 – Dec 31, 2021 June 2021 – March 31, 2022 February 2019 – August 31, 2021 January 2022 – January 31, 2023 October 2021- September 30, 2022 January 2020 – December 2021
Team Based Care	Innovation	$39,670	April 1, 2020 – March 31, 2022
Virtual Care Coordinator	RccBC	$65,808.99	September 2021 – March 31, 2022
Virtual Clinic Cranbrook and Creston (MOA reimbursement through IH)	IH	$9,393	April 1, 2020 – March 31, 2022

2021-2022 Budget DRAFT

East Kootenay Division of Family Practice

Revenue:	
MoH - Infrastructure	$ 442,222
Sessional Lift	$ 26,056
Collaboration Funding	$ 69,456
Top up for PCN work	$ 24,462
Carry-over/Shortfall	$ 95,510
Total Revenue	$ 657,706
Expenses:	
Human Resources	
Physician - Board	$ 59,614
Physician - Travel Hours	$ 17,169
Physician - Committee	$ 34,020
Physician Lead	$ 30,522
Physician CPP (employer portion) 5.1%	$ 7,208
Physician sub-total	**$ 148,532**
Executive Director	$ 124,051
Operations Lead	$ 44,554
Program Manager	$ 59,405
Employer's Costs, 12% Mercs	$ 39,036
Employee Benefits, 5%	$ 16,265
Finance Coordinator	$ 44,554
Project Coordinator & Pathways	$ 20,367
Project Coordinator, Maternity Top Up 33 weeks	$ 4,521
Administrative Assistant	$ 27,846
Employee sub-total	**$ 380,598**
Communications Contract	$ 18,721
Recruitment Contract	$ 16,380
Professional Development	$ 4,000
Total Human Resources	**$ 568,231**
General Administration	
Society fees, memberships, subscriptions	$ 1,000
Recruitment advertising	$ 500
Banking Fees, e-processing	$ 1,500
Insurance	$ 2,250
Accounting and Legal Fees	$ 15,000
Total Administration	**$ 20,250**

Meeting Costs		
Event Costs (AGM)	$	1,000
Catering	$	6,000
Room rental	$	300
Total Meeting Costs	**$**	**7,300**
Travel		
Physician Accomodation	$	4,320
Physician Travel - mileage	$	4,700
Physician Travel air	$	1,500
Physicians meals/incidentals	$	800
Physician car rental/taxi etc	$	100
Physician Travel total	$	11,420
Staff - Mileage	$	3,360
Staffs - Airfare	$	1,000
Staff - Accomodation	$	800
Staff - Meals & Incidentals	$	1,200
Staff - Car Rental/Taxi etc	$	200
Staff Travel Total	$	6,560
Total Travel	**$**	**17,980**
Facilities		
Rent, utilities	$	12,000
Repairs & Maintenance	$	3,000
Telephone and Communications	$	6,000
Total Facilities	**$**	**21,000**
Supplies & Equipment		
Office Supplies	$	4,735
Computers - Hardware	$	5,000
Computers - Software	$	5,000
Computer Repair & Maintenance	$	1,000
Other Equipment	$	1,000
Postage and Courier	$	200
Printing	$	500
Leasehold improvements	$	3,000
Furniture	$	2,000
Total Supplies & Equipment	**$**	**22,435**
Contingency	$	510
Total Expenses	**$**	**657,706**
Surplus /Deficit	**$**	**0**

East Kootenay
Division of Family Practice
A GPSC initiative

2021-2022
Calculation table

Sessional costs:	# People	Rate	# Hours	# Events	Total	
Chair prep/planning 2 hrs wk for 48 weeks	1	158.97	2.00	48	$15,261	
Treasurer Approvals and FRC meetings prep	1	158.97	0.50	26	$2,067	
Board members meeting	6	158.97	4.00	6	$22,892	$59,614
Physician Lead 4 hrs wk for 48 weeks	1	158.97	4.00	48	$30,522	
Phys Lead/Board Collaborative Travel hours	7	158.97	2.00	6	$13,353	$17,169
CSC Committee NOTE 4	3	158.97	3.00	10	$14,307	
ISC/Collaborative meetings	1	158.97	10.00	4	$6,359	$34,020
ISC/Collaborative Travel hours	1	158.97	6.00	4	$3,815	
HR Committee	2	158.97	4.00	4	$5,087	
Governance Committee	2	158.97	2.00	4	$2,544	
Finance Review Committee	2	158.97	4.00	4	$5,087	
Strategic Planning	7	158.97	6.00	1	$6,677	
Pathways	1	158.97	7	12	$13,353	

Core Staffing:		*per hour*	*Hrs/wk*	*weeks*	*Gross*	**Staffing expensed to Admin and other Projects**				**Allocation**	**Total Hrs**
Executive Director M. Purcell	*1*	*68.16*	*35.00*	*52*	*$124,051*	0	*68.16*	*$*	*-*		35.00
Program Manager J. vanZyl	*1*	*57.12*	*20.00*	*52*	*$59,405*	10	*57.12*	*$*	*29,702*	*Project Admin*	30.00
Operations Lead L. Vanlerberg	*1*	*57.12*	*15.00*	*52*	*$44,554*	10	*57.12*	*$*	*29,702*	*PCN Management*	25.00
Finance administrator T. Hochart	*1*	*40.80*	*21.00*	*52*	*$44,554*	14	*40.80*	*$*	*29,702*	*PCN Management*	35.00
Project Coordinator H. Du Plessis	*1*	*32.64*	*12.00*	*52*	*$20,367*	16	*32.64*	*$*	*27,156*	*CME/Covid/RDEK*	28.00
Admin Assistant K Stanley	*1*	*25.50*	*21.00*	*52*	*$27,846*	4	*25.50*	*$*	*5,304*	*Project Admin*	25.00
Project Cordinator, Maternity Top up	*1*	*137.00*	*1.00*	*33*	*$4,521*						
					$325,298			$	121,568		
			Mercs/Benefits Costs (17		$55,301	Mercs/Benefits Costs (17%)		$	20,667		
			Total Core Employee Costs		**$380,598**	Total Additional Employee Costs		**$**	**142,234**		
						Expected Project Admin 2021/22		$	85,562		
						Other Expected Staff Funding		$	101,275		
						Additional Funding Available		**$**	**186,837**		
								$	**44,603**		

Meeting Costs	**# meetings**	**cost/person**	**# people**	**totals**
Room rental: AGM and one Division-wide Meeting		300.00	1	$300
AGM Catering	1	30.00	100	$3,000
Board Catering	5	30.00	10	$1,500
RPRC Catering	5	30.00	10	$1,500

GP Travel	***GPs***	***rate***	***#trips***	***km/trip***	***totals***
Travel board mileage	*5*	*0.56*	*5*	*250*	*$3,500*
Travel board accomodation	*4*	*120.00*	*4*		*$1,920*
Travel members mileage	*12*	*0.56*	*1*	*250*	*$1,680*
Travel members accomodation	*6*	*120.00*	*1*		*$720*
Travel air/accom collaborative travel	*1.5*	*1200.00*	*2*		*$3,600*
					$11,420

Staff Travel	***staff***	***rate***	***#trips***	***km/trip***	***totals***
Staff travel km's	*4*	*0.56*	*6*	*250*	*$3,360*
Staff air/accom collaborative travel	*1*	*1200*	*2*	*0*	*$2,400*
Staff incidentals/meals					*$800*

Budget Notes

Note 1: Estimated $95,000 surplus from 2021/21 but could be between $90,000 - $100,000.
Note 2: All sessionals rates increased to the new JCC rate of $158.97
Note 3: 2% cost of living increase for all staff positions
Note 4: Travel and catering costs are approx half of a typical year but take into account rising costs.
Note 5: Lease and many other overhead costs reduced by the 25% that PCN is covering
Note 6: Leasehold Improvement higher than normal to cover potential painting of the office.

East Kootenay
Division of Family Practice
A GPSC initiative

PCN Change Management Budget		2021/22
		as of April 1
Opening Bal/Carry forward**		$ -
Project Funding received		$ 428,954
Total April 1 2021 thru Mar 31 2022		**$ 428,954**
Expenses:		
Specialist Sessionals		$ -
Physician Sessionals		$ -
Change Management (3) Coaches		$ 250,000
Evaluation	28 hrs/week at $50/hr	$ 73,000
Consulting Fees - Communications & Team Based Care		$ 72,686
Advertising & Marketing		$ 6,000
Employer costs		$ -
Project Administration 10%		$ -
Meeting space/venue	6 events	$ 1,000
Meeting catering	1 lunch and 1 dinner per member	$ 10,000
Meeting supplies		$ 575
Physician Travel		$ -
Employee Travel - Coaches/Evaluation	4-5 trips to 5 communities	$ 9,000
Contigency		$ 6,693
Total		$ 428,954
Revenue Balance		**$ -**

East Kootenay
Division of Family Practice
A GPSC initiative

PCN Budget		2021/22
Governance		**as of April 1**
Opening Bal/Carry forward**		$ -
Project Funding received		$ 40,000
Total April 1 2021 thru Mar 31 2022		**$ 40,000**
Expenses:		
Physician Sessionals		$ 30,000
NP Sessionals	Part of IH Contract for Year 1 & 2	$ -
Consulting (Facilitation, Training)		$ 3,000
Meeting space/venue	In Kind	$ -
Meeting catering		$ 3,000
Meeting supplies		$ 560
Physician Travel		$ 3,440
Contingency		$ -
Total		$ 40,000
Revenue Balance		**$ -**

East Kootenay
Division of Family Practice
A GPSC initiative

PCN Budget Management	2020/21 as of April 1	
Opening Bal/Carry forward**	$	-
Project Funding received	$	246,150
Total April 1 2020 thru Mar 31 2021	**$**	**246,150**
Expenses:		
PCN Manger	$	117,125
PCN Operations Lead (0.3 FTE)	$	25,500
PCN Finance Administrator (0.4 FTE)	$	34,500
PCN Admin (0.7 FTE)	$	28,000
Employer costs — included in each position	$	-
Overhead 20%	$	41,025
Total	$	246,150
Revenue Balance	**$**	**-**

East Kootenay
Division of Family Practice
A GPSC initiative

Budget		**2021/22**	
Physician Change Management		**as of April 1**	
Opening Bal/Carry forward**		$	181,666
Project Funding received		$	138,620
Total April 1 2021 thru Mar 31 2022		**$**	**320,286**
Expenses:			
RPRC Meetings	**7-8 GPs for 6 - 3 hour meetings**	$	22,000
Cranbrook In-patient	**Community wide meeting and follow up**	$	10,000
Physician Engagements		$	24,000
PCN UPCC (and Maternity Clinic)	**6 GPS for 10 - 2hr meeetings**	$	20,000
PCN Clinic/ Community Engagements	**100 GPs for a 1.5 hour meeting**	$	24,000
PCN Clinic Lead Interviews	**17 GPs for a 1 hour meeting**	$	3,000
PCN On-Boarding New Team Members	**17 GPs for 25 hours of work**	$	68,000
PCN Physician Leadership Time	**17 GPs for 7 hours work**	$	20,000
NUKA (Invermere) Training		$	5,000
PCN Sessionals		**$**	**140,000**
Clinic Team Building/Support	**6 Clinic - 8 GPs each for afternoon (3 hrs)**	$	23,000
GP Community Wellness/ Resiliency Leads	**7 GPs quarterly/ 2 Resiliency GP Leads monthly**	$	27,000
Physician Sessionals		**$**	**246,000**
MOA /Clinic Staff ($25/hour)	**Clinic Engagements/Onboarding/Team Building**	$	30,000
Project Administration 10%		$	13,862
Physician Travel		$	22,109
MOA Travel		$	5,000
Catering		$	3,315
Total		$	320,286
Revenue Balance		**$**	**0**

Letter of Intent – Primary Care Networks

This letter is intended to serve as an agreement that will enable provision of funding to the undersigned Division of Family Practice and Health Authority to support implementation of Primary Care Networks (PCNs). This funding is in addition to resources provided by the General Practice Services Committee (GPSC) to support divisions and physicians to participate in primary care reform (general infrastructure funding, change management support and minor tenant improvements).

Details with respect to governance and roles and responsibilities of parties are set out in an accompanying document, *Primary Care Networks Collaborative Governance - Roles and Responsibilities*. Funding, information sharing, and reporting and evaluation will continue to be defined in collaboration as our collective work on primary care transformation progresses.

The signatories to this agreement are the GPSC, the Health Authority and the respective Division of Family Practice (the "Parties"), each of which will play a key role in realizing the successful establishment and operations of the local PCNs. Local First Nations may also be a signatory.

Collaboration on Primary Care Networks

The Parties are committed to improving primary care access and attachment, patient experience, and health outcomes for British Columbians through the establishment of local PCNs, which consist of Patient Medical Homes and other models of care – such as Urgent and Primary Care Centres, Community Health Centres and First Nations primary care clinics -- networked to each other and linked to Health Authority primary and community care services, Indigenous health organizations and community-based health and social services.

There is a long history of collaboration in primary care in BC, expressed provincially through the General Practice Services Committee (GPSC), representing the strategic partnership of the Doctors of BC and the Ministry, supported by the Health Authorities, including First Nations Health Authority. This collaborative approach is expressed locally through Collaborative Services Committees (CSC), representing Divisions of Family Practice, Health Authorities, First Nations and local community partners as key stakeholders, supported by the Ministry, Doctors of BC, the GPSC, and regionally through the CSC Interdivisional Strategic Councils.

As the BC health system is redesigned around patients and their interactions with primary care, the Parties have made a commitment to the following principles in how the system changes through PCNs will be planned, designed, and delivered:

- The patient is at the centre of the PCN. Care is designed to be patient centered and culturally safe, through shared design and delivery of primary health care with First Nations in BC, consistent with the Government of BC's commitment to true, lasting reconciliation with First Nations in BC by fully adopting and implementing the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), and Calls to Action of the Truth and Reconciliation Commission.

- The local PCN recognizes the importance of family and community in supporting patient care.
- The local PCN is intended to respect and preserve the longitudinal relationship between patients and their family physician or nurse practitioner.
- All partners in the local PCN will participate in information sharing and reporting within and between the local PCNs and with the rest of the health care system, based on provincial collaborative direction (under development), to support optimization of direct patient care, as well as quality improvement and planning at the community level. This is not a tool for quality assurance.
- The local PCN acknowledges and respects the clinical and business autonomy of a primary care practice.
- Standardization and consistency of provincial policy direction are set by the Ministry, and implementation is enabled through local decision making and flexibility in response to prioritized community needs.
- Support for implementation will occur through current collaborative structures and relationships, expanded to be inclusive of the local broader primary care service context as appropriate. New structures will be established only as needed to allow effective functioning of the system.
- The local PCN is intended to be inclusive of multi-disciplinary providers, where all providers are able to work to optimize their scope of practice.
- The local PCN will support the optimization of Patient Medical Homes, as the foundation of the local PCN, in the best interests of patients and the local population.
- The local PCN will support the optimization of UPCC, CHCs, FN PCC, NP Clinics and Foundry Clinics as key models of primary care service in the community. Ongoing iterative adjustments will be made as approaches are developed and tested, and measurement and evaluation metrics will be co-developed by the Parties.
- The local PCN will consult and engage with their community to ensure the needs of the community are met.
- The local PCN will seek to address disparities in primary care access, including, but not limited to, rural and First Nations patients.

Key Provisions

1. Collaborative Local Partnership

Collaborative local partnership is a hallmark feature of the local PCN. The CSC (or rural alternative) will establish the local PCN Steering Committee, in consultation with local PCN members, which will oversee the establishment and ongoing operation of the local PCN in accordance with an approved service plan, will be accountable to the CSC to ensure ongoing shared governance, coordination and partnership.

The local PCN Steering Committee will be minimally comprised of local patient representatives, local First Nations representatives, physician representatives from local

primary care practices, nurse practitioner representatives, the Division, and the Health Authority. Other local partners may be invited to participate as members of the PCN Steering Committee at the discretion of the CSC.

Each PCN Steering Committee will be co-chaired by a (i) representative of the regional Health Authority and (ii) a Physician representative from the Division. A local First Nations representative will also be invited to co-chair the PCN Steering Committee.

2. PCN Resource Management

The Health Authority and Division will act as fund administrators for the local PCN in their region. The CSC will retain authority and accountability while the PCN Steering Committee will collaboratively make operational decisions with respect to allocation of funds and other resources to enable timely access to care for patients within the network (the "Fund Administrator(s)"). Specifically with respect to funding:

- Health Authorities will generally receive Ministry funding to contract physicians and nurse practitioners and to directly employ nursing and allied providers on behalf of the PCN;
- Divisions will generally receive Ministry funding for clinical service management and administration, change management and collaborative governance, and will contract or directly hire individuals to support those functions on behalf of the PCN.

Details regarding the operations of the PCN will be set out in a service plan developed by the local CSC and approved by the Ministry in writing (the "Service Plan"). Specific operational details will be further developed by the PCN Steering Committee.

3. Funding and Reporting

Upon acceptance of this agreement, the Ministry will provide funding to the Fund Administrator(s) for the current fiscal year in order to proceed with the implementation of the local PCN, in accordance with the approved Service Plan. These funds will be used by the Fund Administrator(s) only for the purposes of implementing the Service Plan.

The undersigned Parties acknowledge shared decision-making and accountability regarding the use of the local PCN funding in accordance with the Service Plan. The Fund Administrator(s) will provide financial and other reporting on regular intervals to the Ministry, as directed by the Ministry under separate cover.

Key Next Steps

This agreement is intended to confirm the Parties' intent to establish a local PCN in accordance with the minimum expectations and guiding principles set out above.

Please indicate your agreement to continue planning for the implementation of the local PCN in accordance with the terms summarized in this letter by signing below and returning to your Regional Director at the Ministry of Health.

On behalf of the GPSC, we look forward to continuing to work with your organization to meaningfully improve the impact of primary care delivery for the residents of BC.

Sincerely,

Ted Patterson, co-chair
General Practice Services Committee

Dr. Shelley Ross, co-chair
General Practice Services Committee

Signatures to the Local Primary Care Network

Interior Health Authority

Shannon Statham

Signing representative name

Signature

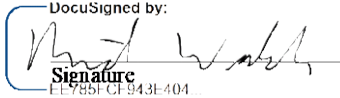
March 27, 2020

Date

East Kootenay
Division of Family Practice

Dr. Mike Walsh

Signing representative name



Signature

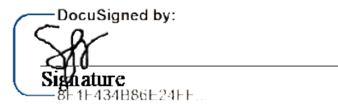
March 27, 2020

Date

Ktunaxa Nation
First Nations Organization

Shawna Janvier, CAO

Signing representative name



Signature

March 27, 2020

Date

GPSC
General Practice Services Committee

Primary Care Networks Collaborative Governance - Roles and Responsibilities

The vision for primary care is to enable access to quality primary health care that effectively meets the needs of patients and populations in BC, using the patient medical home as the foundation for care delivery within a broader, integrated system of primary and community care.

A key component for achieving this vision is the implementation of primary care networks (PCNs) across the province with specific attention to enhancing capacity and patient access through team-based primary care services. PCNs are clinical networks of local primary care providers and community service organizations that collectively meet the comprehensive primary care needs of a geographic population. PCNs link together and integrate patient medical homes, Urgent and Primary Care Centers (UPCCs), Community Health Centers (CHCs), health authority primary care services, First Nations Primary Care Clinics, Indigenous health organizations and non-governmental community agencies; and link with a range of specialized community service programs including those focused on serving complex medical and/or frail adults; and mental health and addictions.

Patient medical homes (PMH) are the cornerstone of PCNs. A PMH is an evidence-based practice model that supports the delivery of key service attributes associated with full service, longitudinal primary care. In a PMH, family physicians and nurse practitioners work to their full scope and are complimented by a team of health care professionals either in practice or connected to their practice through their PCN.

Principles

There is a long history of collaboration and partnership in primary care in BC, expressed provincially through the GPSC, representing the strategic partnership of the Doctors of BC and Ministry of Health, supported by the Health Authorities. This collaborative approach is expressed locally through Collaborative Services Committees (CSC), representing Divisions of Family Practice and Health Authority as key partners, supported by the Ministry, Doctors of BC, the GPSC, First Nations Health Authority, local First Nations and community partners; and regionally through the CSC Interdivisional Strategic Councils.

In moving forward to redesign the system around primary care, the partners have committed to the following principles in the planning and design of system changes through Primary Care Networks:

- **The patient is at the centre of the local PCN.** Care is designed to be patient centered; as well as culturally safe through shared design and delivery of primary health care with First Nations in BC consistent with the Government of BC's commitment to true, lasting reconciliation with First Nations in BC by fully adopting and implementing the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), and Calls to Action of the Truth and Reconciliation Commission.
- The local PCN recognizes the importance of family and community in supporting patient care.
- The local PCN is intended to respect and preserve the longitudinal relationship between patients and their family physician or nurse practitioner.

British Columbia

doctors of bc

- All partners in the local PCN will participate in information sharing and reporting within and between the local PCNs and with the rest of the health care system, based on provincial collaborative direction (under development), to support optimization of direct patient care, as well as quality improvement and planning at the community level. This is not a tool for quality assurance.
- The local PCN acknowledges and respects the clinical and business autonomy of a primary care practice.
- Provincial policy direction, standardization and consistency are set by the Ministry of Health, and implementation is enabled through local decision making and flexibility in response to prioritized community needs.
- Support for implementation will occur through current collaborative structures and relationships, expanded to be inclusive of the local broader primary care service context as appropriate. New structures will be established only as needed to allow effective functioning of the system.
- The local PCN is intended to be inclusive of multi-disciplinary providers, where all providers are able to optimize their scope of practice.
- The local PCN will support the optimization of Patient Medical Homes as the cornerstone of the local PCN in the best interests of patients and the local population.
- The local PCN will support the optimization of UPCC, CHCs, FN PCC, NP Clinics and Foundry Clinics as key models of primary care service in the community
- Ongoing iterative adjustments will be made as approaches are developed and tested, and measurement and evaluation metrics will be co-developed by the Parties.
- The local PCN will consult and engage with their community to ensure the needs of the community are met.
- The local PCN will seek to address disparities in primary care access, including, but not limited to, rural and First Nations patients.

Roles and Responsibilities:

1. Primary Care Network Steering Committee

Established by the local CSC, the PCN SC has primary responsibility and oversight to operationalize the PCN clinical services, as defined in the PCN service plan and as part of the local network of primary care services. The PCN SC will be co-chaired by a practicing physician member of the local division, and a Health Authority representative. A local First Nations representative may also co-chair the PCN Steering Committee. The local PCN Steering Committee will be minimally comprised of local patient representatives, local First Nations representatives, physician representatives from local primary care practices, nurse practitioners, the Division, and the Health Authority. Other local partners may be invited to participate as members of the PCN Steering Committee at the discretion of the CSC. Decisions in regards to the operations of the local PCN will be made by consensus, consistent with existing primary care governance committees.

2. Collaborative Services Committees (CSC)

Community based Collaborative Services Committees are co-led by Health Authority Primary and Community Care leadership and Division of Family Practice leadership. The CSC governs local Primary Care Networks and facilitates broad engagement of providers and key community partnerships including local FN service provider organizations, community agencies and service providers, patients and families. They provide PCN strategic leadership with respect to establishment of local PCN Steering Committee(s), PCN design and implementation, SCSP alignment, and analysis of data to help identify community care needs and outcomes.

3. Regional Health Authorities

Regional Heath Authorities (HAs) provide integrated and effectively linked primary and community care services to the Primary Care Network and PMHs. HAs act as a co-chair of local Collaborative Services Committees (CSC), and participate in the PCN Steering Committee (PCN SC), which is formed by the CSC to coordinate the operations and implementation of the PCN. The HA is a signatory to information and data sharing agreements in support of the PCN and linked SCSP services. Health Authorities provide fund administration and contract management for team based clinical providers (RNs and Allied Health Providers) as well as new GP and NP service contracts. Decisions regarding hiring, and deployment of these providers will be made through the CSC and PCN steering committee partnership, and these clinicians will be working under the clinical coordination and direction of the PCN SC and the practices.

Regionally, the HA participates as an ISC co-chair partner and helps to ensure regional alignment and local support of HA primary care services and SCSPs. Provincially, the HAs participate in the PCC Advisory Forum and GPSC.

4. Divisions of Family Practice

Divisions of Family Practice (Divisions) are community-based networks of family physicians, and NPs in some cases organized into not for profit societies with funding and support from GPSC through the Physician Master Agreement. Divisions provide support to their members in the delivery of primary care, and implement GPSC funded and supported initiatives such as, Patient Medical Home enhancements, Primary Care Network implementation, and Residential Care and Hospital Care initiatives in agreement with GPSC. Divisions support clinical network development and work in partnership with their local HA and other community partners through the Collaborative Services Committee to examine gaps in health care in their community and to address these gaps.

Together with the HA and other community partners, the Division contributes to the design and governance of local PCNs, and facilitates broad engagement as a co-chair of the Collaborative Services Committee. The division provides a practicing physician co-chair to the PCN Steering Committee which is formed by the CSC to oversee the operations of the PCN. The division provides fund administration and contract management for change management and PCN clinical coordination and administration, with hiring, and management of these supports being made through the PCN steering committee partners. As a principle partner, the division helps to enable community information and data sharing in support of the PCN. The division advises GP and NP members on local, regional and provincial direction and issues related to implementation of PCNs and patient medical homes, UPCCs, and CHCs in local communities and SCSP developments; it informs and participates in SCSP alignment/linkages through the CSC.

Regionally, the divisions participate in interdivisional Strategic Councils; they provide physician leadership including a co-chair to these regional strategic committees. Provincially, they provide input to the GPSC with respect to GPSC funding initiatives and policy/practice issues related to implementation of PCNs and patient medical homes, UPCCs, and CHCs in local communities and SCSP developments. They are a participant in the provincial PCC Advisory Forum.

5. Interdivisional Strategic Councils (ISC)

Interdivisional strategic councils are a regional forum including representatives of all Division and HA Primary Care leads within a region. They provide an opportunity for information sharing and problem solving and help to ensure strategic alignment of PCNs and primary care services within a HA region. They provide HA and Divisional representation to the provincial PCC Advisory Forum in consultation with the HA and GPSC. They advise the Primary and Community Care Advisory Forum and GPSC on issues related to PCN implementation and SCSP alignment, and GPSC on issues related primarily to PMH implementation. The ISC advises local Collaborative Services Committees on regional issues related to PMH/PCN implementation and SCSP alignment.

6. General Practice Services Committee (GPSC)

The GPSC is a strategically important collaborative committee between the Doctors of BC and the Ministry which includes HA and Division participation. It is the leading collaborative table for primary healthcare transformation in BC, supporting the creation of Patient Medical Homes (PMHs) and the implementation of Primary Care Networks (PCNs) enabled by team-based care.

It advises the Ministry of Health with respect to key issues regarding primary and community care policy framework and implementation. It supports and facilitates partnership and inter-professional tables at the local, regional, and provincial levels and provides communication to physicians on shared provincial direction related to primary care. It provides governance and deployment of GPSC resources in support of full-service family practice and broader primary care reform.

The GPSC is responsible for the support and provincial oversight of PMH policy implementation through physician engagement and leadership, and provides in-practice coaching and supports, incentives, and technology supports for family practices to provide team-based, comprehensive, longitudinal care. GPSC was the creator of the Divisions of Family Practice, provides policy direction to Divisions, and is responsible for governance, financial, and other support to Divisions.

The GPSC supports PCN development and delivery through support of the PMH as the cornerstone of PCN, physician incentives, funding to divisions, communication tools and resources, and support of physician leadership, engagement and partnerships, ensuring inclusion of NPs and AHPs as appropriate in PCN planning and implementation at the local, regional, and provincial levels.

7. Nurse Practitioner Council of Nurse and Nurse Practitioners of BC (NPC)

NNPBC is the Association for nurses and nurse practitioners in BC and advances all nursing designations through advocacy, education and leadership. They provide strategic advice to other provincial bodies and local PCNs on the implementation of LPN, RPN, RN, and NP roles and provide ongoing role clarity relevant to PCN implementation.

The Nurse Practitioner Council (NPC) of NNPBC provides strategic advice and influence on primary care

policy and is a member of both the Primary and Community Care Advisory Forum and GPSC. In its advocacy role for NPs, the NPC reviews NP contracts and agreements. As a member of the NP Provincial Services Committee, a collaborative committee between the MOH and NNPBC, the NNPBC, in collaboration with the NPC, will provide a Practice Support and Leadership Program for NPs in PCNs in the coming months.

8. Primary and Community Advisory Forum

This provincial forum, chaired by the Ministry of Health, has been developed to advise Ministry decision making on BC's health system transformation agenda through collaboration and consensus. Specifically, it will allow partners to:

- Share information and provide advice regarding the implementation of Primary Care Network (PCN) policy (including Urgent and Primary Care Centres, Community Health Centres, NP Primary Care Clinics, First Nations Primary Care Clinics and Foundry Clinics) and Specialized Community Service Programs (SCSP) policy for Mental Health and Substance Use & Adults with Complex Medical Conditions and/or Frailty;
- Provide updates on progress, challenges, and issues;
- Seek advice on how best to continue to move work forward and how to resolve issues.

It has a broad membership reflective of the PCC partners. This includes 5 regional divisions of family practice physician representatives, 5 regional HA representatives, and representation from Nursing and Nurse Practitioner association, First Nations Health Authority, allied health, public health, and patient representation.

9. Doctors of BC

In its strategic collaboration with the Ministry of Health through the GPSC, Doctors of BC (DoBC) also holds joint accountability for the Patient Medical Home policy and implementation and for community engagement and local implementation of the PCN. DoBC provides strategic advice and influence to the primary care policy direction, and is a participant in the provincial Primary and Community Care (PCC) Advisory Forum. Doctors of BC employs staff for the collaborative committees and provides administrative and practice support services on behalf of GPSC. DoBC also communicates to its members as needed regarding the PMH/PCN policy and implementation. In its advocacy role for physicians and its commitment to helping achieve the highest standard of health care, DoBC participates in the development of physician payment models and reviews physician contracts and agreements.

10. First Nations Health Authority (FNHA)

FNHA will work collaboratively to provide strategic advice, resources and supports to other provincial bodies and local PCNs as needed related to relevant issues and programs for indigenous populations; in order to enhance and enable cultural safety and humility at the local level; and to support information sharing across all local PCN and Specialized Community Service Programs. FNHA is a member of the Provincial PCC Advisory Forum and plays a key role in planning, implementation and oversight of FN Primary Care Clinics provincially, regionally and locally,

11. Provincial Health Services Authority (PHSA)

PHSA will communicate collaboratively with other provincial bodies and with local PCNs as needed on issues relevant to the PCN program and with effective linkages to SCSPs, and will support information sharing across all local PCN and Specialized Community Service Programs.

12. Ministry of Health

The Ministry of Health holds the overall accountability and funding for the health care system. Through the General Practice Services Committee (GPSC) it holds joint accountability for the support and establishment of the Patient Medical Home as the ideal primary care practice and the cornerstone for Primary Care Networks and for community engagement and local implementation of the PCN The Ministry is responsible for the PCN, Team Based Care and Specialized Community Service Program (SCSP) policy development, oversight, funding and accountability. The Ministry provides data for regional and local planning and evaluation, and oversees ongoing monitoring and evaluation and policy revisions. In addition, the Ministry is developing and evaluating new physician payment models and contracts in support of this work

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May 6, 2020

Dr. Todd Loewen, East Kootenay CSC Co-Chair, East Kootenay Division of Family Practice
Ms. Shannon Statham, East Kootenay CSC Co-Chair, Interior Health Authority
Ms. Megan Purcell, Executive Director, East Kootenay Division of Family Practice
Mr. Bart H Knudsgaard, PCN Lead, Ktunaxa Nation
Ms. Debbie Whitehead, Director of Social Investment Sector, Ktunaxa Nation
Ms. Codie Morigeau, Social Investment Sector Chair, Ktunaxa Nation

Dear PCN Steering Committee:

Thank you very much for submitting your completed Primary Care Network (PCN) Service Plan and for taking the time to undertake such substantial and significant primary care planning for your communities. We recognize the hard work and collaboration it has taken to get to this point – congratulations!

As you know well, PCNs are intended to be the over-arching structure that links together the various primary care service providers and organizations in a community in order to provide comprehensive primary care services. Through the collaborative local development of PCNs, we will over time transform the way primary care services are delivered and improve the way British Columbians access every day health care so that they can get the care they need, when and where they need it.

As you know, you are part of the second cohort of PCNs to submit Service Plans, with the first cohort well underway with implementation. As a result of that work, the Ministry of Health (the Ministry) has incorporated lessons learned into the new PCN implementation process. The process, outlined below, is intended to better support PCNs to make measured progress and demonstrate success in terms of implementing their plans on reasonable implementation timelines.

Service Plan Approval

I am pleased to inform you that your PCN Service Plan has been approved as outlined in Schedules 1 and 4. The implementation of the PCN Service Plan and associated funding is to be managed collaboratively by you, the PCN Steering Committee.

Your Service Plan proposal was assessed based on a standardized funding framework to ensure equity of opportunity among the various PCN proposals from across the province. Consideration was given to demonstrated need in the community alongside the eight core attributes of a PCN, with implementation phased to ensure overall funding sustainability.

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Ministry of Health
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Assistant Deputy Minister
Ted Patterson

PO Box 9638 STN PROV GOVT
Victoria BC V8W 9P1

PCNs are to ensure a collaborative governance structure, with all funding provided by the Ministry for the PCN to be administered at the joint direction of the partners through the PCN Steering Committee. All funds allocated to either the Health Authority, the Ktunaxa Nation via subsequent flow-through from the Health Authority, or the Division of Family Practice are to be considered a flow-through and are to be drawn-down/ expensed at the direction of the PCN Steering Committee. The funding to be allocated to the Steering Committee for fiscal year 2020/21, through both the Division of Family Practice and Health Authority, is outlined in Schedules 5 and 6.

Four-year Implementation/ Funding Allocations

One of the key takeaways from the first cohort of PCN communities is that getting started with PCN implementation requires considerable time and effort as PCN partners identify and work through various issues that may arise. As a result, we have adjusted the implementation timeframe for PCNs from three years to four years, (i.e., 2020/21 to 2023/24) as outlined in schedule 5. Budgets will be allocated annually, and PCNs will receive a targeted percentage increase each year, based on successful recruitment and achievement of deliverables. This will allow PCNs to show tangible progress at a managed pace while also ensuring we appropriately manage cash flows.

In year one (2020/21), you will receive 20% of your overall budget for hiring clinical positions; in year two (2021/22) it will be increased to 45%, year three (2022/23) will lift to 70% and by year four (2023/24) you will have reached 100% of your targeted hiring budget. The PCN manager and administrative staff will be fully funded beginning in year one, in recognition that these are crucial roles to the overall success of your PCN and should be hired right away. Annual PCN governance costs are also fully funded beginning in year one.

The PCN will be required to demonstrate results achieved with the annual targeted funding (refer to Schedule 2 Reporting requirements) before additional funds will be allocated. If your PCN is able to successfully meet your annual implementation target and deliverables at an accelerated rate during any year, consideration will be given by the Ministry to provide additional annual funding in that year to continue to support an accelerated rate of implementation.

One-time funding for change management has been allocated based on plans submitted by your PCN over the next three years as outlined in schedule 8. Other requests for one-time funding for tenant improvements, capital and start-up will need to be discussed with your MoH/GPSC Liaisons based on pacing of PCN implementation.

In addition, going forward the Ministry will hold funding for family physician positions centrally and will allocate it to communities as needed upon a successful recruitment. This means, if a new-to-practice family physician is recruited on a Service Contract or a physician with an existing patient panel signs a Service Contract (presently under development with Doctors of BC), simply inform the Ministry and the funds will be provided accordingly. The recruitment and onboarding process will not change for fee for service family physicians; however, you will be required to report new fee for service physicians recruited in a PCN (further details in Schedule 2 - Reporting Requirements).

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Also important in the early work to implement your PCN will be establishing a plan for communications with patients and providers. We are, therefore, asking all PCN Steering Committees to ensure that they have a targeted communications plan in place. This should include, for example, consideration of local health promotion and patient self-management information to help patients become active participants in their own health through the PCN. Part of this work will also include working with HealthLink BC on your dedicated PCN public facing website.

Demonstrating Progress and Reporting

The Ministry appreciates the need to hire resources to begin implementation. In addition to reporting on implementation milestones (e.g., positions hired, funds expended) it is imperative that PCNs are also be able to demonstrate and report on tangible and meaningful progress for patients.

Based on the PCN attributes, it is important that your PCN can demonstrate that it is improving both access to primary care services for patients and increasing attachment.

Reporting will be expected on both a period, quarterly and annual basis. You will find a detailed reporting outlined in Schedule 2.

It will also be useful to keep track of positive progress through success stories or patient testimonials. The Ministry or GPSC may approach PCNs periodically to ask for updates on successes to date.

Next steps

The PCN Steering Committee is required to submit a budget plan for fiscal 2020/21 outlining what component(s) of the overall PCN service plan will be implemented in Year 1 and how funds allocated to both the Health Authority and Division of Family Practice will be drawn-down and spent. Details should include at a minimum: specific positions to be hired, tangible services to be delivered to patients, change management initiatives to be undertaken, communications activities and PCN governance. This plan will be the basis for reporting out to the Ministry to demonstrate/track your performance against key deliverables.

Schedules to this letter, will be updated as required (i.e. Schedule 4 - Overall Funding).

There are a number of resources available to you online through the PCN Toolkit. This Toolkit is updated regularly as new material is available, and we encourage you to check it regularly. Please reference Schedule 3 for a listing of current information that is available.

Again, thank you for your dedication to improving primary care for patients and providers in your community. If you have any questions about the information included in this funding letter, or its associated schedules, please contact your Ministry liaison.

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I look forward to continuing to work together to make your PCN a reality.

Yours sincerely,

Ted Patterson
Assistant Deputy Minister
Primary Care Division
Ministry of Health

pc: Ms. Donna Lommer, Chief Financial Officer, Interior Health Authority
Ms. Shawna Janvier, Chief Administrative Officer, Ktunaxa Nation
Ms. Lynn Armstrong, Director of Finance, Ktunaxa Nation
Ms. Roberta Vansteinburg, Manager of Finance, Ktunaxa Nation
Ms. Kelly McQuillen, Executive Director, Primary Care Division
Mr. Philip Twyford, Assistant Deputy Minister, Finance and Corporate Services
Ms. Kerri Harrison, Executive Director, Finance and Corporate Services
Mr. Gordon Cross, Executive Director, Regional Grants and Decision Support

Attachments:

Schedule 1 – PCN Approval Letter
Schedule 2 – Reporting Requirements
Schedule 3 – Administrative Requirements
Schedule 4 – Resource Summary
Schedule 5 – Budget Allocation
Schedule 6 – Funds Transfer Agreement
Schedule 7 – Attachment and Compensation
Schedule 8 – Change Management

Schedule 1 – East Kootenay PCN Approved Strategies and Resources

The approved resources for the East Kootenay PCN outlined below will address the Ministry's priority to close the attachment gap by 18,217 and provide team-based care through interdisciplinary teams of nursing and allied health professionals.

Supporting Attachment – Family Physician (FP), Nurse Practitioner (NP) and Register Nurse (RN)

- The Ministry approves the addition of 19.6 FTE primary care resources to support attachment in the general population. These resources will generate capacity to attach net new patients.
    - 12.6 FTE RNs (5,040 attachment target)
    - 6.0 FTE FPs (4,800 attachment target)
        - 1.0 FTE Alternative Payment Program (APP) Contract in Sparwood (attachment target 800)
        - 2.2 FTE Service Contract (attachment target 1,760)
        - 2.8 FTE FFS FPs (attachment target 2,240)
    - 1.0 FTE NP (attachment target 800)
- Target attachment for these new resources is 10,640 by year 4 (2022/2023).
- An overhead provision for each of the positions listed above has been provided for non-clinical and non-wage related costs.

Supporting Attachment and Vulnerable Populations – Swaps

- The Ministry supports the provision of team-based care to support attachment and vulnerable populations in the community; and approves the addition of 9.9 Allied Health Professionals (AHP).
    - 8.1 FTE Social Worker (2,430 attachment target)
    - 1.8 FTE Mental Wellness Clinician (Masters level Social Worker) (540 attachment target)
- Target attachment for these new resources is 2,970 by year 4 (2022/2023).
- An overhead provision for each of the positions listed above has been provided for non-clinical and non-wage related costs.

Allied Health Professional Teams

- The Ministry supports the provision of team-based care across East Kootenay through the approval of the following resources:
    - 13.0 FTE AHPs
        - 10.0 FTE AHPs to be placed at the discretion of the PCN Steering Committee
        - 1.0 FTE AHP to provide services within the rural node of Golden (CHSA 1160)
        - 1.0 FTE AHP to provide services within the rural node of Kimberley (CHSA 1160)

        - 1.0 FTE AHP to provide services within the rural node of Windermere (CHSA 1160)
    - 1.0 FTE Clinical Pharmacist
- An overhead provision for each of the positions listed above has been provided for non-clinical and non-wage related costs.

General Practice – Focus on Special Populations

- These resources provide enhanced team-based care to sub-populations (Child and youth mental health and substance use, Men's health, Oncology, Geriatric/Medically Frail, Adult Substance Use and Maternity) in Golden and Creston:
    - 1.0 FTE FP in Golden to support the attachment of 800 patients
    - 0.4 FTE FP in Creston to support the attachment of 320 patients
- Target attachment for these new resources is 1,120 by year 4 (2022/2023).
- The above resources were requested in the form of sessional payments. The Ministry commits to continued discussion with the PCN Planning Committee on the development of group contracts to support these strategies.
- Overhead provision for these positions (including administrative support) has been provided for non-clinical and non-wage related costs.

Extended Hours Services

- The Ministry supports the provision of urgent primary care and extended hours services in Cranbrook and Kimberley to facilitate improved access and attachment to primary care resources.
- The provision of these services will also provide net new capacity for patient attachment to primary care providers in the community:
    - 2.2 FTE FP to support episodic extended hours care:
        - 1.2 FTE FP in Cranbrook (attachment target 672)
        - 1.0 FTE FP in Kimberley (attachment target 560)
    - 2.0 FTE RN to support the attachment 800 patients
        - 1.0 FTE RN in Cranbrook (attachment target 400)
        - 1.0 FTE RN in Kimberley (attachment target 400)
- In addition, 1.6 FTE Medical Imaging and 1.5 FTE Lab assistants have been requested to support these services. The Ministry is at this time providing notional approval; final approval is subject to further discussion and scoping. The Ministry commits to working with the PCN Planning Committee to support the addition of these services.
- Target facilitated attachment for the FP and RN new resources is 2,032 by year 4 (2022/2023).
- The above FP resources were requested in the form of a FP group contract to support episodic extended hours care. The Ministry supports and acknowledges the importance of access to timely and appropriate medical care and recognizes the need for extended hours primary care in this area. The Ministry commits to continued discussion with the PCN Planning Committee on the provision of urgent primary care and extended hours services to determine the most appropriate compensation model.

- The Ministry acknowledges that this model of care reflects both access to urgent primary care and the provision of extended hours for primary care in the community; attachment targets have been reduced to 70 per cent accordingly. Continued discussion will be supported to ensure attachment targets fit the needs of the community with this model of care.

Additional Support for Aboriginal Health and Care in East Kootenay

- These resources provide focussed care to the Lower Kootenay Band in Creston and the Ktunaxa Health Centre in Cranbrook and have lowered primary care provider attachment targets.
- The resources will facilitate the attachment of net new patients:
    - 0.7 FTE FP (attachment target 455)
    - 1.0 FTE NP (attachment target 600)
    - 1.0 FTE RN (attachment target 400)
- Target attachment for the FP, NP, and RN is 1,455 by year 4 (2022/2023).
- The above FP resources were requested in the form of sessional payments. The Ministry commits to continued discussion with the PCN Planning Committee on the development of group contracts to support these strategies. The following additional resources to support Aboriginal health and wellness are approved:
    - 3.0 FTE Aboriginal Health Coordinators
    - 1.0 FTE Elder equivalent
- Funding for the equivalent of 1.0 FTE Elder has been approved to support Elder honoraria and associated services throughout the East Kootenay region.

East Kootenay PCN Early Draws

- East Kootenay PCN has accessed $191,044 of funding for the implementation in advance of the funding letter.
- The amount of $191,044 has been accounted for in the overall Primary Care Network funding for East Kootenay PCN community. This amount is included in Schedule 5- PCN Budget Allocation.

The Ministry is supporting a collaborative governance model. All funds provided to either the health authority or the division are a flow-through for the purposes of the PCN and will be deployed at the direction of the partnership.

The Ministry will allocate 5% of the overall PCN budget (over 3 years) to cover a portion of the overall change management costs through this approval. Further discussions will take place to ensure the spend is in alignment with approved Change Management parameters.

The Ministry will flow funds for nurse practitioners, nursing and allied health professionals through the health authority, and will flow funds for the PCN administrative costs and change management supports through the Division of Family Practice. Funds for family physician services will be available as required, as the funding source is dependent on the compensation model required by the provider. All funds will be administered at the joint direction of the

partners through the PCN Steering Committee. If applicable, First Nation or Indigenous Health Serving Organization resources will be provided via a subsequent flow through from the Health Authority.

An annual provision of $40,000 for PCN Collaborative Governance related costs is provided. This funding envelope is to support the governance structure.

The PCN will receive additional funding for one PCN manager and administrative position to manage the requirements of the East Kootenay PCN.

East Kootenay has requested a total of $6,350,000 for one-time and capital costs. The Ministry will continue to dialogue with you about this request. Funding requests for one time, capital and tenant improvements will be reviewed once the implementation plan for year one is clarified, and will be supported through a separate process.

Schedule 2 – Reporting Requirements

The Ministry will monitor the implementation of the PCN against the service plan approval and implementation schedule on a period, quarterly and annual basis through an online portal developed and maintained by the Ministry; Health Authority financial reporting will take place through the Health Authority Management Information System (HAMIS). The requirements in this section will be a collaborative effort between Division of Family Practice, Regional Health Authority and other signatories on the Letter of Intent.

Period Reporting

Period reporting will be required for the following:

a) Spend by category
b) Spend to date in the fiscal year by category
c) Forecast spend per category for the remainder of the fiscal year
d) Number of FTEs hired and removed in each category (e.g., Family Physicians (both Fee-For-Service and Contract), Nurse Practitioners, Registered Nurses, Allied Health (by profession), PCN Management), changes in hours, and associated cash flow
e) Other indicators as determined collaboratively to support quality improvement, evaluation, and to determine the efficacy of the initiative

Health Authority Management Information System (HAMIS)					
Reporting Periods					
Fiscal year 2020/2021 - period start/end dates					
Period	Start Date	End Date	No. of Days	Cumulative Days	HAMIS Due Date (3 weeks)
01	01-Apr-2020	30-Apr-2020	30	30	**21-May-2020**
02	01-May-2020	28-May-2020	28	58	**18-Jun-2020**
03	29-May-2020	25-Jun-2020	28	86	**16-Jul-2020**
04	26-Jun-2020	23-Jul-2020	28	114	**13-Aug-2020**
05	24-Jul-2020	20-Aug-2020	28	142	**10-Sep-2020**
06	21-Aug-2020	17-Sep-2020	28	170	**08-Oct-2020**
07	18-Sep-2020	15-Oct-2020	28	198	**05-Nov-2020**
08	16-Oct-2020	12-Nov-2020	28	226	**03-Dec-2020**
09	13-Nov-2020	10-Dec-2020	28	254	**31-Dec-2020**
10	11-Dec-2020	07-Jan-2021	28	282	**28-Jan-2021**
11	08-Jan-2021	04-Feb-2021	28	310	**25-Feb-2021**
12	05-Feb-2021	04-Mar-2021	28	338	**25-Mar-2021**
13	05-Mar-2021	31-Mar-2021	27	365	**22-Apr-2021**
PA	01-Apr-2020	31-Mar-2021	365		**28-Jun-2021**

Quarterly Reporting

Quarterly reporting will be required for the following:

a) Allied Health visits (both unique visits and number of unique patients served)
b) Implemented enhanced hours of service (when there is a change in hours)
c) Other indicators as determined collaboratively to support quality improvement, evaluation, and to determine the efficacy of the initiative

Annual Reporting

Annual indicators will include the above, as well as an increased focus on all eight attributes of PCN. It may be used to inform a co-developed evaluation framework.

The East Kootenay PCN Steering Committee will ensure that an Annual Report is updated and submitted to the Ministry by June 1 of each year. The Ministry will provide a template for the report, which will include:

a) Review of Service Plan for the previous year
b) Demonstration of progress toward PCN attributes
c) Highlights of local PCN governance matters
d) Completed financial reporting for the fiscal year
e) Progress against local quality improvement plan
f) Anticipated changes to services in the upcoming year

The template for the 2019/2020 PCN Annual Report is currently under development. This template is being shared for input and will be used as the basis for the 2020/21 PCN Annual Report Template. The template will include financial indicators and indicators to measure PCN progress against each of the 8 PCN Attributes.

PCN Attributes:

1. Process for ensuring all people in a community have access to quality primary care, and are attached within a PCN.
2. Provision of extended hours of care including early mornings, evenings and weekends.
3. Provision of same day access for urgently needed care through the PCN or an Urgent Primary Care Centre.
4. Access to advice and information virtually (e.g. online, text, e-mail) and face to face.
5. Provision of comprehensive primary care services through networking of PMHs with other primary care providers and teams, to include maternity, inpatient, residential, mild/moderate mental health and substance use, and preventative care.
6. Coordination of care with diagnostic services, hospital care, specialty care and specialized community services for all patients and with particular emphasis on those with mental health and substance use conditions, those with complex medical conditions and/or frailty and surgical services provided in community.

7. Clear communication within the network of providers and to the public to create awareness about and appropriate use of services.
8. Care is culturally safe and appropriate.

The data in the Annual Report will be supplied from a variety of sources including:

- Primary Care Networks
- Ministry of Health
- General Practice Services Committee

Further information concerning reporting requirements will be provided under separate cover.

Schedule 3 – Administrative Requirements

Attachment Reporting

All family physicians and nurse practitioners participating in the PCN are required to use the zero-fee attachment code to identify new patients attached to their practice as described in the PCN Service Plan Approval. The attachment code for East Kootenay is 97634.

Further information regarding attachment reporting can be found here: https://www.pcnbc.ca/en/pcn/permalink/pcn90

Encounter Reporting

Family Physicians and Nurse Practitioners under service contract are required to encounter report as per their service contract.

Further information regarding encounter reporting for Family Physicians on PCN service contracts can be found here: https://www.pcnbc.ca/en/pcn/permalink/pcn93

Contracted and Health Authority employed Nurse Practitioners are also required to encounter report as described here: https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/7-encounter-codes.pdf

PCN-funded Registered nurses (RNs) and licensed practical nurses (LPNs) are required to encounter report through the Medical Service Plan Teleplan system for services provided.

Teleplan Setup and Encounter Record Submission Procedures for PCN-funded practitioners who are required to encounter report (including contracted GPs and NPs, and Health Authority employed RNs and LPNs) can be found here: https://www.pcnbc.ca/en/pcn/permalink/pcn91

Forthcoming RN/LPN manual and developments with encounter reporting will be posted to the PCN Toolkit as it is available (Primary Care Network Toolkit).

Roles and Responsibilities

There is a long history of collaboration and partnership in primary care in BC, expressed provincially through the GPSC, representing the strategic partnership of the Doctors of BC and Ministry of Health, supported by the health authorities. This collaborative approach is expressed locally through Collaborative Services Committees (CSC), representing divisions of family practice and health authority as key partners, supported by the Ministry, Doctors of BC, the GPSC, First Nations Health Authority, local First Nations and community partners; and regionally through the CSC Interdivisional Strategic Councils.

In moving forward to redesign the system around primary care, the partners have committed to the following principles in the planning and design of system changes through primary care networks:

- The patient is at the centre of the local PCN. Care is designed to be patient centred; as well as culturally safe through shared design and delivery of primary health care with First Nations in BC consistent with the Government of BC's commitment to true, lasting reconciliation with First Nations in BC by fully adopting and implementing the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), and Calls to Action of the Truth and Reconciliation Commission.
- The local PCN recognizes the importance of family and community in supporting patient care.
- The local PCN is intended to respect and preserve the longitudinal relationship between patients and their family physician or nurse practitioner.
- All partners in the local PCN will participate in information sharing and reporting within and between the local PCNs and with the rest of the health care system, based on provincial collaborative direction (under development), to support optimization of direct patient care, as well as quality improvement and planning at the community level. This is not a tool for quality assurance.
- The local PCN acknowledges and respects the clinical and business autonomy of a primary care practice.
- Standardization and consistency of provincial policy direction are set by the Ministry of Health, and implementation is enabled through local decision making and flexibility in response to prioritized community needs.
- Support for implementation will occur through current collaborative structures and relationships, expanded to be inclusive of the local broader primary care service context as appropriate. New structures will be established only as needed to allow effective functioning of the system.
- The local PCN is intended to be inclusive of multi-disciplinary providers, where all providers are able to work to optimize their scope of practice.
- The local PCN will support the optimization of patient medical homes as the cornerstone of the local PCN in the best interests of patients and the local population.
- The local PCN will support the optimization of Urgent and Primary Care Centres, Community Health Centres, First Nations Primary Care Clinics, Nurse Practitioner Clinics and Foundry Clinics as key models of primary care service in the community.
- Ongoing iterative adjustments will be made as approaches are developed and tested, and measurement and evaluation metrics will be co-developed by the Parties.
- The local PCN will consult and engage with their community to ensure the needs of the community are met.
- The local PCN will seek to address disparities in primary care access, including, but not limited to, rural and First Nations patients

Further information about roles and responsibilities and additional information on Primary Care Networks can be found on the [Primary Care Network Toolkit](#).

Primary Care Network Management

The CSC and PCN Steering Committee will ensure the following management functions are undertaken on behalf of the partnership:

a. Administer PCN in accordance with the Service Plan approval;
b. Review the PCN's finances on a period basis and be accountable for expenditure of funds;
c. Ensure reporting to the Ministry as outlined in the appendices;
d. Submit an implementation plan to the Ministry for each fiscal year based on established cashflow/budget targets;
e. Ensure an annual progress report is updated and submitted to the Ministry annually by July 1 of each year;
f. Manage patient attachment to applicable PCN members from the provincial Health Connect Registry, once available;
g. Provide notification to the Ministry as soon as it is aware of any event that could materially impact the ability of the local PCN to meet its goals or obligations under the PCN service plan approval;
h. Dialogue regularly with the Ministry to mitigate issues and problem solve as needed.

The PCN Steering Committee, utilizing the funds flowed through to the Division of Family Practice, shall hire a PCN Manager and administrative support for the PCN to:

(i) provide overall project leadership for the implementation of the primary care initiative within the PCN, which includes working with Patient Medical Home (PMH) programs/services, primary care providers, the regional health authority, community agencies, and other stakeholders;

(ii) work with the Division and other local groups to facilitate engagement of physicians, nurse practitioners, nurses, allied health and other community member participation in the PCN;

(iii) provide project management services, which includes proposal development, establishment of the governance structure and operational plan, identification and management of the operating budget, including resource allocation, development of an implementation plan, and completion of necessary reports and evaluation;

(iv) establish operational procedures/resources as required to ensure consistent practice across regional PCN(s);

(v) ensure the Ministry of Health reporting and deliverables for the Funding are achieved.

(vi) assist in the selection and monitoring of performance indicators at the local level and preparation of reports as referenced in Article 5; and

(vii) participate in identifying opportunities for improvement in processes designed to facilitate access and improved quality of care for populations served by the PCN.

(viii) ensure the execution of a communications, marketing and health promotion plan.

PCN Governance

The PCN Steering Committee, utilizing the funds flowed to the Division of Family Practice, shall ensure the governance requirements outlined in the Interim Letter of Intent signed by the Division, Health Authority and First Nations partner(s) are provided within the Funding envelope. No additional funds will be made available for the governance functions required by the PCN Steering Committee, including advisory committees and working groups.

Appendix – RN and LPN Encounter Codes

RN/ LPN ENCOUNTER CODES

FEE CODE	TITLE
IMMUNIZATIONS	
38010	NIPCP IMMUNIZATION-PATIENT <19 YRS-DTAP-IPV
38011	NIPCP IMMUNIZATION-PATIENT <19 YRS-DTAP-IPV-HIB
38012	NIPCP IMMUNIZATION-PATIENT <19 YRS-TD
38013	NIPCP IMMUNIZATION-PATIENT <19 YRS-TD/IPV
38014	NIPCP IMMUNIZATION-PATIENT <19 YRS-TDAP
38015	NIPCP IMMUNIZATION-PATIENT <19 YRS-INFLUENZA (FLU)
38016	NIPCP IMMUNIZATION-PATIENT <19 YRS-HEPATITIS A
38017	NIPCP IMMUNIZATION-PATIENT <19 YRS-HEPATITIS B
38018	NIPCP IMMUNIZATION-PATIENT <19 YRS-HIB
38019	NIPCP IMMUNIZATION-PATIENT <19 YRS-IPV
38020	NIPCP IMMUNIZATION-PATIENT <19 YRS-MEN-C
38021	NIPCP IMMUNIZATION-PATIENT <19 YRS-ACYW135
38022	NIPCP IMMUNIZATION-PATIENT <19 YRS-MMR
38023	NIPCP IMMUNIZATION-PATIENT <19 YRS-PCV13
38024	NIPCP IMMUNIZATION-PATIENT <19 YRS-PPV23
38025	NIPCP IMMUNIZATION-PATIENT <19 YRS-RABIES
38026	NIPCP IMMUNIZATION-PATIENT <19 YRS-VARICELLA
38027	NIPCP IMMUNIZATION-PATIENT <19 YRS-DTAP-HB-IPV-HIB
38028	NIPCP IMMUNIZATION-PATIENT <19 YRS-HPV
38029	NIPCP IMMUNIZATION-PATIENT <19 YRS-ROTAVIRUS
38030	NIPCP IMMUNIZATION-PATIENT <19 YRS-MMR/V
38035	NIPCP IMMUNIZATION-MMR -PATIENT >18 YEARS OF AGE
38038	NIPCP IMMUNIZATION-INFLUENZA- ADULTS WHO QUALIFY FOR FREE VACCINE
38041	NIPCP IMMUNIZATION-PNEUMOCOCCAL POLYSACCHARIDE (PPV23) For pts > 64 yrs of age or pts > 18 years of age whose health conditions qualify them for free vaccine or who reside in residential care or assisted living facilities. (pts < 19 yrs -bill 38024)
38042	NIPCP IMMUNIZATION HEPATITIS A - ADULTS AT RISK
38043	NIPCP IMMUNIZATION HEPATITIS B - ADULTS AT RISK
38044	NIPCP IMMUNIZATION-NOS (NOT OTHERWISE SPECIFIED) (includes oral polio vaccine, etc.)
38045	NIPCP CLIENT CONTACT FOR ADVERSE EVENT FOLLOWING IMMUNIZATION
MEDICATION	
38060	NIPCP MEDICATION USAGE INTERVENTIONS- The identification of a patient's drug related problems and recommendations for their resolution (i.e. inappropriate dosing, drug level monitoring, drug interactions, treatment of adverse drug reactions)

38061	NIPCP MEDICATION WORK-UP- The completion of a patient's drug history during a structured interview and through chart and pharmanet searches (upon obtaining patient consent)
38062	NIPCP MEDICATION THERAPY MONITORING-The regular monitoring of a patient's medication adherence and drug toxicity through structured interviews, especially for patients with complex medication regimens or patients that are confused, forgetful or less compliant about medications.
38063	NIPCP MEDICATION THERAPY COORDINATION - Liaising with community and hospital pharmacies in an effort to provide seamless care for a patient (i.e. coordinating refills, obtaining prescriptions, providing up to date information on the patient's current drug therapy, dispensing medication, obtaining approval for medications)
38064	NIPCP MEDICATION INFORMATION- Answering patient-specific medication information questions from health care professionals and patients (i.e. dosing, adverse effects, drug interactions, suggestions for therapy)
38065	NIPCP MEDICATION THERAPY COUNSELING-Counseling a patient on the appropriate use of the patient's medication(s), adverse effects, and monitoring via a structured interview (i.e. provision of drug information sheets, setting up weekly dosettes, setting up medication timers). **Claim must state start and end times**
VISIT	
38070	NIPCP REQUESTING ADVICE FROM AN NP/GP - Collaborate with team members to support nurses assessment of patient care
38071	NIPCP REFERRAL TO IN-CLINIC TEAM MEMBER - Reviews assessment with GP/NP and queries action that is outside of scope of practice
38072	NIPCP REFERRAL TO NON HEALTH SERVICE PROVIDER - Referral to community resources (e.g., any service provider that does not require an MSP referral)
38073	NIPCP - GP REFERRAL TO NURSE
38080	NIPCP VISIT - IN OFFICE (AGE 0-1) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38081	NIPCP VISIT - IN OFFICE (AGE 2-49) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38082	NIPCP VISIT - IN OFFICE (AGE 50-59) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38083	NIPCP VISIT - IN OFFICE (AGE 60-69) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38084	NIPCP VISIT - IN OFFICE (AGE 70-79) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38085	NIPCP VISIT - IN OFFICE (AGE 80+) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT

38195	NIPCP VISIT - CHRONIC DISEASE MANAGEMENT A visit to review ongoing management of a chronic disease. Visit activities include: reviewing patient's care plan; patient's health outcomes; monitoring condition subsequent to an intervention; discussing continuing care strategies; discussing various management options, such as life style/self-care, psychotherapy, pharmacological management; etc. Activities performed in visit are generally brief discussions; however, if more elaborate discussion occurs, bill separate encounter code in addition visit encounter (e.g., education nutrition, medication therapy monitoring, etc.) **Claim must state start and end times.**
38116	NIPCP ROUTINE HEALTH HISTORY - NEW PATIENT-Recording the medical/social history of a new patient
38117	NIPCP BODY COMPOSITION ASSESSMENT-BIOELECTRICAL IMPEDANCE ANALYSIS AND/OR ANTHROPOMETRIC ASSESSMENT (MULTIPLE SITE SKINFOLDS AND CIRCUMFERENCES).
38119	NIPCP PATIENT ASSESSMENT Evaluation of a client's condition, problem or functional status to establish a nursing diagnosis and/or identify information to support a clinical diagnosis and/or identify treatment or rehabilitation measures and/or monitor a client's response to an existing treatment/rehabilitation plan. Also includes, where applicable, ordering diagnostic investigations, reviewing results, prescribing medications, counseling patient, coordinating care with other providers or agencies, etc. **Claim must state start and end times.**
38120	NIPCP ROUTINE PELVIC EXAM INCLUDING PAP Routine pelvic examination including Papanicolaou smear.
38123	NIPCP COMMUNICABLE DISEASE FOLLOW UP Evaluation of a client's condition, related to a previously diagnosed communicable disease, and/or monitoring of a client's response to an existing treatment/rehabilitation plan. Also includes, where applicable, ordering diagnostic investigations, reviewing results, prescribing medications, counseling patient, coordinating care with other providers or agencies, etc.
38125	NIPCP COMPLETION OF FORMS, NO REIMBURSEMENT Completion of all relevant documentation/forms, where there is no reimbursement from third party or direct billing, required as a result of a specific incident, or to obtain client consent.
38130	NIPCP CASE CONFERENCE Meeting with members of the health care team, representatives of other agencies involved in the management of the client, to plan and coordinate activities and services and to share information necessary to meet the client's needs/goals and expected outcomes. **Claim must state start and end times.**
38131	NIPCP CASE MANAGEMENT Multiple telephone calls to develop a comprehensive service plan, link the client to the required services, coordinate and maintain links with resources/services/supports in the client's environment, and evaluate services provided. May include activities such as searching for the appropriate resources and negotiating with potential providers (eg. probation officers, child and family services, social assistance, education, housing etc.) Claim must state start and end times.

38135	NIPCP FAMILY CONFERENCE - A conference with the patient's family/friend during which client needs are identified (based on previous assessment findings) and strategies are developed to ensure that needs are addressed and expected outcomes will be met. The intervention includes activities such as goal setting and designing resources that are required (patient may or may not be present). **Claim must state start and end times.**
EDUCATION	
38140	NIPCP EDUCATION - GROUP **-** Bill to the PHN for each patient attending the group meeting. Start and end times should be listed for each PHN **Claim must state start and end times.**
38141	NIPCP EDUCATION - CHOLESTEROL **Claim must state start and end times.**
38142	NIPCP EDUCATION - INSULIN STARTS **Claim must state start and end times.**
38143	NIPCP EDUCATION - INHALER USE **Claim must state start and end times.**
38144	NIPCP EDUCATION - RELATED TO SPECIFIC DIAGNOSIS Information provided in a structured format, to enhance knowledge and skill that directly or indirectly assists the client/family to understand, monitor and manage their condition/impairment. Includes, where applicable, provision of educational material such as pamphlets, tapes, books and videos. **Claim must state start and end times.**
38145	NIPCP EDUCATION - HEALTH PROMOTION/DISEASE PREVENT Information provided in a structured format, to enhance knowledge and skill that directly or indirectly promote health or influence changes in unhealthy lifestyles. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books and videos (e.g. exercise, nutrition, hygiene, STD education). **Claim must state start and end times.**
38146	NIPCP EDUCATION - FAMILY PLANNING Information about contraception provided in a structured format, to enhance knowledge and skill that directly or indirectly promotes health or influences changes in unhealthy life styles. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books and videos. **Claim must state start and end times.**
38147	NIPCP EDUCATION - SMOKING Therapeutic communication, provided to or on behalf of a client, to identify and evaluate, introduce and/or eliminate, reinforce and/or reduce certain attitudes on the part of the client regarding health risks due to smoking/tobacco use and their potential effect on health status, which could alter attitudes and in turn change/modify behaviour. **Claim must state start and end times.**
38148	NIPCP EDUCATION - SUBSTANCE ABUSE Therapeutic communication, provided to or on behalf of a client, to identify and evaluate, introduce and/or eliminate, reinforce and/or reduce certain attitudes on the part of the client regarding health risks due to drug use/abuse or alcohol consumption and their potential effect on health status, which could alter attitudes and in turn change/modify behavior. **Claim must state start and end times.**

38150	NIPCP EDUCATION - PARENTING Information to improve parenting skills provided in a structured format, to enhance knowledge and skill that directly or indirectly promote health or influence changes in unhealthy life styles. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books, and videos. **Claim must state start and end times.**
38153	NIPCP EDUCATION - ENVIRONMENTAL ISSUES Therapeutic communication, provided to or on behalf of a client, to identify and evaluate, introduce and/or eliminate, reinforce and/or reduce certain attitudes on the part of the client regarding health risks related to environmental risk/injury and their potential effect on health status, which could alter attitudes and in turn change/modify behavior. **Claim must state start and end times.**
38155	NIPCP EDUCATION - NUTRITION Therapeutic communication, provided to or on behalf of a patient, to enhance knowledge and skill that directly or indirectly promote nutritional health status or influence changes in unhealthy lifestyles that impact on nutritional status for the specific patient. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books and videos that pertain specifically to nutrition. **Claim must state start and end times.**

INJECTIONS	
38160	NIPCP INJECTION, INTRAMUSCULAR - Intramuscular medications.
38161	NIPCP INJECTION, VENEPUNCTURE - Venepuncture and dispatch of specimen to laboratory, when no other blood work performed.
38162	NIPCP MEDICATION INJECTION, SUBCUTANEOUS - Subcutaneous medication, including desensitization treatments
MISC PROCEDURES	
38163	NIPCP MINI TRAY FEE
38165	NIPCP GLUCOSE - SEMIQUANTITATIVE (dipstick analyzed visually or by reflectance meter)
38166	NIPCP PREGNANCY TEST, IMMUNOLOGIC, URINE
38167	NIPCP URINALYSIS - SCREENING Urinalysis - Chemical or any part of (screening)
38168	NIPCP SYRINGING – EAR Irrigation of the external auditory meatus.
38169	NIPCP SUTURE/STAPLE REMOVAL Removal of sutures, staples, clips, etc.
38170	NIPCP DRESSING CHANGE Replacement of bandage/dressing.
38171	NIPCP ELECTROSURGERY/CRYOTHERAPY FOR REMOVAL/WARTS Forms of treatment other than excision, x-ray, or grenz ray; such as removal of haemangiomas and warts with electrosurgery, cryotherapy, etc. - per visit
38172	NIPCP FOOT CARE
38173	NIPCP SUTURING MINOR LACERATIONS
38174	NIPCP ASSISTING WITH PRODECURES
38175	NIPCP WOUND CARE Includes cleansing, irrigating, probing, debriding, packing and dressing a wound. It also includes suturing a laceration and changing dressings.
38176	NIPCP INR MANAGEMENT
38177	NIPCP ULTRASOUND - Handheld device

38005	NIPCP LIFETIME PREVENTION SCREENING Lifetime Prevention Screening includes initiating any of the clinical prevention services for specific patient groups as outlined in the Lifetime Prevention Schedule. Encounter is used for one or more intervention provided based on patient's demographics (e.g., age, sex).
38006	NIPCP PALLIATIVE/EOL CARE PLANNING
TELEPHONE	
38180	NIPCP PHONE CONTACT WITH PROFESSIONAL CARE PROVIDER Telephone contact to exchange information about a client between service providers, includes a verbal or written follow up communication with the Referring service provider (ag social worker, home care etc.)
38184	NIPCP TELEPHONE CONTACT WITH PATIENT FAMILY/FRIEND A single telephone call to patient's family/friend during which client needs are identified (based on previous assessment findings) and strategies are developed to ensure that needs are addressed and expected outcomes will be met. This intervention includes activities such as goal setting and designing resources and services that are required.
38185	NIPCP TELEPHONE CONSULTATION
38186	NIPCP TELEPHONE FOLLOW-UP Telephone contact with a patient to monitor client's response to an existing treatment/rehabilitation plan. Also includes, where applicable, ordering diagnostic investigations, reviewing results, prescribing medications, counseling patient, etc.
38188	NIPCP TELEPHONE CALL (PHARMACY) Telephone call to initiate prescription or renew the directions and/or instructions for the preparation, dispensing, fabrication, or implementation of the pharmacological agents.
COUNSELING	
38191	NIPCP CRISIS COUNSELING Issue-or incident-specific counseling session with a patient, resulting from self, physician, health or non-health professional referral. **Claim must state start and end times**.
38192	NIPCP SHORT-TERM COUNSELING A counseling session with a patient resulting from self, physician, health or non-health professional referral. **Claim must state start and end times.**

Schedule 4 - Summary of PCN Service Plan Resource Approval

The table below summarizes the East Kootenay PCN Service Plan overall resources and attachment targets approved based on full implementation (i.e. steady-state by year 4).

Resource	Category	FTE	FTE (incl. relief)	Total Attachment (Annual)	Salary/FTE (Annual)	Overhead/FTE (Annual)	Total Salary Costs (Annual)	Total Overhead Costs (Annual)	Total Operating Costs (Annual)	Total Change Management Cost Bucket
Family Physician	Attachment	3.20	3.20	2,560	$298,699.00	Included in salary	$955,836.80	Included in salary	$955,836.80	
Family Physician - FFS	Attachment	2.80	2.80	2,240	$268,322.00	Included in salary	$751,301.60	Included in salary	$751,301.60	
Family Physician - Group Contracts	Attachment	4.30	4.30	2,807	$265,000.00	Included in salary	$1,139,500.00	Included in salary	$1,139,500.00	
Nurse Practitioner	Attachment	2.00	2.00	1,400	$160,000.00	$75,000.00	$320,000.00	$150,000.00	$470,000.00	
Registered Nurse	Attachment	15.60	17.94	6,240	$109,000.00	$16,350.00	$1,955,460.00	$293,319.00	$2,248,779.00	
Social Worker	Team-Based Care	8.10	8.10	2,430	$102,000.00	$15,300.00	$826,200.00	$123,930.00	$950,130.00	
Mental Health Clinician	Team-Based Care	1.80	1.80	540	$103,000.00	$15,450.00	$185,400.00	$27,810.00	$213,210.00	
Allied Health Professional	Team-Based Care	13.00	13.00		$101,500.00	$15,225.00	$1,319,500.00	$197,925.00	$1,517,425.00	
Lab Assistant	Team-Based Care	1.50	1.50		$59,000.00	$8,850.00	$88,500.00	$13,275.00	$101,775.00	
Radiological Tech (Medical Imaging)	Team-Based Care	1.60	1.60		$48,709.68	$7,306.45	$77,935.49	$11,690.32	$89,625.81	
Clinical Pharmacist	Team-Based Care	1.00	1.00		$0.00	$19,350.00	$0.00	$19,350.00	$19,350.00	
Aboriginal Health Coordinator	Indigenous Care	3.00	3.00		$80,000.00	$12,000.00	$240,000.00	$36,000.00	$276,000.00	
Elder/Community Champion Honoraria	Indigenous Care								$100,000.00	
PCN Manager	Administration	1.00	1.00		$142,625.00	$28,525.00	$142,625.00	$28,525.00	$171,150.00	
Administrative Support	Administration	1.00	1.00		$62,500.00	$12,500.00	$62,500.00	$12,500.00	$75,000.00	
Governance									$40,000.00	
Change Management										$1,286,862.00

Schedule 5 - PCN Service Plan – 2020/21 Budget Allocation

PCNs are to ensure a collaborative governance structure, with all funding provided by the Ministry for the PCN to be administered at the joint direction of the partners through the PCN Steering Committee and in accordance with the PCN service plan approval. Funds allocated to the Health Authority and the Division of Family Practice are to be considered a flow-through and are to be drawn-down / expensed at the direction of the PCN Steering Committee.

As shown in the table below targeted funding of up to $1,350,094 in 2020/21 will be provided to Interior Health Authority, as Funds Administrator, to support implementation of the East Kootenay PCN as directed by the PCN Steering Committee. Health Authorities may not reduce or redirect funding provided for primary care services without the prior, written approval of the Ministry. Unless otherwise advised by the Ministry, any unspent funding will be recovered.

As shown in the Table below targeted funding of up to $715,104 in 2020/21 will be provided to the Doctors of BC who will subsequently allocate this funding to the Division of Family Practice Funds Administrator, to support implementation of the East Kootenay PCNs as directed by the PCN Steering Committee and in accordance with the Funds Transfer Agreement (Schedule 6).

This schedule will be updated annually.

Table 1- East Kootenay PCN (1)

Funding Source	Component	Year 1 2020/21 Funding Allocation	Year 2 2021/22 Notional Approval for Planning Purposes	Year 3 2022/23 Notional Approval for Planning Purposes	Year 4 2023/24 Notional Approval for Planning Purposes
MoH	**General Practitioners**	**569,328**	**$ 1,280,987**	**$ 1,992,647**	**$ 2,846,638**
	% Implementation	*20%*	*45%*	*70%*	*100%*
Health Authority	Approvals in Advance of PCN Planning	191,044	191,044	191,044	191,044
	Clinical Resources (Excluding GPs)	1,159,050	$ 2,607,863	$ 4,056,676	$ 5,795,251
	% Implementation	*20%*	*45%*	*70%*	*100%*
	Total Health Authority	**1,350,094**	**2,798,907**	**4,247,720**	**5,986,295**
Division of Family Practice	PCN Manager & Admin	$ 246,150	$ 246,150	$ 246,150	$ 246,150
	Governance	$ 40,000	$ 40,000	$ 40,000	$ 40,000
	Sub-total	**$ 286,150**	**$ 286,150**	**$ 286,150**	**$ 286,150**
	% Implementation	*100%*	*100%*	*100%*	*100%*
	Change Management Funding Envelop	**$ 428,954**	**$ 428,954**	**$ 428,954**	**$ -**
	Assumed cashflow over 3 years				
	Total Division of Family Practice	**$ 715,104**	**$ 715,104**	**$ 715,104**	**$ 286,150**
TOTAL PCN		**$ 2,634,526**	**$ 4,794,998**	**$ 6,955,470**	**$ 9,119,083**

FUNDS TRANSFER AGREEMENT

PRIMARY CARE NETWORK

BETWEEN:

British Columbia Medical Association,
operating as Doctors of BC ("Doctors of BC")

AND:

East Kootenay Division of Family Practice Society ("Division")

WHEREAS the Collaborative Services Committee (CSC) is a local community partnership between the Divisions of Family Practice ("DoFP") and the local Health Authority (the "CSC") that provides governance and strategic leadership for the local community Primary Care Network (PCN) planning process, establishes and oversees the Primary Care Network Steering Committee, and ensures engagement of key community partnerships including local First Nations service provider organizations, community agencies and service providers, patients and families.

AND WHEREAS Doctors of BC has agreed to receive, hold and distribute funding on behalf of the CSC and, in particular, the Doctors of BC has agreed to hold and distribute Primary Care Network funding provided by the Government of British Columbia (the "Province") to the CSC, and subsequently allocate such funding to the participating Divisions in support of an integrated system of primary and community care in accordance with the PCN Service Plan Approval.

AND WHEREAS the funding described in this agreement will be in support of three categories of collaborative activity described in the PCN Service Plan Approval and Budget Allocation, namely PCN Clinical Service Management and Administration, PCN Governance and PCN Change Management.

AND WHEREAS the Division has been identified as the Fund Administrator for the East Kootenay region Primary Care Networks (the "PCNs");

AND WHEREAS the Doctors of BC agrees to transfer funds to the Division that are identified for the purposes prescribed in each of PCN Clinical Service Management and Administration, PCN Governance and Change Management categories in the PCN Service Plan Approval.

NOW THEREFORE in consideration of the mutual covenants and agreements contained in this Agreement, the Doctors of BC and the Division agree as follows:

DEFINITIONS

"Agreement" means this Fund Transfer Agreement

"**Division Fund Administrator**" means an individual designated this title by the local Collaborative Services Committee

"PCN Service Plan" means the plan submitted to the Ministry of Health by the local CSC outlining primary care services required to address the eight core attributes of a PCN.

"PCN Service Plan Approval" means the response from the Ministry approving resources for the PCN provided to the CSC.

"**PCN Steering Committee**" means the committee established under the guidance of the CSC that oversees the establishment and ongoing operations of the PCN in accordance with PCN Service Plan and Service Plan Approval for the purpose of implementing and coordinating the operations of the PCN. The committee reports to the CSC to ensure ongoing community coordination and partnership, and is minimally comprised of local patient representatives, local First Nations representatives, physician representatives from local primary care practices, nurse practitioner representatives, the Division of Family Practice and the local regional Health Authority.

Article 1: Term

1.1 This Agreement will be in effect upon its execution and shall continue until March 31, 2024 or until the Agreement is terminated pursuant to Article 3.

Article 2: Funding

2.1 The Doctors of BC shall provide the Division Fund Administrator with up to **$715,104** in 2020/21, ("the Funds" or "Funding") subject to confirmation through ongoing reporting.

Funding is to be provided in quarterly installments, with the exception of funding for one-time costs and tenant improvements, where applicable, which will be provided in the first quarterly payment.

2.2 The Funds shall be disbursed by the Division to implement the PCN Service Plan Approval in accordance with this Agreement.

2.3 The Division shall receive and administer the Funds for the development and coordination of the PCN in accordance with the following, and as agreed to by the PCN Steering Committee:

(a) **PCN Clinical Services Management and Administration**

The Division shall hire a PCN Manager and administrative support for the PCN to:

(i) provide overall project leadership for the implementation of the primary care initiative within the PCN, which includes working with Patient Medical Home (PMH) programs/services, primary care providers, the regional health authority, community agencies, and other stakeholders;

(ii) work with the Division and other local groups to facilitate engagement of physicians, nurse practitioners, nurses, allied health and other community member participation in the PCN;

(iii) provide project management services, which includes proposal development, establishment of the governance structure and operational plan, identification and management of the operating budget, including resource allocation, development of an implementation plan, and completion of necessary reports and evaluation;

(iv) establish operational procedures/resources as required to ensure consistent practice across regional PCN(s);

(v) ensure the Ministry of Health reporting and deliverables for the Funding are achieved;

(vi) assist in the selection and monitoring of performance indicators at the local level and preparation of reports as referenced in Article 5; and

(vii) participate in identifying opportunities for improvement in processes designed to facilitate access and improved quality of care for populations served by the PCN.

(b) **PCN Governance**

The Division shall ensure the governance requirements outlined in the Interim Letter of Intent signed by the Division and Health Authority partner are provided within the Funding envelope. No additional funds will be made available for the governance functions required by the PCN Steering Committee, including advisory committees and working groups.

(c) **PCN Change Management:**

The Division shall distribute Funds to facilitate change management activities to transition from status quo to a fully implemented PCN Service Plan as directed by the PCN Steering Committee. All change management expenditures must be fully itemized in reporting and disclosed in detail as part of the PCN Annual Report against PCN Service Plan deliverables. Change management costs considered in-scope for funding provided under this Agreement are as follows:

(i) clinical service model development, including transition to team-based models of care and development of team workflows, protocols and integration within GP/NP practices;

(ii) support and facilitation of cross provider service delivery;

(iii) recruitment and training for GPs, NPs, nursing and allied health providers;

(iv) patient engagement;

(v) community partner engagement;

(vi) communications including public awareness, advertising, and marketing;

(vii) engagement with Indigenous Health providers;

(viii) evaluation;

(ix) attachment process through the centralized provincial waitlist once operational; and

(x) Nurse Practitioner integration.

Change management costs considered out of scope for funding provided under this Agreement are as follows:

(i) GP engagement and GP participation in implementation of the PCN;

(ii) Division resources, such as the Executive Director salary, that are covered by other funding sources; and

(iii) Health Authority staff costs managed within the Health Authority global budget.

2.4 The Division shall not use the Funding to duplicate or replicate work/projects/supplies where pre-existing funding is allocated or available from partner organizations and/or Joint Collaborative Committee (JCC) initiatives or for purposes that are expressly described as out of scope, including:

(a) capital costs of the PCN, unless the Ministry approves otherwise; and

(b) remuneration for physicians or other health service providers for services covered under fee-for-service billings.

2.5 Notwithstanding any other provisions of this Agreement, any payment of Funds to the Division by the Doctors of BC under this Agreement is contingent upon its receipt of associated funding from the Province.

Article 3: Termination

3.1 Either party may terminate this Agreement without cause on giving 6 months written notice of termination to the other party.

3.2 The Doctors of BC may terminate this Agreement immediately if there is a change in the operations of the Division which adversely affect its ability to meet its obligations under this Agreement.

3.3 Either party may terminate this Agreement immediately upon providing written notice to this effect if the other party breaches a fundamental term of this Agreement.

3.4 Upon termination of the Agreement all remaining unspent Annual Funds that are allocated to the Division and are held by the Division must be returned to the Doctors of BC.

Article 4: Accounting

4.1 The Division, on behalf of the PCN, shall establish and maintain books of account, and retain invoices, receipts and vouchers for all expenditures of the Funds for a period of six years (the “Accounting Records ”), unless directed by the Province to dispose of them or deliver them to the Province following the discontinuance of the PCN or this Agreement.

4.2 The Division shall make the Accounting Records available to the Doctors of BC and the Ministry upon request.

4.3 Within three months of being requested to do so by the Province, the Division, on behalf of the PCN, will provide to the Province any audited financial statements prepared by a recognized accounting firm, relating to any part of this Agreement.

4.4 The Division will keep PCN funds separate and distinct from other funds or revenue, and will track and report on specific PCN funds separately.

Article 5: Reporting

5.1 The Division will participate in collaborative reporting with the Regional Health Authority and First Nations through the PCN Steering Committee. The annual reporting requirements for the Steering Committee are described at in the funding package.

5.2 Implementation of the PCN will be monitored against the PCN Service Plan Approval and the PCN Budget Allocation as updated by the PCN Steering Committee through an online portal developed and maintained by the Ministry.

5.3 The Division will provide financial reporting to the PCN Steering Committee in support of PCN financial reports and the PCN Annual Report, which include items 5.3(a - e) submitted by period and 5.3(f-g) submitted by quarter.

a) spend by category;[1]
b) spend to date in the fiscal year by category;
c) forecast spend per category for the remainder of the fiscal year;
d) number of FTEs hired and removed in each category such as General Practitioners, Nurse Practitioners, Registered Nurses, Allied Health professionals, and PCN management staff with associated cash flow;
e) one-time funding spend by clinic (including tenant improvements);
f) allied health visits (both unique visits and the number of patients served);
g) implemented enhanced hours of service (where there is a change in hours).
h) other indicators as determined collaboratively to support quality improvement, evaluation, and to determine the efficacy of the initiative

5.4 A failure of the Division to meet its financial reporting obligations under this Agreement will be considered a breach of this Agreement.

Article 6: Liability

6.1 Notwithstanding any other provision of this Agreement, the Doctors of BC and its employees, directors, officers or agents shall not be liable to the Division for any claim arising out of or in any way related to this Agreement. Without restricting the generality of the foregoing, the Doctors of BC shall not be liable in any way for any direct, indirect, consequential, compensatory or punitive damages resulting from the Doctors of BC's administration of the Funding or any representation or warranty given by the Doctors of BC or any of its employees, directors, officers or agents in connection with the subject matter of this Agreement. For greater certainty, the foregoing limitation shall not apply to any losses that arise

[1] For each PCN approval, in support of three categories of collaborative activity described in the PCN Service Plan Approval and Budget Allocation (i.e. Governance, PCN Administration, Change Management) report: FTEs hired; salary and benefit costs by FTE; details on all non-wage related costs including lease costs; and details on all one-time costs including tenant improvements.

as a direct result of the Doctors of BC's gross negligence, fraudulent actions or willful or intentional misconduct.

Article 7: Recoveries

7.1 If the Division Fund Administrator does not use the Funds in accordance with the Service Plan Approval and Implementation Schedule as required under the Agreement, the portion of Funds that have not been used as required will be a debt owing to the Province and the Province may, after consultation with the PCN Steering Committee and, at its option, do any of the following:

a. recover the amount owed as a debt due to the Province in accordance with the Financial Administration Act (FAA);

b. reduce future Local PCN payments to the Fund Administrator under this Agreement until the amount owed is recovered; or

c. propose a modification to the Service Plan Approval or funding thereunder, provided the effect of any such modifications occur within the current fiscal year (April 1 – March 31).

7.2 If, after the Local PCN Members meet their obligations under this Agreement and the Service Plan Approval, there are surplus funds, this surplus revenue is a debt owing to the Province and the Province may, after consultation with the Parties and, at the Province's option, take any of the steps provided for in section 7.1 (a), (b) or (c) above

Article 8: Notices

8.1 Any notice contemplated by this Agreement, to be effective, must be in writing and be:

a) sent by email to the addressee's email specified in this Agreement;

b) delivered by hand to the addressee's address specified in this Agreement; or

c) mailed by prepaid registered mail to the addressee's address specified in this Agreement.

8.2 Any notice mailed in accordance with sub-section (c) is deemed to be received 96 hours after mailing. Either of the parties may give notice to the other of a substitute address or fax number from time to time.

<u>Address of the Doctors of BC:</u>
Suite 115 - 1665 West Broadway
Vancouver, BC V6J 5A4
Tel: 604-538-2869
Attention: Alana Godin

<u>Address of the Division:</u>
200-201 14th Ave North
PO Box 742
Cranbrook, BC, V1C 4J5
Tel: 250-432-9062
Attention: Megan Purcell

Article 9: General

9.1 This Agreement is governed by and is to be construed in accordance with the laws of British Columbia.

9.2 The Division shall ensure that its employees and contractors comply with all applicable privacy legislation in relation to this Agreement.

9.3 Time is of the essence in this Agreement.

9.4 A waiver of any term of this Agreement or of any breach by the Division of this Agreement is effective only if it is in writing and signed by the Doctors of BC and is not a waiver of any other term or any other breach.

9.5 No modification of this Agreement is effective unless it is in writing and signed by the Parties.

9.6 This Agreement and any modification of it constitutes the entire Agreement between the Parties and supersedes all previous communications, representations, understandings and agreements, whether oral or written, between them with respect to the subject matter of this Agreement.

9.7 All disputes arising out of or in connection with this Agreement or in respect of any defined legal relationship associated with it or derived from it, must, unless the Parties otherwise agree, be referred to and finally resolved by arbitration under the British Columbia *Arbitration Act.*

9.8 Sections 3.4, 4.1 to 4.3, and 9.7 continue in force indefinitely, even after this Agreement ends.

9.9 The Agreement may be entered into by each party signing a separate copy of this Agreement (including a photocopy or faxed copy) and delivering it to the other party by fax.

9.10 In this Agreement,

a) the words "includes" and "including" are not intended to be limiting; and

b) unless the context otherwise requires, references to sections by number are to sections of this Agreement.

IN WITNESS WHEREOF the parties have executed this Agreement as of the

______ day of ___________________, 2020.

___________________________________	___________________________________
Division of Family Practice	Doctors of BC
________________________________	________________________________
Signing representative name	Signing representative name
_________________	_______________
Signature	Signature

Schedule 7 - Attachment and Compensation Assumptions

Attachment Assumptions

The below are attachment assumptions based on Family Physician (FP) and Nurse Practitioner (NP) contracts for average panels. The attachment targets may be reduced based on complexity of the population the FP or NP is supporting. Please contact your Ministry Liaison from more information.

	Yr1	Yr2	Yr3	On-going
New GP Contract	600	700	800	800
New NP Contract	600	700	800	800
RN	300	400	400	400

Compensation Assumptions

- Contract rates for new-to-practice Family Physicians (FP) (without existing patient panels):

Practice Category	Year 1	Year 2 & Ongoing
GP PCN Contract Non-JSC	253,134	268,322
GP PCN Contract JSC A	279,460	298,699
GP PCN Contract JSC B	270,348	288,573
GP PCN Contract JSC C	265,285	283,511

  - Compensation rates include provision for overheads

- Contract for established Family Physicians, with existing patient panels:
  - The Ministry is working on a clinical services contract option for family physicians with existing patient panels, and we are currently in consultation with Doctors of BC.
  - The target to have this option available for physicians is within the next few months.

- Contract rates for new Nurse Practitioners (NP):
  - Year 1- $150,000
  - Year 2- $155,000
  - Year 3 & ongoing- $160,000
  - A separate overhead provision of $85,000 per NP in metro areas and $75,000 per NP in other areas.

- Registered Nurse (RN):
  - $109,000 (salary and benefits)
  - RN positions include an additional 15% for relief[i]
  - An overhead provision of $16,350 (15%) per RN

- Allied Health Professionals (AHP):
  - $101,500 (salary and benefits). Blended rate of Social worker ($102,000) and Occupational Therapist ($101,000).
  - An overhead provision of $15,225 (15%) per AHP

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[i] The approved FP/NP FTEs do not include a provision for relief as it is expected that within contract funding amounts clinics will adjust schedules to accommodate leave/ relief coverage for FP and NP positions.

Schedule 8 – Change Management

Change management is an essential component in moving from the current system of care to the team-based model of care proposed in your service plan that will meet the needs of patients in their community. As part of the annual report, each PCN Steering Committee will be required to provide a detailed accounting of all change management related expenditures.

The Ministry will allocate funds to cover a portion of the overall change management costs through this approval. The General Practice Services Committee will also be funding change management costs related to the continued participation of physicians and Division of Family Practice. All change management expenditures will need to be fully itemized against PCN Service Plan deliverables and disclosed in detail as part of the PCN Annual Progress Report.

Change management costs considered in-scope for Ministry funding are activities required to transition from the status quo to full PCN approved service plan implementation (except for out-of-scope costs). These include:

- Clinical service model development, including transition to team-based models of care and development of team workflows, protocols and integration within FP/NP practices;
- Cross provider service delivery;
- Recruitment and training for FPs, NPs, nursing and allied health providers;
- Patient engagement;
- Community partner engagement;
- Communications including public awareness, advertising, and marketing;
- Engagement with Indigenous Health providers;
- Evaluation;
- Attachment process through the centralized provincial waitlist once operational;
- Nurse Practitioner integration.

Change management costs associated with activities provided by another entity within the health system are considered out of scope for Ministry funding. These include:

- Additional funding for FP engagement and FP participation in implementation of PCN to be considered by the GPSC;
- Divisions resources (for example the Executive Director's salary) that are covered by infrastructure funding;
- Health authority staff costs to be managed from within health authority global budgets.

East Kootenay Division of Family Practice Society
Financial Statements
For the Year Ended March 31, 2022

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Independent Auditor's Report

To the Board of Directors of East Kootenay Division of Family Practice Society

Report on Financial Statements

Opinion

We have audited the financial statements of East Kootenay Division of Family Practice Society (the Society), which comprise the statement of financial position as at March 31, 2022, the statements of operations, changes in net assets and 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 Society as at March 31, 2022, and its financial performance and cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

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 Society 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.

Other Matters

We draw attention to the fact that the supplementary information included in Schedules 1 to 21 is presented for the purposes of additional analysis and does not conform to part of the audited financial statements. We have not audited or this supplementary information and, accordingly, we do not express any opinion, review, conclusion or any form of assurance on this supplementary information.

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 accounting standards for not-for-profit organizations, 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 Society'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 Society or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the Society'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.

BDO Canada LLP, a Canadian limited liability partnership, is a member of BDO International Limited, a UK District limited by guarantee, and forms part of the international BDO network of independent member firms.

BDO

Independent Auditor's Report (Continued)

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 Society'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 Society'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 Society 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.

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.

Report on Other Legal and Regulatory Requirements
As required by the Societies Act (British Columbia), we report that, in our opinion, the accounting principles used in these financial statements have been applied on a basis consistent with that of the preceding year.

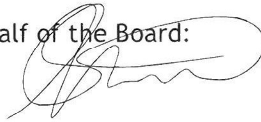
Chartered Professional Accountants

Cranbrook, BC
June 23, 2022

East Kootenay Division of Family Practice Society
Statement of Financial Position

March 31	2022	2021
Assets		
Current		
Cash	$ 489,228	$ 324,706
Short-term investments (Note 4)	1,228,827	1,223,181
Accounts receivable (Note 5)	16,187	38,798
Prepaid expenses	9,609	4,346
	$ 1,743,851	$ 1,591,031
Liabilities and Net Assets		
Current		
Accounts payable and accrued liabilities	$ 559,216	$ 237,940
Deferred revenue (Note 6)	947,635	1,214,478
	1,506,851	1,452,418
Long-term debt (Note 7)	30,000	30,000
	1,536,851	1,482,418
Net Assets		
Internally Restricted	65,616	59,970
Unrestricted	141,384	48,643
	207,000	108,613
	$ 1,743,851	$ 1,591,031

On behalf of the Board:



_______________ Director

_______________ Director

The accompanying notes are an integral part of these financial statements.

East Kootenay Division of Family Practice Society
Statement of Changes in Net Assets

For the year ended March 31	Internally Restricted	Unrestricted	2022 Total	2021 Total
Balance, beginning of the year	**$ 59,970**	**$ 48,643**	**$ 108,613**	$ 64,613
Excess of revenues over expenses	**5,646**	**92,741**	**98,387**	44,000
Balance, end of the year	**$ 65,616**	**$ 141,384**	**$ 207,000**	$ 108,613

The accompanying notes are an integral part of these financial statements.

East Kootenay Division of Family Practice Society
Statement of Operations

For the year ended March 31		2022		2021
Revenue				
Core/Infrastructure	$	**550,338**	$	493,550
Shared Care		**155,833**		172,225
Long Term Care		**236,761**		195,884
Regional District of East Kootenay'		**9,704**		24,293
Primary Care Networks		**459,015**		334,154
Rural Coordination Centre of British Columbia		**-**		11,077
Cranbrook Continuing Medical Education		**4,872**		3,931
East Kootenay Continuing Professional Development		**52,457**		12,281
Physician Change Management		**120,137**		74,305
Patient Attachment Mechanism		**5,908**		4,603
Team Based Care		**26,019**		11,718
Inpatient Unassigned		**343,100**		343,100
Maternity Care Initiative		**48,139**		66,861
Minor Tenant Improvements		**47,481**		40,585
Virtual Clinics		**28,810**		15,225
COVID		**57,877**		112,770
Nuka Initiative		**-**		17,671
Virtual Care Coordinator		**21,599**		-
Interest and other (Note 7)		**5,646**		17,463
		2,173,696		1,951,696
Expenses				
Advertising and promotion		**17,451**		7,434
COVID		**-**		2,818
Computer		**23,105**		24,394
Contractors and consulting		**48,251**		62,251
Events		**23,905**		6,803
Human resources		**948,163**		857,023
Inpatient program fees		**343,100**		343,100
Insurance		**3,439**		2,783
Interest and bank charges		**1,509**		1,537
Meetings		**16,767**		1,882
Office		**28,534**		21,681
Office rent		**15,616**		15,616
Physicians and specialists		**514,160**		478,678
Professional fees		**10,810**		11,952
Repairs and maintenance		**53,076**		55,195
Telephone and internet		**8,544**		7,308
Training		**2,409**		2,333
Travel		**16,470**		4,908
		2,075,309		1,907,696
Excess of revenues over expenses	$	**98,387**	$	44,000

The accompanying notes are an integral part of these financial statements.

East Kootenay Division of Family Practice Society
Statement of Cash Flows

For the year ended March 31	2022	2021
Cash flows from operating activities		
Cash receipts from funding agencies	**$ 1,974,185**	$ 2,720,276
Cash paid to suppliers and employees	**(1,809,663)**	(1,755,304)
Interest received	**5,646**	7,463
	170,168	972,435
Cash flows from investing activity		
Purchase of investments	**(5,646)**	(707,463)
Cash flows from financing activities		
Proceeds from long-term debt	**-**	30,000
Net increase in cash	**164,522**	294,972
Cash, beginning of the year	**324,706**	29,734
Cash, end of the year	**$ 489,228**	$ 324,706

The accompanying notes are an integral part of these financial statements.

March 31, 2022

1. Significant Accounting Policies

Nature of Organization

East Kootenay Division of Family Practice Society (the "Society") is an organization that represents Primary Care Providers in the East Kootenay region. Together, members work to improve patient access to local primary care, increase local physicians' influence on health care delivery and policy, and provide professional support for physicians. The Society was registered under the *Societies Act* for the Province of British Columbia on March 2, 2011 and is exempt from tax under section 149(1)(l) of the Income Tax Act.

Basis of Accounting

The Society has prepared its financial statements in accordance with Canadian accounting standards for not-for-profit organizations ("ASNPO").

Revenue Recognition

The Society follows the deferral method of accounting for contributions. Restricted contributions are recognized as revenue in the year in which the related expenses are incurred. Unrestricted contributions are recognized as revenue when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured. Other revenues are recognized as revenue when events are held.

1. Significant Accounting Policies (continued)

Fund Accounting

The Society maintains the following funds:

The Operating Fund which reports the general operating and administrative activities of the Society.

The Society also maintains the following programs within these funds, the results of which are tracked separately within the Operating Fund:

The Infrastructure program is funding received from Doctors of BC (formerly BCMA) to permit General Practitioners to work collaboratively to provide improved patient access to primary health care.

The Project Administration program is to record expenses of the organization that are distributed across multiple projects as permitted by funding agreements.

The Shared Care program relates to the Society's implementation of projects that will focus on prototyping tools and procedures to improve the effectiveness and efficiency of the interactions between General Practitioners and Specialists with the aim of improving patient care.

The Long Term Care program supports family physicians in all Division communities to provide care to patients in residential and long term care facilities and to address quality improvement with their colleagues and other care provider partners

The Recruitment program reports funding received from the Regional District of East Kootenay in support of recruitment and retention of physicians.

The Primary Care Network program is to provide overall project leadership for the implementation of the primary care network initiative, ensure the governance requirements are met and facilitate change management activities and transition from status quo to a fully implemented PCN Service Plan as directed by the PCN Steering Committee and overseen by the Collaborative Services Committee

The Primary Care Network 2 program is an advance on the overall funding envelope that may be provided for any approved primary care networks. Service Plans jointly developed by all primary care networks.

The Rural Coordination Centre of BC Fund program is to support the development of a Primary Care Network.

1. Significant Accounting Policies (continued)

The Continuing Medical Education program supports the CME portion of the Division's AGM. Funding is from the Facilities Engagement Initiative, Reverted Rural Continuing Medical Education Funds and Eventbrite fees from specialists.

The Cranbrook Continuing Medical Education program employs a CME Project Coordinator to plan and manage CME events within Cranbrook with the leadership of the Cranbrook Physician. This position is reimbursed through the Cranbrook CME Reverted Funds.

The East Kootenay Continuing Professional Development program is to support opportunities throughout the East Kootenays for physicians to participate in medical education to update and enhance medical skills and credentials.

The Physician Change Management program is to encourage and sustain the active involvement of physicians and physician leaders in local development and implementation of Primary Care Networks and Patient Medical Home programs.

The Patient Attachment Mechanism program is to support linkages between primary care networks and a patient attachment mechanism.

The Team Based Care program is to support communication and conflict resolution in physician clinics to enhance team based care and to ensure successful integration and readiness for learning in the primary care network.

The Inpatient Unassigned Networks program relates to management on behalf of the Doctors of British Columbia to provide payment to physicians looking after patients in emergency who do not have a family physician.

The Maternity Care Initiative program is to support family doctors who are delivering maternity care and care of the newborn across the Division.

The Minor Tenant Improvements program is to support minor tenant improvements to family physician owned/leased clinics participating in their local primary care networks.

The Virtual Clinics program is to support use of virtual care and technology to support patients remotely.

1. Significant Accounting Policies (continued)

The COVID program is to support to support the Division in active physician planning for the second wave of COVID-19, and for implementation and monitoring of that planning at the local and regional level.

The Nuka Initiative program is to support training in a style of evidence based team based care that will help guide leaders.

The Provisional program consists of internally restricted funds, investment revenue and rental revenues.

The Virtual Care Coordinator program is to collaborate with patients, primary care teams, specialists, and clinics to support and facilitate virtual health care platforms and develop and review current technologies to enable "closer to home" patient-centered care.

Use of Estimates

The preparation of financial statements in accordance with Canadian accounting standards for not-for-profit organizations requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities at the date of the financial statements, and the reported amounts of revenues and expenditures during the reporting period. Actual results could differ from management's best estimates as additional information becomes available in the future.

Financial Instruments

Financial Instruments are recorded at fair value at initial recognition.

In subsequent periods, equities traded in an active market and derivatives are reported at fair value, with any change in fair value reported in income. All other financial instruments are reported at cost or amortized cost less impairment. Transaction costs on the acquisition, sale or issue of financial instruments are expensed for those items measured at fair value and charged to the financial instrument for those measured at amortized cost.

Financial assets are tested for impairment when indicators of impairment exist. When a significant change in the expected timing or amount of the future cash flows of the financial asset is identified, the carrying amount of the financial asset is reduced and the amount of the write-down is recognized in net income. A previously recognized impairment loss may be reversed to the extent of the improvement, provided it is not greater than the amount that would have been reported at the date of the reversal had the impairment not been recognized previously, and the amount of the reversal is recognized in net income.

March 31, 2022

2. Change in Comparative Figures

The comparative figures have been reclassified, where applicable, to conform to the presentation used in the current year, which includes increasing cash and accounts payable by an offsetting amount of $149,121 and updating the statement of cashflows for the same. The changes do not affect prior year deficiency of revenue over expenses for the year or net assets.

3. Economic Dependence

The Society receives its operating funding from the Doctors of BC and is currently dependent upon this funding to continue its operations.

4. Short-Term Investments

The carrying amounts of short-term investments are comprised of the following:

	2022	2021
At amortized cost:		
Guaranteed investment certificate, with a rate of 0.80%, maturing March 2023	**$ 1,228,827**	$ -
Guaranteed investment certificate, matured	**-**	521,982
Guaranteed investment certificate, redeemed prior to maturity	**-**	501,036
Guaranteed investment certificate, redeemed prior to maturity	**-**	200,163
	$ 1,228,827	$ 1,223,181

March 31, 2022

5. Accounts Receivable

	2022	2021
GPSC Collaborative Program	$ -	$ 17,938
Receiver General - GST Rebate	5,475	7,293
Interior Health Authority	9,319	5,555
RCME Cranbrook	-	4,941
General trade receivables	1,393	3,071
	$ 16,187	$ 38,798

6. Deferred Revenue

	2021	Funding Received	Revenue Recognized	Funding to be Repaid	2022
Infrastructure	$ 95,510	$ 562,196	$ (550,339)	$ (7,367)	$ 100,000
Shared Care	230,852	335,000	(155,833)	(12,367)	397,652
Long Term Care	73,549	211,200	(236,761)	-	47,988
Regional District of East Kootenay	6,895	23,750	(9,704)	-	20,941
Primary Care Network	383,447	331,657	(459,016)	-	256,088
Network Development		343,100	(343,100)	-	-
Cranbrook Continuing Medical Education	10,895	18,445	(4,872)	-	24,468
East Kootenay Continuing Professional Development	43,905	48,987	(52,457)	-	40,435
Physician Change Management	181,666	138,620	(120,137)	(200,149)	-
Patient Attachment Mechanism	42,897	25,000	(5,908)	(61,989)	-
Team Based Care	28,224	523	(26,019)	(2,728)	-
Maternity Care Initiative	48,139	-	(48,139)	-	-
Virtual Care Coordinator	-	65,809	(21,599)	-	44,210
Virtual Clinics	2,837	27,924	(28,810)	-	1,951
COVID	57,230	6,117	(57,877)	-	5,470
Nuka Initiative	8,432	-	-	-	8,432
	$ 1,214,478	$2,138,328	$ (2,120,571)	$ (284,600)	$ 947,635

7. Canadian Emergency Business Account (CEBA)

Canada Emergency Business Account Loan, in the amount of $30,000, represents the unforgivable balance of the $40,000 interest-free loan received under the Government of Canada COVID-19 response program. 25% of the $40,000 loan will be eligible for loan forgiveness if the loan is fully repaid on or before December 31, 2023. In the event that the Society does not repay the $30,000 by the end of 2023, the entire $40,000 would become due, repayable monthly including interest.

8. Lease Commitments

The Society has a lease with respect to its premises at 201 14th Avenue N., Cranbrook, BC, beginning May 1, 2021. Tenancy will be confirmed annually by the Society with the approval of provincial funding for the following year, not less than 60 days prior to the May 1 anniversary date of the lease. Future minimum lease payments, excluding GST, as at March 31, 2021, are as follows:

2023	$ 15,240
2024	1,270
	$ 16,510

9. Wages, Honoraria and Benefits

The *Societies Act* (British Columbia) requires certain information to be reported with regards to remuneration of employees, contractors and directors.

Included in wages and benefits are six (2021 - three) employees with remuneration over $75,000 each. The total remuneration paid to these individuals for the year ended 2022 was $ 560,718 (2021 - $ 297,576).

10. Financial Instruments

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 Society is exposed to credit risk resulting from the possibility that a customer or counterparty to a financial instrument defaults on their financial obligations; if there is a concentration of transactions carried out with the same counterparty; or of financial obligations which have similar economic characteristics such that they could be similarly affected by changes in economic conditions. The Society's financial instruments that are exposed to concentrations of credit risk relate primarily to its accounts and contributions receivable. The majority of the Society's receivables are from government sources and the Society works to ensure it meets all eligibility criteria in order to qualify to receive the funding.

The Society is also exposed to credit risk arising from all of its bank accounts being held at one financial institution and deposits are only insured up to $100,000.

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 Society is exposed to interest rate risk on its fixed interest rate financial instruments. Fixed interest instruments subject the Society to a fair value risk.

Unless otherwise noted, it is management's opinion that the Society is not exposed to significant other price risks arising from these financial instruments and risk is not significantly different from that of the previous year.

East Kootenay Division of Family Practice Society
Schedule 1 - Infrastructure
(Unaudited)

For the year ended March 31	2022	2021
Revenue		
Division Infrastructure	$ 562,196	$ 569,146
Deferred revenue recognized	95,510	19,914
Revenue deferred to future years	(100,000)	(95,510)
Funding to be returned	(7,367)	-
	550,339	493,550
Expenses		
Advertising and promotion	5,040	25
Computer	12,793	8,989
Contractors and consulting	2,131	6,652
COVID	-	2,818
Events	618	6,620
Human resources	397,201	293,971
Insurance	2,579	2,496
Interest and bank charges	1,144	1,341
Meetings	2,909	262
Office and miscellaneous	15,019	8,369
Office rent	11,712	12,688
Physicians and specialists	72,824	113,747
Professional fees	10,810	11,952
Repairs and maintenance	4,267	14,441
Telephone	4,437	5,393
Training	1,492	2,333
Travel	5,363	1,453
	550,339	493,550
Surplus for the year	$ -	$ -

East Kootenay Division of Family Practice Society
Schedule 2 - Project Administration
(Unaudited)

For the year ended March 31		**2022**		2021
Revenue				
Project Administration	**$**	**92,741**	$	77,565
Expenses				
Human resources		**-**		51,519
Office and miscellaneous (recovery)		**-**		(487)
		-		51,032
Surplus for the year		**92,741**		26,533
Surplus, beginning of year		**48,569**		22,036
Surplus, end of year	**$**	**141,310**	$	48,569

East Kootenay Division of Family Practice Society
Schedule 3 - Shared Care
(Unaudited)

For the year ended March 31	2022	2021
Revenue		
Shared Care	$ 335,000	$ 276,691
Deferred revenue recognized	230,852	126,385
Revenue deferred to future years	(397,652)	(230,852)
Return of unused funds	(12,367)	-
	155,833	172,224
Expenses		
Advertising and promotion	1,248	476
Computer	790	345
Contractors and consulting	7,795	4,339
Events (recoveries)	325	(617)
Human resources	68,830	85,138
Meetings	393	1,077
Office and miscellaneous	494	803
Physicians and specialists	29,434	66,999
Project administration	46,407	13,500
Telephone	14	-
Travel	103	164
	155,833	172,224
Surplus for the year	$ -	$ -

East Kootenay Division of Family Practice Society
Schedule 4 - Long Term Care
(Unaudited)

For the year ended March 31		2022		2021
Revenue				
Long Term Care	$	**211,200**	$	211,200
Deferred revenue recognized		**73,549**		58,233
Revenue deferred to future years		**(47,988)**		(73,549)
		236,761		195,884
Expenses				
Human resources		**676**		349
Meetings		**1,328**		-
Physicians and specialists		**226,639**		187,417
Project administration		**8,118**		8,118
		236,761		195,884
Surplus for the year	**$**	**-**	$	-

East Kootenay Division of Family Practice Society
Schedule 5 - Recruitment
(Unaudited)

For the year ended March 31	2022	2021
Revenue		
RDEK - Recruitment and Retention	$ 15,000	$ 10,000
Interior Physician Recruitment and Retention	8,750	5,000
Deferred revenue recognized	6,895	16,188
Revenue deferred to future years	(20,941)	(6,895)
	9,704	24,293
Expenses		
Advertising and promotion	667	353
Contractors and consulting	-	10,693
Human resources	6,172	10,847
Meetings	-	28
Office and miscellaneous	-	164
Physicians and specialists	715	708
Project administration	2,150	1,500
	9,704	24,293
Surplus for the year	$ -	$ -

East Kootenay Division of Family Practice Society
Schedule 6 - Primary Care Network
(Unaudited)

For the year ended March 31		**2022**		2021
Revenue				
Primary Care Network	**$**	**331,657**	$	715,104
Deferred revenue recognized		**383,447**		-
Revenue deferred to future years		**(256,088)**		(383,447)
		459,016		331,657
Expenses				
Advertising and promotion		**3,212**		3,075
Computer		**4,957**		6,895
Contractors and consulting		**795**		716
Human resources		**412,279**		305,505
Insurance		**860**		287
Interest and bank charges		**365**		196
Meetings		**2,112**		-
Office and miscellaneous		**2,113**		4,847
Office rent		**3,904**		2,928
Physicians and specialists		**18,253**		3,301
Repairs and maintenance		**1,328**		170
Telephone		**3,532**		1,793
Training expense		**917**		-
Travel		**4,389**		1,944
		459,016		331,657
Surplus for the year	**$**	**-**	$	-

East Kootenay Division of Family Practice Society
Schedule 7 - Primary Care Network 2
(Unaudited)

For the year ended March 31	**2022**	2021
Revenue		
Deferred revenue recognized	**$ -**	$ 2,497
Expenses		
Contractors and consulting	**-**	87
Human resources	**-**	2,410
	-	2,497
Surplus for the year	**$ -**	$ -

East Kootenay Division of Family Practice Society
Schedule 8 - Rural Coordination Centre of British Columbia
(Unaudited)

For the year ended March 31	2022	2021
Revenue		
Rural Coordination Centre of BC	$ -	$ 4,209
Deferred revenue recognized	-	6,868
	-	11,077
Expenses		
Contractors and consulting	-	5,125
Human resources	-	712
Physicians and specialists	-	5,240
	-	11,077
Surplus for the year	$ -	$ -

East Kootenay Division of Family Practice Society
Schedule 9 - Cranbrook Continuing Medical Education
(Unaudited)

For the year ended March 31	**2022**	2021
Revenue		
Continuing Medical Education	**$ 18,445**	$ 14,826
Deferred revenue recognized	**10,895**	-
Revenue deferred to future years	**(24,468)**	(10,895)
	4,872	3,931
Expenses		
Human resources	**4,872**	3,931
Surplus for the year	**$ -**	$ -

East Kootenay Division of Family Practice Society
Schedule 10 - East Kootenay Continuing Professional Development
(Unaudited)

For the year ended March 31	**2022**	2021
Revenue		
East Kootenay Continuing Professional Development	**$ 48,987**	$ 19,165
Deferred revenue recognized	**43,905**	37,020
Revenue deferred to future years	**(40,435)**	(43,905)
	52,457	12,280
Expenses		
Computer	**479**	1,152
Events	**20,089**	-
Meetings	**9,775**	-
Office and miscellaneous	**168**	-
Physicians and specialists	**15,922**	5,509
Project administration	**4,094**	5,619
Travel	**1,930**	-
	52,457	12,280
Surplus for the year	**$ -**	$ -

East Kootenay Division of Family Practice Society
Schedule 11 - Physician Change Management
(Unaudited)

For the year ended March 31	2022	2021
Revenue		
Physician Change Management	$ **138,620**	$ 138,620
Deferred revenue recognized	**181,666**	117,351
Revenue deferred to future years	**-**	(181,666)
Funding to be returned	**(200,149)**	-
	120,137	74,305
Expenses		
Human resources	**319**	532
Meetings	**-**	298
Physicians and specialists	**105,736**	59,613
Project administration	**13,862**	13,862
Travel	**220**	-
	120,137	74,305
Surplus for the year	$ **-**	$ -

East Kootenay Division of Family Practice Society
Schedule 12 - Patient Attachment Mechanism
(Unaudited)

For the year ended March 31	**2022**	2021
Revenue		
Patient Attachment Mechanism	**$ 25,000**	$ 25,000
Deferred revenue recognized	**42,897**	22,500
Revenue deferred to future years	**-**	(42,897)
Funding to be returned	**(61,989)**	-
	5,908	4,603
Expenses		
Computer	**49**	-
Contractors and consulting	**-**	51
Human resources	**3,329**	2,052
Project administration	**2,500**	2,500
Telephone	**30**	-
	5,908	4,603
Surplus for the year	**$ -**	$ -

East Kootenay Division of Family Practice Society
Schedule 13 - Team Based Care
(Unaudited)

For the year ended March 31		2022		2021
Revenue				
Team Based Care	$	523	$	272
Deferred revenue recognized		28,224		39,670
Revenue deferred to future years		-		(28,224)
Funding to be returned		(2,728)		-
		26,019		11,718
Expenses				
Advertising and promotion		110		-
Contractors and consulting		10,238		3,755
Human resources		-		1,129
Events		2,874		800
Physicians and specialists		12,002		2,067
Project administration		795		3,967
		26,019		11,718
Surplus for the year	$	-	$	-

East Kootenay Division of Family Practice Society
Schedule 14 - Inpatient Unassigned Networks
(Unaudited)

For the year ended March 31	2022	2021
Revenue		
Inpatient Unassigned Networks	**$ 343,100**	$ 343,100
Expenses		
Inpatient program fees	**343,100**	343,100
Surplus for the year	**$ -**	$ -

East Kootenay Division of Family Practice Society
Schedule 15 - Maternity Care Initiative
(Unaudited)

For the year ended March 31		**2022**		2021
Revenue				
Maternity Care Initiative	**$**	**-**	$	115,000
Deferred revenue recognized		**48,139**		-
Revenue deferred to future years		**-**		(48,139)
		48,139		66,861
Expenses				
Advertising and promotion		**7,175**		3,505
Computer		**108**		304
Contractors and consulting		**106**		305
Human resources		**17,699**		28,127
Meetings		**251**		218
Office and miscellaneous		**8,777**		7,985
Physicians and specialists		**9,426**		14,917
Project administration		**41**		11,500
Telephone		**114**		-
Travel		**4,442**		-
		48,139		66,861
Surplus for the year	**$**	**-**	$	-

East Kootenay Division of Family Practice Society
Schedule 16 - Minor Tenant Improvements
(Unaudited)

For the year ended March 31	2022	2021
Revenue		
Minor Tenant Improvements	$ **47,481**	$ 40,585
Expenses		
Repairs and maintenance	**47,481**	40,585
Surplus for the year	$ **-**	$ -

East Kootenay Division of Family Practice Society
Schedule 17 - Virtual Clinics
(Unaudited)

For the year ended March 31	**2022**	2021
Revenue		
Virtual Clinics	**$ 27,924**	$ 18,061
Deferred revenue recognized	**2,837**	-
Revenue deferred to future years	**(1,951)**	(2,837)
	28,810	15,224
Expenses		
Contractors and consulting	**27,064**	12,726
Human resources	**1,746**	18
Physicians and specialists	**-**	2,480
	28,810	15,224
Surplus for the year	**$ -**	$ -

East Kootenay Division of Family Practice Society
Schedule 18 - COVID
(Unaudited)

For the year ended March 31	**2022**	2021
Revenue		
COVID	**$ 6,117**	$ 170,000
Deferred revenue recognized	**57,230**	-
Revenue deferred to future years	**(5,470)**	(57,230)
	57,877	112,770
Expenses		
Computer	**5,816**	6,709
Contractors and consulting	**-**	132
Human resources	**28,360**	70,780
Office and miscellaneous	**76**	-
Physicians and specialists	**23,208**	16,678
Project administration	**-**	17,000
Telephone	**417**	123
Travel	**-**	1,348
	57,877	112,770
Surplus for the year	**$ -**	$ -

East Kootenay Division of Family Practice Society
Schedule 19 - Nuka Initiative
(Unaudited)

For the year ended March 31	**2022**	2021
Revenue		
Donations - Nuka	**$ -**	$ 26,103
Deferred revenue recognized	**8,432**	-
Revenue deferred to future years	**(8,432)**	(8,432)
	-	17,671
Expenses		
Contractors and consulting	**-**	17,671
Surplus for the year	**$ -**	$ -

East Kootenay Division of Family Practice Society
Schedule 20 - Provisional
(Unaudited)

For the year ended March 31	2022	2021
Revenue		
Interest and other	**$ 5,646**	$ 17,463
Surplus for the year	**$ 5,646**	$ 17,463

East Kootenay Division of Family Practice Society
Schedule 21 - Virtual Care Coordinator
(Unaudited)

For the year ended March 31	2022	2021
Revenue		
Virtual Clinics	$ 65,809	$ -
Revenue deferred to future years	(44,210)	-
	21,599	-
Expenses		
Contractors and consulting	122	-
Human resources	6,680	-
Project administration	14,775	-
Travel	22	-
	21,599	-
Surplus for the year	$ -	$ -

SOCITIES ACT BYLAWS

TO BE APPROVED AT OCTOBER AGM

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BYLAWS OF THE EAST KOOTENAY DIVISION OF FAMILY PRACTICE

1. INTERPRETATION

1.1 Definitions

In these Bylaws and the Constitution of the Society, unless the context otherwise requires:

a. "**Address of the Society**" means the address of the Society as filed from time to time with the Registrar;

b. "**Area**" means the geographic region or regions for which the Society is responsible, as determined from time to time by the Board in consultation with the Provincial Divisions Office;

c. "**Board**" means the Directors acting as authorized by *Societies Act*, the Constitution and these Bylaws in managing or supervising the management of the affairs of the Society and exercising the powers of the Society;

d. "**Board Resolution**" means:

   i. a resolution passed by a simple majority of the votes cast in respect of the resolution by the Directors entitled to vote on such matter:

      1. in person at a duly constituted meeting of the Board, or
      2. by Electronic Means in accordance with these Bylaws, or
      3. by combined total of the votes cast in person and by Electronic Means; or

   ii. a resolution that has been submitted to all Directors and consented to in writing by 2/3 of the Directors who would have been entitled to vote on the resolution at a meeting of the Board,

   and a Board Resolution approved by any of these methods is effective as though passed at a meeting of the Board;

e. "**Bylaws**" means the bylaws of the Society as filed with the Registrar;

f. "**Chair**" means the Person elected to the office of chairperson of the Society in accordance with Part 12 of these Bylaws;

g. "**College**" means the College of Physicians and Surgeons of British Columbia, and includes a successor thereto;

h. "**Constitution**" means the constitution of the Society as filed with the Registrar;

i. "**Directors**" means those Persons who are, or who subsequently become, directors in accordance with these Bylaws and have not ceased to be directors;

j. "**Electronic Means**" means any system or combination of systems, including but not limited to mail, telephonic, electronic, radio, computer or web-based technology or communication facility, that:

   i. in relation to a meeting or proceeding, permits all participants to communicate with each other or otherwise participate in the proceeding

contemporaneously, in a manner comparable, but not necessarily identical, to a meeting where all were present in the same location, and

ii. in relation to a vote, permits all eligible voters to cast a vote on the matter for determination in a manner that adequately discloses the intentions of the voters;

k. "**Eligible Party**" means:

i. a Person who is or was a Director or officer of the Society, as determined in accordance with these Bylaws; or

ii. such other Person described in the *Societies Act* that is appointed or elected by the Directors to exercise authority to manage the activities or internal affairs of the Society as a whole or in respect of a principal unit of the Society; or

iii. a Person who holds or held a position equivalent to what is described in either sub-paragraph (i) or (ii) above in a subsidiary of the Society, if any; or

iv. the heir or personal or legal representative of a Person described in (i), (ii) or (iii) above.

l. "**Executive Director**" means the Senior Manager appointed by the Board in accordance with section 13.1 with the duties set out in section 13.2;

m. "***Income Tax Act***" means the *Income Tax Act*, R.S.C. 1985 (5th Supp.), c.1 as amended from time to time;

n. "**General Meeting**" means a meeting of the Members, and includes any annual general meeting and any special or extraordinary general meetings of the Society;

o. "**Members**" means those Persons who are, or who subsequently become, members of the Society in accordance with these Bylaws and, in either case, have not ceased to be members;

p. "***mutatis mutandis***" means with the necessary changes having been made to ensure that the language makes sense in the context;

q. "**Ordinary Resolution**" means:

i. a resolution passed by a simple majority of the votes cast in respect of the resolution by those Members entitled to vote:

1. in person at a duly constituted general meeting, or
2. by Electronic Means in accordance with these Bylaws, or
3. by combined total of the votes cast in person at a General Meeting and the votes cast by Electronic Means; or

ii. a resolution that has been submitted to the Members and consented to in writing by not less than the threshold required by the *Societies Act*,

iii. and an Ordinary Resolution approved by any one or more of these methods is effective as though passed at a General Meeting of the Society;

r. "**Person**" means a natural person;

s. "**Registered Address**" of a Member or Director means the address of that Person as recorded in the register of Members or the register of Directors;

t. "**Provincial Divisions Office**" means the department of Doctors of BC responsible for the support and administration of divisions;

u. "**Registrar**" means the Registrar of Companies of the Province of British Columbia;

v. "**Secretary**" means a Person elected to the office of secretary of the Society in accordance with Part 12 of these Bylaws;

w. "**Senior Manager**" means a Person appointed by the Board under section 13.1, if any, to exercise the Board's delegated authority to manage the activities or internal affairs of the Society as a whole or in respect of a principal unit of the Society;

x. "**Society**" means the "East Kootenay Division of Family Practice Society";

y. "***Societies Act***" means the *Societies Act* of British Columbia, as amended from time to time, and includes any successor legislation thereto;

z. "**Special Resolution**" means:

   i. a resolution, of which the notice required by the *Societies Act* and these Bylaws has been provided, passed by the threshold of votes required by the *Societies Act* cast in respect of the resolution by those Members entitled to vote:

      1. in person at a duly constituted general meeting, or
      2. by Electronic Means in accordance with these Bylaws, or
      3. by combined total of the votes cast in person at a general meeting and the votes cast by Electronic Means; or a resolution that has been submitted to the Members and consented to in writing by every Member who would have been entitled to vote on the resolution in person at a General Meeting of the Society,

   ii. and a Special Resolution approved by any one or more of these methods is effective as though passed at a General Meeting of the Society;

aa. "**Treasurer**" means a Person elected to the office of treasurer of the Society in accordance with Part 12 of these Bylaws; and

bb. "Vice-Chair" means a Person elected to the office of vice-chair of the Society in accordance with Part 12 of these Bylaws.

1.2 *Societies Act* Definitions

Except as otherwise provided, the definitions in the Societies Act on the date these Bylaws become effective apply to these Bylaws and the Constitution.

1.3 Plural and Singular Forms

In these Bylaws, a word defined in the plural form includes the singular and vice-versa.

2. MEMBERSHIP

2.1 Membership Classes

There are two classes of membership in the Society, consisting of one voting class, called "General Members", and one non-voting class, called "Associate Members".

Membership in the Society will be restricted to:

a. those Persons who are currently members and who transition to a continuing class of membership under paragraph 2.2(a); and

b. those eligible Persons whose subsequent application for admission as a Member has been accepted in accordance with these Bylaws.

2.2 Transition of Membership

On the date these Bylaws come into force:

a. each Person who is a member of the Society and who is eligible for membership under these Bylaws will continue as a Member in the appropriate class, as determined by the Board, until the conclusion of the current term of membership, unless sooner ceasing; and

b. each Person who is a member of the Society who is not eligible for any class of membership under these Bylaws will be deemed to have resigned from membership effective that date.

2.3 Eligibility for Membership

To be eligible for transition or admission as a Member in a particular class, a Person must meet the requirements below for that class:

General Member

a. be 19 years of age or older;

b. be a general practitioner or family physician who is duly licensed by, and in good standing with, the College; and

c. practice as a general practitioner or family physician with or without hospital privileges within the Area.

Associate Member

a. not be eligible for admission as a General Member; and

b. belong to one or more of the following categories:

c. medical resident in good standing with the College;

d. retired general practitioner or family physician who, at the time of his or her retirement, was in good standing with the College;

e. ordinarily reside or practice (or practiced) as one of the above categories within the Area.

In the case of any ambiguity or doubt regarding the eligibility of a Person for membership, such ambiguity or doubt will be resolved by the Board in its discretion and the Board's decision will be final.

2.4 Membership Coordinator

The Board may delegate the review and acceptance of new applications and re-applications for membership to a position, including the Executive Director, or committee within the Society, which Person or body will be referred to for the purposes of these sections as the membership coordinator.

If no membership coordinator is designated by the Board, then the duties for that position set out in these Bylaws remain with the Board.

2.5 Application for Membership

An eligible Person may apply to the Society to become a Member as follows:

a. by submitting a completed application, in such form and manner as may be established by the Society, at the Address of the Society or to an authorized representative of the Society; and

b. by submitting such information or documentation as the membership coordinator may require to confirm eligibility for membership.

2.6 Reviewing and Acceptance of Application

The membership coordinator, if any, shall review all applications for membership in the Society and may, if necessary to determine eligibility for membership, request the Person or Organization to provide further information or documentation in support of the application.

The membership coordinator may, by entering the Person's information into the membership register, accept that Person as a Member in the appropriate class as determined in accordance with these Bylaws.

2.7 Reporting and Ratification of Membership

The membership coordinator, if any, shall regularly report to the Board in relation to applications for membership received and approved.

At such times, the Board shall consider a Board Resolution to ratify the approval of memberships made in the last interval and may, if necessary determine any issues related to membership of an applicant.

2.8 Referral of Application to Board

The membership coordinator, if any, may at any time refer an application for membership to the Board for further consideration and, if so referred, the Board may, by Board Resolution, accept, postpone or refuse an application for membership.

The Board may refuse or postpone an application for membership for any reason which, in the Board's view, is necessary or prudent to protect the reputation and integrity of the Society.

2.9 Membership not Transferable

Membership is not transferable by a Member.

2.10 Term of Membership

Once accepted as a Member, a Person continues as a Member for a term of five (5) years, which term will expire at the conclusion of the annual general meeting that occurs during the fifth year (or portion thereof) of the Member's term, unless sooner ceasing.

2.11 Renewal and Re-application of Membership

A Member who continues to be eligible may renew his or her membership prior to its expiry in such manner as may be determined by the Board from time to time.

A Person whose membership has expired or otherwise ceased other than by expulsion and who remains eligible may re-apply for membership after its expiry in accordance with section 2.5.

A Person who was expelled from membership may, unless prohibited by the terms of the expulsion, re-apply for membership in accordance with the terms of the expulsion resolution,

provided that if the expulsion resolution provided no restrictions related to reapplication, the Person may reapply for membership after one (1) year from the date of expulsion.

All reapplications for membership are subject to acceptance by the Board.

2.12 Cessation of Membership

A Person will immediately cease to be a Member:

a. upon the date of:
b. delivering his or her resignation in writing to the Address of the Society; or
c. the effective date of the resignation stated thereon, whichever is later; or
d. upon the expiry of his or her term, unless renewed pursuant to section 2.11; or
e. upon ceasing to be eligible for more than 60 consecutive days; or
f. upon his or her expulsion; or
g. upon his or her death.

3. MEMBERSHIP RIGHTS AND OBLIGATIONS

3.1 Rights of Membership

A Member in good standing has the following rights of membership by class:

General Member

a. to receive notice of, and to attend, all General Meetings;
b. to make or second motions at a General Meeting and to speak in debate on motions under consideration in accordance with such rules of order as may be adopted;
c. to serve on committees of the Society, as invited;
d. to exercise a vote on matters for determination at General Meetings;
e. to nominate for the election of Directors;
f. may be nominated, if eligible, to stand for election as a Director;
g. may participate in the programs and initiatives of the Society, in accordance with such criteria as may be determined by the Board from time to time.

Associate Member

a. to receive notice of, and to attend, all General Meetings;

b. to speak in debate on motions under consideration in accordance with such rules of order as may be adopted;

c. may serve on committees of the Society, as invited;

d. to participate in the programs and initiatives of the Society, in accordance with such criteria as may be determined by the Board from time to time.

3.2 Standing of Members

All Members are deemed to be in good standing except a Member who has been suspended by the Society.

A Member who is not in good standing has the right to receive notice of, and attend, all General Meetings, and the right to participate in programs or initiatives of the Society (subject to eligibility) but is suspended from all other rights set out in section 3.1 for as long as he or she remains not in good standing.

3.3 Dues

There will be no annual membership dues.

3.4 Compliance with Constitution, Bylaws and Policies

Every Member will, at all times:

a. uphold the Constitution and comply with these Bylaws, the Regulations and the policies of the Society in effect from time to time;

b. abide by such codes of conduct and ethics adopted by the Society; and

c. further and not hinder the purposes, aims and objects of the Society.

3.5 Suspension or Expulsion of Member

Following an appropriate investigation or review of a Member's conduct or actions in accordance with such policies as may be established by the Board, the Board may, by Board Resolution, expel, suspend or otherwise discipline a Member for conduct which, in the reasonable opinion of the Board:

a. is improper or unbecoming for a Member;

b. is contrary to section 3.4; or

c. is likely to endanger the reputation or hinder the interests of the Society.

The Board must provide notice of a proposed expulsion, suspension or discipline of a Member to the Member in question, accompanied by a brief statement of the reasons for the disciplinary action.

The Member who is the subject of the proposed expulsion, suspension or discipline will be provided a reasonable opportunity to respond to the proposed discipline at or before the time the Board Resolution is considered.

3.6 No Distribution of Income to Members

The activities of the Society will be carried on without purpose of gain for its members and

any income, profits or other accretions to the Society will be used in promoting the purposes of the Society. This section was previously unalterable.

4. MEETINGS OF MEMBERS

4.1 Time and Place of General Meetings

The General Meetings of the Society will be held at such time and place, in accordance with the *Societies Act*, as the Board decides.

4.2 Annual General Meetings

An annual general meeting will be held at least once in every calendar year and in accordance with the requirements of the *Societies Act*.

4.3 Extraordinary General Meeting

Every General Meeting other than an annual general meeting is an extraordinary general meeting.

4.4 Calling of Extraordinary General Meeting

The Society will convene an extraordinary general meeting by providing notice in accordance with the *Societies Act* and these Bylaws in any of the following circumstances:

a. at the call of the Chair;

b. when resolved by Board Resolution; or

c. when such a meeting is requisitioned by the Members in accordance with the *Societies Act.*

4.5 Notice of General Meeting

The Society will send notice of every General Meeting to:

a. each Member shown on the register of Members on the date the notice is sent; and

b. the auditor, if any is appointed,

c. not less than 14 days and not more than 60 days prior to the date of the General Meeting. No other Person is entitled to be given notice of a General Meeting.

d. Notice of a General Meeting may be sent by the Society to a Member either personally, by delivery, courier or by mail posted to such Member's Registered Address, or, where the member has provided a fax number or e-mail address, by fax or e-mail, respectively.

4.6 Contents of Notice

Notice of a General Meeting will specify the place, the day and the time of the meeting and will include the text of every Special Resolution to be proposed or considered at that meeting.

If the Board has determined to hold a General Meeting that will include participation by Electronic Means, the notice of that meeting must inform Members that they may participate by Electronic Means and provide instructions on how this may be done.

4.7 Omission of Notice

The accidental omission to give notice of a General Meeting to a Member, or the non-receipt of notice by a Member, does not invalidate proceedings at that meeting.

5. PROCEEDINGS AT GENERAL MEETINGS

5.1 Business Required at Annual General Meeting

The following business is required to be conducted at each annual general meeting of the Society:

a. the adoption of an agenda;

b. the approval of the minutes of the previous annual general meeting and any extraordinary general meetings held since the previous annual general meeting;

c. consideration of the report of the Directors;

d. consideration of the financial statements and the report of the auditor thereon, if any;

e. the appointment of an auditor;

f. the election/appointment of Directors; and

g. the consideration of any Members' proposals submitted in accordance with the *Societies Act*.

The annual general meeting may include other business as determined by the Board in its discretion.

5.2 Attendance at General Meetings

In addition to Members, Directors and the Society's auditor, the Board may also invite any other Person or Persons to attend a General Meeting as observers and guests. All observers and guests may only address the assembly at the invitation of the Person presiding as chair, or by Ordinary Resolution.

5.3 Electronic Participation in General Meetings

The Board may determine, in its discretion, to hold any General Meeting in whole or in part by Electronic Means, so as to allow some or all Members to participate in the meeting remotely.

Where a General Meeting is to be conducted using Electronic Means, the Board must take reasonable steps to ensure that all participants are able to communicate and participate in the meeting adequately and, in particular, that remote participants are able to participate in a manner comparable to participants present in person, if any.

Persons participating by permitted Electronic Means are deemed to be present at the General Meeting.

5.4 Registration of Members

Every Member attending a General Meeting must register their attendance prior to the call to order for the meeting in such manner as may be established by the Board from time to time.

5.5 Requirement of Quorum

No business, other than the confirmation or election of a Person to chair the meeting and the adjournment or termination of the meeting, will be conducted at a General Meeting at a time when a quorum is not present.

5.6 Quorum

A quorum at a General Meeting is five (5) General Members in good standing as of the date of the meeting, present in person or by permitted Electronic Means.

5.7 Lack of Quorum

If a quorum is not present within 60 minutes (or such lesser time as may be determined by the Person presiding as chairperson) from the time appointed for a General Meeting, the meeting will be terminated and, except where the meeting was convened on the requisition of Members, the Board will reconvene the meeting at a later date with notice provided in accordance with section 4.5.

5.8 Loss of Quorum

If at any time during a General Meeting there ceases to be a quorum present, business then in progress will be suspended until there is a quorum present or until the meeting is adjourned or terminated.

5.9 Chair

The Chair will, subject to a Board Resolution appointing another Person, preside as chairperson at all General Meetings.

If at any General Meeting the Chair and such alternate Person appointed by a Board Resolution, if any, are not present within 15 minutes after the time appointed for the meeting, the Directors present may choose one of their number to preside as chairperson at that meeting.

5.10 Alternate Chair

If a Person presiding as chairperson of a General Meeting wishes to step down as chairperson for all or part of that meeting, he or she may designate an alternate to preside as chairperson for such meeting or portion thereof, and upon such designated alternate receiving the consent of a majority of the Members present at such meeting, he or she may preside as chairperson.

5.11 Chair to Determine Procedure

In the event of any doubt, dispute or ambiguity in relation to procedural matters or parliamentary process at a General Meeting, the Person presiding as chairperson will have the authority to interpret and apply such rules of order as the meeting has adopted and determine matters in accordance with those rules, as well as the *Societies Act* and these Bylaws.

5.12 Adjournment

A General Meeting may be adjourned from time to time and from place to place, but no business will be transacted at an adjourned meeting other than the business left unfinished at the meeting from which the adjournment took place.

5.13 Notice of Adjournment

It is not necessary to give notice of an adjournment or of the business to be transacted at an adjourned meeting except where a meeting is adjourned for more than 14 days, in which case notice of the adjourned meeting will be given pursuant to section 4.5.

5.14 Minutes of General Meetings

The Secretary or such other Person designated by the Board will ensure that minutes are taken for all General Meetings.

6. VOTING BY MEMBERS

6.1 Ordinary Resolution Sufficient

Unless the *Societies Act,* these Bylaws or adopted rules of order provide otherwise, every issue for determination by a vote of the Members will be decided by an Ordinary Resolution.

6.2 Entitlement to Vote

Each General Member in good standing is entitled to one (1) vote on matters for determination by the Members. No other Person is entitled to vote on a matter for determination by the Members, whether at a General Meeting or otherwise.

6.3 Voting Other than at General Meeting

The Board may, in its sole discretion, conduct a vote of the Members other than at a General Meeting, whether by mail-in ballot or Electronic Means, provided in each case that the Society provides each Member in good standing with notice of:

a. the text of the resolutions to be voted on;

b. the open and closing dates for casting a vote; and

c. instructions on how a Member may cast a vote.

6.4 Voting Methods

Voting by Members may occur by any one or more of the following methods, in the discretion of the Board:

d. by show of hands or voting cards;

e. by written ballot; or

f. by vote conducted by Electronic Means.

Where a vote is to be conducted by show of hands or voting cards, and prior to the question being put to a vote, a number of Members equal to not less than 10% of the votes present may request a secret ballot, and where so requested the vote in question will then be conducted by written ballot or other means whereby the tallied votes can be presented anonymously in such a way that it is impossible for the assembly to discern how a given Member voted.

6.5 Voting by Proxy

Voting by proxy is not permitted.

6.6 Voting by Chair

If the Person presiding as chairperson of a General Meeting is a General Member, then he or she may, in his or her sole discretion, cast a vote on any motion or resolution under consideration at the same time as voting occurs by all Members. A chairperson who is not a General Member has no vote.

The chairperson of a General Meeting does not have a second or a casting vote in the event of a tie and a motion or resolution that is tied is defeated.

7. DIRECTORS

7.1 Management of Property and Affairs

The Board will have the authority and responsibility to manage, or supervise the management of, the property and the affairs of the Society.

7.2 Composition of Board

The Board will be composed of a minimum of five (5) and a maximum of seven (7) Directors, each of whom will be elected or appointed in accordance with these Bylaws. The exact number of directors to be elected or appointed from time to time shall be determined by the then-existing Board in its discretion.

The Board composition will be subject to the following rules:

a. At least two (2) and not more than three (3) Directors who are General Members;

b. Up to 4 additional Directors who are not members may be any Person ordinarily resident in the Area who is nominated in accordance with section 8.1 hereof and who has skills or experience that may benefit the Society in the reasonable opinion of the Board.

c. To the extent possible, the Board will strive to be composed of Directors from the various communities in the Society's Area.

d. A Director who is eligible for one of the above categories on election [or appointment], but who later ceases to be eligible for that category will remain in office until the next annual general meeting, at which an election may be held for the vacated position.

7.3 Invalidation of Acts

No act or proceeding of the Board is invalid by reason only of there being less than the required number of Directors in office.

7.4 Duties of Directors

Every Director will:

a. further and not hinder the purposes, aims and objects of the Society;

b. act honestly and in good faith with a view to the best interests of the society;

c. exercise the care, diligence and skill that a reasonably prudent individual would exercise in comparable circumstances;

d. act in accordance with *Societies Act*;

e. uphold the Constitution and comply with these Bylaws, the Regulations and the policies of the Society in effect from time to time; and

f. abide by such codes of conduct and ethics adopted by the Society.

7.5 Qualifications of Directors

A Person may not be nominated, elected or appointed to serve (or continue to serve) as a Director if he or she:

a. is less than 18 years of age;

b. has been found by any court, in Canada or elsewhere, to be incapable of managing his or her own affairs;

c. is an undischarged bankrupt;

d. if a director referred to in subsection 7.2(a) above is not a General Member;

e. if a director referred to in subsection 7.2(b) above does not hold the qualifications referred to in that subsection; or

f. has been convicted of a prescribed offence within the prescribed period, for which no pardon has been granted, all in accordance with the *Societies Act*.

7.6 Term of Directors

The term of office of Directors will normally be two (2) years. However, the Board may by Board Resolution determine that some or all vacant Directors' positions will have a term of less than two (2) years, the length of such term to be determined by the Directors in their discretion.

For purposes of calculating the duration of a Director's term of office, the term will be deemed to commence at the close of the annual general meeting at which such Director was elected. If, however, the Director was elected at an extraordinary general meeting his or her term of office will be deemed to have commenced at the close of the annual general meeting next following such extraordinary general meeting.

7.7 Consecutive Terms and Term Limits

Directors may be elected for up to eight (8) consecutive years, by any combination of terms. A Person who has served as a Director for eight (8) consecutive years may not be re-elected for at least one (1) year following the expiry of his or her latest term.

7.8 Extension of Term to Maintain Minimum Number of Directors

Every Director serving a term of office will retire from office at the close of the annual general meeting in the year in which his or her term expires, provided that if insufficient successors are elected and the result is that the number of Directors would fall below five (5), the Person or Persons previously elected as Directors may, if they consent, continue to hold office, and the term of such Director or Directors is deemed to be extended, until such time as successor Directors are elected.

7.9 Appointment to fill Vacancy

If a Director ceases to hold office before the expiry of his or her term, the Board, by Board Resolution, may appoint a person qualified in accordance with section 7.5 and otherwise eligible for that category of director position to fill the resulting vacancy.

The position occupied by an appointed replacement Director will become available for election at the next annual general meeting and each such appointed replacement Director will continue in office until the conclusion of the next annual general meeting unless sooner ceasing to be a Director. The appointed replacement Director may run for the vacant position.

The period during which a Person serves as an appointed replacement Director does not count toward the term limits set out above.

7.10 Removal of Director

The Members may remove a Director before the expiration of such Director's term of office by Special Resolution and may elect a replacement Director by Ordinary Resolution to serve for the balance of the removed Director's term.

7.11 Ceasing to be a Director

A Person will immediately and automatically cease to be a Director:

a. upon the date which is the later of:
b. the date of delivering his or her resignation in writing to the Chair or to the Address of the Society; and
c. the effective date of the resignation stated therein; or
d. upon the expiry of his or her term, unless re-elected; or
e. upon the date such Person is no longer qualified pursuant to section 7.5; or
f. upon his or her removal; or
g. upon his or her death.

7.12 Transition of Directors' Terms

Each Person who is a Director on the date these Bylaws become effective will continue as a Director for the term to which he or she was most recently elected.
Previous terms served by Directors on transition will be counted towards the term limits set out above.

8. NOMINATION AND ELECTION OF DIRECTORS

8.1 Nomination of Directors

Nominations for election as a Director must be made in accordance with the applicable provisions of these Bylaws, including this section, and such policies and procedures as are established by the Board from time to time, provided that such policies or procedures do not conflict with these Bylaws.

All nominations are subject to the following rules:

a. A nomination must be made in writing, in a form established by the Society.
b. A nominee must be qualified in accordance with section 7.5 to be nominated and must remain qualified in order to stand for election;
c. A Member may nominate him or herself, and the nomination must be signed by the Member nominated and one (1) other General Member in good standing.
d. A Member may not nominate more nominees than the total number of Director

positions available for election.

e. Nominations must be submitted in advance of an election, in accordance with such deadlines as may be established by policy. Nominations will not be permitted from the floor at a General Meeting.

8.2 Elections Generally

Directors will be elected by acclamation or by vote of the Members, in accordance with the applicable provisions of these Bylaws and such election policies and procedures as are established by the Society from time to time.

To the extent possible, approximately half of Director positions will become vacant for election or re-election each year.

8.3 Election at Annual General Meeting

Election of Directors will normally take place at, or prior to, the annual general meeting and Directors so elected will take office commencing at the close of such meeting.

8.4 Election by Acclamation

In elections where the number of eligible nominees at the close of the nomination period is equal to or less than the number of positions for Directors that will become vacant at the close of the next annual general meeting, then the eligible nominees are deemed to be elected by acclamation and no vote will be required.

8.5 Election by Secret Ballot

In elections where there are more eligible nominees than vacant positions for Directors at the close of the nomination period, election will be by secret ballot and the following rules will apply:

a. The secret ballot may be conducted by written ballot or Electronic Means, either at or prior to the annual general meeting, all at the discretion of the Board.

b. Ballots will be sent or otherwise made accessible to all Members in good standing, and only to those Persons.

c. Each ballot will include the name of each eligible nominee and the number of vacancies to be filled.

d. No Member will vote for more Directors than the number of vacant positions. Any ballot will be deemed to be void if it records votes for more nominees than there are vacant positions.

e. Ballots will be counted following the close of the election period by scrutineers appointed by the Board.

f. Nominees will be deemed to be elected in order of those nominees receiving the most votes.

g. In the event of a tie between two or more eligible nominees for the final vacant position, the scrutineers will place one ballot marked for each tied nominee into a suitable container and the Chair will draw one ballot from the container at random, which nominee selected will be elected to the final vacant position.

h. The results of an election by secret ballot will be announced to all Members following the counting of the ballots.

8.6 Nomination and Election Policies

The Board may establish, by Board Resolution from time to time, such additional policies and procedures related to the nomination and election of Directors as it determines are necessary or prudent for the Society, provided that no such policy and procedure is valid to the extent that it is contrary to the Societies Act or these Bylaws.

9. POWERS AND RESPONSIBILITIES OF THE BOARD

9.1 Powers of Directors

The Board may exercise all such powers and do all such acts and things as the Society may exercise and do, and which are not by these Bylaws or by statute or otherwise lawfully directed or required to be exercised or done by the Members in General Meeting, but nevertheless subject to the provisions of:

a. all laws affecting the Society; and
b. these Bylaws and the Constitution.

Without limiting the generality of the foregoing, the Board will have the power to make expenditures, including grants, gifts and loans, whether or not secured or interest-bearing, in furtherance of the purposes of the Society. The Board will also have the power to enter into trust arrangements or contracts on behalf of the Society in furtherance of the purposes of the Society.

9.2 Policies and Procedures

The Board may establish such rules, regulations, policies or procedures relating to the affairs of the Society as it deems expedient, provided that no rule, regulation, policy or procedure is valid to the extent that it is inconsistent with the *Societies Act*, the Constitution or these Bylaws.

9.3 Remuneration of Directors and Officers and Reimbursement of Expenses

Subject to the *Societies Act*, Directors may receive remuneration from the Society for acting in their capacity as Directors, in accordance with the policies established by the Board. In addition, a Director may be reimbursed for all expenses necessarily and reasonably incurred by him or her while engaged in the affairs of the Board, provided that all claims for reimbursement are in accordance with established policies.

A majority of the Directors must not receive or be entitled to receive remuneration from the society under contracts of employment or contracts for services, other than remuneration for being a Director.

9.4 Investment of Property and Standard of Care

If the Board is required to invest funds on behalf of the Society, the Board may invest the property of the Society in any form of property or security in which a prudent investor might invest. The standard of care required of the Directors is that they will exercise the care, skill, diligence and judgment that a prudent investor would exercise in making investments in light of the purposes and distribution requirements of the Society. The Board may establish further policies related to the investment of the Society's funds and property, provided that such policies are not contrary to the *Societies Act* or these Bylaws.

9.5 Investment Advice

The Directors may obtain advice with respect to the investment of the property of the Society and may rely on such advice if a prudent investor would rely upon the advice in comparable circumstances.

9.6 Delegation of Investment Authority to Agent

The Directors may delegate to a stockbroker, investment dealer, or investment counsel the degree of authority with respect to the investment of the Society's property that a prudent investor might delegate in accordance with ordinary business practice.

10. PROCEEDINGS OF THE BOARD

10.1 Board Meetings

Meetings of the Board may be held at any time and place determined by the Board. Meetings may include regular meetings and ad hoc meetings, as determined by the Board.

10.2 Regular Meetings

The Board may decide to hold regularly scheduled meetings to take place at dates and times set in advance by the Board. Once the schedule for regular meetings is determined and notice given to all Directors, no further notice of those meetings is required to be provided to a Director unless:

a. that Director was not in office at the time notice of regular meetings was provided; or

b. the date, time or place of a regular meeting has been altered.

10.3 Ad Hoc Meetings

The Board may hold an ad hoc meeting in any of the following circumstances:

a. at the call of the Chair; or

b. by request of any two (2) or more Directors.

10.4 Notice of Board Meetings

At least two (2) days' notice will be sent to each Director of:

a. an ad hoc board meeting; or

b. a change to a regular board meeting for which notice was previously provided.

However, no formal notice will be necessary if all Directors were present at the preceding meeting when the time and place of the meeting was decided or are present at the meeting or waive notice thereof in writing or give a prior verbal waiver to the Secretary.

For the purposes of the first meeting of the Board held immediately following the election of a Director or Directors conducted at a general meeting, or for the purposes of a meeting of the Board at which a Director is appointed to fill a vacancy in the Board, it is not necessary to give notice of the meeting to the newly elected or appointed Director or Directors for the meeting to be properly constituted.

If a meeting of the Board will permit participation by Electronic Means, the notice of that meeting must inform Directors and other participants (if any) that they may participate by

Electronic Means and provide instructions on how to do so.

10.5 Attendance at Board Meetings

Every Director is entitled to attend each meeting of the Board.

No other Person is entitled to attend meetings of the Board, but the Board may invite any Person or Persons to attend one or more meetings of the Board as advisors, observers or guests.

10.6 Participation by Electronic Means

The Board may determine, in its discretion, to hold any meeting or meetings of the Board in whole or in part by Electronic Means, so as to allow some or all parties to participate in the meeting remotely.

Where a meeting of the Board is conducted by Electronic Means, the Society must take reasonable steps to ensure that all participants are able to communicate and participate in the meeting.

10.7 Quorum

Quorum for meetings of the Board will be a majority of the Directors currently in office.

10.8 Director Conflict of Interest

A Director who has a direct or indirect material interest in a contract or transaction (whether existing or proposed) with the Society, or a matter for consideration by the Directors:

a. will be counted in the quorum at a meeting of the Board at which the contract, transaction or matter is considered;
b. will disclose, in accordance with the *Societies Act*, fully and promptly the nature
c. and extent of his or her interest in the contract, transaction or matter;
d. may not vote on the contract, transaction or matter;
e. will absent him or herself from the meeting or portion thereof:
    i. at which the contract, transaction or matter is discussed, unless requested by the Board to remain to provide relevant information; and
    ii. in any case, during the vote on the contract, transaction or matter; and
f. will refrain from any action intended to influence the discussion or vote.

The Board may establish further policies governing conflicts of interest of Directors and others, provided that such policies must not contradict the *Societies Act* or these Bylaws.

10.9 Chair of Meetings

The Chair will, subject to a Board Resolution appointing another Person, preside as chair at all meetings of the Board.

If at any meeting of the Board the Chair and such alternate Person appointed by a Board Resolution, if any, are not present within 15 minutes after the time appointed for the meeting or requests that he or she not chair that meeting, the Directors present may choose one of their number to chair that meeting.

10.10 Alternate Chair

If the Person presiding as chair of a meeting of the Board wishes to step down as chair for all or part of that meeting, he or she may designate an alternate to chair such meeting or portion thereof, and upon such designated alternate receiving the consent of a majority of the Directors present at such meeting, he or she may preside as chair.

10.11 Chair to Determine Procedure

In the event of any doubt, dispute or ambiguity in relation to procedural matters or parliamentary process at a meeting of the Board, the person presiding as chair will have the authority to interpret and apply such rules of order as the meeting has adopted and determine matters in accordance with those rules, as well as the *Societies Act* and these Bylaws.

10.12 Minutes of Board Meetings

The Secretary or such other Person designated by the Board will ensure that minutes are taken for all meetings of the Board.

11. DECISION MAKING AT BOARD MEETINGS

11.1 Passing Resolutions and Motions

Any issue at a meeting of the Board which is not required by the *Societies Act*, these Bylaws or such rules of order as may apply to be decided by a resolution requiring more than a simple majority will be decided by Board Resolution.

11.2 Resolution in Writing

A Board Resolution may be in two or more counterparts which together will be deemed to constitute one resolution in writing. Such resolution will be filed with minutes of the proceedings of the Board and will be deemed to be passed on the date stated therein or, in the absence of such a date being stated, on the latest date stated on any counterpart.

11.3 Entitlement to Vote

Subject to section 10.8, each Director is entitled to one (1) vote on all matters at a meeting of Board. No other Person is entitled to a vote at a meeting of the Board.

11.4 Procedure for Voting

Except where expressly provided for in these Bylaws, voting on matters at a meeting of the Board may occur by any one or more of the following mechanisms, in the discretion of the Chair:

a. by show of hands;

b. by written ballot;

c. by roll-call vote or poll; or

d. by Electronic Means.

On the request of any one (1) or more Directors, a vote will be conducted by written ballot or other means whereby the tallied votes can be presented anonymously, in such a way that it is impossible for the assembly to discern how a given Director voted.

12. OFFICERS

12.1 Officers

The officers of the Society are the Chair, Vice-Chair, Secretary and Treasurer, together with such other offices, if any, as the Board, in its discretion, may create. The above required officers must be Directors.

The Board may, by Board Resolution, create and remove such other offices of the Society as it deems necessary and determine the duties and responsibilities of all officers.

12.2 Election of Officers

At each meeting of the Board immediately following an annual general meeting, the Board will elect the officers.

12.3 Term of Officer

The term of office for each officer will be one (1) year, commencing on the date the Director is elected as an officer in accordance with section 12.2 and continuing until the first meeting of the Board held after the next following annual general meeting. A Director may be elected as an officer for consecutive terms.

12.4 Removal of Officers

A Person may be removed as an officer by Board Resolution.

12.5 Replacement

Should the Chair or any other officer for any reason be unable to complete his or her term, the Board will remove such officer from his or her office and will elect a replacement without delay.

12.6 Duties of Chair

The Chair will supervise the other officers in the execution of their duties and will preside at all meetings of the Society and of the Board.

12.7 Duties of Vice-Chair

The Vice-Chair will assist the Chair in the performance of his or her duties and will, in the absence of the Chair, perform those duties. The Vice-Chair shall also perform such additional duties as may be assigned by the Board.

12.8 Duties of Secretary

The Secretary will be responsible for making the necessary arrangements for:

a. the issuance of notices of meetings of the Society and the Board;
b. the keeping of minutes of all meetings of the Society and the Board;
c. the custody of all records and documents of the Society, except those required to be kept by the Treasurer;
d. the maintenance of the register of Members; and
e. the conduct of the correspondence of the Society.

12.9 Duties of Treasurer

The Treasurer will be responsible for making the necessary arrangements for:

a. the keeping of such financial records, reports and returns, including books of account, as are necessary to comply with the *Societies Act* and the *Income Tax Act*; and

b. the rendering of financial statements to the Directors, Members and others, when required.

12.9 Absence of Secretary at Meeting

If the Secretary is absent from any General meeting or meeting of the Board, the Directors present will appoint another Person to act as secretary at that meeting.

12.9 Combination of Offices of Secretary and Treasurer

The offices of Secretary and Treasurer may be held by one Person who will be known as the Secretary-Treasurer.

13. SENIOR MANAGERS

13.1 Appointment of Senior Managers

The Board may, by Board Resolution, appoint an Executive Director and may appoint other Senior Managers as it determines necessary from time to time.

The Board is responsible to supervise all Senior Managers in the performance of their duties.

13.2 Executive Director

The Executive Director, if any is appointed, will manage the affairs of the Society and shall be responsible for the administration of the Society. The Executive Director will direct and manage the Society's office and personnel. The Executive Director will have such other duties and responsibilities as determined by the Board.

The Executive Director shall regularly report to and advise the Board on all matters relevant to the affairs of the Society.

13.3 Removal of Senior Manager

A Person may be removed by Board Resolution.

14. INDEMNIFICATION

14.1 Indemnification of an Eligible Party

Subject to section 14.4 and the provisions of the *Societies Act*, an Eligible Party will be indemnified by the Society against all costs, charges and expenses, including legal and other fees, actually and reasonably incurred in connection with any legal proceeding or investigative action, whether current, threatened, pending or completed, to which that Eligible Party, by reason of his or her holding or having held authority within the Society:

a. is or may be joined as a party to such legal proceeding or investigative action; or

b. is or may be liable for or in respect of a judgment, penalty or fine awarded or imposed in, or an amount paid in settlement of, such legal proceeding or investigative action.

14.2 Indemnification of an Eligible Party in a Subsidiary

Notwithstanding section 14.1, the Society may, in its discretion, determine whether or not to indemnify an Eligible Party to the extent he or she is liable for or in respect of expenses by reason of holding or having held a position in a subsidiary, if any, of the Society, which position is equivalent to the position of an Eligible Party in the Society itself.

14.3 Advancement of Expenses

To the extent permitted by the *Societies Act* and subject to section 14.4, all costs, charges and expenses incurred by an Eligible Party with respect to any legal proceeding or investigative action may be advanced by the Society prior to the final disposition thereof, in the discretion of the Board, and upon receipt of an undertaking satisfactory in form and amount to the Board by or on behalf of the Eligible Party to repay such amount unless it is ultimately determined that the Eligible Party is entitled to indemnification hereunder.

14.4 Indemnification Prohibited

Notwithstanding sections 14.1 and 14.2, the Society must not indemnify an Eligible Party against any costs, charges and expenses, including legal and other fees, incurred in connection with any legal proceeding or investigative action, if such Eligible Party:

a. has already been reimbursed for such expenses;

b. has been judged by a court, in Canada or elsewhere, or by another competent authority to have committed any fault or to have omitted to do anything that he or she ought to have done;

c. in relation to the subject matter of the legal proceeding or investigative action, did not act honestly and in good faith with a view to the best interests of the Society or any subsidiary of the Society; or

d. in the case of a legal proceeding other than a civil proceeding, did not have reasonable grounds for believing that his or her conduct, in respect of which the legal proceeding or investigative action was brought, was lawful.

14.5 Indemnification not Invalidated by Non-Compliance

The failure of an Eligible Party of the Society to comply with the provisions of the *Societies Act,* or of the Constitution or these Bylaws, will not invalidate any indemnity to which he or she is entitled under this part.

14.6 Approval of Court

The Society may apply to the court for any approval of the court to the extent such approval is required by the *Societies Act* or otherwise to ensure that the indemnities herein are effective and enforceable.

14.7 Indemnification Deemed Term

Each Eligible Party of the Society on being elected or appointed will be deemed to have contracted with the Society upon the terms of the foregoing indemnities.

14.8 Purchase of Insurance

The Society may purchase and maintain insurance for the benefit of any or all Directors, officers, employees or agents against personal liability incurred by any such Person as a Director, officer, employee or agent.

15. COMMITTEES

15.1 Creation and Delegation to Committees

The Board may create such standing and special committees, working groups or task forces as may from time to time be required. Any such committee will limit its activities to the purpose or purposes for which it is appointed and will have no powers except those specifically conferred by a Board Resolution.

The Board may delegate any, but not all, of its powers to committees which may be in whole or in part composed of Directors as it thinks fit.

15.2 Standing and Special Committees

Unless specifically designated as a standing committee, a committee is deemed to be a special committee and any special committee so created must be created for a specified time period only.

A special committee will automatically be dissolved upon the earlier of the following:

a. the completion of the specified time period; or

b. the completion of the task for which it was created.

15.3 Terms of Reference and Rules

In the event the Board decides to create a committee, it must establish Terms of Reference for such committee. A committee, in the exercise of the powers delegated to it, will conform to any rules that may from time to time be imposed by the Board in the Terms of Reference or otherwise, and will report every act or thing done in exercise of those powers at the next meeting of the Board held after it has been done, or at such other time or times as the Board may determine.

15.4 Meetings

The members of a committee may meet and adjourn as they think proper and meetings of the committees will be governed *mutatis mutandis* by the rules set out in these Bylaws governing proceedings of the Board.

15.5 Dissolution of Committee

The Board may dissolve any committee by Board Resolution.

16. EXECUTION OF INSTRUMENTS

16.1 No Seal

The Society may have a corporate seal but will not use the seal for the purpose of executing documents.

16.2 Execution of Instruments

Contracts, documents or instruments in writing requiring the signature of the Society may be signed as follows:

a. by the Chair, together with one other director, or

b. in the event that the Chair is unavailable to provide a signature, by any two Directors

and all contracts, documents and instruments in writing so signed will be binding upon the Society without any further authorization or formality.

The Board will have power from time to time by Board Resolution to appoint any officer or officers, or any Person or Persons, on behalf of the Society either to sign contracts, documents and instruments in writing generally or to sign specific contracts, documents or instruments in writing.

16.3 Signing Officers

The Board will, from time to time by Board Resolution, appoint signing officers who shall be authorized to sign cheques and all banking documents on behalf of the Society.

17. FINANCIAL MATTERS AND REPORTING

17.1 Fiscal Year

The fiscal year of the Society may be determined by the Board from time to time.

17.2 Accounting Records

The Society shall maintain such financial and accounting records and books of account as are required by the *Societies Act* and applicable laws.

17.3 Borrowing Powers

In order to carry out the purposes of the Society, the Board may, on behalf of and in the name of the Society, raise or secure the payment or repayment of money in any manner it decides, including the granting of guarantees, and in particular, but without limiting the foregoing, by the issue of debentures.

17.4 Restrictions on Borrowing Powers

The Members may by Ordinary Resolution restrict the borrowing powers of the Board.

17.5 When Audit Required

The Society is not required by the *Societies Act* to be audited. However, the Society will conduct an audit or review of its annual financial statements if:

a. the Directors determine by Board Resolution that it is in the best interests of the Society to conduct an audit or review engagement; or

b. the Members require the appointment of an auditor by Ordinary Resolution,

in which case the Society will appoint an auditor qualified in accordance with, and will comply with all relevant provisions of, Part 9 of the *Societies Act* and these Bylaws.

17.6 Appointment of Auditor at Annual General Meeting

If the Society determines to conduct an audit or review engagement, an auditor will be appointed at an annual general meeting, to hold office until such auditor is reappointed at a subsequent annual general meeting or a successor is appointed in accordance with the procedures set out in the *Societies Act* or until the Society no longer wishes to appoint an auditor.

17.7 Vacancy in Auditor

Except as provided in section 16.12, the Board will fill any vacancy occurring in the office of auditor and an auditor so appointed will hold office until the next annual general

meeting.

17.8 Removal of Auditor

An auditor may be removed and replaced by Ordinary Resolution in accordance with the procedures set out in the *Societies Act*.

17.9 Notice of Appointment

An auditor will be promptly informed in writing of such appointment or removal.

17.10 Restrictions on Appointment

A Person who is not independent of the Society in accordance with section 113 of the *Societies Act* must not be appointed or act as the auditor for the Society.

17.11 Auditor's Report

The auditor, if any is appointed, must prepare a report on the financial statements of the Society in accordance with the requirements of the *Societies Act* and applicable law.

17.12 Participation in General Meetings

The auditor is entitled in respect of a General Meeting to:

a. receive every notice relating to the meeting that a Member is entitled to;
b. attend the meeting; and
c. to be heard at the meeting on any part of the business of the meeting that deals with the auditor's duties or function.

An auditor who is present at a General Meeting at which the financial statements are considered must answer questions concerning those financial statements, the auditor's report, if any, and any other matter relating to the auditor's duties or function.

18. NOTICE GENERALLY

18.1 Method of Giving Notice

Except as otherwise provided in these Bylaws, a notice may be given to a Member or a Director either personally, by delivery, courier or by mail posted to such Person's Registered Address, or, where the member has provided a fax number or electronic mail address, by fax or electronic mail, respectively.

18.2 When Notice Deemed to have been Received

A notice sent by mail will be deemed to have been given on the day following that on which the notice was posted. In proving that notice has been given, it is sufficient to prove the notice was properly addressed and put in a Canadian Government post office receptacle with adequate postage affixed, provided that if, between the time of posting and the deemed giving of the notice, a mail strike or other labour dispute which might reasonably be expected to delay the delivery of such notice by the mails occurs, then such notice will only be effective when actually received.

Any notice delivered personally, by delivery or courier, facsimile, or electronic mail will be deemed to have been given on the day it was so delivered or sent.

18.3 Days to be Counted in Notice

If a number of days' notice or a notice extending over any other period is required to be given, the day the notice is given or deemed to have been given and the day on which the event for which notice is given will not be counted in the number of days required.

19. MISCELLANEOUS

19.1 Dissolution

Upon winding-up or dissolution of the Society, the funds and property remaining after the payment of all costs, charges and expenses properly incurred in the winding-up or dissolution, including the remuneration of the liquidator, and after payment to employees of the Society of any arrears of salaries or wages, and after the payment of any debts of the Society, will be distributed to the Ministry of Health Services of the Province of British Columbia, or in the event such Ministry no longer exists, to the Province of British Columbia. *This section was previously unalterable.*

19.2 Inspection of Documents and Records

The documents and records of the Society, including the financial and accounting records and the minutes of General Meetings, committee meetings and meetings of the Board, will be open to the inspection of any Director at reasonable times and on reasonable notice.

A Member in good standing is entitled, upon providing not less than fourteen (14) days' notice in writing to the Society, to examine any of the following documents and records of the Society at the Address of the Society during the Society's normal business hours:

a. the Constitution and these Bylaws, and any amendments thereto;
b. the statement of directors and registered office of the Society;
c. minutes of any General Meeting, including the text of each resolution passed at the meeting;
d. resolutions of the Members in writing, if any;
e. annual financial statements relating to a past fiscal year that have been received by the Members in a General Meeting;
f. the register of Directors;
g. the register of Members;
h. the Society's certificate of incorporation, and any other certificates, confirmations or records furnished to the Society by the Registrar;
i. copies of orders made by a court, tribunal or government body in respect of the Society;
j. the written consents of Directors to act as such and the written resignations of Directors; and
k. the disclosure of a Director or of the Executive Director regarding a conflict of interest.

Except as expressly provided by statute or at law, a Member will not be entitled or have the right to examine or inspect any other document or record of the Society. However, subject to such policies as the Board may establish, a Member in good standing may

request, in writing delivered to the Address of the Society, to examine any other document or record of the Society and the Board may allow the Member to examine the document or a copy thereof, in whole or in part and subject to such redaction as the Board deems necessary, all in the Board's sole discretion.

Copies of documents to which a Member is allowed to examine may be provided on request by the Member for a reasonable production fee to be determined by the Board.

19.3 Right to become Member of other Society

The Society will have the right to subscribe to, become a member of, and cooperate with any other society, corporation or association whose purposes or objectives are in whole or in part similar to the Society's purposes.

20. BYLAWS

20.1 Entitlement of Members to copy of Constitution and Bylaws

On being admitted to membership, each Member is entitled to, and upon request the Society will provide him or her with, access to a copy of the Constitution and these Bylaws.

20.2 Special Resolution required to Alter Bylaws

These Bylaws will not be altered except by Special Resolution.

20.3 Effective Date of Alteration

Any alteration to the Bylaws or Constitution will be take effect on the date the alteration application is filed with the Registrar in accordance with the *Societies Act*.

THESE BYLAWS ADOPTED BY SPECIAL RESOLUTION DATED: _____________, 2018.

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September 2018

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POLICY **BOARD MEETINGS**

Board meetings

Board meetings provide the structure for members of the Board to formally meet to make decisions regarding the direction of the organization. Board meetings are critical to good governance and they need to occur as often as necessary for the Board of Directors to fulfill their duties, and as stated in the Division's bylaws.

It is important to make good use of Board meeting time and focus on high level governance issues rather than operational or administrative issues. Ground rules for meetings, effective policies and agendas, good minutes and follow-up all contribute to creating productive Board meetings.

Ground rules

Ground rules are the standard of conduct that guide group behavior and help members to work more effectively with each other. Ground rules for Board meetings may include considerations such as:

1. Meetings start and stop on time
2. Honour opinions - focus on issues not personalities - soft on people, hard on ideas
3. Participate - everyone contributes to conversation
4. Engage in respectful, open and honest communication - give benefits first, share all relevant information
5. Discuss un-discussable issues - Explain reasoning and intent
6. No side conversations
7. Evaluate – 10 minutes at end of meeting: did we achieve our objective? What did we do well this meeting, what could we do better? Be constructive in the spirit of continuous improvement.
8. One speaker at a time – hear from everyone who wants to speak
9. Parking lot
10. Action item list
11. Evaluation of meetings

Agendas

Agendas are a tool used by the Chair to manage meetings effectively. They provide structure in the form of discussion content, required action from discussion and timelines.

A good agenda format can improve Board meetings by identifying the topics to be discussed and allowing Board members to prepare for the meeting. Providing materials for Board members to review at least one week in advance will help each member prepare so they are informed and ready to discuss the issues at the meeting.

Guidelines for developing an effective agenda:

1. Have the Chair and Executive Director meet at least a week in advance of the meeting to prepare the Board agenda.
2. In setting the Board agenda, the Chair and Executive Director recommend what items warrant full Board discussion and what items will go on the consent agenda. All Board members have an opportunity in the Board meeting to remove items from the consent agenda for discussion.
3. Format the agenda to include the topic, required action and allotted time.
4. Differentiate attachments, which are FYI only vs. those required for discussion/decisions.
5. Agenda and supporting documents should be sent out prior to the weekend before the scheduled meeting.
6. Whenever possible, attachments should be forwarded all at one time, together with the agenda.
7. If possible, attachments should be imbedded in the agenda. If not, attachments should be numbered according to their place on the agenda in accordance with the subject they are attached to.
8. The Chair will begin the meeting by asking for the agenda to be accepted. At this point items may be added to the agenda.
9. Stick to the agenda and time allotted. If things come up, put them in the 'parking lot' to be discussed at the end of the meeting, or put them on the agenda for the next meeting. Appointing a timekeeper can be helpful.

Minutes

Minutes are a legal document and permanent record of meetings and decisions and need to be approved in a Board meeting. The Chair and recorder can sign the approved minutes. A copy of Board minutes should be kept on file.

It is good practice to complete a draft of Board minutes soon after the meeting, so they can be sent out to Board members. Actions items should be clearly identified so that they can be followed up on between Board meetings and added to the agenda of the next meeting.

The following should be documented in the Board minutes:

1. Date, time and attendance
2. Name of recorder
3. Key discussion points (just the facts not the dialogue) and decisions
4. All resolutions made

5. Any conflicts of interest
6. Action points to be followed up and by whom

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY — BOARD MEMBER CODE OF CONDUCT

This Code of Conduct sets out the minimum standard of conduct required of all Directors of the Division of Family Practice and is based on the duties and obligations imposed on Directors by law. The Directors do not have the power to exempt themselves from any aspect of these duties and obligations. This Code addresses the main relevant areas but is not designed to be exhaustive.

The Board commits itself and its members to ethical, businesslike, and lawful conduct, including proper use of authority and professional decorum when acting as Board members.

Accordingly:

1. Directors must act honestly, in good faith, and with a view to the best interests of the Division as a whole and must exercise the care, diligence and skill of a reasonable prudent person in exercising their powers and performing their functions as Directors.
2. Directors must avoid conflicts of interest with respect to their fiduciary responsibility.

   2.1 The Directors shall annually complete the required form of written disclosure of conflicts or potential conflicts and shall disclose verbally and in writing any other conflict of interest as soon as he or she becomes aware of it. Conflicts and potential conflicts shall be disclosed to all the other Directors.

   2.2 In the event a conflict of interest a member shall absent herself or himself without comment from both the deliberation and final decision-making.
3. Directors shall at all times maintain the confidentiality of information they acquire by virtue of being Directors of the Division.

   3.1 This obligation applies to all information that is not otherwise generally available to the members of the Division. Information may be expressly designated as confidential or may be confidential by implication. If a Director is unsure whether particular information is confidential, he or she should seek the advice of the Directors or, if the concern arises other than at a meeting of the Board, the Director should seek the advice of the Chair of the Board.

   3.2 Directors shall observe confidentiality of discussions and dynamics at Board meetings. Preserving the confidentiality of Board meetings promotes free and full discussion of matters and effective decision-making.

   3.3 The duty of confidentiality continues to bind a Director after he or she ceases to be a Director.
4. As leaders of a membership-based organization, Board members have a responsibility to be reasonably available to family physicians in the community, to attend events and engage both members and community partners and partners in the health care system.
5. Directors may not attempt to exercise individual authority over the organization except as explicitly set forth in Board policies.

   5.1 Board members' interaction with the staff must recognize the lack of authority vested in individuals except when explicitly Board authorized.

5.2 Board members' interactions with public, press or other entities must recognize the same limitation and the inability of any Board member to speak for the Board except to repeat explicitly stated Board decisions.

6. Directors are expected to attend regularly scheduled Board meetings.
7. Board members will be properly prepared for Board deliberation by reading the Board package in advance; informing themselves of matters under consideration; participating in discussion and ask questions at Board meetings; listening to and consider all points of view with an open mind and without having pre-judged the matter; allow full discussion of matters; seeking the advice of staff or other professional or outside advice where necessary.
8. The Directors bring their particular background, experience and points of view to Board meetings in order to inform the Board and assist in a holistic, thoughtful and well-informed decision- making process. The Directors must make decisions in the best interests of the Division as a whole, meaning all members of the Division rather than in their own interests or in the interest of any particular area of practice.
9. Directors will support the legitimacy and authority of Board decisions, irrespective of the Board member's personal position on the issues.
10. Directors shall deal with each other openly, honestly, truthfully and in good faith and shall observe proper decorum at all meetings. Directors' interactions in meetings shall be courteous, respectful and free of animosity. Directors shall share with each other all information that may be relevant to the business and affairs of the Division and the particular matters under discussion by the Board.
11. A Director who is uncertain of his or her duties in any particular instance should raise this concern with the Chair of the Board in order that appropriate guidance and advice may be obtained.

Reference Policy:

Conflict of Interest

Policy Competing Interest Policy

Confidentiality Policy

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY | **COMMITTEES**

Background

The bylaws of the Division empower the Board of the Division of Family Practice to establish committees with delegated authority to bring recommendations to the Board. Committees may be formed to oversee specific tasks of the Division, to assess its projects, or to convene discussion of interest to family physicians.

Committees serve several functions for the Division: Committees enable the Division to accomplish tasks with a broader membership than may be present on the Board. Committees can perform detailed work on well-defined tasks and make recommendations to the Board for further action.

Powers of the Board

The Board will have the power to define committees, and to allocate resources to ensure that its committees are able to accomplish the tasks set out for them by the Board. The Board can also approve payments to members in exchange for their services on committees.

Upon establishing a committee, the Board will approve Terms of Reference (TOR), including financial and time limits for the committee, and will recruit interested members to participate on the committee

Committees will be limited in most cases to three people. Once established, the committee can determine appropriate representation numbers, and, if more than three, may submit a request to the Board for approval.

The Board may appoint a member to represent the Division on a committee.

Expectations of a member in participating on a committee or attending an event on behalf of the Division will be clearly outlined in a TOR for Committee Participation.

The Board will approve committee TOR and membership. Once Board approved, the Executive Director will approve individual sessional and expense payments to committee members.

Any member of any committee may be removed by a majority vote of the Board.

Committee responsibilities

1. The first duty of the chair of each committee, once his or her committee is constituted, is to review or develop the TOR of the committee, in consultation with the committee members, for submission to the Board Chair and, on request of the Board Chair, the chair shall present the TOR at a meeting of the Board.
2. Unless otherwise specifically provided by the Board through TOR for a committee, the duties of all committees shall be advisory only.
3. The directors may extend or restrict the TOR of any committee and may appoint a committee for any purpose provided that if such action interferes with the normal activities of any other committee, such committee shall be notified.

Reporting by committees

Every committee shall keep minutes of each of its meetings and shall make these available to the Board on request.

Unless the Board requires otherwise, the chair of every committee shall present a written report of the committee to the annual general meeting and to any other meeting when requested by the Board. The Executive Director must receive the written report of each committee no later than four weeks before the annual general meeting and one week before any other meeting.

With the prior Board approval of the committee TOR and membership, the project managers and committee staff leads will submit, on behalf of committee members, any expense claims and meeting sessionals to the Executive Director for approval.

Committee chairs and committee members may be remunerated as determined by the Board.

Committee chairs and members of every committee shall be members in good standing, unless otherwise specified in each instance by the Board.

If the Board Chair is named by the Board as a member of a committee, the Board Chair is a full member of that committee, with the same rights and obligations, including the right to vote, as other members of the committee. The Board Chair is an *ex officio*, non-voting member of all other committees and may, but is not required to, attend any meetings of such committees.

Each committee will abide by the decision-making policy and strive for consensus. Unless otherwise provided, the chair of each committee shall not be entitled to vote but, in the event of an equality of votes, shall have a casting vote. Unless otherwise provided, each member of each committee is entitled to one vote.

No liability when acting in good faith

Subject to the Society Act, the members shall not hold the members of any committee individually or collectively liable for decisions and/or actions taken in good faith on behalf of the Division, including, without limitation, in the discharge of their duties as committee members.

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY	**CONFLICT OF INTEREST**

Members of the Board of Directors and staff have a duty to disclose any personal, family or business interests that they have, that, by creating a divided loyalty, could influence their judgment or result in the perception of influence or benefit from their activities on behalf of the Division.

Conflicts of interest are unavoidable and should not prevent an individual from serving, as a Director or staff member unless the extent of the interest is so significant that the potential for divided loyalty is present in a large number of situations.

A conflict of interest exists wherever an individual could benefit, disproportionally from others, directly or indirectly, from access to information or from a decision over which they might have influence, or where someone might reasonably perceive they're to be some benefit or influence.

Procedure for handling conflict of interest

1. The Board as a whole has a duty to disclose specific conflicts of interests to Division members, staff and external stakeholders where that interest may, in their judgment, affect the reputation or credibility of the organization and to disclose the Board's procedure for operating in the presence of such conflicts.
2. Board members and staff have a duty to exempt themselves from participating in any discussion and voting on matters where they have, or may be perceived as having, a conflict of interest. Such exemptions should be recorded in minutes of meetings.
3. Any business relationship between an individual (or a company where the individual is an owner or in a position of authority) and the Division, outside of their relationship as a Board or staff member must be formalized in writing and approved by the Board.

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY	CONSULTATION

CONSULTATION POLICY

As a society representing East Kootenay family physicians, we receive many requests to engage with our membership and Board of Directors. These requests vary widely. The East Kootenay Division's Member Affairs Committee is committed to reviewing each request independently, utilizing this consultation policy to guide all reviews.

Requests to present to the Board from external stakeholders will:

1. Be considered on first come first serve basis
2. Be received 1 month in advance of requested presentation date

Priority Consultation

Priority is given to requests that are in line with the EKDoFP' current Strategic Priorities, as defined by our members and Board of Directors.

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY **DECISION MAKING**

Decision-Making

Divisions of Family Practice place a high value on collaborative decision-making and modelling this behavior as part of the organizational culture. There are a number of different approaches to collaborative decision-making that Boards may choose from depending on what works best for the issue in question and the group making the decision.

Collaborative decision-making approaches: some distinctions[1]

The most common collaborative approaches used to make decisions are either consensus-based or democratic models, or some combination of the two. When undertaking a decision-making process, the Board should discuss, agree on, and post guidelines for reaching decisions.

Consensus

The consensus process allows the entire group to be heard and to participate in decision-making. The goal of consensus decision-making is to find common ground, probing issues until everyone's opinions are voiced and understood by the group. Discussions leading to consensus aim to bring the group to mutual agreement by addressing all concerns.

Consensus does not require unanimity. Rather, everyone must agree they can abide by the decision. Though it can take longer than other decision-making methods, consensus fosters creativity, cooperation and commitment to final decisions. There are no 'winners' and 'losers' in this process, as discussion continues until consensus is achieved.

Restating agreements made and next steps in implementing decisions made close the discussion.

Democratic

Options are discussed fully so that members are informed as to the decision's consequences. The important ground rule here is that the 'losing' side agrees to support the decision, even though it was not their choice. Decisions are made by majority vote.

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[1] Center for Collaborative Planning, a center of Public Health Institute – www.connectccp.org. Adapted in part from: The Citizen's Handbook: A Guide to Building Community in Vancouver. Dobson, Charles and Vancouver Citizen's Committee. http://www.vcn.bc.ca/citizens-handbook/1_09_meet_decide.html

Straw polling

Straw polling entails asking for a show of hands (e.g. thumbs up or down) to see how the group feels about a particular issue. It is a quick check that can save a great deal of time. Silent hand signals can be an invaluable source of feedback for a facilitator working with a large group.

Voting

Voting is a decision-making method that seems best suited to large groups. To avoid alienating large minorities, the group may require a two-thirds (or more) majority for a motion to succeed. Alternatively, voting can be combined with consensus. Some groups institute time limits on discussion and move to voting if consensus cannot be reached.

The role of the Board of Directors is to govern the Division through leadership and oversee the activities of the organization. Board decision-making is a key responsibility in governance. The Board will make decisions by a process of careful deliberation, seeking out the wisdom and experience of many voices as appropriate, which may include its staff, members and others with knowledge of its mission. The Board will also ensure that decisions are aligned with the document of intent, existing contracts, bylaws, policies and strategic plan.

The Directors bring their particular background, experience and points of view to Board meetings in order to inform the Board and assist in a holistic, thoughtful and well-informed decision-making process. The Directors must make decisions in the best interests of the Division as a whole, meaning all members of the Division rather than in their own interests or in the interest of any particular area of practice.

In addition, Directors must also avoid conflicts of interest with respect to their fiduciary responsibility by:

1. Disclosing any conflicts or potential conflicts to all the other Directors.
2. Removing themselves without comment from both the deliberation and final decision-making

Decision-making procedure

Staff and/or Board members suggest a new topic and its required action for the agenda

The Board, chair and Executive Director put the topic and time allotted for deliberation on the Board agenda.

Background materials for the decision are provided to all Board members and the Executive Director at least one week before the Board meeting.

Discussion and/or debate will occur in the Board meeting.

The Board will strive for consensus of opinion in its decision-

making within the time allotted for the topic. If consensus isn't

reached in the time allotted, the Board may decide to defer the discussion to the next Board meeting or assign to a committee and/or staff member for further research before the next Board meeting.

If after another attempt to reach a consensus is not achieved, then a majority vote is conducted among Board members, as long as the quorum of the Board members participated in the vote.

The decision is documented in Board minutes for that Board meeting.

After a Board decision is made Board members are expected to convey a message of acceptance of the decision as a valid outcome of Board deliberations.

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY	**DECLARATION OF COMPETING INTEREST**

This policy is adapted from the Society of General Practitioners Declaration of Competing Interests policy.

A competing interest exists when professional judgment concerning a primary interest (such as patients' welfare) may be influenced by a secondary interest (such as financial gain). It may arise for Division Board or staff or committee members when they have a financial interest that may influence their decisions or contribution to policy work.

Competing interests are almost inevitable. The purpose of this policy is not to eliminate competing interests, but rather to ensure that in all Division matters, competing interests are openly declared. As such, efforts can be made to ensure that where competing interests exist there is a balance of perspectives on committees.

All Division Board members, committee members and senior staff shall complete a declaration annually. Declarations shall be collected and reviewed by the Division's ethics officer (the Chair) and kept on file by the Secretary. Appended (below) is a recommendation for a declaration of competing interests adapted from the British Medical Journal's policy.

These declarations shall be made available to all members of the Division upon request, and where deemed appropriate by the Board, be appended to policy papers in the public domain.

Procedure for handling competing interests

1. The Board as a whole has a duty to disclose specific competing interests to Division members, staff and external stakeholders where that interest may, in their judgment, affect the reputation or credibility of the organization and to disclose the Board's procedure for operating in the presence of such competing interests.
2. Board members and staff have a duty to exempt themselves from participating in any discussion and voting on matters where they have, or may be perceived as having, a competing interest. Such exemptions should be recorded in minutes of meetings.

Effective Date	**Approval** *(Signature)*	**Date Approved**

Declaration of Competing Interest

Please answer the following questions:

1. Do you currently accept or have you in the past five years accepted funding from a Pharmaceutical company, Information Technology Company, Medical Supply Company or community based medical organization for any of the following:

Funding Type	**Organization**
A fee for speaking?	
Fees for consulting	
A fee for organizing education?	
Funds for research?	
Financial support for a member of your staff?	
Purchase of or maintenance of IT equipment?	

2. Do you hold any stocks or shares in any organization that may in any way gain or lose financially from your work in the Division?
3. Do you hold a University appointment? ______ No. _______ Yes
4. Do you sit on any Boards of health care organizations or community organizations or Societies that may gain or lose financially from your work in the Division? _____ No ____ Yes if so please specify

   ____

5. Do you have any other competing interests? _____ No ____ Yes if so please specify

   ____

Name (Please Print) ____

Signature _________________________________ Date ______________

POLICY **BUDGET PROCESS**

The Board is responsible for approving and monitoring the budget. The Board has established the Finance Review Committee to assist in this task. The budget is the EK Division's financial plan, identifying how financial resources are to be used and linking those resources to the goals and objectives of the organization for a specified period of time. The budget is also a monitoring tool. It serves as a guide to track the organization's progress on the achievement of its goals. Regular reports based on this monitoring provide financial oversight for the EK Division.

Policies that outline executive limitations help the Board stay focused on the high-level issues of the budget and not get bogged down in small line items. To focus discussion on the core issues rather than operational issues of the organization, the Board should ask the following questions:

1. Does the budget reflect the organization's priorities?
2. What are the fundamental assumptions upon which the budget has been based?
3. Who is responsible for monitoring and controlling budget expenditures?
4. What are the Board's policies that govern the preparation and control of the budget?

Developing the budget

The Board must identify who is responsible for budget preparation. The EK Division has tasked this to the Finance Review Committee. Typically, the Treasurer, Executive Director and Operations Lead prepare the draft budget for the upcoming year. The balance sheet, current budget, actual profit and loss statement and variances, along with the organization goals are analyzed to develop a budget. The draft budget is prepared and discussed at the Finance Review Committee, then presented to the Board for review and final approval.

Monitoring the budget

The Board will determine the frequency and format of the financial reports it will use for monitoring. A quarterly budget review is performed by the Finance Review Committee for all projects and infrastructure budgets. The committee reviews the revenue and expenses for the time period, as well as any variance between them. The Committee then reports back to the Board on any areas of concern. It is essential that Board members read and understand the financial reports of the EK Division. Regular reviews can alert the Board to the need for potential adjustments to the budget and timely monitoring allows the Board to make adjustments before it becomes a crisis.

Below is a list of common financial reports:

Revenue and expense statement

Sometimes called the operating statement, or the profit and loss statement, the revenue and expense statement show the amount of income received and the amount that was spent. The statement will show one of three possible outcomes: a balance (revenues and expenditures are

equal), a surplus (more revenues than expenses), or a deficit (more expenses than revenue).

Balance sheet

This report shows the total assets, liabilities and equity of an organization at a fixed point in time. Assets are what the organization owns or is owed. Liabilities are debts the organization has not paid. Equity is what is left after the liabilities are subtracted from the assets.

Cash flow projection

The cash flow projection is an internal report used by management to display cash flow coming in and out of the organization. It helps forecast fluctuations in revenue and expenses.

Variance report

This report shows actual revenue and expenses as compared to budget. Variance analysis should be conducted at regular intervals i.e. quarterly. Variance is the difference between what has been budgeted or planned and the actual amount spent. The goal of a variance analysis and the subsequent discussion by the Board, is to identify any worrying trends or problem areas as early as possible in order to take corrective action.

Discussing variances in the budget will also help the Board control expenditures in the future, especially if every activity (for example, an event for family doctors) has a budget developed in advance. It is not necessary to change the EK Division's budget as the Board sees significant variance - corrections can be made to the budget at the end of the year. This should help in planning the budget for the following year.

To ensure financial responsibility, the financial activities of the EK Division will be based on an annual budget approved by the Board of Directors.

Procedure

1. The Executive Director, in conjunction with the Operations Lead and Treasurer, will prepare and present the annual budget to the Finance Review Committee. All approvals shall be completed prior to the end of the current fiscal year.
2. The Board will review and approve the annual budget.
3. Once approved, the Executive Director may expend funds on behalf of the EK Division within the approved annual budget and spending authority limits (see financial limitations policy).
4. Planned expenditures will not exceed the approved annual budget.

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY **MEMBERSHIP**

The Board of Directors of the Division aspires to attract as many eligible physicians to join the Division as possible. This will have the greatest impact on supporting and advocating for family physicians and improving patient health.

Members play a strong role in assessing and improving Division projects. Members can help the Division by providing information and regular feedback to staff and Board members, or by participating in the service agreements negotiated and administered by the Division.

Member involvement is key to the success of the Division. The Division welcomes the involvement of members in its many committees. The Division will have several committees that work directly to support Divisions and others that work with partners in primary health care.

There are funds budgeted for committee work of members.

The Board of Directors of the Division will set policy for membership and will review that policy on a regular basis.

1. Members are required to complete and sign a membership form, as well as to update their contact information if there are any changes.
2. Membership forms can be given to staff or Board members of the Division. Those applications will be discussed at the next Board meeting. Applications must first be approved by the Board of Directors, in accordance with the bylaws of the Division.
3. The membership list must be reviewed and approved annually to reflect changes in the membership such as retirement and relocation of physicians who are no longer practicing in the community.
4. A membership term will be five years, at which point, the member will be notified by email or phone that they need to renew their membership.
5. There are no membership dues.
6. Members are eligible to receive all the benefits of Division participation, including a copy of the constitution and bylaws, receipt of updates and information related to the work of the Division and voting at meetings of the Division.

Criteria

A member must be:

1. A general practitioner, licensed by the College of Physicians, or;
2. A family doctor who delivers the majority of their services in the Divisions' geographical boundaries, or of close geographical proximity and;
3. Properly registered with the Division by completing and signing a membership form.

Subject to the approval and ratification by the Board, a member may be:

1. A physician with or without hospital privileges, or;

2. A physician who is providing family physician services on a sessional or other basis;
3. Family physicians, including those who provide full service, specialized (obstetrical, ER) and walk-in clinic serves.

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY	POLICY REVIEW AND RETAINING RECORDS

The process of policy development and review is an ongoing cycle that is necessary to ensure that policies are relevant and Board practices accurately reflect the policies. Each policy should be reviewed on a regular basis.

If changes are required, the committee writes the first draft and sends it for review by the Board. They also consider distributing the draft to any affected programs for their feedback. Redraft the policies taking into account the feedback received and present them to Board for approval. Distribute the revised policy to Board members for their manual and store it in the policy manual for the Division.

Policy review schedule

Policies will be reviewed annually.

Retaining records

Older policies must be kept on file. In the event that an incident is brought forward, the policy in place at the time of the incident would be reviewed and referred to for resolution. Be sure to include the review and revision dates on any revised policies.

A copy of all outdated or replaced policies and procedures should be retained in a separate file or binder to provide an audit trail. A fundamental role of the Board is to establish, implement, review and evaluate policy.

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY	**ROLE OF THE BOARD OF DIRECTORS**

The role of the Board of Directors is to provide leadership and stewardship of the activities of the Division.

In both roles it will represent the interests of its members and the broader community. In seeking direction, the Board will actively consult the membership, and in demonstrating organizational accountability it will insure the Division operates with transparency and is active and forthright in its internal and external communications.

In providing leadership, the Board will work with staff and external stakeholders in looking towards the future, reviewing mission and objectives, determining outcomes and evaluating overall organizational results.

In providing stewardship, the Board will rely on adherence to a budget and will ensure, through the creation of policies and evaluation of their implementation that the Division adheres to best practice in dealing with clients and in utilizing staff and volunteers. The Board will rely on regular reviews of operational practices rather than approving or advising on day-to-day decisions.

The Board will take responsibility for its own management, continuity and renewal. It will insure effective Board meeting practices, appropriate Director conduct, ongoing Board education, and continuing attention to the recruitment of new members.

Board members will:

1. Attend Board related functions, Board meetings, general meetings and extraordinary meetings
2. Adhere to and support Board decisions and policies once they are collectively established
3. Positively represent the Division, to the best of their ability, in the community, within the Division and to their staff and colleagues

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY **ROLE OF THE CHAIR**

Board member roles

Board membership is made up of two types of positions, officers and members at large. Officer positions include the chair, vice- chair, physician lead, treasurer and secretary, although sometimes the treasurer and secretary roles are combined as the secretary/treasurer. A society is legally required to have at least three Board members, so that each of the officer positions can to be held by different people. Members of the Board who do not hold a role as an officer are referred to as Board members at large.

Other positions can be defined, for example, a Physician lead may serve as the Division representative with partner groups or as the contact person for the senior staff of the Division.

Following are descriptions of the Board member roles:

Policy title: Chair, Board of Directors

The Chair, or Vice-Chair, presides at all meetings of the society and of the Directors. The Chair supervises the other officers of the Board in the execution of their duties and works closely with the Executive Director. In some Divisions, the Chair is combined with the Physician Lead position, in which case the duties may include supervising staff, representing the Division and co-developing service contracts. Currently, in the EK Division these are separate positions, but the duties may be shared between the two roles as needed. As a result, the Chair is a physician member of the society.

General responsibilities

The Chair assures the integrity and fulfillment of the Board's process and attends to the overall functioning of the Board.

Specific duties

In addition to the duties of every Board member, the Chair:

1. Chairs regular meetings of the Board of Directors
2. Collaborates with the Executive Director to develop an agenda and to ensure that the information that will be given at the Board meeting is sufficient for the Board to make informed and responsible decisions
3. Assists the Board by attending to interpersonal dynamics and helping the Board to be highly functional
4. Assists in creating an environment that is conducive to governance dialogue
5. Ensures that the Board operates in a manner consistent with the society's bylaws and policies
6. Enforces rules of conduct as they apply to the Board
7. Chairs the annual general meeting (AGM)

8. Prepares the Board’s annual governance report with input from the Board for inclusion in the annual report
9. Ensures an ongoing planning process exists for the Division that includes coordinating the planning of the Board's activities for the year ahead
10. Ensures that Board members have the information they need to make informed decisions
11. Ensures that all new Board members get a proper orientation to the Board
12. Ensures the delegation of responsibilities, making sure that they are spread out equitably among the Board members
13. Maintains contact with committee chairs, helping them to stay on track and monitoring whether they need any additional support
14. Ensures that all Board committees are properly served by Board members, other community members and staff
15. Co-signs contracts on behalf of the society
16. Performs other responsibilities assigned by the Board

In addition, the Chair may, with greater regularity than other members of the Board:

1. Prepare recommendations for Board consideration
2. Be available to the senior staff position for consultation purposes
3. Represent the Board at meetings of stakeholders and funders

Limitations on the role of the Chair

1. The Chair has no formal authority to direct the Board or the affairs of the society, unless otherwise authorized
2. The Chair may not, on behalf of the society, enter into contracts without the knowledge and approval of the Board

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY	ROLE OF THE PHYSICIAN LEAD

General Responsibilities

The Lead ensures the Division is following a clear Vision, Mission, Principles and Strategic Directions, and represents the Division outwardly with the membership, other stakeholders in the Region, on the CSC, in the Health Authority, on the ISC, and provincially. The Lead may also be the Chair of the Board, but if these roles are divided then very clear communication, collaboration, and clarity of roles and responsibilities between the inner work of the Board and the outer work of representing the Division must be delineated. The Chair and Lead may share some roles, as needed. The Lead is a physician member of the society.

Specific Responsibilities: This role may be held by one person or two as co-Leads

1. Works closely with the Chair of the Board
2. Works closely with the lead Division staff
3. Works with the Chair of the Board as co-Leads to ensures that their roles and responsibilities are clear and regularly reviewed
4. Ensures the Vision, Mission, Principles, and Strategic directions are clear, represent the actual work of the Division, and are regularly reviewed
5. Represents the Division and builds relationship with members, other physician Leaders in the Region (i.e. Chiefs of Staff, Department Heads) and other primary healthcare stakeholders in the Region
6. Develop strong relationship with the Division and Shared Care contractors to ensure work is coordinated
7. Co-chair the CSC which involves significant relationship building with the HA co-chair and his/her HA management team
8. Represent the Division on the HA Interdivisional Strategic Council
9. Relationship building with other Division Leads in IHA
10. Represent the Division and build relationship with Senior Executive HA VPs and Medical Directors
11. Represent the Division Provincially
12. Builds relationship with other Division Leads in the Province

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY	**ROLE OF THE SECRETARY**

Policy title: Secretary, Board of Directors

The secretary is responsible for overseeing the recording, distribution and storage of information important to the society, such as membership lists, meeting minutes, policies and other decisions of the Board and the members, as well as upcoming dates and events.

Specific duties

The secretary will work with the Executive Director to ensure that:

1. All Board meetings and committees have minutes taken, approved and stored in a secure location, making sure that all actions and decisions are duly noted
2. Membership records are accurate and are stored and handled in line with PIPA and other requirements as set by law and by the Board.
3. There is a record of all policies approved by the Board in the Division's policy manual
4. There is a calendar of important dates for the Division such as AGM and reporting dates, and that Board members receive adequate notice of upcoming events
5. The records of staff people including contracts, benefits, evaluations, etc. are maintained and up-to-date
6. All the records of the Division are kept in a safe place
7. Old documents are only destroyed or disposed of with the approval of the Board and in accordance with the statutory obligations of the Division
8. Is sufficiently familiar with major documents and records, the Secretary reminds Board members of applicability of documents during Board operations - for example, articles of incorporation, bylaws, Board policies, Board resolutions, etc.
9. Ensures collection of meeting minutes from committee meetings
10. Ensures review and approval of all meeting minutes

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY	ROLE OF THE TREASURER

Policy title: Treasurer, Board of Directors

The treasurer is responsible for overseeing the financial controls and procedures of the Division. The treasurer works closely with the Executive Director to maintain financial records, including books of account, necessary to comply with the Society Act. The treasurer should review the finances regularly to ensure that they are in order and review annual statements to make sure that they are accurate.

The Executive Director will either prepare the monthly statements or direct an accountant to create them for the treasurer to present to the Directors and members at Board meetings and the AGM. The treasurer helps the Board and members to understand the finances of the organization and guides them in making sound financial decisions.

Specific duties

1. Oversees management of the finances of the organization as approved and reviewed by the Board and managed by the senior staff position and ensures the Board receives monthly financial statements
2. Serves as chair of the finance committee
3. Works with the Executive Director and/or the accountant to review statements before Board meetings
4. Educates Board members about what the finances mean by reviewing the financial statements with the Board, and helping the Board make decisions about allocation of funds or the way that financial statements are presented
5. Leads the Board in understanding and decision-making with
6. regards to the Division's finances
7. Maintains neat and accurate financial records
8. Collaborates with the Executive Director to develop annual budget and provides the annual budget to the Board for approval
9. Responds to annual audit and ensures audit issues and recommendations are fully addressed
10. Ensures development and review of financial policies and procedures
11. Ensures financial policies and procedures are adhered to by Board and staff

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY	ROLE OF THE VICE-CHAIR

Policy title: Vice-Chair, Board of Directors

The Vice-Chair carries out the duties of the Chair in the Chair's absence.

Specific duties

1. May serve as successor to the Chair position
2. Performs Chair responsibilities when the Chair cannot be available
3. Works closely with the Chair and Executive Director
4. Participates closely with the Chair to develop and implement officer transition plans
5. Takes on other responsibilities as assigned by the Board

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY	REIMBURSEMENT FOR TRAVEL EXPENSES

Travel claims are submitted on the Travel Expense Claim Form for EKDoFP staff and through the Sessional Claim Form for physicians.

1. **Air Travel Expenses –** Air travel is to be used only when other, less expensive forms of travel are not possible or reasonable for the particular trip. When air travel is required, the most economical airfare should be obtained. Original receipts are required. Costs for travel by modes other than air will not exceed the cost of the most economical air fare.
2. **Ferry Travel Expenses –** Claims for the full cost of ferry travel will be reimbursed. Original receipts are required.
3. **Vehicle Expenses –** Reimbursement will be made for private vehicle mileage incurred based on current rates.
4. **Parking Expenses –** receipts for parking charges will be reimbursed when driving a private vehicle.
5. **Taxi / Bus / Rapid Transit Expenses –** claims for taxi, bus and rapid transit costs will be reimbursed. Original receipts are required.
6. **Travel Time –** travel time is reimbursed at the rate of pay or sessional.
7. **Accommodations** – Claims for cost of accommodations are reimbursed. Original receipts are required.
8. **Private Accommodations** – Private accommodations are reimbursed based on current rate. Receipts are not required.
9. **Meals and Incidentals** – Reimbursement are made for meals and incidentals as a per diem based on current rates. Receipts are not required.

Payment Terms

1. **Deadline -** members need to submit claims within 30 days of expensed date. Expenses occurring during April and March should be submitted before the Division’s March year-end.

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY **COMPUTER USAGE**

The purpose of the computer usage policy is to document the policy regarding computer access, protect the security and stability of the computer, reduce legal risk and secure the confidentiality of information maintained by the EK Division.

This policy applies to all computer users. For the purposes of this

policy, the term 'computer user' includes all permanent and temporary employees of the EK Division, contractors, consultants and other persons paid by the EK Division. This policy also applies to any other users including, but not limited to, Board and EK Division members and other volunteers.

Computers are defined as all computers and other devices that may gain access to electronic information in any form that is stored in computers owned or operated by the EK Division. This includes, but is not limited to, all computer workstations located within the EK Division offices and any computer workstations or mobile/wireless devices outside the EK Division offices that may access EK Division information via telephone, the internet or other means.

Computer access

All aspects of the EK Division computers are the property of the EK Division and are assigned to users as necessary to assist them in their job function. All computer users must agree to comply with the terms and conditions of this policy before computer access will be provided.

System passwords

1. All system passwords must be kept strictly confidential. Passwords are not to be written down, shared with co-workers, or any other person, or recorded in a central location for use by departmental staff.
2. Passwords suspected of being compromised must be changed immediately. If system policy prevents changing the password (e.g. last password change within 30 days), contact a member of the systems group for assistance.
3. As a security precaution, network users are to ensure access to their workstation or mobile/wireless device is protected when away from it for any length of time. Acceptable methods include but are not limited to:
    a. Two factor authentication devices
    b. Password protected screen savers
    c. Keyboard locking after a period of inactivity

Computer monitoring

1. All information stored in the EK Division computers is the property of the EK Division and may be accessed, monitored or reviewed by management, or someone designated by management, at any time. This includes, but is not limited to, documents, spreadsheets, email messages, internet access logs, etc.

Email usage

1. The EK Division's email server is a business tool and is intended to be used as such
2. Incidental personal use of email is acceptable. Such use should be measured in minutes not hours per day. All policy guidelines apply equally to business and personal use.
3. Style and content of all email communication must represent the EK Division in a professional and respectful manner.
4. Email messages containing materials considered inappropriate, offensive, slanderous, fraudulent or unprofessional (e.g. pornographic material, racial or sexual jokes, etc.) must not be viewed, stored or transmitted within the EK Division network.
5. Email is not a secure method of communication. As a result, confidential information should not be sent as a message or as an attachment.
6. Computer users may not intentionally intercept, eavesdrop, record, read, alter or receive another employee's email messages without management authorization or construct email messages as to appear sent from someone else.
7. Email mailboxes are restricted in size and network users must manage their email usage to prevent exceeding the limits.

Internet usage

1. The EK Division's internet connection is a business tool and is intended to be used as such.
2. Incidental personal use of the EK Division's internet connection is acceptable. Such use should be measured in minutes not hours per day. All policy guidelines apply equally to business and personal use.
3. Personal use of the EK Division's internet connection must not impede normal business use.
4. Personal use sites must be accessed and closed as rapidly as possible. It is not acceptable to leave personal sites open and connected for lengthy periods. High bandwidth sites such as streaming media and internet radio are not appropriate for personal use because of their negative impact on normal business use.
5. The EK Division's internet connection is not to be used to access internet sites that depict or promote inappropriate material or activities (e.g. sexual content, violence, intolerance or racism, gambling, etc.).
6. Under no circumstances are executable programs of any kind to be downloaded from internet sites (e.g. screen savers, games, multimedia tools, etc.)
7. No copyrighted material is to be downloaded except as expressly permitted by the copyright owner. Failure to observe copyright or license agreements will result in disciplinary action.

USB keys

1. The EK Division requires that all USB keys that are used to move or store EK Division data be encrypted. While non-network users may bring data into the EK Division computers on unencrypted keys, only EK Division-issued encrypted keys are to be used for any data leaving the network.

Disciplinary action

1. Breach of this policy may result in disciplinary action up to and including dismissal.

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY	CONFIDENTIALITY

Confidentiality statement

All Board members, staff, consultants and contractors must sign a confidentiality statement. This pledge will remain in effect throughout their relationship with the EK Division and indefinitely after the termination of the relationship. It will be filed in the confidential personnel file.

Confidentiality

All information generated within the organization is private in the sense that it is for the sole purpose of the business of the EK Division. Confidential information is information that, if disclosed, might prejudice the interests of the organization or the privacy rights of its members or partners.

This policy applies to:

1. All Board members, who have a duty of confidentiality that is in effect during their term as Directors and indefinitely following the termination of their Board membership.
2. All contractors and staff of the EK Division, who have a duty of confidentiality that is in effect during the term of their contract or employment and indefinitely following the termination of their contract or employment.
3. Any persons who utilizes or inadvertently accesses confidential information in the normal process of performing the job has the responsibility of not disclosing the information to any unauthorized person(s).
4. Any persons who for any reason deliberately accesses confidential information not needed for performing the job, is breaching confidentiality whether or not the information is disclosed to another person.
5. Any person who uses confidential information for personal use or gain is breaching the duty of confidentiality and the duty to avoid conflicts of interest.

Pledge of Confidentiality

I, ________________________________have read and reviewed the East Kootenay Division of Family Practice policy on confidentiality. I understand that all confidential information to which I may have access is not to be accessed, used or disclosed except as outlined in the confidentiality policy. I understand that breach of the duty of confidentiality may lead to discipline, including termination.

Name: ____

Signature: ____

Witnessed: ____

Date: ____

Effective Date	**Approval** *(Signature)*	**Date Approved**

Confidentiality statement

All Board members, staff, consultants and contractors must sign a confidentiality statement. This pledge will remain in effect throughout the relationship and indefinitely after the termination of the relationship. It will be filed in the confidential personnel file.

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Name: ____

Signature: ____

Witnessed: ____

Date:

POLICY EXECUTIVE DIRECTOR COMMUNICATION AND SUPPORT TO BOARD

Board–Executive Director Working Relationship

The relationship between the Board and Executive Director is vital to the health of the organization. This relationship is a partnership with the Executive Director built on 'mutual trust, forthrightness, and a common commitment to the organizational mission' (Board Source 2010, p. 4). The Executive Director is the Board's formal link to the EK Division's operational achievement and conduct. The staff and contractors are accountable to the Executive Director.

A clear job description and Board consensus about the delegation of authority to the Executive Director is an important aspect of this relationship. The Board oversees rather than implements. This is an important distinction to be aware of in order to reduce the risk of blurred roles that may result in micro-management. Typical levels of non-profit authority are: governance, management and operations/implementation.

Governance is the responsibility of the Board and focuses on:

1. Leading the organization - setting the tone, mission and vision
2. Stewarding the organization through policy and strategic planning as well as monitoring the EK Division's goals and long-term activities
3. Providing direction to and evaluating the Executive Director

Management and implementation is the responsibility of the Executive Director and focuses on:

1. Organizing tasks, people, relationships, resources and technology to achieve organizational goals
2. Allocating resources by interpreting policies approved by the Board
3. Providing financial reports to the Board on a regular basis
4. Planning and managing/coordinating the day to day operations
5. Reporting to the Board on the progress of the organization against the stated goals
6. Implementing the organization's strategic plan consistent with its
7. mission
8. Managing the human resources of the EK Division by recruiting, selecting, orientating, evaluating and directing staff

The Executive Director needs to ensure that the Board has the information required to make decisions and provide oversight. The role of the Executive Director at Board meetings largely depends on how the Board defines the position.

The Executive Director shall communicate with the Board in a timely and sufficient manner to keep the Board informed and prepared for its work.

The Executive Director shall submit monitoring information required by the Board in a timely, accurate and understandable fashion.

The Executive Director shall report and prepare recommendations and suggest corrective action in a timely manner and any actual or anticipated non-compliance with any policy of the Board allowing sufficient time for the Board to consider corrective action.

The Executive Director shall keep the Board informed of relevant trends, anticipated adverse media coverage, material external and internal changes.

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY **HUMAN RESOURCES**

Human Resources activity will be:

1. Managed by the Human Resources Coordinator
2. Governed by the EK Division Human Resources Handbook (see Appendix)
3. Overseen by the Human Resources Committee
4. Actioned by the EK Division Executive Director

The HR Committee

The HR Committee consists of the Executive Director and Operations Lead. The HR Committee will;

1. Support the Human Resources Coordinator in the HR role
2. Act as mediator in the event of contractor or staff conflict
3. Be the final decision in dispute resolution
4. May request the involvement of the Board Chair, or other Board members in any HR areas
5. Report to the Board on any HR issues/changes which may impacting or impairing the society or the operations of the EK Division as a whole

Supports to the EK Division will either be employees or contractors and will be encompassed by this HR policy in addition to other policies or documents governing their work.

Employees

Employees will be governed by the Personnel Policy set out by the EK Division of Family Practice. (see appendix)

Contracts and Contractors:

All contractors shall be self-employed individuals or business entities, supplying their own home-office; and will be contracted as needed for a specific term or piece of work. They will be governed by their Service Agreement.

1. Contractors shall enter into Service Agreement contracts, a template of which can be found in the Appendix.
2. Contracts may initially be established for a 3-month period. They will be reviewed at that time to determine suitability of both contractor to the contract and duties to the contractor. Once the contractor and duties are deemed appropriate to each other, a contract extension may be negotiated.
3. No contract shall exceed the fiscal funding period set forth by the DoFP funders, or project funders.

Contractors will report to the Executive Director and be accountable to the Board, taking

direction for their scope of work from the Executive Director, who will direct the operations for the society and contractors on behalf of the Board.

All contractors will be liable for their own self-employment expenses, benefits and insurances, office equipment, and office and liability insurance, with the exception of Worksafe BC, which is provided by the EK Division of Family Practice, unless, otherwise negotiated.

Effective Date	**Approval** *(Signature)*	**Date Approved**

Summary of rules for protecting personal information

All British Columbia private sector organizations, including non-profits such as the EK Division of Family Practice, must comply with the Personal Information Protection Act (PIPA).

Personal information means information that can identify an individual (for example name, home address, home phone number, ID numbers), and information about an identifiable individual (for example physical description, educational qualifications, blood type).

The Privacy Officer is responsible for the collection, use and disclosure of personal information, for reasonable purposes. In order to collect information, the EK Division is required under PIPA to have appropriate policies in place for managing personal information, providing notice, obtaining consent and allowing access to information. These policies must be available to individuals upon request.

The following guidelines will help the EK Division meet privacy policy requirements:

1. Collect personal information only for reasonable purposes and collect only as much as is reasonable for those purposes.
2. Get consent to collect, use or disclose personal information.

   Consent may be implied, explicit, or 'opt-out'. Use and disclose personal information only for the purpose for which it was collected unless the individual consents.
3. Give notice to members, staff and patients about how their information will be used. Publicize the EK Division's policies and practices governing personal information.
4. Secure electronic and paper data to prevent sharing or disclosing personal information. Keep it for only as long as reasonable for business or legal reasons.
5. If requested, the EK Division must provide access to an individual's
6. information. A minimal service fee may be charged.
7. Train staff about privacy rules and procedures.

Privacy protection for stakeholders

Members

Personal information does not include business contact information. Consequently, information such as name and position or title, business telephone number, business address, business e-mail, business fax number and other business contact information are not subject to PIPA. By joining the EK Division, members will have consented to receiving information about programs and activities sponsored by the organization.

PIPA will only be a concern for members if, in the course of providing member services (e.g. training, practice support, or physician wellness programs), the EK Division obtains, uses or discloses non-business personal information about the membership. Notifying members of the purpose of this information and providing the right to opt-out will offer sufficient protection in most cases.

Patients

Non-identifiable or aggregate information such as statistical information about groups of individuals is not personal information. For research and policy purposes, physicians may provide the EK Division with non-identifying, practice-level data. PIPA also allows for providing data in individually identifiable form without consent when particular research requires it and obtaining consent would be impracticable. This allows physicians to participate in EK Division-led research initiatives without violating their obligations to maintain patient privacy.

Staff

The EK Division may collect, use and disclose employee personal information for reasonable purposes related to managing or recruiting personnel *without consent* as long as it notifies the employee. PIPA considers volunteers to be employees.

Contractual relationships

The EK Division is accountable for all personal information in its custody or control. This includes any information collected, used or disclosed by organizations contracted by the EK Division. Whenever a third party is contracted to perform work on behalf of the EK Division, a confidentiality agreement should be obtained in advance of the work being performed.

The Health Authorities that may contract with the EK Division are public agencies governed by the Freedom of Information and Protection of Privacy Act (FOIPPA). When working under contract for a public body, the EK Division should be clear whether the public body has control of personal information generated or provided under the contract. If the public agency maintains control of the information, FOIPPA (not PIPA) applies to the information.

Breaches

A privacy breach occurs when there is unauthorized access to or collection, use, disclosure or disposal of personal information. The most common privacy breach happens when personal information of customers, patients, clients or employees is stolen, lost or mistakenly disclosed. Examples include when a computer containing personal information is stolen or personal information is mistakenly emailed to the wrong person.

The EK Division must have procedures in place for notifying affected individuals, minimizing damage to those individuals when a privacy breach occurs and ensuring compliance with governing legislation, including reporting to the office of the privacy commissioner for B.C.

POLICY **PRIVACY**

Principle 1: Accountability for personal information

The EK Division of Family Practice is responsible for personal information under its control and will designate an individual or individuals who are accountable for the organization's compliance with established privacy principles.

1. The Board of Directors of the EK Division of Family Practice (EK Division) is accountable for compliance with the privacy policy and procedures. The Board may designate day-to-day operational responsibility to other staff members of the organization. Decisions regarding the interpretation and application of the policies and procedures are the ultimate responsibility of the Board or designate.
2. The EK Division is responsible for personal information in its possession and this includes both information that has been transferred to a third party for processing and information received from a third party. For third parties, the EK Division has contractual agreements in place that commits the third party to protect the information in accordance with the Act.
3. The EK Division has in place an orientation for all staff members so that each staff member is aware of the policies and procedures and the accountability structure.

Principle 2: Identifying purposes for personal information

The EK Division before or at the time the information is collected will identify the purposes for which personal information is collected.

1. The EK Division identifies the purpose for which personal information is collected before or at the time of collection of the information. The need for the information is clearly documented and only personal information with an identified purpose is collected.
2. The EK Division has in place an approval process to review any request for the collection of personal information.

Principle 3: Consent for the collection, use, or disclosure of personal information

The EK Division will ensure that the knowledge and consent of the individual are required for the collection, use, or disclosure of personal information, except where inappropriate.

1. The EK Division obtains consent for the collection, use, and disclosure of personal information before or at the time of collection.
2. The EK Division does not disclose personal information for secondary or other purposes such as marketing. The EK Division only discloses personal information to endorsed service providers and affiliated organizations, and a contractual agreement will be in place that commits the affiliated organization or endorsed provider to protect the information according to the Act (also refer to Policy 1).
3. The EK Division does not make consent a condition for supplying a product or service, unless the information requested is required to fulfill a specified and legitimate purpose.

4. The EK Division will collect, use and disclose employee personal information for the purposes of establishing, managing or terminating the employment relationship.

Principle 4: Limiting collection of personal information

The collection of personal information will be limited to that which is necessary for the purposes identified by the EK Division. Information will be collected by fair and lawful means.

1. The EK Division collects only the personal information necessary to fulfill the purposes identified for the information.
2. The EK Division information collection practices are fair, lawful and respectful of the individual.

Principle 5: Limiting use, disclosure and retention of personal information

The EK Division will not use or disclose personal information for purposes other than those for which it was collected, except with the informed consent of the individual or as required by law. Personal information will be retained only as long as necessary for the fulfillment of those purposes.

1. The EK Division uses or discloses information only for the purposes identified before or at the time of collection. New uses or disclosures are permissible only with the consent of the individual or as required or permitted by law.
2. The EK Division retains personal information for as long as it is needed to achieve the identified purpose(s) or related business or legal obligation. Personal information that is used to make a decision about an individual is retained for at least one year after using it so the individual has a reasonable opportunity to obtain access to it. The EK Division is guided by industry standards related to retention schedules or applicable legislation.
3. The EK Division communicates the limitations on use and disclosure of personal information to staff members. The EK Division allows staff to access and use personal information on a 'need-to-know' basis, i.e. information required to perform their job.

Principle 6: Accuracy of personal information

The EK Division is responsible for ensuring that personal information is as accurate, complete and up-to-date as necessary for the purposes for which it is to be used.

1. The EK Division ensures that personal information being collected is accurate, complete, and up-to-date for the purposes for which the information is collected, used or disclosed.
2. The EK Division updates personal information when necessary to fulfill the purpose(s) for which the information was collected.

Principle 7: Safeguards for personal information

The EK Division ensures personal information is protected by security safeguards appropriate to the sensitivity of the information.

1. The EK Division has security safeguards in place to protect personal information against loss or theft and unauthorized access, disclosure, use, or modification regardless of the format in which it is held (e.g. paper, electronic, audio, video).

2. The EK Division has a higher level of safeguards to protect more sensitive personal information.
3. The EK Division uses care in the disposal or destruction of personal information in order to prevent access to the information by unauthorized parties.

Principle 8: Openness about the management of personal information

The EK Division makes information available about its policies and practices relating to the management of personal information.

1. The EK Division has open and transparent information management practices that ensure accountability for personal information.
2. The EK Division makes contact information available about the person responsible for the EK Division privacy policies and procedures.

Principle 9: Individual access to personal information

Upon request, the EK Division informs an individual of the existence, use, and disclosure of his or her personal information and the individual has access to that information. An individual has the ability to challenge the accuracy and completeness of the information and have it amended as appropriate.

1. The EK Division informs an individual of the existence, use, and disclosure of his or her personal information upon request and provides access at no cost to the individual. Where the DIVISION is unable to provide full access to an individual's request for information, the reasons for limiting access are stated in a specific, reasonable, and justifiable manner.
2. The EK Division provides the opportunity for an individual to correct inaccurate or incomplete information.

Principle 10: Challenging compliance

An individual has the ability to challenge the EK Division's compliance with these principles by contacting the designated individual or individuals accountable for the organization's compliance.

1. The EK Division provides a process for an individual to challenge the organization's compliance with the stated privacy principles, policies and practices.
2. The EK Division investigates all complaints.

Disciplinary action

Breach of this policy may result in disciplinary action up to and including dismissal.

Privacy policy definitions

Access: The entitlement of an individual to examine or obtain his or her own personal information held by an organization.

Accountability: An organization is responsible for personal information under its control and designates individual(s) who are accountable for the organization's compliance with its privacy policies, procedures and practices.

Accuracy: Personal information kept by the organization will be accurate, complete and up-to-date.

Challenging compliance: An individual has the ability to challenge an organization's compliance with its privacy principles, policies, procedures and practices and the complaint is directed to the designated individual(s) accountable for the organization's compliance with its privacy policies, procedures and practices.

Collection: The act of gathering, acquiring, recording, or obtaining personal information from any source, including third parties, by any means.

Consent: An organization will ensure that there is voluntary agreement by an individual, or his or her legally authorized representative, to allow the collection, use or disclosure of the individual's personal information. The consent may be either express or implied and should include an explanation as to the implications of withdrawing consent. Express consent is given explicitly and unambiguously, either verbally or in writing. Implied consent is given when the action/inaction of an individual reasonably infers consent.

Disclosure: Disclosure occurs when personal information is made available to a person who is not employed by or in the service of the party holding the information.

Identify the purpose: Purposes, which includes why the information is being collected and how it is being used is identified by the organization at or preferably before the time of collection. The reason for collection is documented.

Personal information: Personal information is any factual or subjective information, recorded or not, regarding an identifiable individual. Examples include name, age, identification number, income, ethnic origin, blood type, opinions, evaluations, comments, social status, disciplinary actions, employee files, credit or loan records, medical records, or the existence of a dispute between parties.

Privacy: Privacy is the fundamental right of an individual to have their personal information protected.

Retention schedule: A retention schedule identifies the period of time personal information is held. Personal information should not be held for longer than is necessary to fulfill the purposes for which it was collected.

Safeguards: Safeguards are the actions taken to protect personal information. The level of the action is appropriate to the level of sensitivity of the information.

Security: Personal information is protected from unauthorized or unintentional loss, theft, access, use, modification or disclosure.

Third party: A third party is an individual or organization outside the DIVISION.

Use: Use refers to the treatment and handling of personal information within an organization.

Effective Date	**Approval** *(Signature)*	**Date Approved**

Financial Management

This section covers the Board responsibility for financial management. It addresses roles and responsibilities, the budget process, typical financial control techniques such as segregation of duties, signing authority, reporting, retention of records and financial management checklist. More information is also available in the financial systems handbook.

Roles and responsibilities for financial management

Non-profit societies typically have the following bodies involved in financial management: the Board, a Finance Review Committee, the Treasurer and the Executive Director. It is important to understand the roles and responsibilities of each body within the organization to ensure accountability and sound financial management.

The Board

The Board is responsible for financial oversight of the EK Division. The Board is required to:

1. Ensure funds are spent in accordance of organizational goals and objectives
2. Develop and authorize a set of policies for how the organization manages it finances
3. Approve the EK Division's budget
4. Monitor financial statements (at least quarterly)
5. Approve contracts
6. Receive regular written reports from the Treasurer or Executive Director detailing present financial status, anticipated problems and planning
7. Ensure that the EK Division complies with federal and provincial laws regulating fiscal accountability and governance
8. Adhere to sound accounting principles that produce reliable financial information to ensure fiscal responsibility

Finance administration

The Finance Review Committee, comprised of the Executive Director, the Treasurer, the bookkeeper, and at minimum, one additional EK Division member, will oversee the finances of the EK Division. The Executive Director and bookkeeper will oversee the monthly operations with support of the Treasurer. The Finance Review Committee will oversee the financial systems, statements and reports, and perform a quarterly review of budgets to actuals. The committee will also recommend approval of the audit and recommend to the membership the appointment of the external auditor and ensure financial controls are in place.

Treasurer

The Treasurer is the officer of the Board that oversees the management of the finances of the organization as approved and reviewed by the Board and managed by the Executive Director. The Treasurer collaborates with the Executive Director to develop the Annual Budget to prepare it for review by the Finance Review Committee and approval by the Board.

Executive Director

The Executive Director is responsible to the Board. The Board establishes policies that define the Executive Director's roles and responsibilities. The Executive Director ensures that the policies established by the Board are followed and manages the day-to-day financial transactions of the EK Division.

POLICY **DIRECTOR TRANSACTIONS**

Guidelines for authorizing transactions from which a Director or Officer may derive a benefit:

1. As a general rule, the Board should not accept or authorize transactions from which a Director or Officer may derive a benefit, whether direct or indirect. Generally, a transaction, which will benefit a Director or Officer, will violate the duty of loyalty the Director or Officer owes the society. The members of the Board who participate in the decision to authorize the transaction may be in breach of the duty of care that all Directors and Officers owe the society and may find themselves liable for losses experienced by the society that flow from the transaction.
2. There are three groups of exceptions where it is permissible for the Board to authorize a transaction that will benefit a Director or Officer:
    a. A conflict exists, but it provides no benefit, or only a minimal benefit, to a Director or Officer
    b. A conflict exists, but the benefit to the society is such that the conflict should be tolerated (see paragraph 3.1 for more information and examples)
    c. A conflict exists, but there is an overriding policy reason for tolerating the conflict, namely the conflict arises
        i. Because the Director or Officer is a member of a special group, and
        ii. The society needs that special group to be represented on the Board or requires the advice or perspective that a member of that special group can give.
3. The fact that a transaction falls into one of the groups listed in paragraph 1 does not mean that the Board must approve it or should approve it. The transaction must not be approved unless
    a. Overall, the transaction is fair and reasonable and - unquestionably in the best interest of the society,
    b. The transaction is in keeping with public expectations about the conduct of the society's activities,
    c. The Board has made reasonable inquiries which confirm there is no reasonable alternative for accomplishing the objects of the transaction which is not coloured by a conflict of interest, and
    d. Tolerating the conflict will not impair public confidence in the administration of the society or the application of public funds.
4. Paragraph 4 lists further factors which, if present, suggest the Board should not authorize the transaction, even if the transaction otherwise would satisfy the requirements of paragraphs 2 and 3.

Examples of a conflict but no benefit to the director or officer

1. Examples of transactions referred to in paragraph 2(a):
    a. Transactions where the Director or Officer assists the society in obtaining credit
    b. Transactions where the conflict arises because the Director or Officer is also a Director, Officer or member of another society
    c. Transactions between the society and the Director or Officer that are a normal or necessary part of the relationship between them
    d. Transactions with no economic significance
    e. Transactions with a person related to the Director or Officer that provide no financial advantage to the Director or Officer and there is no cause to believe the Director or Officer intervened to confer a benefit on the person
    f. Transactions in which a Director or Officer redeems, repurchases or otherwise acquires for fair market value property previously sold or donated to the society by the Director, Officer or a related person

Examples of a conflict, benefit to Director or Officer, but overriding economic or practical benefit to society

1. Before a transaction benefiting a Director or Officer may be authorized under paragraph 1.2(b) on the ground that there is an overriding benefit to the society, the Board must be satisfied that either:
    a. The transaction is so advantageous to the society that no other decision makes economic sense, or
    b. For practical reasons only the Director, Officer or a person related to the Director or officer can carry out the transaction.

Warning factors

1. The presence of any of the following factors suggest the transaction is not in the society's best interests:
    a. The transaction wastes society resources
    b. The sole reason for authorizing the transaction is to accommodate a director or officer, or to confer an unjustified advantage or preference on a director or officer
    c. The transaction is for economic reward and is of a kind that other people have in the past, or probably would in the future perform gratuitously
    d. The transaction favours or appears to favour the personal interests of the director or officer over those of the society, members of the society, or members of the public
    e. The transaction compromises or appears to compromise the director's or officer's integrity, independence and ability to act impartially on behalf of the society and in the interests of the society
    f. The transaction compromises or appears to compromise the reputation of the society

g. The transaction is to engage a person, such as an auditor, to scrutinize the affairs of the society

Transactions that do not require Board approval because there is no conflict

1. Transactions that do not require Board approval:
   a. An unconditional gift from the member, director or officer
   b. Transactions which relate to the participation by the director, officer or a member of the Director's or Officer's family in activities the society regularly makes available to its members

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY	**FINANCIAL LIMITATIONS**

Financial limitation, often referred to as executive limitation, is an important policy that outlines the limits of spending authority for operational requirements. Financial activity over the limit of authority requires Board approval. This policy allows senior staff to manage financial resources and helps the Board remain focused on the big issues rather than operational issues. As the EK Division's financial resources grow, a more comprehensive policy may be required.

The Executive Director shall not cause or allow the development of fiscal jeopardy or a material deviation of actual expenditures from Board priorities established in Board policies.

Procedures

The Executive Director may not:

1. Expend more funds than have been received in the fiscal year to date.
2. Incur debt in an amount greater than can be repaid by due date of payment on invoices.
3. Use any long-term reserves outside of Board policies.
4. Conduct inter-fund shifting in amounts greater than can be restored to a condition of discrete fund balances by certain, otherwise unencumbered revenues within 30 days.
5. Fail to settle payroll and debts in a timely manner.
6. Allow tax payments or other government ordered payments or filings to be overdue or inaccurately filed.

The Executive Director may not, without prior direction from the Board:

1. Make a single purchase or commitment of greater than $1500. Splitting orders to avoid this limit is not acceptable.
2. Acquire, encumber or dispose of real property.

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY	ACCOUNTS PAYABLE

Accounts receivable and accounts payable

The list of current accounts receivable and accounts payable should be passed to the Executive Director for information and review. They should also be presented with the monthly financial statements for the Board's information, when there are problems with the timeliness of payments or receivables.

An approval process has been implemented in order to generate payment to outside vendors.

Procedures

1. Invoices need to be approved for payment by the Executive Director or designated person by signing their initials to the invoice.
2. Invoices are attached to all cheques and presented to the designated signing authorities as per signing authority policy.
3. For electronic payment, all invoices listed for payment must have first been approved by the Executive Director and/or a designated Board member.
4. An officer of the Board will approve Executive Director invoices.

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY	BANK RECONCILIATIONS

Bank statements should be reconciled monthly by the bookkeeper and reviewed and initialed by the Treasurer. Any questions should be raised with the Executive Director.

Procedures

1. Bank Reconciliation will be completed by the bookkeeper in a timely manner on a monthly basis, for review by the Executive Director.
2. Reconciled bank statements will be reviewed and initialed by the treasurer on a monthly basis.

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY **FINANCIAL REPORTING**

Procedures

1. Financial Reports, including invoices, cancelled cheques, Bank statements, bank and petty cash reconciliations, and monthly paper copies of Revenue and Expense, budget to actual, and any other like reports, will be held securely and in an organized manner at the EK Division office, or at other secure locations, when necessary.
2. Members of the Board of Directors may at any time request to see any of the financial documents of the society held at the divisions office
3. Reports to the Board will include the following:

	Each Meeting	Quarterly
Revenue/Expense Statement	X	X
Budget to Actual	X	X
Balance Sheet	X	X

Effective Date	Approval *(Signature)*	Date Approved

POLICY	SEGREGATON OF DUTIES

Segregation of Duties Policy

The segregation of duties dictates that no financial transaction is ever handled by a single person. To accommodate this different people need to be involved with the following processes: authorizing payments, signing cheques, recording payments and reconciling the bank statement.

Authorization of Payments

1. Payments will be presented by the bookkeeper for authorization to the Executive Director, if under $1500; or by an appointed director of the Board if over $1500 or if the payment is for the Executive Director.
2. Two officers and/or the Executive Director will be required to authorize electronic payments prepared by the bookkeeper for payment.

Signing of Cheques

1. Two officers and/or the Executive Director will be required to sign each cheque prepared by the bookkeeper for payment. Both are to ensure the authorization of the expense prior to signing the cheque.

Recording Payments

1. The bookkeeper is responsible for recording all payments authorized by the Executive Director, for review by the Executive Director or Treasurer at any time

Reconciliation of Bank Statements

1. The bookkeeper will reconcile the bank statement for review and approval by the Treasurer

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY	**SIGNING AUTHORITY**

Signing Authority

1. A minimum of two Board members, plus one additional EK Division member will be authorized on the society's account as cheque signatories
2. The Executive Director will be authorized as an additional signing authority
3. All invoices, sessionals, and timecards will be approved by the Executive Director and/or a Board member prior to payment
4. Once prepared by the bookkeeper, two of the above authorities will be required to authorize the on-line process for electronic payments to physicians, vendors, contractors and staff

Cheque authorization

1. Cheques will require the signatures of two of the authorized signatories

Pre-signed Cheques

1. At no time will the signing authorities appointed provide a signed cheque without attached documentation and the cheque information (payee) completed

Effective Date	**Approval** *(Signature)*	**Date Approved**

POLICY	**MATERNITY LEAVE TOP-UP**

The EK Division will, upon proof of Employment Insurance benefits, top-up EI benefits to equal 70% of an employee's wage for up to 52 weeks. This benefit will be available to any employee who has completed the 3-month probation period (waiting period) required for access to all EK Divisions benefits. This top-up will include an agreement on a return to work duration equal to the number of weeks the employee receives this benefit. Should the employee not remain with the organization for the timeframe agreed upon, they will be responsible to re-pay the pro-rated top-up amount in full.

In addition, the health and wellness benefits available to staff will be available while on leave.

Effective Date	**Approval** *(Signature)*	**Date Approved**

Appendix 1: Request to Present Guidelines

The following operational guidelines have been created to assist external entities to work effectively with the EKDoFP.

Members and external stakeholders are encouraged to contact the Division office for more information:

web: www.divisionsbc.ca/eastkootenay email: pphillips@divisionsbc.ca

phone: 250-426-4890

fax: 250-417-4664

1. If you are requesting to speak or present at an EKDoFP Board of Directors meeting ~ You are encouraged to contact the office as early as possible.

2. If you are requesting circulation of a primary care research opportunity for our membership, we require that your research project is ~

✓ Formally approved by a University research ethics Board, and;

✓ Free of pharmaceutical/industry funding

We will review your proposal for incorporation of project information into one of our member communication mechanisms (Newsletter, EKDoFP Event). We require a minimum notice of 2 weeks. It is the requester's responsibility to ensure that appropriate consent is monitored and received.

3. If you are an external stakeholder requesting to circulate your information to our membership ~

You are encouraged to contact the office as early as possible. We will review your proposal for incorporation of your information into one of our member communication mechanisms (Newsletter, EKDoFP Event). We require a minimum notice of 2 weeks.

4. If you are an external stakeholder planning an event or soliciting representation for a committee and request EKDoFP support or participation ~

Please contact the EKDoFP office at your earliest convenience. In order to respectfully review your proposal and mobilize our resources to assist with your event we require 2-month notice at minimum.

5. If you are an external stakeholder seeking a Family Physician or member's perspective ~
1) East Kootenay Family Physicians and Family Medicine residents are encouraged to serve and/ or volunteer in any capacity that may enhance the climate of primary care in the East Kootenays. We must explicitly note however, that in this informal capacity these individuals do not represent the view of the EKDoFP or in any way endorse a particular position on behalf of the Division. If you require additional clarification, please contact our office at your convenience.

6. If you are an external stakeholder requesting official EKDoFP endorsement of an item (i.e. policy, communication document, position, position paper, etc.) ~

In order for the EKDoFP to respectfully consider your information we require a minimum 30 days from receipt of request. Please note a Board motion will likely be required for a formal

endorsement and the timing of the Board meetings may extend this time frame.

The Board of Directors generally convenes four (4) to six (6) times per year.

7. If you are an external stakeholder requesting EKDoFP feedback on an item (i.e. policy, position, discussion paper, etc.) ~

In order for the EKDoFP to properly consider your information, consult internally and provide feedback, we require a minimum 30 days from receipt to process your request.

What to Include In Your Research Request	**What to Include In Your Request**
1. Your organization/institution with confirmation of ethics Approval. 2. Confirmation that the project is free of pharmaceutical/industry funding. 3. Contact information that clearly indicates the main person of contact. 4. The context of the request (how does the project align with the EKDoFP strategic priorities) including a brief 5. Mode of research (e.g. survey, focus group). 6. Expected time commitment. 7. Any applicable financial considerations.	1. Your organization/institution. 2. Contact information that clearly indicates the main person of contact. 3. The specific request of the division (select an option from the above outline). 4. The context of the request (how does your request align with the EKDoFP strategic priorities) including a brief 5. Required time frame and/or target date. 6. Meeting responsibilities and number of meetings (if applicable). 7. Any applicable financial considerations.

Disclaimer

While the EKDoFP is committed to educating and informing our membership about events/opportunities in primary care, we cannot guarantee access to our membership. Each request will be independently reviewed in a timely fashion.

Appendix 2: Committee Terms of Reference Template

Divisions of Family Practice infrastructure funds can be allocated to pay for involvement in Division Board and committee meetings as well as other work on behalf of the Division.

This template provides an outline for establishing the terms of reference that can be adapted for any committee.

Date of

Formation:____

1. Purpose
   1.1 Goals
   1.2 Deliverables
2. Membership
   2.1 Composition - interested Board or Division members and may include the Executive Director and administrative support (name the members)
   2.2 Chair - as decided by the committee
   2.3 Secretary - as decided by the committee
   2.4 Quorum - a majority of the members of the committee will constitute a quorum
   2.5 Term of membership, if determined
3. Frequency of meetings
   3.1 Meets at the call of the Physician Lead or Chair, or at the direction of the requesting organization, (i.e. if the EK Division physician representation is required by an outside party, such as a Health Authority or other health services partner/stakeholder).
4. Decision-making and Governance
   4.1 Decisions about committee projects and work will be made by consensus. Consensus decision- making is a group decision-making process. It is both a process and outcome. Consensus is a process in which all committee members have their chance to express their views with a focus of discussion amongst the group
   4.2 Consensus seeks the agreement of most participants with minority objections. Consensus does NOT mean everyone gets exactly what they want. It does mean that everyone can live with the decision and support the decision.
   4.3 Scope and Jurisdiction: Committee work and projects must align with East Kootenay Division of Family Practice strategic priorities.
   4.4 Committee projects must be approved by the Board.
5. Minutes and Communication
   5.1 Minutes of meetings will be recorded by the secretary or delegate
   5.2 Minutes will be circulated to committee members and made available to the EK DoFP Board.

5.3 Preferred method of communication for group members will be established

6. Reporting relationship/procedure
   6.1 Reports to the Board on matters relating to the committee work and responsibility will be presented in a timely manner previous to every convening of the Board.
   6.2 Items of business are brought to the attention of the committee by the Chair
7. Resources and Budget
   7.1 Detailed list of resources available to the committee
   7.2 Itemized budget of expected committee expenses, both for meetings and any work being undertaken
8. Remuneration and Expenses
   8.1 Sessional remuneration shall be paid at the rates established by the Physician Master Agreement and expenses reimbursed as per the rates set out by the EKDoFP on the Expense Reimbursement Claim Form.
   8.2 Expenses shall be detailed on the EK Division Sessional and Expenses Claim Forms.

Sessional Fees and Expense Reimbursement

1. Sessional fees for meetings

   Sessional fees are paid based on time involved in the work of Division committees, based on the approval of each committee member by the Board by a resolution, or where specifically permitted by the Board resolution, by approval of the Chair of the Board.
2. Honoraria for cancelled meetings

   There will be no reimbursement for cancelled meetings.
3. Reimbursement will be paid in blocks of 15 minutes
4. Authorization

   Committee chairs will be responsible for informing the Executive Director of the attendees of each meeting. The Executive Director can approve most expenses, but in case of a disagreement, the Executive Director will discuss the issue with the chair of the relevant committee and with the Division lead, who may ask the Board of Directors to make a decision.
5. Sessional and Expense Forms

   The sessional and expense reimbursement claim form for the EKDoFP is used to process and track payments to members for participating on committees and working groups. Completed forms must be signed by the participant. The committee or project lead reviews and submits to the EK Division Executive Director for approval. Participants will be paid for reasonable meeting preparation time.
6. Payment terms

   Payment will be processed within one month of the receipt of a sessional claim form. Payment may be delayed if Board members are required to approve any payment that requires special consideration.

7. Annual general meeting

   No honoraria are paid for attendance at the annual general meeting.

8. CMEs

   No honoraria are paid for attendance at CMEs.

Procedures

1. Only those approved by the membership as Board members, or approved by the Board as participants of a committee, or otherwise performing work for the Division, are eligible to receive sessional fees.
2. Sessional and expense claim forms must be submitted within 60 days of a meeting in order to receive payment.
3. To be reimbursed for out of pocket expenses incurred while participating on an EK Division committee, members must complete a current Sessional.

Rates

Participants engaged in the work of the Division will be reimbursed according to the details specified in the EK Divisions established policies.

Unless otherwise specified, the sessional rate is as negotiated in the Physician Master Agreement for preparation and participation in committee meetings, or the current sessional rate for general practitioners as set by Doctors of BC.

Mileage is reimbursed from the origin of the trip (home or office, whichever is the starting point) to the meeting location. Members working on contract will be reimbursed at the current EKDoFP established rate per kilometer.

A complete Reimbursement Form with rates is attached.

Personnel Policy Revision

V.6 edits

November 2021

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1. Hiring and Personnel Selection

In all hiring and selection processes the East Kootenay Division of Family Practice Society (EK Division) will adhere to the following principles:

- **Fairness:** For all postings, the EK Division will advertise widely, within appropriate budgetary considerations. The interview process will be conducted with the care necessary to ensure the protection of individual rights and the selection criteria will be free of personal agendas.
- **Quality:** From time-to-time EK Division may require the skills of a person or group who may be able to supply specific and/or specialty skills or technical expertise. All such projects should be contracted through timed arrangements.
- **Openness:** No person involved in the EK Division personnel selection process may promise or guarantee any applicant of their eventual hiring. Should a member of the interview panel find themselves in a position of potential conflict of interest, that person will express the potential conflict of interest to the other committee members and/or withdraw from the committee for the duration of that competition.

1.1. HR Committee

The HR Committee is responsible to support the selection and hiring of all EK Division positions except the Executive Director (ED). The EK Board is responsible for the hiring of the ED.

The HR Committee is appointed by the EK Board as required and will normally consist of three to four persons, including one to two Board members, the ED and Operations Lead of the EK Division. From time to time, as needed, the HR Committee may request that a member of the Finance Review Committee assist the HR Committee with the hiring process.

1.2 Hiring Process

- **Postings:** Contract and employment opportunities will be made available to internal candidates and promoted to existing employees at the same time as external postings. Based on the needs of a position and at the discretion of the ED or HR Committee, some postings may be posted internally prior to being posted externally.
- **Direct Award:** From time to time, as part of the EK Division's succession planning, an employee or contractor may be directly awarded a contract or position as it relates to their natural progression of responsibility and transition.
- The process for hiring employees will proceed as follows:
  - EK Division ED and/or Operations Lead oversees all competitions.
  - The EK Division Board will oversee ED competitions and reviews.
  - Advertising shall include web-based, print and other media as deemed appropriate for the purpose of short-listing candidates.
  - Short-listed candidates will be contacted to schedule interviews.
  - Commence interview process.
  - Complete reference checks as determined by the ED or Operations Lead.

- Select suitable candidate.
- Provide letter of offer to the successful candidate and letters and/or phone calls of regret to unsuccessful interview candidates.
- Sign Employment Contract with the successful candidate. All employees are to receive a copy of their job description along with their letter of offer.

1.3 Probationary Period

There is a mandatory three-month probationary period for all new employees. A self-employed and/or independent contractor who was previously providing service to the EK Division for a period of not less than three (3) months and who is being transitioned or grandfathered into an employment position is considered to have completed their mandatory three-month probation.

Unless otherwise constrained by any annual or time-determined funding related to the position, at the end of the probationary period if the EK Division management is satisfied with the employee's performance, organizational and cultural fit, the employee will be placed on permanent status.

2. Office Procedures

2.1 Job Descriptions

Job descriptions for all positions except the ED will be prepared by the ED and/or Operations Lead. The EK Division Board is responsible for reviewing the job description for the ED. Job Descriptions are kept on file for all positions within the organization. Current roles and Job descriptions are included in the Appendix.

Roles may be combined where appropriate and one employee may hold more than one role, position or job description either of which may be permanent or temporary and may require more than one rate of pay in order to correctly compensate the work being done.

Job descriptions may be altered from time to time, in consultation with the employee, in order to accurately reflect the changing needs of the organization and/or in response to succession and other HR planning demands. Employees must be provided with a copy of any revised job description.

If additional terms/deliverables are developed for a contractor, written terms will be provided to the contractor and will be kept on file by EK Divisions.

Annual letters of renewal are based on continued funding and shall be provided no less than one (1) month prior to the expiration of their current letter of employment. The renewal letter will include current wages, hours of work, and job description/title and/or project allocations.

2.2 Career and Performance Support Meetings

Career and performance support meetings are intended to be a positive experience for employees and should be approached with this attitude. The purpose of the meeting is to provide employees with the opportunity to openly discuss with their immediate supervisor:

- How the employee can utilize his/her talents and abilities to the fullest.
- How the employee can help the EK Division to reach its goals.
- The employee's past accomplishments.
- The employee's current performance.
- Future activities and skill and ability development plans.

Career and Performance Support meetings are to be conducted upon the completion of the probationary period and annually upon the completion of each year of employment. Career and Performance Support meetings should also be completed if an employee is struggling with challenges related to accomplishing workplace goals, or if there is a change in the job description or employment environment.

The Career and Performance Support meeting for the ED commences every other year and will include a 360-degree component beginning with a self-assessment, an opportunity for stakeholder input, an interview and a review.

Career and Performance Support meetings for employees will be conducted by the ED and/or the Operations Lead and they may request a board member or other senior employee(s) to support the process as they deem appropriate. The ED's Career and Performance Support meeting will be conducted by the EK Division Board.

Performance Support Assessments are to be completed using the templates in the Appendix.

Completed Performance Support Assessments are to be signed by the employee and management and kept in the employee's personnel file.

2.3 Employee Orientation and Records

All employees will receive an orientation upon hiring. Orientation will include, but is not limited to review of:

- Personnel Policies.
- Occupational Health and Safety Policies.
- The Organization's Strategic Direction.
- Roles and Responsibilities
- And signing the Privacy, Confidentiality, Computer Usage and Conflict of Interest agreements

Employees are to complete a Personnel Information form at the time of hire. (Template in Appendix) This form is to be kept in the employee's personnel file. The employee is responsible to advise the EK Division of any changes to their information

in order to avoid any problems with income tax, benefits and other matters.

The personnel file will be maintained by the Operations Lead and housed securely. Access to the file is available on request, and is restricted to the employee, the HR Committee and the ED.

Personnel files are to include the following items:
- Resume received at time of application for employment,
- Accepted letter(s) of offer,
- Privacy, Confidentiality, Computer Usage and Conflict of Interest agreements,
- Employment renewal letters,
- Personnel Information Form(s),
- Records of disciplinary action (if any),
- Letter(s) of compliment (if any),
- Written record(s) of changes in wages or salaries as approved by the ED /Board of Directors,
- Performance Support Meeting record(s).

3. Hours of Work and Overtime

3.1 Hours of Work

Due to the flexibility required for this work, the current situation of many employees working from home offices, and varying part-time hours for employees, a standardized workday and week are not defined. However, the following shall serve as a guide:
- Schedules and work hours will be determined by the employee in consultation with the ED or Operations Lead in order to provide employee flexibility without compromising the needs of EK Divisions.
- Except where funding dictates otherwise, each employee agrees to have their weekly hours averaged over a stated timeframe (generally three (3) months).
- Employees are expected to not exceed the maximum number of hours allotted within that timeframe unless expressly permitted to do so in advance by finance/operations.
- Each quarter, employees will be informed of the maximum number of hours they were allotted and number of hours worked during that quarter.
- For the purposes of the EK Division, a full-time work week is considered to be 35 hours per week or an average of 7 hours a day.
- Employees who work more than an average of 35 hours per week over a fiscal quarter are eligible for overtime paid at time and a half. Eligible overtime is paid on the last pay period of the quarter in which it was earned.

3.2 Meals & Coffee Breaks

Employees are entitled to a daily, 60-minute, unpaid lunch break.

Employees shall be provided with a 15-minute paid coffee break for every 3.5 hours worked.

3.3 Notification of Illness and Absence

If an employee anticipates they may be unable to work due to illness or absence, for a period greater than three (3) days, notice must be provided to the ED and/or Operations Lead.

3.4 Safety on the Job

EK Division is committed to ensuring the ongoing health and well-being of all employees. Employees are expected to follow common sense safety precautions. Should they find themselves in a hazardous situation, they are expected to act in a manner that can best ensure their safety.

e.g., No employee is expected to travel on roads which may be hazardous for normal driving. Should an employee find themselves on the road on behalf of the EK Division or on their way to work when such conditions develop, they must find an appropriate rest stop and wait for the conditions to improve prior to resuming their drive.

If an employee has an accident while performing their work duties, regardless of perceived triviality, the employee must report it to the Operations Lead or designate immediately when possible, or within 24 hours. The Operations Lead will ensure all required documents are completed and submitted to Work Safe BC.

A copy of the Occupational Health and Safety Standards, and WorkSafe BC Injury report forms will be provided to all employees.

4. Employee Benefits

Benefits include the mandatory benefits of EI, CPP, WorkSafe BC and Annual Vacation Pay. In addition, the EK Division provides its employees with paid sick and personal leave as outlined in 6.2.

The EK Division offers Olympia Trust reimbursable health benefits and EK Division Personal Spending Wellness Benefits. These benefits are available after 3 months of employment with the Division. Olympia benefits are only available to employees who work 15 hours or greater per week.

Detailed information packages on each of these benefits, and how to access them, will be provided to each employee. These benefits currently total 5% of an employee's expected annual gross wages, as determined April 1st (or subsequent date-of-hire) of each year. A review and adjustments are completed at the 6-month mark.

The 5% of annual gross wages breaks down as follows:

- Olympia Trust benefits equal 3%. These benefits typically cover medical and extended health type services on a reimbursement basis. These benefits are not taxable.
- Personal Spending Wellness benefits equal 2%. These benefits typically reimburse wellness activities such as sports, fitness classes, memberships and other defined wellness costs. These benefits are taxable.

5. Employee Travel

Note: The following provisions shall apply to anyone traveling on behalf of the EK Division.

The principle of paid travel is that, when an employee travels under the direction or control of, or is engaging in work on behalf of, EK Division which takes place outside of their designated work location, their time is counted as time worked.

Employees earning travel wages will receive their usual wage rate.

5.1 Definitions

Travel: Paid travel time is considered to be time worked. Kilometers and time are recorded from the designated work location, such as the EK Division office at 200-201 14th Ave., N. Cranbrook BC, to their final work-related destination.

Travel includes:
- Trips to stores to purchase supplies, conduct banking, getting cheques signed or expenditures authorized.
- Trips to outlying communities.
- Trips to attend meetings, seminars and training programs.
- Other travel as authorized by the ED/Operations Lead.

Commute: Unpaid; not considered to be time worked. The trip from home to a worksite, such as the EK Division's office, is normally a commute. It is done at the employee's expense (unless otherwise stated) and no service or labour is provided or performed.

5.2 Employee Travel and Other Out-of-Pocket Expenses

EK Division will pay an employee's travel expenses if:
- The employee has received prior approval for the trip.
- The trip is necessary to the performance of the employee's job.

Employee expense claims will be reimbursed in accordance with the rates prescribed on the expense claim form, as determined by the Physicians Master Agreement (PMA). A copy of the expense claim form can be found in the Appendix.

Employees should keep all receipts, including meals and any incidentals, whether being paid by per diem or not, as there may be an opportunity for reimbursement from 3rd party funding providers.

Reimbursement for time and travel costs are calculated using the most expeditious, cost-effective means and route. For example, if an employee chooses to drive to a meeting in Kelowna vs. flying; they may claim the least expensive means of travel. When flying, reimbursement will be based on economy fare.

5.3 Company Credit Card

Employees who regularly make purchases on behalf of the organization may be

provided access to a company credit card. This credit card has a board-established limit, shared amongst all users. Currently that collective limit is $8000 and requires employees to notify each other and the Operations Lead if they expect their usage to be over $1500 during a cycle.

Employees using the EK Divisions credit card agree to all provisions in the credit card issuer's terms of agreement. Lost or stolen cards are to be reported immediately. Employees will provide all receipts for charges, attached to their statement and submitted in a timely manner to ensure the card does not incur interest, overdue fees or charges.

A credit card policy and usage agreement form can be found in the appendix.

5.4 Travel and General Expense Advances

Anyone traveling on business for the EK Division may request a travel advance of up to 90% of anticipated travel expenses. Requests for travel advances must be submitted on an expense claim form.

Employees making purchases on their personal credit cards or accounts on behalf of the Division may also request an advance. Alternatively, receipts for large purchases may be submitted for reimbursement immediately. Should any employee not wish to make such purchases, they should speak with the ED or Operations Lead to discuss alternatives.

Reconciliations of travel advances must be done within one month of the trip for which the advance was given and prior to another advance can be given.

5.5 Business Use Insurance

Employees who are required to travel beyond the requirement for personal use insurance may submit an invoice to the EK Division for reimbursement of the additional cost of Business Use insurance required on their personal vehicle. This will be reimbursed annually on the employee's vehicle insurance renewal date, after the completion of one year of continuous employment, and will cover the previous year's "Business Use" insurance differential only.

6. Leaves with Pay

6.1 Annual Vacation

6.1.1 Eligibility

Both full-time and part-time employees are eligible for annual vacations or vacation pay.

6.1.2 Annual Vacation Entitlement

Any new employee will receive 4% of gross earnings in annual vacation pay,

(unless otherwise negotiated.) An additional 2% increase to vacation pay will occur after three (3) consecutive years of employment, an additional increase of 2% after five (5) consecutive years. Subsequent increases will be 2% for every additional three (3) consecutive years of employment up until a maximum of 16% is reached.

6.1.3 Vacation Pay

A person employed for less than five calendar days is not entitled to vacation pay.

Any vacation pay received by an employee is counted as part of the total wages paid in any given year.

6.1.4 Paying Vacation Pay

Employees may receive their vacation pay (advance payment) prior to the commencement of their vacation or paid out on each regular payday. The EK Division will strive to ensure employees take their annual vacation within 12 months of the year in which the vacation was earned.

No advance payment of vacation pay will be made unless specifically requested, in writing, by the employee.

6.1.5 Scheduled Vacation

Employees will not be forced to take vacation in periods shorter than one week. However, an employee may request a vacation period of less than one week. Employees may not book more than three (3) consecutive weeks of vacation unless prior approval has been given by ED and/or Operations Lead and a plan has been put in place for an extended leave.

Vacation schedules will be developed collaboratively and will be posted on the EK Divisions staff Team-up Calendar. In the event of conflict, seniority will apply.

If a paid holiday occurs during a scheduled vacation, the holiday is not counted as part of the vacation.

6.1.6 Paying Vacation Pay Upon Termination

Any/all outstanding wages, including vacation pay, will be paid within two (2) business days if EK Division terminates the employment. If an employee terminates their employment, all outstanding wages and vacation pay will be paid within fourteen (14) days.

6.2 Sick and Personal Leave with Pay

After three consecutive months of continuous employment all permanent employees

will earn sick leave at the rate of 1/10th of their average weekly scheduled hours per month, up to a maximum of six (6) full days per annum.

Accumulated sick days may carry over the calendar year to a maximum of ten (10) workdays. Use of sick leave must be approved by the Operations Lead on the timesheet submitted.

If the employee is absent for three or more consecutive days, the ED or Operations Lead may request a certificate of disability from a physician.

An employee who has exhausted his/her sick leave credits may request a general leave of absence, without pay, until he/she is able to return to work.

6.3 Marriage Leave with Pay

After the completion of one year of continuous employment an employee may be granted up to two days' special leave, with pay, for the purpose of getting married.

6.4 Bereavement or Compassionate Leave with Pay

For the purpose of this section, immediate family is defined as grandparents, father, mother, brother, sister, spouse, child or ward of the employee, father-in-law, mother-in-law and any other person permanently residing in the employee's household or with whom the employee permanently resides.

Employees should consult with the ED in special cases. At the discretion of the ED, this definition may include other close, personal relationships not otherwise included.

When a member of an employee's immediate family dies, the employee is entitled to special leave, with pay, up to four (4) days and may, in addition, be granted up to three days special leave for the purpose of travel related to the death.

An employee may be granted one day of special leave with pay in the event of the death of other close relatives not defined above.

7. Unpaid Leaves

7.1 Pregnancy Leave

A pregnant employee is entitled to up to seventeen (17) consecutive weeks of pregnancy leave. This leave may start no earlier than eleven (11) weeks prior to the expected birth date and must end no earlier than six (6) weeks after the birth date unless the employee requests a shorter period.

A request for pregnancy leave made during the pregnancy must be made in writing at least four (4) weeks prior to the proposed start date.

If pregnancy leave is not requested until after the birth of a child or completion of the pregnancy, the employee is entitled to up to six (6) consecutive weeks of leave beginning on the date of the birth of the child or completion of the pregnancy.

The initial period of leave may be extended up to six (6) consecutive weeks if an employee is unable to return to work for reasons related to the birth or completion of the pregnancy.

A request to return from leave earlier than six weeks from the birth must be made in writing at least one week prior to the determined return date.

EK Division may require an employee to provide a doctor's certificate in support of a request for leave or a leave extension.

7.2 Parental Leave for Birth and Adopting Parents

A birth mother who has taken pregnancy leave is entitled to 35 consecutive weeks of standard parental leave or, if they choose, an extended parental leave entitling them to 61 weeks. A birth mother must begin her parental leave immediately following the expiration of her pregnancy leave unless otherwise agreed upon by the mother and EK Division.

A birth father or an adopting parent is entitled to up to 61 consecutive weeks of unpaid parental leave. A birth father must begin the leave within one (1) year of the birth of the child and an adopting parent within one (1) year of child being placed in the care of the parent.

An initial period of parental leave may be extended up to five (5) consecutive weeks if the child requires an additional period of parental care.

A request for parental leave by a birth parent must be made in writing at least four (4) weeks prior to the proposed leave date.

EK Division may require an employee to provide a doctor's certificate or other documentation outlining the employee's entitlement to the requested leave or leave extension.

7.3 Parental Leave Top-up

The EK Division will, upon proof of Employment Insurance benefits, top-up EI benefits to equal 70% of an employee's wage for up to 52 weeks with standard paternal leave. If an employee chooses to take an extended parental leave the standard leave top of 70% will be distributed across this longer time-period.

This benefit will be available to any employee who has completed the three (3) month probation period (waiting period) required for access to all EK Divisions benefits.

This top-up will include an agreement that the employee return to work for at least an equal number of weeks the employee will receive the top-up. Should the employee not remain with the organization for the timeframe outlined above, they are responsible to re-pay the pro-rated top-up amount for the number of weeks they will no longer be employed with EK Division.

e.g., If an employee arranges to receive the 70% top requiring they return to work for 20 weeks but leaves the employ of EK Division after thirteen (13) weeks, they must pay back the pro-rated weekly amount multiplied by seven (7) weeks.

7.4 Other Unpaid Leaves of Absence

The EK Division will recognize and follow all standards for job-protected leave, as outlined in the Employment Standards Act.

Leaves of absence of less than one month may be approved by the ED. Any leave of more than one month must be approved by the EK Board.

All requests for a leave of absence must be submitted in writing and must be contain a rationale for the leave. All accumulated time (vacation, sick leave, etc.) is to be used first, whenever possible.

A request for a leave of absence may not exceed one (1) year except for an extended parental leave.

7.5 Employment Considered Continuous

If an employee is on a leave covered by the Employment Standards Act, their employment is considered continuous:
- The employee continues to receive any planned wage or benefit increases.
- The EK Division will continue to make payments to the health and wellness benefits plans.
- The EK Division will continue to calculate annual vacation, termination entitlements, benefits or length of service in a continuous manner.

7.6 Conditions of Employment to Remain the Same during Leave

EK Division will not terminate an employee or change a condition of employment because of a leave or jury duty without the employee’s written consent.

7.7 Return to Work

When a leave or jury duty ends, an employee will be returned to their former position or to a comparable position.

8. Employee’s Performance Change Support

The intent of any type of employee performance change support measures is to support

change in the employee's approach to their responsibilities. These measures should be implemented in a respectful and supportive manner and clearly convey expectations and steps toward making the identified changes.

Any employee performance change action is the responsibility of the EK Division ED, or appointee. Concerns can be brought forward by any team member to the ED. Should issues include the ED, or be considered inappropriate to take to the ED, they may be brought to a member of the HR committee, who may bring it to the attention of the Board.

Change measures may include, but are not limited to, initial identification of concerns, informal conversations, counseling, formalized meetings, documenting of concerns and a corrective action plan.

8.1 Corrective Performance Process

Simple dissatisfaction with performance is not just cause for termination of employment. Corrective actions involve reasonable attempts by EK Division to assist employees to achieve change(s) resulting in satisfactory performance, including meeting established standards, goals and objectives.

The ED will make the employee aware of an expected standard of performance. (EK Division has the right to determine how the business will be conducted and can adopt any procedure as long as it is not unlawful, dishonest, or unsafe, and is within the ability of the employee to perform).

In the event the employee fails to meet the standard(s) set out during the employee's corrective performance process, the ED, or appointee, will make reasonable efforts to assist the employee –through training or other methods—to meet the expected performance standards.

Employees who fail to respond to change support processes may be terminated for just cause if the employee has:

- been informed that continued failure to perform to established standards of performance will result in dismissal, and
- the employee continuously or repeatedly fails to meet acceptable standards of performance. The termination must relate to the matters that gave rise to the corrective process.

All employee performance change meetings must be documented.

8.2 Inter-Employee Concerns

The EK Division embraces a culture of employee equality and a team-based philosophy that supports employees receiving fair and equitable treatment and that expects all employee relations are conducted in a harmonious manner. It is recognized that situations may arise where an employee is dissatisfied with his/her treatment in the workplace.

In cases of dissatisfaction an employee can pursue the following process:

1. Communicate concerns to the employee's immediate supervisor and attempt to find resolution.
2. If the problem remains unsolved, advise the ED. The ED will then discuss the concerns with the employee and attempt to resolve it. If the ED is the employee's immediate supervisor, go to step three (3).
3. If the problem remains unsolved (or if the ED is the employee's direct supervisor), provide a written outline of concerns to the HR Committee. The HR Committee will arrange a meeting with the employee to attempt to resolve the grievance. The HR Committee may, or may not, decide to bring the issue to the Board of Directors. The decision of the HR Committee, or Board, is final.

All individuals' concerns are to receive a fair, unbiased and thorough opportunity to be consideration.

9. Termination of Employment

9.1 Resignation (Voluntary Termination)

Employees may resign their position with EK Division by giving two weeks written notice to their supervisor.

Except in the most extenuating circumstances, an employee who fails to report for work for five scheduled days without contacting their supervisor will be considered to have voluntarily resigned.

9.2 Involuntary Termination

Involuntary terminations include but are not limited to layoffs and termination for cause. All involuntary terminations must be provided to the employee in writing.

9.2.1 Layoff

Layoff may be necessary due to redundancy, the elimination of a position or to address a lack of funding. In such cases the employee will be given notice or compensation as outlined in 9.6.

9.2.2 Dismissal

An employee may be dismissed for Just Cause. Just Cause includes, but is not limited to:

- Serious willful misconduct.[1]
- Assault or harassment of co-workers.
- Breach of duty or negligence.
- Conflict of interest[2] (especially fiduciary).

[1] *Willful misconduct means the employee knew what to do and deliberately did not do it, or knew what not to do, and deliberately did it. A mistake, especially if due to inexperience or lack of training, is not considered to be willful misconduct.*

[2] *As defined by the signed employee Conflict of Interest Agreement included in Appendix*

- Theft.
- Serious breach of EK Division rules or practices.
- Fraud/dishonesty.[3]
- Chronic absenteeism or tardiness.
- Serious undermining of the corporate culture.
- Unsatisfactory work performance (as per section 8.1).
- Breach of confidentiality/privacy.

Some of these reasons, such as theft, fraud, dishonesty, or conflict of interest, require only one provable incident to justify dismissal without compensation or notice. Others, like poor performance, low productivity, absenteeism or tardiness require EK Division to advise the employee of expectations, and the consequence of dismissal for failure to meet expectations.

9.3 Compensation upon Termination

9.3.1 Compensation Eligibility

An employee who is terminated without just cause will be eligible for compensation based on the following formula (unless the conditions of 9.3.2 are met):

- After three (3) consecutive months of employment - one (1) week's pay.
- After twelve (12) consecutive months of employment - two (2) weeks' pay.
- After three (3) consecutive years - three (3) weeks' pay,
- For each additional year of employment one (1) additional week's pay per additional year, to a maximum of eight weeks.

A week's pay is determined by multiplying an employee's current hourly wage by the average maximum weekly hours in the employee's most current Employment Contract or Amendment.

9.3.2 No Compensation Required with Working Notice

No compensation is required if an employee is given advance written notice of termination equal to the number of weeks for which the employee is eligible. This notice MUST be in writing.

EK Division can also provide a combination of written notice and compensation equal to the number of weeks' pay for which the employee is eligible.

EK Division cannot give notice while an employee is on vacation, leave, temporary layoff, or is unavailable for work due to medical reasons.

If employment continues after the notice period ends, the notice is of no effect. Once written notice has been given, EK Division may not alter any condition of employment, including the wage rate, without the employee's written consent.

[3] *lack of honesty or integrity : disposition to defraud or deceive.*

9.3.3 No Notice or Compensation Required

EK Division will not provide notice or compensation in lieu of notice if:

- The employee has not completed three consecutive months of employment.
- The employee quit or retired.
- The employee was dismissed for just cause.
- The employee worked on an on-call basis doing temporary assignments, for which he or she could accept or reject.
- The employee was employed for a defined term and the termination occurred at the end of this term.
- The employee was hired for specific work to be completed in 12 months or less and the termination occurred after 12 months.
- Circumstances legally out of EK Division's control.
- The employee refused reasonable alternate employment.

If a definite term or specific work is extended for at least three months past its scheduled completion, the definite term and specific work exceptions described above do not apply.

Final wages, including any outstanding wages such as annual vacation pay, designated holiday pay and overtime either worked or in a time bank, will be paid to the employee within fourteen (14) days following the employee's final day of work.

9.4 Temporary Layoff

EK Division is not required to give notice of termination or pay compensation if an employee is laid off temporarily.

A week of layoff is a week in which an employee earns less than 50 percent of his or her weekly wages at the regular rate, averaged over the previous eight weeks.

When a temporary layoff becomes a termination, the last day worked is the termination date and the employee's entitlement to compensation for length of service is based on that date.

A temporary layoff becomes a termination once a layoff exceeds thirteen (13) weeks in any period of twenty (20) consecutive weeks.

A layoff other than a temporary layoff is considered a termination.

9.5 References

When an employee is terminated or voluntarily terminates their employment the immediate supervisor may provide a letter of reference, if requested, to assist the employee to obtain future employment.

All inquiries from prospective employers about a past employee's employment record, performance or attendance must be referred to the ED or appointee.

10. Paying Wages

10.1 Paydays

Pay days will occur on or before the 8th day of each month.

All employees will be paid monthly, with a mid-month advance of not more than 50% of their anticipated gross for the month. Employees will have the opportunity to define the amount of their advance within these parameters.

Employees will be paid through a direct deposit system, unless otherwise notified or agreed upon.

10.2 Pay Period

Pay periods will be monthly (12 per year) and end on the 28th of the month. All employees are paid on an hourly basis.

All money earned in a pay period will be paid by the 8th of the following month.

Time sheets are due and are to be submitted to the EK Division Operations Lead, or designate, by 5:00 pm MDT on the 28th of the month.

On months where the pay period ends on a weekend day, time sheets are to be submitted to the Operations Lead by 5:00 pm MDT on the Friday prior to the 28th, to allow time for processing direct deposit payments.

10.3 Timesheets

Timesheets are for recording all time worked and expenses claimed, including travel claims and wellness reimbursements. The timesheet spreadsheet consists of 5 pages: time tracking, hours summary print off, expense and mileage print off, wellness claim and travel expenses claim. A copy of the template is in the appendix. The entire document should be submitted to the Operations Lead as per section 10.2.

10.4 Expenses

Approved employee expenses will be reimbursed based on the same submission guidelines detailed for the pay period (10.2).

10.4.1 Personal Cell Phone Use Expense

Employees will receive a monthly stipend of $60 to help offset and reimburse the cost of using their personal cell phones to complete work for the EK Division, unless otherwise negotiated within their contract or determined by specific project budget parameters.

10.5 Wage Statements

On paydays, employees will receive a written wage statement for the pay period, which includes the following information:

- EK Division's name and address.
- The hours worked by the employee.
- The employee's wage rate, whether hourly, salary, flat rate, piece rate, commission, or other incentive basis.
- Any money, allowance or other payment the employee is entitled to. This can include vacation or designated holiday pay and Wellness Benefit reimbursements.
- The amount and purpose of each deduction.
- The employee's gross and net wages.
- Any amounts withdrawn from the employee's sick time bank and how much time remains.
- A running balance of sick leave available
- A running balance of vacation pay if accrued.

10.6 Deductions

EK Division will only deduct money as required or permitted by the Employment Standards Act, or by another Act of either British Columbia or Canada. Examples of required deductions include those for income tax, Canada Pension Plan and Employment Insurance.

Any other deductions, such as union or professional dues, require the employee's written permission.

10.7 When Employment Ends

An employee who is given notice of termination or has been laid off will be paid in full within 48 hours of their last day of work. If an employee resigns or retires, he or she will be paid wages in full within fourteen (14) days of their last day worked.

These times are by the clock and the calendar. They are not working hours and business days.

If an employee cannot be located, EK Division will pay the wages to the Director of Employment Standards within 60 days after the wages become payable. The Director holds these wages in trust for the employee.

11. Designated Paid Holidays

11.1 Statutory Holidays paid by the EK Division

The Division observes 12 statutory holidays in British Columbia:

- New Year's Day
- BC Family Day
- Good Friday
- Easter Monday

- Victoria Day
- Canada Day
- B. C. Day
- Labour Day
- Thanksgiving Day
- Remembrance Day
- Christmas Day
- Boxing Day

11.2 Eligibility

Employees become eligible for a paid day off on a designated holiday after they have been employed for 15 calendar days.

11.3 Calculation of Statutory Holiday pay

Statutory holiday pay for each stat will be calculated by dividing by 5 the employee's maximum average weekly hours of work, as stated in his/her most current Employment Contract or Amendment.

Example: if an employee's maximum weekly average is 20 hours, the statutory holiday will be paid at 20/5=4 hours, regardless of the number of hours the employee may have worked in prior days or weeks.

This formula forms part of the averaging agreement included in the employee's employment contracts.

11.4 Designated Holidays for Those Not Eligible

An employee who is not eligible for the designated holiday and who works on the holiday will be paid as if it were a regular workday and is not entitled to an alternate day off.

An employee who is not eligible for the designated holiday and who does not work on the holiday receives the day off without pay.

11.5 Substituting Designated Holidays

Where EK Division and a majority of affected employees agree, EK Division may substitute another day off for a designated holiday.

12. Education and Training

EK Division recognizes that education and training is a lifelong pursuit. Accordingly, employees are encouraged to continue their education and training. Courses and programs of mutual benefit to the employer and the employee may be paid for by the EK Division.

To receive compensation the employee must:

1. Receive prior approval from the ED. If the ED requests compensation, they

require approval from the HR committee or EK Board Chair.

2. Complete an Expense Claim form and attach appropriate receipts. These include, but are not limited to, course fees and texts. Travel expenses may also be reimbursed, if in the opinion of the ED there is sufficient merit.

Compensation approval is subject to funds being available in the annual budget approved by the Board of Directors.

If an employee fails to complete or pass a course paid for by the EK Division, the next course or training program the employee requests compensation for will only be compensated after the successful completion of the course.

13. Confidentiality

All employees are required to review and sign the Confidentiality Agreement and Privacy Policy included in the EK Division Policies. A copy of the document is included in the Appendix.

A breach of confidentially could result in an employee's immediate dismissal.

EK Division reserves any and all legal rights it has against employees for violating confidentiality.

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1. Employee Timesheet

a. Time tracking form

TIMESHEET TEMPLATE

Name of Staff

Rate:	20.00
Week:	25.00
Daily avg.	5.00

Date	Project work	Project trav	Total Hours Per Day	Total KM	Total $	Notes
Date	Hours	kms				
Prev month 29			0.00	0.00		
Prev month 30			0.00	0.00		
Prev month 31			0.00	0.00		
1			0.00	0.00		
2			0.00	0.00		
3			0.00	0.00		
4			0.00	0.00		
Stat example 5	5.00		5.00	0.00		
6			0.00	0.00		
7			0.00	0.00		
8			0.00	0.00		
9			0.00	0.00		
10			0.00	0.00		
11			0.00	0.00		
12			0.00	0.00		
13			0.00	0.00		
14			0.00	0.00		
15			0.00	0.00		
Sub-total	5.00	0.00	5.00	0.00		
16			0.00	0.00		
17			0.00	0.00		
18			0.00	0.00		
19			0.00	0.00		
20			0.00	0.00		
21			0.00	0.00		
22			0.00	0.00		
23			0.00	0.00		
24			0.00	0.00		
25			0.00	0.00		
26			0.00	0.00		
27			0.00	0.00		
28			0.00	0.00		
Sub-total	0.00	0.00	0.00	0.00		
Hour Totals	5.00		5.00		100.00	105.00 Hours left for the month
KM Totals		0.00		0.00	0.00	

	# days	Hrs per day				
Vacation Payable					100.00	example
Vacation days taken		5.00		0.00	0.00	
98.00					100.00	
Sick benifit available					5.00	example
Sick hours taken					0.00	
Sick benifit remaining					5.00	
					Max 50 hours	

Hours	Q1 April-Jun	Q2 Jul-Aug	Q3 Sept-Dec	Q4 Jan-Mar	2021_22 YTD
Budgeted	0.00	0.00	0.00	0.00	0.00
Actual hrs worked					0.00
Diffrence	0.00	0.00	0.00	0.00	0.00

Olympia Benefit Carry Over from Previous July 20__ - June 20__	500	example
Olympia Benefit Limit July 20__ - June 20__	500	example
(Please check your Olympia online account for you year to date balance)		
Wellness Balance April 20__ - March 20__	200	example

b. Hours summary print-off

Staff Name

		0%	# Hours	# Hours	# Hours	0%	0%	0%	0%			0%	$ 20.00	
Month	**HOURS**	**CORE**	**CBK LTC**	**RDEK**	**EASE**	**PMH**	**NDF**	**PCN2**	**Proj Adm**			**Total Hours**	**$**	Notes
1st-15th	0.00	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00			0.00	$ -	
16th to Month-end	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00			0.00	$ -	
Total Hours	0.00	0	0.00	0.00	0.00	0	0	0	0			0.00	$0.00	

0	Hours vacation paid this period	$0.00
	Payroll for this period	**$0.00**
	Total actual hours worked	0.00
0	Hours sick leave included in hours worked	$0.00
	Sick leave allocation	17.5
	Wellness for this period	$0.00
	Advance	$1,000.00

Date		**Position**	
Name		**Signature**	

c. Expenses and mileage print-off

Staff Name **Month Year**

Expenses

Date	Item	Supplier	GST	Total	Coding
Month Year	Cell Stipend			$60.00	Core
		Total Expense	**$ -**	**$60.00**	

Mileage	CORE	CBK RCI	RDEK	EASE	PMH	NDF	PCN2	Total KMS	Rate	Total
Total KM	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.55	**$0.00**

Travel expense claim paid	**$0.00**
Wellness expense paid	**$0.00**
Total Expense paid this period	**$60.00**

Date		**Position**	
Name		**Signature**	

** Please remember to attach original receipts

d. Wellness benefits claim

WELLNESS EXPENSE Reimbursement Claim

NAME		CLAIM DATE	
Address Change			

Expense Date	Item	Supplier	Pre-tax Cost	GST	Total Cost
Welllness to claim to be used before March 31, 2021					$10.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
Total Claim:			$0.00	$0.00	**$0.00**
			GST:	$0.00	
			Wellness after this claim		**$10.00**

Signed		**Code**	
Approved		**Date**	

Note: Original receipts are required.

For Payment please fax to 250-417-4664, or scan and email to lvanlerberg@divisionsbc.ca

Claims must be made prior to March 31 2021 for the 2020-2021 year.

e. Travel Expense Claim Form

TRAVEL EXPENSE CLAIM

NAME:		**CLAIM DATE**	
MEETING NAME		**MEETING DATE**	
TRAVEL FROM		**TO**	

Expense	Item		# of	Cost	Cost minus GST	GST	Total Cost	Acc Code
Mileage	#km's			$0.55			$0.00	
Transportation other than car:	Indicate: i.e airfare,etc.						$0.00	
Accommodations (Receipt required)	# nights						$0.00	
Private Accom. (No receipt required)	# nights			$40.00			$0.00	
Meals Per diem:			# days		Sub-total:		$0.00	
Full day	Urban	$90		n/a	n/a	n/a	$0.00	
	local	$60						
Breakfast	Urban	$20		n/a	n/a	n/a	$0.00	
	local	$15						
Lunch	Urban	$20		n/a	n/a	n/a	$0.00	
	local	$15						
Dinner	Urban	$50		n/a	n/a	n/a	$0.00	
	local	$30						
Incidentals		$15		n/a	n/a	n/a	$0.00	
Miscellaneous Expenses	Item (i.e parking, taxi, etc.)			Cost	Cost minus GST	GST	Total Cost	
(Itemize and provide receipts)							$0.00	
							$0.00	
							$0.00	
Total Claim:							$0.00	

Signed		**Code**	
Approved By		**Date**	

2. Employee Development

a. Employee Development Plan

East Kootenay Division of Family Practice
A GPSC initiative

EMPLOYEE DEVELOPMENT PLAN

EMPLOYEE INFO					
EMPLOYEE NAME			POSITION		
REVIEWER NAME			REVIEWER TITLE		
REVIEW PERIOD			DATE OF REVIEW		
CURRENT RESPONSIBILITIES					
List key responsibilities.					
Assess your performance in relation to your key responsibilities.					
DEVELOPMENTAL GOALS					
List performance and work objectives (include expected completion dates)					
Assess your performance in regard to previously set performance and work objectives.					
CORE VALUES					
Assess your performance in relation to core values.					
COMMENTS AND APPROVAL					
Include any additional comments.					
EMPLOYEE SIGNATURE			REVIEWER SIGNATURE		

b. Executive Director Performance Review

Executive Director Performance Review

Board Toolkit

October 2012

The board's role in growing and developing the organization includes assessment of the Executive Director. The performance review process is ongoing throughout the year and involves: setting goals, clarifying roles and expectations, seeking development opportunities, providing appropriate feedback and conducting a formal evaluation. At its core, this process is about ensuring high level leadership capability for the success of the organization.

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SAMPLE PROCESS

Vantage Point Executive Director Performance Review

Goal

To ensure we are a model organization for providing appropriate feedback to the Executive Director – in order to ensure high level leadership capability

Integrity of the Process

An external expert in data analysis will be recruited to collate all material in order to ensure honest feedback and appropriate, positive use of information.

Groups to Provide Feedback

- All board members
- The ED - self (same tool as board)
- Leadership team of employees (same tool as board)
- Selected community leaders
- All employees & volunteers through satisfaction survey

Steps/Timeline

1. Chair convenes ED Development Committee to lead process – Oct
2. ED provides names of those to be surveyed: executive team employees and 5 key community leaders (see next section for process for determining community leaders) who are influential and will provide honest critical feedback – Oct
3. Chair provides copy of current year ED goals to internal respondents (board, staff, ED) – Nov
4. Chair provides survey to board members, ED & staff leadership team - Nov
5. ED asks community leaders if they will take part in her performance review. If any decline, the ED must identify replacement respondents – Nov
6. Chair forwards survey to selected community leaders – Nov
7. Employee satisfaction survey conducted with all employees – Nov
8. All material returned to Data Analysis Expert (volunteer) – Dec
9. Data Analyst provides report to Chair and ED Development Committee – Jan
10. ED reports to board on previous year – Feb
11. Performance Review Summary and Analysis presented to the board by Data Analyst - Feb
12. ED Development Committee presents results to the ED with appropriate remuneration adjustments – Feb
13. ED and Chair draft ED goals for next year
14. Board reviews, comments and approves next year ED goals

Process for determining community leaders:

1. When conducting a comprehensive survey of the Executive Director's performance, the Board will seek survey results from at least five individuals selected by the Executive Director. These participants will advise the Board about their perspective about the ED's performance as seen by Vantage Point's external stakeholders.

2. The Board will decide who will provide such feedback to the board. However, the Board will accord significant deference to the Executive Director's recommendations and will not deny the Executive Director's recommendation without good reason, which it will communicate to the ED.

3. The ED will recommend individuals who will provide feedback to the board regarding the ED's performance in the past two years. While the ED exercises complete discretion as to who he or she will recommend to the board, the ED will select, and the Board will prefer, to select individuals who collectively represent a fair representation of the following stakeholders:

    - Vantage Point's major funders;
    - Vantage Point's major or significant customers;
    - Organizations or individuals, who are not employees or contractors of Vantage Point, who work closely with the Executive Director to deliver Vantage Point programs or who engage in public advocacy activities with the Executive Director;

The individuals selected have sufficient exposure to the Executive Director to provide a fair assessment of the Executive Director's skills and performance

TEMPLATE: TERMS OF REFERENCE

Executive Director Development Committee

Goal: To ensure a model organization for attracting and retaining high level paid employees

Role: The Role is focused on assessing the critical function of the ED, the qualities and skill sets required of this position, and through the year determining ongoing development opportunities.

Core Values for Guiding the Committee

1. We value a culture of "appreciative inquiry" which includes valuing innovation.
2. We value a culture of mutual respect, diversity, and learning

Membership[1]

- The committee will be convened by the Chair of the Board
- Incoming Chair
- Past Chair
- Other ED on Board
- HR expertise
- ED

Objectives

- To review and amend role of the ED
- To liaise with the Board of Directors
- To determine performance as outlined in a predetermined template
- To determine development opportunities for the ED

Responsible to: Chair of the Board

Meeting Schedule: The Committee will meet in person a minimum of once per year and as often as required, dependent on work to be completed.

---

[1] Members of the Committee sit as individuals and not as representatives of their organization.

TEMPLATE: EXECUTIVE DIRECTOR EVALUATION SURVEY #1

For Board, Self and Leadership Staff

Date: ________________

Thank-you for completing this survey by [DATE]. Your feedback as a member of the Board [or self or leadership staff] is very important. We believe the process of growing and developing the organization includes the assessment of the ED. It clarifies roles and expectations for the ED and Directors. This process is in place to obtain the Board's [or self or leadership staff's perception of ED strengths, opportunities for improvement, and overall performance.

Section One: Executive Director Strategic Goals

(Note: The following section should focus on your organization's strategic goals. These might be long-term, 3-5 year goals. Keep in mind that this is about progress made if they are long-term goals, rather than simply completion).

Please mark the appropriate response below the goal and then continue to the table and post your comments beside the applicable objectives.

Goal:	Exceeded	Met	Not Met
[Goal one]			
[Goal two]			
[Goal three]			
[Goal four]			
[Goal five]			

To be filled out by Executive Director prior to distribution of survey

Based on the above major goals, the ED of this organization will achieve these specific objectives this year.

Objective	Related to Goal #	Measures	Targets	Initiatives	**Reviewers Comments**

To be filled out by Executive Director prior to distribution of survey

Section Two: Key Competency Areas

There are four key competency areas derived from the job description for the ED and from research that finds common competency requirements for leaders in organizations. Each key competency area contains several sub areas that are key components of the ED Role. Each competency area includes a definition to consider while responding to that area.

For each question in section two, please circle one response, and then provide your comments related to that competency category in the box provided.

Category One – Leadership

1. Integrity and honesty – the ED avoids saying one thing and doing another; acts consistently with words; follow through on promises and commitments; models the core values; leads by example

   Exceeds **Meets** **Needs Development** **Not Applicable**

2. Practices self-development – makes constructive efforts to change and improve based on feedback from others; seeks feedback and development opportunities actively; models self-development for staff and volunteers

   Exceeds **Meets** **Needs Development** **Not Applicable**

3. Inspires and motivates staff and volunteers – energizes people to go the extra mile; has the ability to get people to stretch and reach goals, perhaps beyond what they originally thought possible; inspires commitment, high energy and a winning attitude

   Exceeds **Meets** **Needs Development** **Not Applicable**

4. Develops others – is genuinely concerned about the development of staff and volunteers' career and development goals; gives individuals an appropriate balance of positive and corrective performance feedback; supports others' growth and success; takes interest in the work of others

   Exceeds **Meets** **Needs Development** **Not Applicable**

Please provide any comments on the above competency category of Leadership that supports or further explains your responses:

Category Two – Technical/Professional

1. Entrepreneurial – promotes the organization in a positive manner that gets results oriented to the strategic plan.

   Exceeds **Meets** **Needs Development** **Not Applicable**

2. Innovation – encourages innovation and new ideas; consistently generates creative, resourceful solutions to problems; constructively challenges the usual approach of doing things and finds new and better ways to get the job done; creates of culture of learning that drives individual development; encourages new ideas and works to improve them; encourages staff and volunteers to find innovative ways to accomplish their goals.

   Exceeds **Meets** **Needs Development** **Not Applicable**

3. Financial Management – obtains funding and manages finances in a manner that is consistent with the strategic plan and the values of the organization.

   Exceeds **Meets** **Needs Development** **Not Applicable**

4. Governance Practices – understands and models solid governance practices; through research, learning, and consultation, works to strengthen governance capacity and communicates this information to the Board; helps ensure objectives are realized, resources are well managed, important relationships are nurtured, and interests of stakeholders are reflected in decisions.

   Exceeds **Meets** **Needs Development** **Not Applicable**

5. Program Management – ensures program results through effective management practices; provides clear communication and provides solid coaching to staff and volunteers that enable them to meet the program goals and achieve results.

   Exceeds **Meets** **Needs Development** **Not Applicable**

6. Strategic Planning – participates effectively in the strategic planning process; recommends adjustments to the strategic plan where appropriate throughout the year; reports appropriately on the status of the organization's ongoing work to meet the goals of the strategic plan.

   Exceeds **Meets** **Needs Development** **Not Applicable**

Please provide any comments on the above competency category of Technical/Professional that supports or further explains your responses:

Category Three – Interpersonal Skills

1. Communication – provides staff and volunteers with a definite sense of direction and purpose; helps people understand how their work contributes to the strategic plan and the stakeholder groups; communicates clearly, concisely, and adequately with stakeholder groups.

   Exceeds **Meets** **Needs Development** **Not Applicable**

2. Relationship Management – is trusted by staff, volunteers, and stakeholder groups; balances concern for productivity and results with sensitivity for employees' needs/problems; are approachable and friendly; handles difficult situations constructively and tactfully.

   Exceeds **Meets** **Needs Development** **Not Applicable**

3. Partnership Management – forms partnerships with significant community groups that develop results oriented initiatives that benefit the community. Follows through on commitment to partnership groups by ensuring the results meet the goals set out in the initiatives.

   Exceeds **Meets** **Needs Development** **Not Applicable**

Please provide any comments on the above competency category of Interpersonal Skills that supports or further explains your responses:

Category Four – Change Management

1. Develops strategic perspectives – understands how work relates to the organization's strategic plan; able to translate the vision and objectives into challenging and meaningful goals for others; takes the long view where appropriate; can be trusted to balance short-term and long-term needs of the organization

   Exceeds **Meets** **Needs Development** **Not Applicable**

2. Champions change – Is the champion for appropriate projects or programs; able to present them so that others support them; is an effective marketer for the staff and volunteer groups projects and programs.

   Exceeds **Meets** **Needs Development** **Not Applicable**

3. Connects internal groups with the outside world – demonstrates the ability to represent the staff and volunteer groups to internal and external stakeholders; helps staff and volunteers understand how meeting stakeholders' (clients') needs is central to the mission and goals of the organization

   Exceeds **Meets** **Needs Development** **Not Applicable**

4. Change Communication – Is proactive in change-related communications; drives clarity of message related to change both internally and externally to the Board, staff, volunteers, stakeholders and joint partners.

   Exceeds **Meets** **Needs Development** **Not Applicable**

Please provide any comments on the above competency category of Change Management that supports or further explains your responses:

Section Three: General Comments

For the questions in section three, please provide any comments you deem relevant and important to the performance of the ED in future.

1. Please describe the two most important areas of focus for the ED for the next year:

2. Please describe one thing that if the ED did this over the next year it would make a significant difference to the success of the organization: (note- this should be different from items in the first question)

3. Please provide up to three comments on your overall ratings in the first section of this review (ED Strategic Objectives) that clarifies your responses:

References:
- Executive Directors Performance Review, author, and date unknown.
- Vantage Point, (2009). Job Description, Executive Director
- Wills, K, (2006). Resilience, Change & Organizations, thesis. Royal Roads University.
- Zenger, J. H., & Folkman, J. (2002). The extraordinary leader: Turning good managers into great leaders. New York: McGraw-Hill.

TEMPLATE: EXECUTIVE DIRECTOR EVALUATION SURVEY #2

For Community Leaders

You are being asked to complete this survey for the Executive Director of Vantage Point. Your contribution to completing this survey will help this executive continue to reach their personal goals. Thank you for taking the time to complete the survey. This is not a judgment of whether or not you think this person is good or not good at their job. Rather, we are asking how you think this person could be more effective in the role. We are focusing our questions on two specific areas:

1) What the ED does well or needs to improve on when building relationships with your organization
2) How the ED represents their organization in the community.

ITEM	DO A LOT MORE OF	DO A LITTLE MORE OF	CONTINUE AS IS	DO A LITTLE LESS OF	DO A LOT LESS OF
Meets with me on a regular basis.					
Invests time to develop our relationship					
Develops joint programs collaboratively					
Outlines a clear partnering relationship of mutual benefit					
Is an expert in the sector					
Invests in herself to maintain her expertise					
Shares knowledge appropriately					
Creates an environment that encourages innovation					
Creates an atmosphere that supports the open expression of ideas					
Creates an environment that builds trust					
Demonstrates a recognition of the various psychological and emotional needs of others					

ITEM	DO A LOT MORE OF	DO A LITTLE	CONTINUE AS IS	DO A LITTLE	DO A LOT LESS OF
Follows through effectively when new directions or procedures are introduced					
Creates a sense of urgency to accomplish goals					
Identifies underlying cause of current challenges					
Shares vital information in a timely manner					
Represents the organization in a positive manner to constituencies					
Tells the story of the organization to constituencies					
Gives a clear picture of the direction in which the organization is headed					
Shares strategic perspectives with external partners that contribute to developing and implementing new programs					
Is a role model for the organization's values					
Showcases skills of employees of the organization					
Showcases skills of volunteers of the organization					

Please share your thoughts on the following questions:

a. How does the Executive Director represent the organization in the community?
b. What specifically does the Executive Director do to serve and further your relationship with their organization?

Additional Comments:
Please share any comments you may have that support your responses or is additional information that you feel is important. Please remember that this survey is intended to provide constructive feedback in a positive manner and try to form your comments with that in mind.

Thank-you for completing this survey. We very much appreciate your responses and comments.

TEMPLATE: EMPLOYEE AND VOLUNTEER ENGAGEMENT SURVEY

For All Salaried Employees and Volunteers

Date: ______________________________

I am completing this survey as:

a) **Employee**
b) **Volunteer**

QUESTIONNAIRE

Employee and Volunteer Opinion Survey on Quality of Engagement

INSTRUCTIONS: This survey was designed to get feedback from you regarding your work experiences at our organization. The results of this survey will enable us to identify what we do well as an organization as well as identify areas that may require improvement. Your responses will be completely anonymous. The report of survey results will be in general terms and will not identify individuals. Please respond to each numbered item in the table below. Please note that question 6 is for employees only and question 7 is for volunteers only. Otherwise all questions are for all respondents. We very much appreciate your feedback!

	ITEM	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
1	Considering everything, I am satisfied working/volunteering for this organization right now.					
2	I am doing something I consider satisfying and worthwhile in my role.					
3	My role is challenging and interesting.					
4	I am proud to be part of this organization.					
5	I am committed to seeing this organization succeed.					
6	I see myself working as an employee for this organization three years from now.					
7	I see myself working as a volunteer for this organization one year from now.					

	ITEM	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
8	I am confident we can face the business challenges of the future.					
9	I am treated with dignity and respect.					
10	I have the freedom I need to do my job.					
11	I am involved with decisions that affect my role.					
12	The work I do is very important to the success of the organization.					
13	I am expected to produce significant but reasonable results.					
14	I am satisfied with my opportunity for growth and development.					
15	I believe my career/volunteer aspirations can be achieved at this organization.					
16	I am satisfied with the level of balance between my role at this organization and personal life.					
17	I have the flexibility to arrange my responsibilities at this organization so that I can meet my business objectives and balance my family and personal needs.					

a) Please identify at least 2 or 3 things this organization could be doing to improve as an organization:

b) Please identify at least 2 or 3 things you like about working for this organization:

c) Please note whether you talk about your work/volunteer role at this organization with people external to the organization and if so, what do you generally tell people.

Thank you for your time and feedback!

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3. Draft Letter - Offer of Employment

Date: MONTH XX, 20XX

RE: Offer of Employment
"Position" East Kootenay Division of Family Practice Society

Dear **"Successful Candidate"**

The East Kootenay Division of Family Practice Society is pleased to offer you the position of **"Position".** We offer the following employment terms as per the attached **Employment Contract,** with pertinent information summarized below.

Start Date:	MONTH XX, 20XX
Average Hours:	XX hours/ week
Probationary Review:	A review at three months to ensure fit for both employee and employer, and to address any concerns, on or before **MONTH XX, 20XX**
Term:	MONTH XX, 20XX to MONTH XX, 20XX. Extension renewal to take effect April 1, 20XX, pending approved annual funding for the East Kootenay Division of Family Practice by the GPSC
Wages:	$XX Rate per hour
Benefits:	As per policies; 5% of estimated gross.
Annual Leave:	4%

Unless otherwise stated in this contract or the Personnel Policies, the BC Employment Standards Act will be the default for Employer-Employee relations and any disputes which might arise.

Should you agree with the terms outlined in this document, please sign the attached Employment Contract and return to the East Kootenay Division of Family Practice Society by **MONTH XX, 20XX.** A signed copy will be returned to you.

We look forward to working with you in this capacity to forward the endeavors of the Society.

Regards;

Laura Vanlerberg
Operation Lead, EK Division of Family Practice

4. Employee Contract Template

Employment Contract

THIS AGREEMENT is made effective the______day of___________, 20XX.

BETWEEN:

__________________ DIVISION OF FAMILY PRACTICE

(The "Employer")

AND:

Your name

(The "Employee")

WHEREAS:

A. The Employer is a society providing services to its members in the Kootenay Rockies region in the Province of British Columbia, and is registered pursuant to the provisions of the *Society Act*, chapter 433.
B. Subject to the terms and conditions set out below the Employer agrees to employ the Employee and the Employee agrees to be employed by the Employer in the position of Executive Director.
C. The Employer and the Employee wish to enter into this Agreement to set forth the terms and conditions of the Employee's employment with the Employer.

NOW THEREFORE IN CONSIDERATION of the mutual promises and covenants contained herein, the receipt and sufficiency of which is hereby acknowledged, the Employer and Employee agree as follows:

POSITION

1. The Employer and the Employee hereby agree that the Employee shall be employed as Executive Director or such other position as the parties hereto may from time to time mutually agree, on the terms and conditions set out in this Agreement.

REPORTING

2. The Employee shall be employed as the principal employee of the society and shall report and be answerable directly to the Board of Directors (the Board).

DUTIES

3. The Employee, throughout the term of her employment with the Employer, shall diligently and faithfully devote the whole of her working time to the achievement of the Employer's goals and to the performance of her duties to the utmost of her ability and shall abide by all the Employer's policies as are applicable and as are amended from time to

time, and shall use her best efforts to promote the interests and goodwill of the Employer.

4. The Employee shall perform those duties as outlined in the Position Description attached hereto and forming a part of this Agreement as **Appendix "A"** (the "Duties") plus any further duties assigned to her from time to time by the Board.

5. The Employee agrees that the elimination or modification of any of the duties referred to in paragraph 4 by the Employer does not constitute a constructive dismissal of the Employee or a breach of this Agreement.

6. The Employee represents to the Employer that she has the required skills, experience and qualifications to perform the Duties.

TERM OF EMPLOYMENT

7. The Employee's employment by the Employer pursuant to this Agreement shall take effect as of the date of this Agreement and be for a term of ____________________ year expiring__________________, or until terminated in accordance with this Agreement (the "term").

8. The contract may be renewed for an additional one year term, if the employee's performance is evaluated at satisfactory or better and the employer has sufficient resources to continue the employment,

9. Either party must provide notice of non-renewal to the other party by ________________.

PERFORMANCE REVIEW

10. Before_________________, jointly agreed upon performance management review criteria for evaluation of the Employee and Employee performance expectations for the probation period will be specified.

11. The Employee's performance shall be reviewed prior to the completion of the Probationary Term.

12. At the completion of the Probation Term, the jointly agreed performance expectations for the remaining portion of the contract period will be established. The Employee's subsequent annual performance shall be reviewed before_____.

RENUMERATION

13. During the Probationary Term, and pursuant to this Agreement, the Employer shall pay to the Employee an annual base salary of $__________per annum. (or hourly rate)

14. The Salary shall be paid by the Employer to the Employee bi-monthly in arrears, less any statutory deductions or in such other manner as the Employer may in its discretion determine.

15. Save and except for the salary increases expressed herein, any change in the Employee's salary shall be in the sole discretion of the Board having regard to all of the circumstances of the Employee's employment including, but not necessarily limited to: the Employee's performance, any change in the cost of living, and the Employer's budgetary allocation for employee compensation.

16. Any change of the Employee's salary shall not terminate this Agreement and shall not constitute a constructive dismissal of the Employee.

BENEFITS

17. Subject to this Agreement, during the Term, the Employee shall not be entitled to any employment related benefits other than the statutory benefits of employment insurance, Canada pension plan, workers compensation, and statutory holidays.

18. In lieu of receiving additional employment related benefits, the employee will be compensated an additional____________% of the base salary as amended from time to time.

19. If the Employee's employment is terminated for any reason, the Employer shall not provide compensation in lieu of benefits beyond the Employee's termination.

ANNUAL VACATION/PERSONAL LEAVE

20. During the term of this agreement, the Employee shall be entitled to annual vacation of_____________days.

21. The Employee's vacation shall be scheduled subject to the Employer's operational needs.

22. The Employer shall use its best efforts to accommodate the Employee's request for vacation leave, and shall endeavor to ensure that the Employee is able to use her annual vacation leave in increments of at least one week.

23. The Employee is entitled to use up to five vacation days for personal leave days for health or illness reasons, without the scheduled consent of the employer.

HOURS OF WORK

24. The Employee shall regularly be required to provide services and perform the Duties 25 hours per week, Monday to Friday. In addition, and for the salary expressed herein the Employee understands and agrees that she may be required to work irregular hours, evenings and weekend days to fulfill and perform the Duties, as requested by the Board.

25. The Employee shall not be paid any additional remuneration for time worked in excess of_____________hours per week, and shall not be entitled to any

accumulated time off in lieu of overtime, without the consent of the Board.

OFFICE EXPENSES

26. The Employee will work out of a home office until such time as an external EKDoFP office is established. To compensate for basic office expenses, such as telephone, fax, Internet, computer and desk office supplies incurred on behalf of EKDoFP, the Employee will be compensated $___per month upon receipt of an invoice. Other operations office expenses such as photocopies, reports, meeting expenses, conference call expenses or the toll free telephone line will be paid directly by EKDoFP.

TRAVEL EXPENSES

27. The Employee is required to travel for the purpose of performing her regular duties for EKDoFP and will supply a personal vehicle for such travel. EKDoFP will compensate the Employee at a rate of $0.50 per kilometer for authorized travel upon presentation of appropriate travel claim. Other travel expenses as required will be reimbursed as per Divisions policy.

PROFESSIONAL DEVELOPMENT

28. The Employer may, in its sole discretion, and subject to the availability of budgetary resources pay for the appropriate and reasonable costs of seminars or conferences related to the professional development of the Employee as Executive Director, only with the prior approval of the Board.

TERMINATION OF EMPLOYMENT

29. In this Agreement, "just cause" includes but is not limited to dishonesty, theft, moral turpitude, serious neglect or willful misconduct, reckless disregard of duties or acts, which damage or may damage the reputation or standing of the Employer.

(i) Termination for Just Cause

30. The Employee's employment may be terminated without notice or pay in lieu thereof for just cause.

(ii) Termination without Just Cause

31. The Employee's employment may be terminated for reasons other than for just cause on the affirmative vote of 75% of all the members of the Board by:

- **a)** Giving the employee one month written notice of the terminations during the term of this employment contract.
- **b)** Giving the employee pay in lieu of notice referred paragraph 31(a) as a lump sum.

32. For the purposes of sub-section 31(b) "pay in lieu of notice" means and is limited to the salary and the % of pay in lieu of benefits, to which the Employee would have been entitled during the applicable period of notice, less all applicable deductions as required by law and by the terms of this Agreement.

33. The Employee agrees that the notice, or pay in lieu thereof referred to in paragraph 31 shall be in full and complete satisfaction of the obligations of the Employer arising pursuant to the Employment Standards Act, R.S.B.C., c. 113 (as amended), the common law, and under this Agreement.

(iii) Termination by the Employee

34. The Employee may terminate her employment with the Employer at any time and for any reason upon giving the Employer written notice of not less than thirty days of her intention to do so.

(iv) Frustration

35. This Agreement shall be terminated by frustration on the death of the Employee, or by any other event outside the reasonable control of the parties hereto which renders the performance of this Agreement by either of the parties impossible.

CONFIDENTIAL INFORMATION

36. The Employee agrees, during the course of employment and afterward, to keep confidential and refrain from using, directly or indirectly, all confidential information known or used by the Employer in its business and not publicly known. These covenants survive the termination of the employment relationship. This confidential information shall include, but shall not be limited to:

a) Information regarding any prospective contracts between the Employer and any third party;

b) All information supplied to the Employer on a confidential basis;

c) Information concerning the administrative and financial affairs of the Employer,

d) Information about the Employer's members, partners and employees, and

e) Information about the Employer's financial resources, budget and actual and proposed expenditures.

37. Upon termination of the Employee's employment for any reason, the Employee shall deliver up to the Employer all documents, papers, plans, materials and any other property relating to the affairs of the Employer which may then be in the possession or under the control of the Employee, including any copies of these items.

NON-WAIVER

38. No consent or waiver, express or implied, by any party to or of any breach or default by the other party in the performance by the other of its obligations hereunder shall be deemed or construed to be a consent or waiver to or of any other breach or default of the same or any other obligation of such party. Failure on the part of any party to complain or any act or failure to act of the other of them, or to declare the other party in default irrespective of how long such failure continues shall not constitute a waiver by such party of its rights hereunder or of the right to then or subsequently declare a default.

39. All modifications and amendments to this Agreement are void and unenforceable unless evidence in writing by all parties to this Agreement.

GOVERNING LAW

40. This Agreement shall be deemed a contract made under, and for all purposes, shall be construed in accordance with the laws of the Province of British Columbia.

INDEPENDENT LEGAL ADVICE

41. The Employee acknowledges that this Agreement has been prepared by the Employer and that she has been given the opportunity to obtain independent legal advice prior to its execution by her.

GENDER AND NUMBER

42. In this Agreement, unless context otherwise requires, words importing the singular include the plural and vice versa and words importing gender include all genders.

SEVERABILITY

43. In the event that any provision or portion of this Agreement is determined to be invalid or unenforceable for any reason the remaining provisions or portions of this Agreement shall be unaffected thereby and shall remain in full force and effect to the fullest extent permitted by law.

ENTIRE AGREEMENT

44. This Agreement, including the Appendices hereto, contains the entire agreement between the parties pertaining to the subject matter hereof, and supersedes all undertakings and agreements, whether oral or in writing, if an, previously entered into by them with respect thereto. There are no oral or written inducements, promises, representations or agreements, except as expressly set out herein. This Agreement may only be modified by an instrument in writing signed by the parties.

HEADINGS

45. The headings in this Agreement are for convenience only and do not form part of this Agreement and shall not interpret, define or limit the scope, content or intent of this Agreement.

NON-DISCLOSURE

46. The Employee and the Employer mutually agree that the terms of this Agreement shall not be disclosed to any person, firm or corporation except the signatories or by mutual written consent, or as required by law.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date hereof.

East Kootenay Division of Family Practice Society

____
Authorized Signatory

____
Title

____
Authorized Signatory

____
Title

____
Date

Signed and delivered your name in the presence of

______________________________	______________________________
Witness	your name

____
Address

____
Occupation

____
Date

5. New Employee agreements

a. Personnel Information Form

Personnel Information Form

NAME	
ADDRESS	
TELEPHONE NUMBER	
DATE OF BIRTH	
ALTERNATIVE E-MAIL	
NEXT OF KIN	
NEXT OF KIN CONTACT INFORM	

Copies:

Licenses ☐ Criminal Record ☐ Liability Insurance ☐

Other ☐ ______________________________

Signed Copies:

Resume ☐ Acceptance Letters of Offer ☐

Confidentiality Agreement ☐ Computer Usage Agreement ☐

Conflict of Interest Agreement ☐ PIPA and Privacy ☐

Three Month Performance Interview ☐

Employment Renewal Letters
Year 1 ☐ Year 2 ☐ Year 3 ☐ Year 4 ☐ Year 5 ☐
Year 6 ☐ Year 7 ☐ Year 8 ☐ Year 9 ☐ Year 10 ☐

Performance Support Meeting
Year 1 ☐ Year 2 ☐ Year 3 ☐ Year 4 ☐ Year 5 ☐
Year 6 ☐ Year 7 ☐ Year 8 ☐ Year 9 ☐ Year 10 ☐

Written records of changes in Wages/salaries, approved by Division ED/Board of Directors
Year 1 ☐ Year 2 ☐ Year 3 ☐ Year 4 ☐ Year 5 ☐
Year 6 ☐ Year 7 ☐ Year 8 ☐ Year 9 ☐ Year 10 ☐

Records of Disciplinary Action ☐ Letters of Compliment ☐

List of equipment: ______________________________

____

Signature of employee: ______________________________ Date: ______________

The employee shall advise the EK Division of Family Practice of any changes to the information so as to avoid any problems with income tax, benefits and other matters

Orientation:

- ☐ Reviewed Personnel Policies
- ☐ Reviewed OH and S Policies
- ☐ Reviewed Strategic direction of the Organization
- ☐ Reviewed Role and Responsibilities
- ☐ Reviewed and signed Privacy, Confidentiality, Computer Usage and Conflict of interest agreements
- ☐ Reviewed Sync.com and Folders

The employee shall advise the EK Division of Family Practice of any changes to the information so as to avoid any problems with income tax, benefits and other matters

b. Confidentiality Statement

Confidentiality statement

All board members, staff, consultants and contractors must sign a confidentiality statement. This pledge will remain in effect throughout their relationship with the Division and indefinitely after the termination of the relationship. It will be filed in the confidential personnel file.

Confidentiality

All information generated within the organization is private in the sense that it is for the sole purpose of the business of the Division.
Confidential information is information that, if disclosed, might prejudice the interests of the organization or the privacy rights of its members or partners.

This policy applies to:

- All board members, who have a duty of confidentiality that is in effect during their term as directors and indefinitely following the termination of their board membership.
- All contractors and staff of the EK Division, who have a duty of confidentiality that is in effect during the term of their contract or employment and indefinitely following the termination of their contract or employment.
- Any persons who utilizes or inadvertently accesses confidential information in the normal process of performing the job has the responsibility of not disclosing the information to any unauthorized person(s).
- Any persons who for any reason deliberately accesses confidential information not needed for performing the job, is breaching confidentiality whether or not the information is disclosed to another person.
- Any person who uses confidential information for personal use or gain is breaching the duty of confidentiality and the duty to avoid conflicts of interest.

Pledge of Confidentiality

I, ______________________________ have read and reviewed the East Kootenay Division of Family Practice policy on confidentiality. I understand that all confidential information to which I may have access is not to be accessed, used or disclosed except as outlined in the confidentiality policy. I understand that breach of the duty of confidentiality may lead to discipline, including termination.

Name: ______________________________

Signature: ______________________________

Witnessed: ______________________________

Date: ______________________________

c. Privacy Policy

PIPA and Privacy

Summary of rules for protecting personal information

All British Columbia private sector organizations, including non-profits such as the Divisions of Family Practice, must comply with the Personal Information Protection Act (PIPA).

Personal information means information that can identify an individual (for example name, home address, home phone number, ID numbers), and information about an identifiable individual (for example physical description, educational qualifications, blood type).

Divisions are required to identify a 'privacy officer' typically the coordinator, to be responsible for compliance with PIPA. The privacy officer is responsible for the collection, use and disclosure of personal information, for reasonable purposes. In order to collect information, the Division is required under PIPA to have appropriate policies in place for managing personal information, providing notice, obtaining consent and allowing access to information. These policies must be available to individuals upon request.

The following guidelines will help the Division meet privacy policy requirements:

- Collect personal information only for reasonable purposes and collect only as much as is reasonable for those purposes.
- Get consent to collect, use or disclose personal information. Consent may be implied, explicit, or 'opt-out'. Use and disclose personal information only for the purpose for which it was collected unless the individual consents.
- Give notice to members, staff and patients about how their information will be used. Publicize the Division's policies and practices governing personal information.
- Secure electronic and paper data to prevent sharing or disclosing personal information. Keep it for only as long as reasonable for business or legal reasons.
- If requested, the Division must provide access to an individual's information. A minimal service fee may be charged.
- Train staff about privacy rules and procedures.

East Kootenay
Division of Family Practice
A GPSC initiative

PRIVACY POLICY

Privacy protection for stakeholders

Members

Personal information does not include business contact information. Consequently, information such as name and position or title, business telephone number, business address, business e-mail, business fax number and other business contact information are not subject to PIPA. By joining the Division, physician members will have consented to receiving information about programs and activities sponsored by the organization.

PIPA will only be a concern for members if, in the course of providing member services (e.g. training, practice support, or physician wellness programs), the Division obtains, uses or discloses non-business personal information about the membership. Notifying members of the purpose of this information and providing the right to opt-out will offer sufficient protection in most cases.

Patients

Non-identifiable or aggregate information such as statistical information about groups of individuals is not personal information. For research and policy purposes, physicians may provide the Division with non-identifying, practice-level data. PIPA also allows for providing data in individually identifiable form without consent when particular research requires it and obtaining consent would be impracticable. This allows physicians to participate in Division-led research initiatives without violating their obligations to maintain patient privacy.

Staff

The Division may collect, use and disclose employee personal information for reasonable purposes related to managing or recruiting personnel *without consent* as long as it notifies the employee. PIPA considers volunteers to be employees.

Contractual relationships

A Division is accountable for all personal information in its custody or control. This includes any information collected, used or disclosed by organizations contracted by the Division. Whenever a third party is

contracted to perform work on behalf of the Division, a confidentiality agreement should be obtained in advance of the work being performed.

The health authorities that may contract with the Division are public agencies governed by the Freedom of Information and Protection of Privacy Act (FOIPPA). When working under contract for a public body, the Division should be clear whether the public body has control of personal information generated or provided under the contract. If the public agency maintains control of the information, FOIPPA (not PIPA) applies to the information.

Breaches

A privacy breach occurs when there is unauthorized access to or collection, use, disclosure or disposal of personal information. The most common privacy breach happens when personal information of customers, patients, clients or employees is stolen, lost or mistakenly disclosed. Examples include when a computer containing personal information is stolen or personal information is mistakenly emailed to the wrong person.

The Division must have procedures in place for notifying affected individuals, minimizing damage to those individuals when a privacy breach occurs and ensuring compliance with governing legislation, including reporting to the office of the privacy commissioner for B.C.

Principle 1: accountability for personal information

The EK Division of Family Practice is responsible for personal information under its control and will designate an individual or individuals who are accountable for the organization's compliance with established privacy principles.

Policy 1.1

The board of directors of the EK Division of Family Practice (DIVISION) is accountable for compliance with the privacy policy and procedures. The board may designate day-to-day operational responsibility to other staff members of the organization. Decisions regarding the interpretation and application of the policies and procedures are the ultimate responsibility of the board or designate.

Policy 1.2

The DIVISION is responsible for personal information in its possession and this includes both information that has been transferred to a third party for processing and information received from a third party. For third parties, the DIVISION has contractual agreements in place that commits the third party to protect the information in accordance with the Act.

Policy 1.3

The DIVISION has in place an orientation for all staff members so that each staff member is aware of the policies and procedures and the accountability structure.

Principle 2: identifying purposes for personal information

The DIVISION before or at the time the information is collected will identify the purposes for which personal information is collected.

Policy 2.1

The DIVISION identifies the purpose for which personal information is collected before or at the time of collection of the information. The need for the information is clearly documented and only personal information with an identified purpose is collected.

Policy 2.2

The DIVISION has in place an approval process to review any request for the collection of personal information.

Principle 3: consent for the collection, use, or disclosure of personal information

The DIVISION will ensure that the knowledge and consent of the individual are required for the collection, use, or disclosure of personal information, except where inappropriate.

Policy 3.1

The DIVISION obtains consent for the collection, use, and disclosure of personal information before or at the time of collection.

Policy 3.2

The DIVISION does not disclose personal information for secondary or other purposes such as marketing. The DIVISION only discloses personal information to endorsed service providers and affiliated organizations, and a contractual agreement will be in place that commits the affiliated organization or endorsed provider to protect the information according to the Act (also refer to Policy 1.2).

Policy 3.3

The DIVISION does not make consent a condition for supplying a product or service, unless the information requested is required to fulfill a specified and legitimate purpose.

Policy 3.4

The DIVISION will collect, use and disclose employee personal information for the purposes of establishing, managing or terminating the employment relationship.

Principle 4: limiting collection of personal information

The collection of personal information will be limited to that which is necessary for the purposes identified by the DIVISION. Information will be collected by fair and lawful means.

Policy 4.1

The DIVISION collects only the personal information necessary to fulfill the purposes identified for the information.

Policy 4.2

The DIVISION information collection practices are fair, lawful and respectful of the individual.

Principle 5: limiting use, disclosure and retention of personal information

The DIVISION will not use or disclose personal information for purposes other than those for which it was collected, except with the informed consent of the individual or as required by law. Personal information will be retained only as long as necessary for the fulfillment of those purposes.

Policy 5.1

The DIVISION uses or discloses information only for the purposes identified before or at the time of collection. New uses or disclosures are permissible only with the consent of the individual or as required or permitted by law.

Policy 5.2

The DIVISION retains personal information for as long as it is needed to achieve the identified purpose(s) or related business or legal obligation. Personal information that is used to make a decision about an individual is retained for at least one year after using it so the individual has a reasonable opportunity to obtain access to it. The DIVISION is guided by industry standards related to retention schedules or applicable legislation.

Policy 5.3

The DIVISION communicates the limitations on use and disclosure of personal information to staff members. The DIVISION allows staff to access and use personal information on a 'need-to-know' basis, i.e. information required to perform their job.

Principle 6: accuracy of personal information

The DIVISION is responsible for ensuring that personal information is as accurate, complete and up-to-date as necessary for the purposes for which it is to be used.

Policy 6.1

The DIVISION ensures that personal information being collected is accurate, complete, and up-to-date for the purposes for which the information is collected, used or disclosed.

Policy 6.2

The DIVISION updates personal information when necessary to fulfill the purpose(s) for which the information was collected.

Principle 7: safeguards for personal information

The DIVISION ensures personal information is protected by security safeguards appropriate to the sensitivity of the information.

Policy 7.1

The DIVISION has security safeguards in place to protect personal information against loss or theft and unauthorized access, disclosure, use, or modification regardless of the format in which it is held (e.g. paper, electronic, audio, video).

Policy 7.2

The DIVISION has a higher level of safeguards to protect more sensitive personal information.

Policy 7.3

The DIVISION uses care in the disposal or destruction of personal information in order to prevent access to the information by unauthorized parties.

Principle 8: openness about the management of personal information

The DIVISION makes information available about its policies and practices relating to the management of personal information.

Policy 8.1

The DIVISION has open and transparent information management practices that ensure accountability for personal information.

Policy 8.2

The DIVISION makes contact information available about the person responsible for the DIVISION privacy policies and procedures.

Principle 9: individual access to personal information

Upon request, the DIVISION informs an individual of the existence, use, and disclosure of his or her personal information and the individual has access to that information. An individual has the ability to challenge the accuracy and completeness of the information and have it amended as appropriate.

Policy 9.1

The DIVISION informs an individual of the existence, use, and disclosure of his or her personal information upon request, and provides access at no cost to the individual. Where the DIVISION is

unable to provide full access to an individual's request for information, the reasons for limiting access are stated in a specific, reasonable, and justifiable manner.

Policy 9.2
The DIVISION provides the opportunity for an individual to correct inaccurate or incomplete information.

Principle 10: challenging compliance

An individual has the ability to challenge the DIVISION's compliance with these principles by contacting the designated individual or individuals accountable for the organization's compliance.

Policy 10.1
The DIVISION provides a process for an individual to challenge the organization's compliance with the stated privacy principles, policies and practices.

Policy 10.2
The DIVISION investigates all complaints.

Disciplinary action

Breach of this policy may result in disciplinary action up to and including dismissal.

Privacy policy definitions

Access: The entitlement of an individual to examine or obtain his or her own personal information held by an organization.

Accountability: An organization is responsible for personal information under its control and designates individual(s) who are accountable for the organization's compliance with its privacy policies, procedures and practices.

Accuracy: Personal information kept by the organization will be accurate, complete and up-to-date.

Challenging compliance: An individual has the ability to challenge an organization's compliance with its privacy principles, policies, procedures and practices and the complaint is directed to the designated individual(s) accountable for the organization's compliance with its privacy policies,

procedures and practices.

Collection: The act of gathering, acquiring, recording, or obtaining personal information from any source, including third parties, by any means.

Consent: An organization will ensure that there is voluntary agreement by an individual, or his or her legally authorized representative, to allow the collection, use or disclosure of the individual's personal information. The consent may be either express or implied and should include an explanation as to the implications of withdrawing consent. Express consent is given explicitly and unambiguously, either verbally or in writing. Implied consent is given when the action/inaction of an individual reasonably infers consent.

Disclosure: Disclosure occurs when personal information is made available to a person who is not employed by or in the service of the party holding the information.

Identify the purpose: Purposes, which includes why the information is being collected and how it is being used is identified by the organization at or preferably before the time of collection. The reason for collection is documented.

Personal information: Personal information is any factual or subjective information, recorded or not, regarding an identifiable individual. Examples include name, age, identification number, income, ethnic origin, blood type, opinions, evaluations, comments, social status, disciplinary actions, employee files, credit or loan records, medical records, or the existence of a dispute between parties.

Privacy: Privacy is the fundamental right of an individual to have their personal information protected.

Retention schedule: A retention schedule identifies the period of time personal information is held. Personal information should not be held for longer than is necessary to fulfill the purposes for which it was collected.

Safeguards: Safeguards are the actions taken to protect personal information. The level of the action is appropriate to the level of sensitivity of the information.

Security: Personal information is protected from unauthorized or unintentional loss, theft, access, use, modification or disclosure.

Third party: A third party is an individual or organization outside the DIVISION.

Use: Use refers to the treatment and handling of personal information within an organization.

Pledge of Privacy

I, ________________________________ have read and reviewed the

East Kootenay Division of Family Practice PIPA and Privacy policy. I understand that all information to which I may have access is not to be accessed, used or disclosed except as outlined in the Privacy policy. I understand that breach of the duty of PIPA and Privacy may lead to discipline, including termination.

Name: ________________________________

Signature: ________________________________

Witnessed: ________________________________

Date: ________________________________

d. Computer Use policy

East Kootenay Division of Family Practice

Computer Use Policy

Computer usage agreement

The purpose of the computer usage policy is to document the policy regarding computer access, protect the security and stability of the computer, reduce legal risk and secure the confidentiality of information maintained by the Division.

This policy applies to all computer users. For the purposes of this policy, the term 'computer user' includes all permanent and temporary employees of the BCMA, contractors, consultants and other persons paid by the DIVISION. This policy also applies to any other users including, but not limited to, board and Division members and other volunteers.

Computers are defined as all computers and other devices that may gain access to electronic information in any form that is stored in computers owned or operated by the Division. This includes, but is not limited to, all computer workstations located within the Division offices and any computer workstations or mobile/wireless devices outside the Division offices that may access Division information via telephone, the Internet or other means.

Computer access

All aspects of the Division computers are the property of the Division and are assigned to users as necessary to assist them in their job function. All computer users must agree to comply with the terms and conditions of this policy before computer access will be provided.

System passwords

- All system passwords must be kept strictly confidential. Passwords are not to be written down, shared with co-workers, or any other person, or recorded in a central location for use by departmental staff.
- Passwords suspected of being compromised must be changed immediately. If system policy prevents changing the password (e.g. last password change within 30 days), contact a member of the systems group for assistance.
- As a security precaution, network users are to ensure access to their workstation or mobile/wireless device is protected when away from it for any length of time. Acceptable methods include but are not limited to:
  - Two factor authentication devices
  - Password protected screen savers

- Keyboard locking after a period of inactivity

Computer monitoring

- All information stored in the Division computers is the property of the Division and may be accessed, monitored or reviewed by management, or someone designated by management, at any time. This includes, but is not limited to, documents, spreadsheets, email messages, Internet access logs, etc.

Email usage

- The Division's email server is a business tool and is intended to be used as such.
- Incidental personal use of email is acceptable. Such use should be measured in minutes not hours per day. All policy guidelines apply equally to business and personal use.
- Style and content of all email communication must represent the Doctors of BC in a professional and respectful manner.
- Email messages containing materials considered inappropriate, offensive, slanderous, fraudulent or unprofessional (e.g. pornographic material, racial or sexual jokes, etc.) must not be viewed, stored or transmitted within the BCMA network.
- Email is not a secure method of communication. As a result, confidential information should not be sent as a message or as an attachment.
- Computer users may not intentionally intercept, eavesdrop, record, read, alter or receive another employee's email messages without management authorization or construct email messages as to appear sent from someone else.
- Email mailboxes are restricted in size and network users must manage their email usage to prevent exceeding the limits.

Internet usage

- The Division's Internet connection is a business tool and is intended to be used as such.
- Incidental personal use of the Division's Internet connection is acceptable. Such use should be measured in minutes not hours per day. All policy guidelines apply equally to business and personal use.
- Personal use of the Division's Internet connection must not impede normal business use.
- Personal use sites must be accessed and closed as rapidly as possible. It is not acceptable to leave personal sites open and connected for lengthy periods. High bandwidth sites such as

streaming media and Internet radio are not appropriate for personal use because of their negative impact on normal business use.
- The Division's Internet connection is not to be used to access Internet sites that depict or promote inappropriate material or activities (e.g. sexual content, violence, intolerance or racism, gambling, etc.).
- Under no circumstances are executable programs of any kind to be downloaded from Internet sites (e.g. screen savers, games, multimedia tools, etc.)
- No copyrighted material is to be downloaded except as expressly permitted by the copyright owner. Failure to observe copyright or license agreements will result in disciplinary action.

USB keys

- The Division requires that all USB keys that are used to move or store Division data be encrypted. While non-network users may bring data into the Division computers on unencrypted keys, only Division-issued encrypted keys are to be used for any data leaving the network.

Disciplinary action

- Breach of this policy may result in disciplinary action up to and including dismissal.

I agree with the terms of this policy.

____

Contractor/Employee Name and Signature

____

Date Approved by (Signature)

e. Conflict of Interest Agreement

Conflict of Interest Agreement

Members of the board of directors, contractors and staff have a duty to disclose any personal, family or business interests that they have, that, by creating a divided loyalty, could influence their judgment or result in the perception of influence or benefit from their activities on behalf of the Division.

Conflicts of interest are unavoidable and should not prevent an individual from serving, as a director, contractor, or staff member unless the extent of the interest is so significant that the potential for divided loyalty is present in a large number of situations.

A conflict of interest exists wherever an individual could benefit, disproportionally from others, directly or indirectly, from access to information or from a decision over which they might have influence, or where someone might reasonably perceive they're to be some benefit or influence.

Procedure for handling conflict of interest

- The board as a whole has a duty to disclose specific conflicts of interests to Division members, staff and external stakeholders where that interest may, in their judgment, affect the reputation or credibility of the organization and to disclose the board's procedure for operating in the presence of such conflicts.
- Board members, contractors, and staff have a duty to exempt themselves from participating in any discussion and voting on matters where they have, or may be perceived as having, a conflict of interest. Such exemptions should be recorded in minutes of meetings.
- Any business relationship between an individual (or a company where the individual is an owner or in a position of authority) and the Division, outside of their relationship as a board, contractor, or staff

I agree with the terms of the Conflict of Interest Agreement

______________________	______________________
Name	Signature
______________________	______________________
Date	Witness

East Kootenay Division of Family Practice

RESPECTFUL WORKPLACE POLICY

Applies to:	All employees, contractors, and board members
Policy	The Employer recognizes the right of all employees to work in an environment which shows respect for an employees' health and physical well-being. As a result, all efforts shall be deployed to prevent and correct any situation and any conduct liable to compromise the health and safety of an employee or deteriorate the work environment. This Respectful Workplace Policy (the Policy) outlines the requirements and expectations of all of us to ensure a "Respectful Workplace" is always maintained. Discrimination, harassment or bullying and violent behaviour will not be tolerated from any person in the workplace and is prohibited. The Employer will ensure that a resolution process appropriate to the circumstances is conducted in a fair, respectful, and timely manner once management becomes aware of an incident or receives a complaint of discrimination, harassment, bullying or violence. The Policy was drafted to comply with provincial legislation at the time of drafting. In the event of any changes in the law, the Policy shall be deemed amended to comply with such amendments. The Policy applies to interpersonal and electronic communication, including email and social media.
Definitions	**Bullying:** any inappropriate conduct or comment by a person towards a worker that the person knew or reasonably ought to have known would cause that person to be humiliated or intimidated. Bullying excludes any reasonable action taken by an employer or supervisor relating to the management and direction of workers or the place of employment. **Complainant:** the individual who is accusing another of bullying and/or harassment. **Discrimination:** when an employee suffers adverse treatment based on the employee or job applicant belonging to a protected group under human rights legislation or a characteristic associated with that group. At work, this might mean that someone is denied a job, a pay increase or a promotion, because of, amongst other grounds, their race, colour, ancestry, place of origin, political belief, religion, marital status, family status, physical or mental disability, sex, sexual orientation, age, gender identity of expression, or criminal history that is unrelated to their employment. **Disrespectful Conduct:** harassing or bullying behaviour directed against another person that a reasonable person knows, or ought to know, would cause offence, humiliation, or intimidation. Disrespectful conduct does not have to be based on a prohibited ground under the Human Rights Code. **Incident:** an accident or other occurrence which resulted in, or had the potential for, causing an injury or occupational disease.

	Personal and Psychological Harassment: objectionable conduct – either repeated, persistent, or a single serious incident – that an individual would reasonably conclude: · Creates a risk to an employee's psychological or physical well-being; causes a worker substantial distress; or results in an employee's humiliation or intimidation; or · Is discriminatory behaviour that causes substantial distress and is based on a person's race, colour, place of origin, political beliefs, religion, marital status, physical or mental disability, sex, age, sexual orientation or gender identity; or · Is seriously inappropriate and serves no legitimate work-related purpose Examples of Personal and Psychological Harassment include, but are not limited to: · Remarks, jokes or innuendos related to an individual's race, colour, ancestry, place of origin, sex, marital status, religion, physical or mental disability, sexual orientation, gender expression or gender identity, age, or any other ground; · Physical threats or intimidation; · Words, gestures, actions, or jokes, which may humiliate, degrade or abuse, in including intentionally using incorrect pronouns to refer to an individual; · Displays or circulation of offensive pictures, graffiti, or materials, whether in print form or via email, or other electronic means; or · Comments ridiculing an individual because of characteristics, dress, etc. that are related to a ground of discrimination Note: Not everyone may share the same taste in humour and should consider that when sharing humour in the workplace. Similarly, not every unwelcome attempt at humour is harassment. **Respectful Workplace** refers to: · An environment that is free from workplace harassment and discrimination as prohibited by the Human Rights Code, as well as workplace violence and bullying and harassment as defined herein · An environment that embraces diversity and promotes human dignity and respectful behaviours at work. It is a work environment where employees feel comfortable, safe, and valued as individuals · An environment that promotes a healthy work environment where employee concerns and complaints are acknowledged and dealt with in a timely and effective manner, while respecting the privacy of all concerned as much as possible **Respondent:** the individual who is being accused of behaviour described under this Policy. **Retaliation:** any adverse action (i.e. false accusations) taken against an individual for: · Having invoked the Policy in good faith whether on behalf of oneself or another individual · Having participated or cooperated in any investigation under the Policy · Having been associated with a person who has invoked the Policy or participated in these procedures **Sexual Harassment:** sexually oriented verbal or physical behaviour which an individual would reasonably find to be unwanted or unwelcome, giving

consideration to all surrounding circumstances and which may detrimentally affect the work environment. Such behaviour could include, but is not limited to:

- Engaging in a course of vexatious comment or conduct against a worker in a workplace because of sex, sexual orientation, gender identity or gender expression, where the course of comment or conduct is known or ought reasonably to be known to be unwelcome or offensive; and/or
- Making an unwelcome sexual solicitation or advance where the person making the solicitation or advance is in a position to confer, grant or deny a benefit or advancement to the worker and the person expressly or by reasonable implication ties the receipt of such benefit or advantage to accepting the solicitation or advance ("quid pro quo" harassment)

Examples of Sexual Harassment include, but are not limited to:

- Remarks, jokes, innuendoes or other comments regarding someone's body, appearance, physical or sexual characteristics or orientation or gender or clothing;
- Making gender-related comments about someone's physical characteristics, mannerisms, or conformity to sex-role stereotypes and/or conformity to any particular performance of gender expression;
- Displaying of sexually offensive or derogatory pictures, cartoons, or other material (including materials on computers, such as email);
- Unwelcome questions or sharing of information regarding a person's sexuality, sexual activity, or sexual orientation;
- Leering or inappropriate sustained staring;
- Unnecessary and unusual physical closeness i.e. needlessly brushing up against another employee's body when passing;
- Repeatedly seeking hugs, dates, or sexual favours where not welcomed, particularly by a superior or person in a position of relatively higher power or status within the organization;
- Sexual solicitation or romantic advances or propositions made by a person in a position to confer or deny a benefit or advancement to acceptance is an explicit or implied condition of receiving such benefit or advancement; or
- Unwanted physical touching

Workplace Violence refers to:

- The exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker
- An attempt to exercise physical force against a worker, in a workplace, that could cause physical injury to the worker
- A statement or behaviour that it is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker

Examples of Workplace Violence include, but are not limited to:

- Verbally threatening to attack an employee;
- Leaving threatening notes at or sending threatening emails to the workplace;
- Shaking a fist in an employee's face;
- Hitting or throwing to hit an employee;
- Throwing an object at an employee;
- Sexual violence against an employee;
- Kicking an object, the employee is standing on, i.e., ladder; or
- Slamming a door with the intent to intimidate a staff member

	Assault, damage to personal or Employer property, and stalking are considered criminal harassment and are dealt with by the Criminal Code. For workplace violence to occur, a person must apply, attempt to apply, or threaten to apply physical force against a worker. However, they do not need to have the intention or capacity to appreciate that these actions could cause physical harm. If an incident of workplace violence occurs or is likely to occur, an employee must immediately contact management.
Roles & Responsibilities	Every employee must accept personal responsibility to co-create and maintain a respectful workplace. That includes complying with the Policy personally but also: · Encouraging others to do so; · Not tolerating discrimination, violence, bullying or harassment by others and reporting it if necessary; · Cooperating in any investigation and/or remedial actions; and · Reporting violent incidents or risks of violence in the workplace to management Management is responsible for ensuring that they do not discriminate or harass based on the Protected Grounds and for ensuring that the work environment of the employees that report to them is free from discrimination, harassment, bullying and violence as defined in the Policy. If management suspects that discrimination, harassment, bullying, or violence is occurring, they must take steps to address the issue, including seeking assistance from management. Employees that are found to be engaging in behaviour that breaches the Policy will be supported to change behaviour so that it conforms to the expectations outlined in the Policy and may also be disciplined. Employees that are unwilling or unable to amend behaviour or are found responsible for serious breaches of the Policy will be subject to discipline up to and including termination of employment.
Conditions	**Protection of Complainant:** · Individuals are not to be penalized or disciplined for reporting an incident or for participating in an investigation · Any attempt to retaliate or threaten retaliation against an employee who filed a complaint in any way, including through social exclusion, by the alleged perpetrator or anyone sympathetic to the employee is strictly prohibited, as is any interference with the proper conduct of an investigation, such as trying to influence witness' evidence · Breach of this requirement will result in disciplinary action **False or Bad Faith Claims:** · It is serious for an employee to make a false or bad faith claim of discrimination, workplace violence, bullying or harassment and any employee found to have done so will be subject to discipline up to and including termination · Employees should be particularly aware that a supervisor's criticism of performance or conduct will normally not be considered harassment, provided it is not done in an offensive or humiliating manner · The Policy is not intended to limit or constrain the reasonable exercise of management function in the workplace

	Confidentiality: All complaints will be kept confidential by the complainant, the respondent, the Employer, and the witnesses. **Reporting:** · If an employee sees others behaving in a way that is contrary to the Policy, the employee may, if they feel comfortable doing so, speak respectfully to the Respondent but in cases of serious breach of the Policy, it is mandatory to bring the matter to the attention of the HR Department and/or Executive Director · Employees can report incidents or complaints of workplace harassment, discrimination and/or bullying verbally or in writing but a written complaint will be required where an investigation is done · Employees will be asked the name and position of the person(s) involved in the bullying, harassing or discriminating, the names of any witnesses or other persons with relevant information to provide about the incident(s), the existence of documentary evidence (i.e., texts, emails, posts to websites) and details as to what has been happening to the employee including the date(s), frequency and location(s) of the alleged incident(s) · Incidents or complaints should be reported as soon as possible after experiencing or witnessing an incident of bullying and harassment. This allows the incident to be investigated and addressed promptly · A complainant has the right to file a complaint under the Human Rights Code **Complaints Against the Executive Director or Systemic Issues/Multiple Complaints:** If an employee's complaint is about the Executive Director, they can contact the HR Department or the Chair of the Board of Directors. **Informal Resolution:** A complainant may try to informally resolve their complaint with the assistance of a supervisor, staff representative or mediator. If the complainant is satisfied with the outcome reached at this point, the complaint is resolved. **Investigation:** Until a harassment complaint is resolved, the Employer may take interim measures, including separating the complainant and respondent.
Procedures	**Prevention:** 1. The Employer will provide a copy of Policy 1.1: Respectful Workplace to all new employees upon hiring. 2. Employees will be required to acknowledge in writing or by email that they have received and read the Policy and any amendments. 3. The Employer's Policy 1.1: Respectful Workplace will be placed in a prominent location where all employees will see it and have regular access to it. The Employer will provide direction and supervision to affected employees, offering training on managing difficult situations, or imposing workplace arrangements to minimize the risk of bullying and harassment. **Complaint Resolution:** 1. In less serious cases, the Employer may offer the complainant the option of informal complaint resolution, typically involving facilitating a resolution

	of the problem with the respondent. 2. If they request a more formal resolution or in cases of serious misconduct, a formal investigation will be undertaken if management determines the complaint falls within the Policy and may have merit. The investigation will be undertaken by an appropriate employee or external resource as the Employer determines is appropriate. 3. Depending on the nature of the complaint, the investigation may entail interviewing the complainant, witnesses and the respondent, and a review of documents or other evidence. In some cases, interim protective measures may be taken during the investigation, i.e., arranging for the complainant and respondent to work in separate areas. 4. To protect the interests of everyone involved, confidentiality must be maintained throughout the complaint resolution process. Information that must be shared, particularly in an investigative process, will be disclosed only as necessary to protect employees, to investigate the complaint or incident, to take remedial action or as otherwise required by law. In most cases, it will be necessary to disclose the details of allegations of misconduct and often this will effectively disclose the source of information to the respondent to allow them to respond to the allegations. Both the complainant and respondent, as well as co-workers, must not discuss the complaint or allegations or evidence. Breach of this requirement will lead to discipline up to and including termination. 5. At the conclusion of an investigation, the Employer will determine whether any remedial action such as discipline is warranted and share the key findings and remedies of the investigation with the complainant and respondent. Note: Privacy rules, as well as other considerations, will limit the extent of disclosure of details of the investigation to all participants.

Effective Date	**Approval** *(Signature)*	**Date Approved**

f. Credit Card Usage Policy and Agreement

Credit Card Usage Policy and Agreement for **NAME**

Effective **DATE**

As an employee of the EK Division of Family Practice Society, I agree to abide by the terms of the Credit Card agreement, of which I have received a copy, issued on behalf of the EK Division from **BANK**.

Employee Credit Cards are to be used only for agreed upon purchases for the EK Division of Family Practice Society which include office supplies, catering, room rentals and travel costs. At no time should your Credit Card be used to withdraw cash. Purchases that are unexpected or over $1500 need written preapproval by someone with signing authority.

I take full responsibility for all charges made by me, and only by me, on card# **NUMBER**, and I will provide receipt copies to that end each month, based on the charges listed on my statement.

Should any discrepancies be found, I will notify the Division Operations Lead as soon as I am aware.

I will not be responsible for the making of any payments to the balance on the card, nor for any late fees or interest that might accrue on behalf of the Division.

I understand the cumulative limit for the card is $8000, shared amongst 4 employees and that a possibility exists that credit maximum might be reached, thereby rendering the card unavailable to use. Should I intend to place more than $1500 in one month on the card, I will notify the 3 other employees as to my intentions, and vice versa, so we can avoid over limit transactions.

In the unlikely event that the card is lost or stolen, I will follow the requirements of the Cardholder Agreement, including notifying the Operations Lead and other card holders as soon as possible.

Signed this **Day** of **Month**, 20__

____
Employee Signature

6. Job Descriptions

a. Executive Director

East Kootenay Division of Family Practice
A GPSC initiative

EXECUTIVE DIRECTOR

Position:	EXECUTIVE DIRECTOR		
Reports to:	Board of Directors	Schedule:	Flexible work schedule, average 25-35 hours per week
Direct Reports:	All staff	Notes:	

Division Summary:

The East Kootenay Division of Family Practice (Division) is part of a province-wide initiative designed to improve patient care, increase family physician influence on health care delivery and design, and enhance professional satisfaction for physicians. The Division is a non-profit society led by a Board of Directors.

Role Accountability:

The Executive Director (ED) is the lead staff for the Division and responsible for the leadership and management of the Division according to the strategic direction set by the Board. The ED will report to the Board and will be supervised and receive direction from the Board Chair. The ED is expected to work independently, have regular contact with the Board Chair and Physician Lead, and attend regular meetings with the Board.

Job Description

PRIMARY DUTIES AND RESPONSIBILITIES

The ED will work closely with other staff, contractors, project managers/leads as part of a networked team.

Governance and Leadership

- Work with the Board to develop and update the vision and strategic plan to guide the Division
- Identify, assess and inform the Board of internal and external issues that affect the Division
- Act as an advisor to the Board on all aspects of Division activities
- Foster effective team work between the Board and the ED, and between the ED and staff/contractors
- Conduct official correspondence on behalf of and jointly with the Board, as required
- Represent the Division at community meetings and events to enhance the Division's profile, act as a spokesperson for the Division
- Co-Develop policies and procedures for Board approval (review and update annually or as required) and ensure their effective application
- Support committees and member working groups in clinical and systems change processes
- Oversee the development of project and program proposals, and subsequent implementation
- Ensure the alignment of projects and programs undertaken with the strategic priorities of the Division

ED job desc 2018

East Kootenay Division of Family Practice
A GPSC initiative

EXECUTIVE DIRECTOR

Operational Planning, Management and Reporting

- Co-Develop an annual operational plan to achieve the strategic objectives of the Division
- Oversee the Division's operations, supporting the Operations Lead, Project Leads, and any other senior leadership team members to meet the requirements of the Board, members and funders, and all relevant regulatory bodies
- Support the Board by organizing and attending meetings, overseeing the development of the Board meeting package (i.e., agenda, past minutes, working group reports, briefings), ensuring record keeping of all Board meetings (i.e., minutes, decisions), responding to Board member requests, and advising the Board on relevant issues
- Support working groups in task management, ensuring facilitation and administrative support as needed
- Ensure alignment amongst projects and programs without duplication; and look for opportunities to increase cross-pollination of work, sharing resources and information across the EK Division and beyond
- Ensure the provision of reports, provide recommendations and evaluation support to the board, working groups and project/committee leads as required
- Ensure the planning, implementation, oversight, quality improvement (PDSA cycles) and evaluation of all Division programs, services and special projects

Human Resources (HR) Planning and Oversight

- Oversee all aspects of Human Resources
- Supervise and build a strong and collaborative team, facilitate open communication, ensure ongoing wellness, development, recognition and appreciation
- In collaboration and working closely with Operations Lead:
  - Determine staffing requirements for Division operations, program, and project delivery
  - Ensure HR policies, procedures and job descriptions are developed and reviewed
  - Ensure procurement policies, procedures and contract agreements are in place
  - Co-develop and implement a performance management process for performance of staff/contractors to support the strategic direction of the Division and approved HR policies

Financial Planning and Oversight

- Work with Operations Lead, staff and the Board to prepare a comprehensive annual budget aligned with strategic and operational plans
- Work with the Board to secure adequate funding for the operation of the Division and its programs/projects, including researching funding sources and writing funding proposals
- Oversee the administration of the divisions finances, monitor monthly financials.
- Working with the Operations Lead, provide the Board with regular, comprehensive reports on revenue, expenditures, trends and projections; and alert the Board of risks and provide mitigation recommendations

Communications/Media, Stakeholder and Member Relations

- Oversee the implementation and development of all EK Division's communication strategies, ensuring communication with all partners and stakeholders
- Foster and encourage effective relations with, and between, family physicians

East Kootenay Division of Family Practice
A GPSC initiative

EXECUTIVE DIRECTOR

- Work closely with the provincial Divisions of Family Practice office to ensure alignment with all relevant messaging and communications
- Liaise and collaborate with other Divisions and the Provincial Divisions office
- Communicate and engage with members, stakeholders and the broader community, as appropriate, to ensure information sharing and capacity building
- Establish or build positive working relationships and collaborative initiatives, where appropriate and aligned with the Divisions strategic direction, with the Ministry of Health, Health Authority, General Practice Services Committee, Specialists, other Divisions, other health care providers and community organizations interested in improving primary health care

Risk Management

- Identify and evaluate the risks to the Division board, members, staff, contractors, property, finances, goodwill and image, and implement measures to control risks
- Ensure the development of, and adherence to, security and privacy policies and procedures to maximize risk mitigation
- Ensure that the Board of Directors/Division carries appropriate and adequate insurance coverage, and that the Board and staff understand the terms, conditions and limitations of the coverage
- Act as the Division's Privacy Officer:
    - Oversees and ensures the regular review and updating of existing privacy policies of the organization
    - Ensures the Board is kept abreast of new, emerging privacy rules
    - and regulations
    - With the Operations Lead, and other team leaders, ensures the privacy policies of the organization are fully implemented
    - Educates and leads the Board in understanding and decision-making with regards to privacy policies

Reviewed By:	Name	Date:	Date
Approved By:	Name	Date:	Date
Last Updated By:	Name	Date/Time:	Date/Time

b. Operations Lead

East Kootenay Division of Family Practice
A GPSC initiative

OPERATIONS LEAD

Position:	OPERATIONS LEAD		
Reports to:	Executive Director	Schedule:	Flexible work schedule, average 15-25 hours per week
Direct Reports:	Finance Coordinator, Administrative and Office Support staff/contractors,	Notes:	

Division Summary:

The East Kootenay Division of Family Practice (Division) is part of a province-wide initiative designed to improve patient care, increase family physician influence on health care delivery and design, and enhance professional satisfaction for physicians. The Division is a non-profit society led by a Board of Directors.

Role Accountability:

To provide support to the Executive Director and Board of Directors by coordinating and overseeing all operational aspects of the organization.

Job Description

PRIMARY DUTIES AND RESPONSIBILITIES

Manage and oversee the day-to-day activities of the EK Division of Family Practice Society, including maintaining the physical office, maintaining files and records, directing staff and overseeing regular HR functions, overseeing and approving financial record keeping and processes.

Human Resources Coordination

- Develop and implement the recruitment, training/orientation and mentorship staffing processes
- Develop and review HR policies, procedures and job descriptions regularly in collaboration with the ED; and ensure the Division meets legislation requirements, such as the Employment Standards Act and WorkSafeBC
- Coordinate any benefit administration
- Develop, review and manage any independent contractor agreements
- Coordinate transitions of contractors to employees when appropriate
- Assist in developing, and implement tools to assess staff satisfaction, work to ensure continuous QI
- Assist in developing, and implement ways to support opportunities for staff advancement, individual career support and succession planning
- Assist in the development and coordination of performance management processes to support, maximize and enhance the performance of staff/contractors
- ensure individual staff and contractor reviews are completed as appropriate

Ops Lead job desc 2018

East Kootenay Division of Family Practice
A GPSC initiative

OPERATIONS LEAD

Financial Management

- Manage new and existing funding contracts, establish budget tracking mechanisms, ensure reporting requirements are met
- Administer the funds of the Division according to the approved budget and delegated authority; monitor monthly financials and cash flow; provide the Board and ED with regular, comprehensive reports on revenue, expenditures, trends and projections; and alert the Board of risks and provide mitigation recommendations
- Ensure that sound bookkeeping and accounting procedures are followed which may include procurement and monitoring of a bookkeeper and/or accountant
- Ensure that the Division complies with all legislation regarding taxation, withholdings and remittances, and in collaboration with the bookkeeper/accountant, work with auditor annually or as required by funders.
- Manage and oversee the day-to-day budgetary operations and provide reporting as required to the Executive Director and the board.
- Under direction of the ED, pursue alternate and additional funding sources for programs and initiatives consistent with the strategic goals.
- Assist in the development of annual budgets

Planning and Management

- Co-develop and recommend continuous improvements to processes, policies and day-to-day functions of the organization
- Update and ensure appropriate policies and procedures are in place and acted upon
- Provide input into operational impacts of projects and activities the society may be considering undertaking
- Collaborate with other senior staff in ensuring alignment of operational needs with workplans, strategic priorities and targeted activities
- Support and assist the Executive Director as needed, and act as Division ED in their absence
- Notify and inform the ED of any changes or impacts to the organization that the ED may be unaware of
- Assist with appropriate dissemination of operational information to board
- Work closely with ED and other senior staff, contractors and project managers/leads as part of a networked and coordinated team
- Oversee and ensure:
  a. office and facility maintenance,
  b. filing systems updates and maintenance
  c. occupational health and safety requirements

Reviewed By:	Name	Date:	Date
Approved By:	Name	Date:	Date
Last Updated By:	Name	Date/Time:	Date/Time

c. Finance Coordinator

FINANCE COORDINATOR

Position:	FINANCE COORDINATOR		
Reports to:	Operations Lead	Schedule:	30-35 hours per week
Direct Reports:	n/a	Notes:	

Division Summary:

The East Kootenay Division of Family Practice (Division) is part of a province-wide initiative designed to improve patient care, increase family physician influence on health care delivery and design, and enhance professional satisfaction for physicians. The Division is a non-profit society led by a Board of Directors.

Role Accountability:

This position is responsible for supporting the financial operational functions of the organization. Under the direction of the Operations Lead, the Finance Coordinator is responsible for the bookkeeping, payroll and overall financial information management and reporting deliverables.

Job Description

PRIMARY DUTIES AND RESPONSIBILITIES

1. Using SAGE accounting software, the Finance Coordinator will:
   a. Maintain general journal, ledger accounts, including A.P and A.R. and perform all payroll and bookkeeping functions required for the successful fiscally responsible operation of the society and in accordance with generally accepted accounting principles (GAAP), which included but are not limited to:
      i. Prepare cheques for expenses and re-imbursements, including physician sessional payments
      ii. Prepare automatic and electronic payments and funds transfers as approved
      iii. Monitor bookkeeping of any project dollars and additional revenues beyond the core fund transfer payments
      iv. Summarize and reconcile all monthly transactions against bank statements within eight business days of receiving the bank statement.
      v. Summarize and reconcile all monthly credit card transactions against credit card statements within eight business days of receiving the statement.
      vi. Process payroll of employees, board, and others as required, including all CRA and other withholding requirements
      vii. Generate timely billings according to contractual requirements
      viii. Provide T4 and T4A's and ROE's as required by Canada Revenue Agency
      ix. Increase the scope and usage of SAGE software to create more streamlined processes
   b. Prepare monthly reports for review and presentation by Operations Lead and/or Treasurer to the Board of Directors within 20 days of the month-end that includes:
      i. Statement of revenues and expenditures (profit and loss) by project, by month, and by YTD
      ii. Statement of financial position, YTD
      iii. Balance sheet
      iv. Other financial information and reports as required
   c. Work with Operations Lead to ensure financial accuracy, streamline processes, and create efficiencies for quality improvement
   d. Assist with preparation and collection of information and documents required by the auditor for annual review

East Kootenay
Division of Family Practice
A GPSC Initiative

FINANCE COORDINATOR

e. Compile and prepare fiscal year-end data for the accountant and per auditor's requirements
f. Ensure compliance of Society Act fiscal requirements

2. **Provides financial operational support and assistance by:**
   a. Prepare financial reports for review by Operations Lead, Executive Director, Board, and Finance Review Committee, as needed
   b. Access bank account for viewing only, to review current information, or provide data to Operations Lead
   c. Develop, maintain and update all budget to actual spreadsheets for all funds and prepare quarterly report for Finance Review Committee
   d. Participate in Core and project-based budget preparation
   e. Under the direction of the Executive Director, act as the Operations Lead in their absence
   f. Secure approvals on expenses and invoices, and ensure cheque signing, distribution. and off-site bank runs
   g. Ensure society finance documents are delivered to, and appropriately stored at, the EK Divisions office and sync.com within 30-45 days of posting, once month-ends are completed
   h. Support the payroll process and distribute pay records to staff. This includes, but is not limited to:
      i. Ensure effective communication to employees and senior staff regarding payroll-related issues, such as pay periods, vacation/sick leave balances
      ii. Monitor, maintain records of, and administer, Personal Wellness spending accounts and Olympia employee benefits.
      iii. Maintain, record, and monitor total/average hours of work for each employee and contractors on a monthly basis.
   i. Act as the communication liaison for contact between the staff, contractors, or suppliers by email, phone or letter. This includes, but is not limited to: request for information, clarification, corrections, notices of payments/deposits, notice of delays, errors, corrections in payroll, etc.
   j. Calculate and process Long Term Care and Unassigned flow-through funding
   k. Liaison to funders, regarding FTA requirements

Reviewed By:	Name	Date:	Date
Approved By:	Name	Date:	Date
Last Updated By:	Name	Date/Time:	Date/Time

d. **Program Manager**

East Kootenay Division of Family Practice
A GPSC initiative

PROGRAM MANAGER

Position:	**PROGRAM MANAGER**		
Reports to:	Executive Director	**Schedule:**	Flexible work schedule. 25-30 hours per week
Direct Reports:	Project Coordinator	**Notes:**	

Division Summary:

The East Kootenay Division of Family Practice (Division) is part of a province-wide initiative designed to improve patient care, increase family physician influence on health care delivery and design, and enhance professional satisfaction for physicians. The Division is a non-profit society led by a Board of Directors.

Role Accountability:

The Program Manager supports and oversees the implementation of programs within the Division. This includes the enhancement of communication and strategic alignment within the Division by working closely with the Executive Director, Project Leads and Project Coordinators.

Job Description

PRIMARY DUTIES AND RESPONSIBILITIES

- Support and oversee the Shared Care Program:
  - Support the early development of new projects
  - Hire and orient Shared Care Project Leads
  - Organize and lead Shared Care Project Lead meetings as needed, and link the project leads in with other Division work as needed.
  - Work with the Operations Lead to oversee budget management and reporting for all projects, including evaluation and communications
  - Engage with Shared Care Liaison
  - Inform and consult with the Executive Director for strategic alignment with other work
  - Attend Provincial Shared Care meetings, as required
- Support and oversee Project Coordinators to develop and implement their programs, including:
  - Pathways implementation
  - Patient Attachment Mechanism
  - Recruitment & Retention
  - MBMD
  - CME
  - Any new programs, as needed
- Ensure that programs are aligned with the Division's strategic priorities. Ensure that there is alignment amongst projects and programs without duplication and look for opportunities to share work and information within the Division.
- Support working groups in task management, arrange administrative support when needed, facilitate the organization of meetings, when required.

East Kootenay Division of Family Practice
A GPSC initiative

PROGRAM MANAGER

- Provide reports, recommendations and evaluations to Executive Director, RPRC and Board, as required.
- Assist and support the Executive Director, and act as Executive Director in her/his absence.
- Work closely with Executive Director and other staff, contractors and project leads as part of a networked and coordinated team.
- Collaboratively develop new member support services and programs that meet member needs and align with strategic priorities
- Manage the communication strategy and staff
- Ongoing physician engagement and leadership

Position Qualifications

- Proven leadership skills
- Facilitation skills
- Strong communications skills, oral and written
- Strong interpersonal skills and emotional intelligence
- Bachelor's degree in a related field preferred
- 3 or more years of progressive management experience, preferably in health care and/or the non-profit sector
- Project and program planning, implementation, management and evaluation skills
- Ability to work independently and within a team environment, and effectively motivate and influence others
- Excellent organizational skills with ability to prioritize and manage multiple tasks to meet commitments and deadlines
- Proficiency in the use of computers: Microsoft Word, Excel, Outlook, PowerPoint, and Internet navigation/research
- Strong background in health care field with a good understanding of current issues in BC, specifically the East Kootenay region
- Experience in collaborative approaches and team environments
- Capacity to work from a home office
- Reliable vehicle, able to travel throughout the region, and provincially when necessary

Reviewed By:	Name	Date:	Date
Approved By:	Name	Date:	Date
Last Updated By:	Name	Date/Time:	Date/Time

e. **Project Coordinator**

East Kootenay Division of Family Practice
A GPSC Initiative

PROJECT COORDINATOR

Position:	PROJECT COORDINATOR		
Reports to:	Program Manager	Schedule:	Flexible work schedule.
Direct Reports:	n/a	Notes:	25-30 hours per week

Division Summary:

The East Kootenay Division of Family Practice (Division) is part of a province-wide initiative designed to improve patient care, increase family physician influence on health care delivery and design, and enhance professional satisfaction for physicians. The Division is a non-profit society led by a Board of Directors.

Role Accountability:

The project coordinator is responsible to assist the program manager in the overall direction, coordination, implementation, execution, control and completion of specific project deliverables ensuring consistency and alignment with EK Divisions and funder strategy, commitments and goals. Projects will include the development and enhancement of services and tools that support family physicians, as we work toward a more integrated system of care.

Job Description

PRIMARY DUTIES AND RESPONSIBILITIES

Direct Project Coordination

- Coordinate project development and mapping, including budgets, planning, scheduling, timelines, and deliverables
- Liaise with members to identify and define requirements, scope and objectives
- Coordinate project implementation, including monitoring budgets, timelines and deliverables and preparing reporting
- Monitor project progress and handle any issues that arise
- Act as the point of contact and communicate project status to all participants
- Facilitate meetings and create conversation opportunities
- Recruit and retain committee members
- Conduct research on behalf of the committee and their goals
- Ensure standards and requirements are met through conducting quality improvement and assisting with evaluation
- Create and maintain comprehensive project documentation, plans and reports
- Prepare presentations
- Attend local, regional and Provincial level meetings, as appropriate

Event Coordination

- Assist in the development and coordination of events
- Liaise with committee chairs and stakeholders to initiate meetings and other functions.
- Work collaboratively with stakeholders and Divisions staff, including communications and evaluation supports

East Kootenay Division of Family Practice
A GPSC Initiative

PROJECT COORDINATOR

Administrative Tasks:

- Schedule meetings, maintain the schedules and ensure the Committee Members and those in attendance at the meetings are prepared for meetings.
- Organize and maintain correspondence, reports, briefing notes, and a variety of documents for Working group or committee members.
- Take meeting notes including action items, maintain accurate records and follow-up on decisions made.

Virtual Clinic Management

- Manage the Cranbrook and Creston Virtual COVID Clinic in consultation with the Executive Director (ED) and other Division staff as needed
- Schedule, train and oversee the Virtual MOAs
- Connect with participating Physicians and provide training and support as needed

Recruitment & Retention

- Coordinate and support the community-based Red-Carpet Committee
- Organize and facilitate events for visiting GP's, and other meetings as required
- Develop and maintain a data base to identify and track opportunities in the EK region for GP's and locums
- Develop and maintain a data base to identify and track GP's and locum recruits interested in the EK region
- Promote the region and the opportunities to interested physicians
- Develop and maintain a strong network of supportive stakeholders, including Interior Health, family physicians, government, and community stakeholders.

Reviewed By:	Name	Date:	Date
Approved By:	Name	Date:	Date
Last Updated By:	Name	Date/Time:	Date/Time

f. Administrative Assistant

East Kootenay Division of Family Practice
A GPSC initiative

ADMINISTRATIVE ASSISTANT

Position:	**ADMINISTRATIVE ASSISTANT**		
Reports to:	Executive Director Operations Lead	**Schedule:**	Flexible work schedule
Direct Reports:	n/a	**Notes:**	25 – 30 hrs/week
Division Summary:			
The East Kootenay Division of Family Practice (Division) is part of a province-wide initiative designed to improve patient care, increase family physician influence on health care delivery and design, and enhance professional satisfaction for physicians. The Division is a non-profit society led by a Board of Directors.			
Role Accountability:			
Under direction of the Executive Director, the Administrative Assistant position is responsible for providing executive-level administrative and meeting support to the Executive Director and Board Members of the EK Division of Family Practice.			
Job Description			

PRIMARY DUTIES AND RESPONSIBILITIES

- Provide administrative and meeting support to the Executive Director, Board of Directors and various Division-lead committees, to include:
  - Organization of and attendance at weekly Agenda setting, Board meetings, and follow up meetings with Board/Committee Chairs
  - Draft meeting agenda and agenda packages
  - Maintain, manage and update meeting calendar
  - Ensure the taking and transcribing of minutes, maintaining accurate records, following-up on decisions made, and ensuring required action is initiate
  - Communicating with and responding to Division, Board and committee members regarding various issues and requests.
  - Arranging meeting logistics and catering as required
- Act as point of contact for all employees, clients and external partners
- Manage information flow in a timely and accurate manner
- Monitor executives' calendars and set up meetings, as requested
- Research and compose correspondence, reports, and a variety of documents for committees.
- Provide administrative support to all other Division team members and board committees, as required
- Upload and distribute Take 2 newsletter content to the website
- Maintain Divisions website for current content

MEMBER SUPPORT

- Ensuring members are well connected to the organization through regular communication and updates on relevant events and opportunities, including opportunities for input and feedback.

- Communication to new members and UpToDate set up
- Assistance and training of UpToDate, as requested
- Unassigned and Assigned In-patient support to members
- Responding to enquiries from doctors, committee members, and general membership regarding Division matters
- Maintain membership lists, services to members and the membership database for the Division

HR ADMINISTRATION

- Organize, coordinate and complete position openings and postings through resume review and short-listing candidates
- Support and assist Operations Lead as required

GENERAL OFFICE DUTIES

- Facility maintenance; liaise with landlord and contractors as required
- Identify opportunities to streamline, adapt and implement new process and technology
- Payment for catering, office supplies, etc., and reconciling credit card
- Answer phones, open and distribute mail
- Maintain office equipment, to include printers/toners, stationery and office/kitchen supplies purchasing as required
- Maintenance of electronic and paper filing systems
- Other duties as assigned

Reviewed By:	Name	Date:	Date
Approved By:	Name	Date:	Date
Last Updated By:	Name	Date/Time:	Date/Time

Current Division initiatives requiring ongoing support (December 2020)

- Board of Directors (Board)
- AGM Support and minutes
- Regional Physician Representative Committee (RPRC) support
- EK Collaborative Services Committee (EK CSC) support
- EK Division Team meeting support
- Long Term Care (LTC) support
- Red Carpet Committee support
- Shared Care Steering Committee support
- COVID Clinic Lead meeting support

g. Evaluation Lead

EVALUATION LEAD

Position:	EVALUATION LEAD		
Reports to:	Executive Director	Schedule:	Flexible work schedule
Direct Reports:	n/a	Notes:	25-35 hrs/week

Division Summary:

The East Kootenay Division of Family Practice (Division) is part of a province-wide initiative designed to improve patient care, increase family physician influence on health care delivery and design, and enhance professional satisfaction for physicians. The Division is a non-profit society led by a Board of Directors.

Role Accountability:

This position involves leading and supporting the evaluation of the EK Division of Family Practice projects and initiatives, and the EK PCN. The Evaluation Lead will work closely with EK Division Project Leads and EK PCN Managers to develop evaluation frameworks and plans, and conduct evaluation activities. The Evaluation Lead will be responsible for sharing evaluation results and process improvement recommendations with the Executive Director, EK Division of Family Practice Board, Project Leads, EK PCN Steering Committee, and other stakeholders as necessary. This position will also support other project work such as proposal writing and development.

Job Description

PRIMARY DUTIES AND RESPONSIBILITIES

- Shared Care project proposal development in collaboration with Program Manager, physician leaders and partners
- Using a Developmental Evaluation approach, develop and implement evaluation frameworks to measure the effectiveness of the EK PCN and other specific EK Division projects and initiatives; use results to inform program improvements
- Work closely with PCN Managers and EK Division Project Leads to engage and consult with all stakeholders on evaluation needs and processes
- Develop evaluation protocols and data collection tools necessary to measure various short term and long-term outcomes
- Conduct evaluation activities, in accordance with the evaluation protocols, incorporating all the principles of cultural safety where appropriate. Collect, compile, analyze, interpret both qualitative and quantitative data
- Lead and coordinate all secondary data access from relevant sources (e.g., Ministry of Health, Interior Health Authority).
- Develop various tools (e.g., reports, infographics, presentations) as a means to share results with Executive Director, EK Division of Family Practice Board, Project Leads, EK PCN Steering Committee, and other project stakeholders where relevant.
- Lead and coordinate literature reviews as needed to inform project development and implementation.
- Lead and/or support the development of funding proposals; work closely with project leads during program development

- Manage multiple ongoing evaluations simultaneously and help to cross-pollinate learning across projects and the EK PCN
- Support the EK Division in measuring and reporting on the requirements of the Division Impact Measurement Framework.
- Liaise with and report to provincial and regional evaluation teams, the Practice Support Program, and other partners, as needed.
- Participate as a member of any relevant committees and attend other meetings as required.
- Support the process for physicians to join the Health Data Coalition.

WORKING RELATIONSHIPS

- Work closely with senior leaders (including Executive Director, Board, Project Leads) and PCN Partners to develop evaluation frameworks or plans
- Implement measures to assess the effectiveness of relevant programs or projects.
- Prepare, or oversee the preparation of, high quality reports and presentations for the Board and senior executive committees, PCN Partners
- Evaluate and continually improve our project teams' approaches to ensure ongoing effectiveness.

Reviewed By:	Name	Date:	Date
Approved By:	Name	Date:	Date
Last Updated By:	Name	Date/Time:	Date/Time

h. PCN Strategic Manager

East Kootenay Division of Family Practice
A GPSC Initiative

PCN STRATEGIC MANAGER

Position:	PCN STRATEGIC MANAGER		
Reports to:	Executive Director	Schedule:	Flexible work schedule, average 35 hours per week
Direct Reports:	PCN Support Coaches PCN Administrative Assistant	Notes:	

Division Summary:

The East Kootenay Division of Family Practice (Division) is part of a province-wide initiative designed to improve patient care, increase family physician influence on health care delivery and design, and enhance professional satisfaction for physicians. The Division is a non-profit society led by a Board of Directors.

Role Accountability:

The PCN Strategic Manager will work with the EK Division of Family practice to support physicians through various programs, primary care providers (GPs and NPs), health authority staff, Ktunaxa staff, Practice Support Program and community organizations in the development and growth of the PCN.

Job Description

PRIMARY DUTIES AND RESPONSIBILITIES

The PCN Strategic Manager is responsible for collaboratively co-leading the development of the EK Primary Care Network initiative, together with the IH PCN Manager and the Ktunaxa Health Care Manager. The three leaders will implement the EK PCN Model of Care – the strategic direction set by the EK Collaborative Services Committee.

KEY RESPONSIBILITIES AND DUTIES

The below responsibilities and duties will be accomplished in collaboration with the IH PCN Manager and Ktunaxa Health Care Manager, as appropriate:

- Provides overall project leadership for the implementation of the Primary Care Network initiative within the East Kootenay, which includes working with PMH programs/services, physicians, nurse practitioners, primary care providers, Interior Health leadership and clinical staff, Indigenous partners, community agencies, and other stakeholders.
- Works in a matrix leadership model with the Interior Health PCN Manager and Ktunaxa Health Care Manager.
- Works with the EK Division of Family Practice and other local groups to facilitate engagement of physicians and other community members in participating in the PCN.
- Provides project management that includes proposal development, establishing the governance structure and operational plan, developing an implementation plan, evaluation, and reporting.
- Works with the EK Division PCN Operations Lead and Executive Director to manage the Division-held operating budget on behalf of the PCN Steering Committee (including resource

allocation).

- Works with other PCN Managers to complete all required reporting to the Ministry of Health and partner organizations.
- Establishes operational procedures/resources as required to ensure consistent practice across the PCN.
- Promote cultural agility in the provision of culturally safe care.
- Ensures that the security and confidentiality of all PCN data is maintained consistent with provincial regulations and policy.
- Accountable to ensure the Ministry of Health deliverables for the funding are being achieved (e.g. reporting).
- Assists in the selection and monitoring of performance indicators at the local level. Works closely with the QI Lead and helps prepares reports as requested.
- Participates in identifying opportunities for improvement in processes to facilitate access and improved quality of care for populations served by the PCN.
- Participates in the recruitment, selection, and orientation of PCN staff, as required.
- Builds strong relationships with Interior Health's Primary and Community and Acute leaders for EK and IH-wide.
- Guides and works collaboratively with the PCN Change Support Team; administrative assistant, coaches, QI/evaluation, IMIT, communication.
- Collaborates with PSP Coordinators to support clinics.
- Works directly with PCN clinics in a coaching capacity to facilitate team-based care implementation, as required.
- Models and promotes self-organizing practices within all PCN teams.
- Promotes positive communications and collaborative practice to improve efficiencies and works with team to resolve conflict as required.
- Develops communication strategies to inform providers of resources available within the team and to inform the public about the PCN.
- Establishes communication strategies with the EK Division Board and partners.
- Other duties, as assigned.

Reviewed By:	Name	Date:	Date
Approved By:	Name	Date:	Date
Last Updated By:	Name	Date/Time:	Date/Time

i. PCN Support Coach

Position:	**PCN SUPPORT COACH**		
Reports to:	Executive Director PCN Strategic Manager	**Schedule:**	Flexible work schedule, average 15-35 hours per week
Direct Reports:		**Notes:**	

Division Summary:

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Role Accountability:

The PCN Support Coach(es) contribute to the implementation of the PCN. The Support Coach(es) will collaborate with the EK PCN Management Team and the PCN Steering Committee to facilitate and roll out the EK PCN Service Plan.

Job Description

PRIMARY DUTIES AND RESPONSIBILITIES

- Reports to and works closely with PCN Strategic Manager
- Supports Primary Care Network (PCN) implementation and change management in one or more East Kootenay (EK) communities, as determined by the PCN Strategic Manager.
- The Support Coach is a representative of the EK PCN to physicians, clinics and teams. He/she focuses on building strong and trusted relationships with physicians, clinic staff, PCN allied health professionals, PCN partners, and other PCN stakeholders.
- Uses the EK PCN Coaching Model which is attached as a framework to guide his/her approach and activities.
- Works with assigned clinics and health centers to support the integration of approved PCN staff and other PCN-related activities (e.g., quality Improvement, team-based care education)
- Facilitates and inspires self-organizing team principles in interactions and processes.
- Prior to exploring or implementing any new initiatives, the Support Coach will make a proposal to the PCN Managers and receive approval before beginning any work on these initiatives/activities.
- Identifies and supports change initiatives at the clinic level to enable the successful implementation of the EK PCN to move it closer to achieving its overall vision and goals.
- Follows appropriate communication channels as established by the PCN partnership. This includes but is not limited to communication with the Ministry of Health, Interior Health, the Ktunaxa Nation, etc.
- Facilitates the development of the EK Learning Collaborative to enable team-based care training and enhancement across the PCN.
- Facilitates individual and group learning, team development, conflict mediation, and coaching.
- Promotes cultural agility in the provision of culturally safe care.

PCN Support Coach Job Description.docx Page 1 of 2

East Kootenay Division of Family Practice
A GPSC initiative

PCN SUPPORT COACH

- Empowers leaders to build capacity in both individuals and teams.
- Embeds a coaching approach in all aspects of work.
- Supports primary care providers with developing quality improvement skills and approaches for practice improvement.
- Collaborates with individuals and teams to analyze and develop strategies for integration, human resources, performance improvement, and communications to mitigate these impacts.
- Supports the adoption of best practice by researching innovations in change management theory, process, tool development, and implementation, specifically for Primary Care Networks, Patient Medical Homes and self-managed care teams.
- Integrates strong change management planning and execution with coaching project management and communications & public engagement planning.
- Works with the PCN managers to contribute to relevant project reporting as per timelines and funding requirements.
- Provides regular updates to the PCN managers and attends various meetings as required.
- Collaboratively executes and monitors all milestones and deliverables.

The work is largely unstructured and requires an adaptable, creative approach to engaging stakeholders. Successful outcomes require the Coach(es) to work independently and in partnership with various teams across EK.

Reviewed By:	Name	Date:	Date
Approved By:	Name	Date:	Date
Last Updated By:	Name	Date/Time:	Date/Time

j. PCN Administrative Assistant

PCN ADMINISTRATIVE ASSISTANT

Position:	PCN ADMINISTRATIVE ASSISTANT		
Reports to:	Executive Director PCN Strategic Manager	Schedule:	Flexible work schedule, average 20-25 hours per week
Direct Reports:		Notes:	

Division Summary:

The East Kootenay Division of Family Practice (Division) is part of a province-wide initiative designed to improve patient care, increase family physician influence on health care delivery and design, and enhance professional satisfaction for physicians. The Division is a non-profit society led by a Board of Directors.

Role Accountability:

Under direction of the Executive Director, the PCN Administrative Assistant position is responsible for providing administrative and meeting support to the PCN, Executive Director, Operations Lead and Board Members of the EK Division of Family Practice as well as Committee and Member Support as required.

Job Description

PRIMARY DUTIES AND RESPONSIBILITIES

- Provide administrative and meeting support for the PCN Strategic Manager and Steering Committee, Executive Director and various Division-lead committees
- Work with the PCN Strategic Manager and Divisions staff to prepare agenda packages and ensure the Committee Members and those in attendance at the meetings are prepared for all meetings.
- Organize correspondence, reports, briefing notes, and a variety of other documents.
- Draft routine correspondence, meeting and event invitations
- Coordinate and schedule meetings and events; arrange meeting/event logistics and catering
- Assist in the preparation of meeting agenda packages; ensure that attendees have all required meeting materials.
- Set up for meetings including preparing the meeting room in advance of the meeting; ensuring the room is tidy after adjournment.
- Take and transcribe meeting minutes; log action items; follow-up on decisions made and ensure required action is initiated; maintain accurate records of meetings
- Maintain paper and electronic filing systems for the PCN and Division meetings
- Act as point of contact for all employees, clients and external partners
- Communicate with and respond to Division, Board, and Committee members and Stakeholders regarding various issues and requests.
- Liaise with committee chairs, stakeholders, and Physician Clinics as required
- Manage information flow in a timely and accurate manner
- Research and compose correspondence, reports and a variety of documents for staff and committees.
- Organize and attend monthly staff team meetings.

- Identify opportunities to streamline, adapt and implement new process and technology.
- Perform other administrative and general office duties as required.

Reviewed By:	Name	Date:	Date
Approved By:	Name	Date:	Date
Last Updated By:	Name	Date/Time:	Date/Time

k. Shared Care Projects Lead

SHARED CARE PROJECTS LEAD

Position:	**SHARED CARE PROJECTS LEAD**		
Reports to:	Executive Director Program Manager	**Schedule:**	Flexible work schedule

Division Summary:

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Role Accountability:

The Shared Care Projects Lead will be accountable to the EK Division of Family Practice through the Project Manager and Executive Director.

Job Description

DUTIES AND RESPONSIBILITIES

- Coordinate, organize and lead meetings of committees and working groups
- Ensure adequate administrative, and other support staff to the projects
- Coordinate additional supports as required, i.e. meeting facilitators, guest speakers, etc.
- Provide regular project reporting to the Division and meet reporting requirements to funders
- Attend local and regional meetings, within budget, which support the project work
- Develop project communications for stakeholders, physicians and the public
- Collect and organize data as needed by any evaluation processes established for projects and contribute as needed to evaluation, assessment and PDSA reviews
- Develop work plans, timelines and budgets
- Review and monitor budget, and administer budget with fiscal responsibility in collaboration with the Operations Lead
- Identify and recommend additional support as needed as work progresses, in coordination with Executive Director

WORKING RELATIONSHIPS

- Act as key point of contact for family physicians, specialists, stakeholders, funders, community, and other Division contractors and staff regarding the Shared Care Project.
- Provide support to the EK Division's member physician(s) in their involvement with the SC Project
- Liaise with SC funding partners, Interior Health, municipal and other community stakeholder groups, as well as any developed regional collaborative teams
- Maintain positive and close working relationships with the staff and contractors of the EK Division of Family Practice and other project team member organizations.

Reviewed By:	Name	Date:	Date
Approved By:	Name	Date:	Date
Last Updated By:	Name	Date/Time:	Date/Time

I. Virtual Clinic Lead

VIRTUAL CLINIC LEAD

Position:	VIRTUAL CLINIC LEAD		
Reports to:	Executive Director	Schedule:	Flexible work schedule
Direct Reports:	n/a	Notes:	

Division Summary:

The East Kootenay Division of Family Practice (Division) is part of a province-wide initiative designed to improve patient care, increase family physician influence on health care delivery and design, and enhance professional satisfaction for physicians. The Division is a non-profit society led by a Board of Directors.

Role Accountability:

This contract involves supporting the Virtual Clinics in the East Kootenay region. The Virtual Clinic Project Lead will support the Clinic Manager, Physicians and MOAs as needed with the EMR and fill in for the Clinic Manager as needed.

Job Description

PRIMARY DUTIES AND RESPONSIBILITIES

- ensure that the relevant forms are on the EMR and up to date.
- EMR is set-up properly for the Physicians.
- Ongoing EMR support for Physicians and MOAs as needed.
- Schedule and provide EMR training to the New Physicians, MOA's and other service providers.
- Schedule Physicians for clinics as well as in-person visits
- Host the fax server for the Cranbrook and Creston Virtual Clinics and respects Accuro and Unite's terms of use and proper storage of data.
- Billing including paperwork and follow-ups that need to be done
- Liaison with Physicians if there are any questions or needs
- Answer any MOA questions that might come up regarding referrals or other clinic needs
- Any other new needs that arise for the clinic
- Attend Regional Divisional Virtual Clinic meetings

WORKING RELATIONSHIPS

- Provide support to the EK Division's member physician(s), MOA(s) and Clinic Manager in their involvement with the Virtual Clinics project

Reviewed By:	Name	Date:	Date
Approved By:	Name	Date:	Date
Last Updated By:	Name	Date/Time:	Date/Time

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m. Virtual Clinic MOA

East Kootenay Division of Family Practice
A GPSC initiative

VIRTUAL CLINIC MOA

Position:	VIRTUAL CLINIC MOA		
Reports to:	Executive Director Virtual Clinic Manager	Schedule:	Flexible work schedule
Direct Reports:	n/a	Notes:	

Division Summary:

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Role Accountability:

This contract involves supporting the Virtual Clinics in the East Kootenay region. The Virtual Clinic MOA will support the Clinic Manager, Clinic Lead and Physicians as needed.

Job Description

PRIMARY DUTIES AND RESPONSIBILITIES

- Virtually greet patients
- Update patient records
- Schedule and confirm virtual medical appointments, using Accuro Electronic Medical Record and an online medical platform (Doxy.me)
- Screen patients using the BC COVID-19 patient screening tool
- Handle correspondence between physicians and patients

KEY COMPETENCES

- a solid understanding of medical confidentiality
- excellent customer service skills
- excellent oral and written communication skills, including computer and keyboarding skills
- good organizational and time management skills
- the ability to maintain accuracy while doing multiple tasks or working under pressure
- a mature attitude toward the human body, wellness, and disease
- the ability to follow directions closely and accurately

Reviewed By:	Name	Date:	Date
Approved By:	Name	Date:	Date
Last Updated By:	Name	Date/Time:	Date/Time

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East Kootenay
Division of Family Practice
A GPSC initiative

BOARD MEETING MINUTES

March 17, 2022, 6:00 PM - 8:00 PM

Zoom

https://us06web.zoom.us/j/88454238508

Board Members		Staff Members	
Dr. Shaun van Zyl	Board Chair	Megan Purcell	Executive Director
Helena Oosthoek	Vice-Chair	Laura Vanlerberg	Operations Lead
Mike Adams	Treasurer and Secretary	Kerry Stanley	Admin Support
Jo Ann Lamb	Board Director		
Greg Wanke	Board Director	**Guest:**	
Dr. Madeline Oosthuizen	Board Director	Sarah Loehr	PCN Strategic Manager
Dr. Nerine Kleinhans	CSC Co-Chair		

Mission	Vision
To empower and support family physicians as they work to optimize the health and wellness of their patients.	Progressive, fulfilled, healthy family physicians who are empowered and equipped to practice optimal primary care in support of healthy communities across the East Kootenay.

DETAILED MEETING MINUTES	
Recorder	Kerry Stanley
Regrets	
Check in	Shaun van Zyl thanked everyone for joining and checked in with everyone
Additions to Agenda/Approval of Agenda Notice to Social Workers	*JoAnn Lamb motioned to approve the Agenda; Seconded by Nerine Kleinhans; All in favour*
CONSENT AGENDA	
1. January 2022 - EKDoFP Board Meeting [Draft] Minutes 2. Staff Report – Megan Purcell, Jacqui van Zyl 3. Initiative Progress Report – Megan Purcell 4. Regional Physician Representatives Committee (RPRC) Report 5. Operations Report – Laura Vanlerberg 6. Financials – Laura Vanlerberg	*Greg Wanke motioned to approve the Consent Agenda; Seconded by Jo Ann Lamb; All in favour*
DECISION AREA	
Approval of Core Budget	• The Infrastructure funds are $60,000 less than last year. The support to Change Management portion of Infrastructure funding has been discontinued but our increase in members has helped balance this decrease. However, we are only allowed to carry over $25,000 in funds from this fiscal whereas last year we carried over $95,000. • HR has been decreased which includes physician sessionals; last year we used only half of the budgeted amount for sessionals. PCN and Shared Care projects have and will continue to fund all sessionals for non-specific Board work. We will use Project Admin funds to subsidize employee wages as needed. • There is a decrease in repairs and maintenance and lease improvements. • Travel has been increased slightly and will include the upcoming retreat and other travel being scheduled. • We will continue to take a percentage from all projects for Project Admin and we will carry this funding over to next year to help cover future employee costs. • There was discussion that future meetings may return to in person with winter meetings remaining virtual. • *Mike Adams motioned to accept the Core Budget as presented; Seconded by Helena Oosthoek; All in favour*

RPRC Attendance for Board Physicians	• The intention for all Board members attending RPRC meetings was to become familiar with the different meetings and information provided with the intention to move to a rotating schedule to attend. • Madeline notes the meetings are informative and provide an overview of other regions. • Nerine identifies a struggle with being informed enough to act as co-chair at CSC and feels best informed after the RPRC meeting. • Shaun comments the RPRC meeting is helpful for his UBC role and pandemic planning. He attends the meeting as a Kimberley representative, not a Board member. • All physician members would like to continue with the option to attend the RPRC meetings. The sessionals are allocated to Physician Change Management and will not affect the Core budget. • The Board members will identify who they are speaking on behalf of during the meeting, Board or community physician/resident, to ensure the group does not become a secondary Board meeting. • The physician attendance will be reviewed again in the fall.
IMG Discussion	• The International Medical Graduate (IMG) program offers physicians trained outside of BC a UBC position in exchange for a Return of Service (ROS). There are 52 positions each year and nine are placed within Interior Health. • The Interior Physician Recruitment and Retention Network (IPRR) has decided to split these placements among each Division within IH with the extra going to CIR. Each Division must identify a clinic and back-up clinic each year that will receive this candidate. The clinic must commit and hold the position for 1 year. From the EOI to the candidate arriving is 18 months. • Andrea Gotaas has been hired by the Division as a Recruitment Coordinator and will be working with the clinics. • The Board will have to approve the method decided upon. • The recruitment system in Creston is functioning well. The candidate needs to have input on where they would like to be placed. • A working group has been identified to create the decision-making process. • Sparwood has an allocation from last year and will receive their placement this year. Invermere is fully staffed and Fernie has interested physicians and may not need to be included.
DISCUSSION AREA	
Questions and Comments from Consent Agenda	•
Clinic Stipend	• Interior Health has now emailed clinic PCN leads with paperwork required for retroactive stipend payments. The Ktunaxa Nation will be emailing soon but the SW extension has added to their workload. • Many questions are expected as IH did not send the previewed draft and Division input was not included.

	• The information provided was a generic form and referenced items of concern: physician leads as the contractor, not the clinic, space must be guaranteed, identify the payments are retroactive, etc. • No stipend funding is provided with non-PCN allied staff. These positions will be polled with PCN positions to create a pooled resource for overhead distribution. • Stipend payments will be monthly going forward. The stipend needs to acknowledge resources not always being space, but EMR access. • The Division has not been included as an equal partner since the planning and implementation. The Division would like to have communication approved by partners and distribute the messaging going forward.
Board and Staff Retreat	• A few options have been presented to Megan and Laura that are between $5k-11k, not including travel and hours. • The Board recommends staying with the East Kootenays to save on travel, spend money locally and invest in team building or a guest speaker.
2022 Divisions AGM and EK CME Day	• October 15 at Copper Point • The 2022 Divisions AGM will be held October 15 at Copper Point and will be combined with the EK CME Day.
PCN Check In: Social workers, PCN Steering Governance, Engagement/Communication	• The Social Worker request is still with Interior Health Labour Relations. • Four Social Workers have now resigned. Two in Cranbrook that were not registered will stay employed with the Ktunaxa Nation in other roles, the Kimberley vacancy has been filled and the Fernie vacancy has been posted internally. • The Nation has extended the remaining contract to the end of April to help with the transition. • The Social Worker in Golden works part-time with IH so can apply internally, has seniority and is fairly confident in securing the position. • The Social Worker in Creston was rehired by IH in December and has been on casual for weekends and holidays to help secure a position. • The Social Worker in Invermere will be hired as an external casual to try and help secure the position but has no seniority. • An applicant from the Kimberley posting interviewed well but did not get the position due to seniority. This applicant has applied for a Cranbrook position and will likely be successful. Both the Kimberley and Cranbrook applicants are from the EKRH ER. • The transition has been messy and weekly meetings to get back on track, retain scope, determine what, if anything, needs to change, figure out the process to support client outside of clinic and how employees with work from home if space is not available. • The goal remains to build self-managing teams with Social Workers accountable to each other, not management looking over them.

<table>
<tr><td></td><td>IH did not realize how independent existing SWs have been; the job is not a cookie cutter position. Tara has offered to meet with Fiona to provide an orientation. The Division has offered Tara a sessional for this time as she has already resigned from her position.
The CSC has identified a small working group to see if a layer is missing from the decision making standpoint between the CSC and PCN Steering Committee.
Jodi Jacobs has been hired, on contract, to create a communication strategy and support improvements with effective and appropriate communication going forward.</td></tr>
<tr><td>Long Term Care Year End Funding</td><td>$14,000 will need to be distributed to the appropriate communities to be under the $50,000 carryover limit. This will be distributed fairly to anyone that had a bed in the last year.
A report and plan for carryover funds is required by the end of April.
Cranbrook, Creston and Invermere have more funds remaining than other communities and new funds will be available in April.</td></tr>
<tr><td colspan="2">FOLLOW UP FROM PREVIOUS MEETING</td></tr>
<tr><td colspan="2">Friends of Children Board member attended a meeting with the Division and is open to idea of supporting prenatal services. Their Board will be meeting next week and will review the fund information from the Creston project. The Division has offered to help with fundraising.
Communication with Dr. Anthon Mayer regarding the future scope of the Division has gone up the chain
COVID tests now available in Kimberley</td></tr>
<tr><td colspan="2">ACTION ITEMS</td></tr>
<tr><td colspan="2">Working group required for IMG placement decisions – Megan*, Jacqui, Nerine, Madeline, Andrea
Sarah to get a list of physician names that received the PCN stipend email
Sarah to provide a follow up to those that received the PCN Stipend or include a FAQ or webinar from IH
Megan and Kerry to meet regarding retreat options</td></tr>
<tr><td>Next meeting</td><td>May 19</td></tr>
<tr><td>Adjourned</td><td>8:00 pm
Greg Wanke motioned to adjourn; All in favour</td></tr>
</table>

EK Division Approval

Date: _________________________________ Position:________________________________

Name:________________________________ Signature:_______________________________

East Kootenay
Division of Family Practice
A GPSC initiative

BOARD MEETING MINUTES

May 19, 2022, 6:00 PM - 8:00 PM

Zoom

https://us06web.zoom.us/j/88454238508

Board Members		Staff Members	
Dr. Shaun van Zyl	Board Chair	Megan Purcell	Executive Director
Helena Oosthoek	Vice-Chair	Laura Vanlerberg	Operations Lead
Mike Adams	Treasurer and Secretary	Kerry Stanley	Admin Support
Jo Ann Lamb	Board Director		
Greg Wanke	Board Director	**Physician Guest:**	
Dr. Madeline Oosthuizen	Board Director	Dr. Gareth Mannheimer	Invermere Physician
Dr. Nerine Kleinhans	CSC Co-Chair	Dr. Edward Schaffer	Invermere Physician
		Dr. Chris Sveen	Invermere Physician
Guest:		Dr. William Brown	Invermere Physician
Sarah Loehr	PCN Strategic Manager	Dr. Karolina Maslowska	Invermere Physician

Mission	Vision
To empower and support family physicians as they work to optimize the health and wellness of their patients.	Progressive, fulfilled, healthy family physicians who are empowered and equipped to practice optimal primary care in support of healthy communities across the East Kootenay.

DETAILED MEETING MINUTES	
Recorder	Kerry Stanley
Regrets	
Check in	Shaun van Zyl thanked everyone for joining and checked in with everyone
Additions to Agenda/Approval of Agenda	*JoAnn Lamb motioned to approve the Agenda; Seconded by Nerine Kleinhans; All in favour*
CONSENT AGENDA	
1. March 2022 - EKDoFP Board Meeting [Draft] Minutes 2. Staff Report – Megan Purcell, Jacqui van Zyl 3. Initiative Progress Report – Megan Purcell 4. Regional Physician Representatives Committee (RPRC) Report 5. Operations Report – Laura Vanlerberg 6. Financials – Laura Vanlerberg	*Mike Adams motioned to approve the Consent Agenda; Seconded by Madeline Oosthuizen; All in favour*
GUESTS	
Invermere Physicians	• Physicians in attendance, and many others, are offended by the comments made by Minister Dix and troubled by the Doctors of BC response. The follow-up meeting with the co-chair of GPSC and Ted Patterson felt insincere. • Invermere physicians would like to differentiate between family practitioners and rural generalists. A rural generalist scope includes five urban physician scopes. • Concern was noted at the lack of local representation at provincial tables. The group doesn't feel the voice of the East Kootenays is being heard. • Unilateral decisions are being made by the tripartite partners. The Division has the smallest voice but carries the biggest burdens. • The PCN engagement sessions created community brainstorming and momentum. With limited reengagement the passion for team based care and the primary care network has fizzled out. • Understanding the Division function is unclear and there is lack of clarity for direction and changes. Concern was noted that the Division is an advocate for physicians but is at risk with requests being dependent on Ministry funds. Division advocates for family physicians at every meeting and will continue to do so but must be cautious of pushing back to funding providers. • Physicians are noting they can monetize staff rather than going through IH and would do exactly what is needed, faster and more cost effective. The PCN has the best of intentions and great people, but political and unionized roadblocks cause roadblocks and frustrations. • The President of DoBC is willing to speak to EK physicians and listen to concerns.

DECISION AREA	
Engagement Partner Invitation	• Patti King is our liaison at GPSC and also oversees FEI MSAs. It is common for Divisions to invite to Board meetings. • Patti has been an advocate to the Division and earned a trusted spot. • *Helena Oosthoek motioned to review inviting Patti King to the Board meeting at each agenda setting; Seconded by Greg Wanke; All in favour*
DISCUSSION AREA	
Audit Approval Meeting Date	• June 9 at 6:00, to be confirmed by Harley Lee.
Questions and Comments from Consent Agenda	•
Board and Staff Retreat	• The draft agenda was reviewed. • The Hedgehog concept will be reviewed, and the videos will be provided prior to the retreat. • Two facilitators have been booked are timing is flexible. • Dealing with conflict and building relationships have been noted as potential topics for the facilitated sessions.
PCN Update	• The concerns previously raised in the stipend contract wording has now been revised. New contract or addendums have been sent to all clinics. • The struggles and power dynamics with partnerships have been difficult but work is continuing. • The Division continues to advocate for change, including the need to continue the coaching roles after year four as they are the Division/physician advocate. • The CDM nurse role is under review, and the Division and physicians should be included in the process led by IH. • Capital projects need to have physician engagement, or the projects will not meet goals and expectations and physicians will disengage. There is understanding of the frustrations with union rules and regulations within IH but work must be done within set guidelines. • An outside facilitator is being determined to work on partner teambuilding. • Division is not permitted to speak in the media regarding politics. This must be done through DoBC, BC Family Doctors or the BC College of Family Physicians. • The PMA negotiations are asking for a small increase as well as money directly to physicians for supports. If it doesn't work, the negotiations will be dragged out.
Board Physician Vacancy	• Dr. Madeline Oosthuizen will be leaving Cranbrook at end of August. This will leave a physician vacancy on the Board. • The bylaws states this position can be filled by an appointment or left vacant until an election during the next AGM. • Dr. Chris Chan was initially interested in the Board and Megan will reach out. If not, the Division can email the group of Invermere physicians that attended this meeting to see if there is interest.

<table>
<tr><th colspan="2">ACTION ITEMS</th></tr>
<tr><td colspan="2">Megan to coordinate DoBC leadership meeting with EK physicians for physician concerns
Megan to contact Dr. Chris Chan to see if there is interest in the Board position
The Division to write a letter to Friends of Children for gratitude of taking on prenatal maternity support, once they decide to proceed.</td></tr>
<tr><td>Next meeting</td><td>June 9 – ad-hoc; Sept 8 (in person?)</td></tr>
<tr><td>Adjourned</td><td>8:05 pm
Greg Wanke motioned to adjourn; All in favour</td></tr>
</table>

EK Division Approval

Date: ____________________________________ Position:___________________________________

Name:___________________________________ Signature:__________________________________

East Kootenay
Division of Family Practice
A GPSC initiative

BOARD MEETING MINUTES

June 9, 2022, 6:00 PM - 7:00 PM

Zoom

https://us06web.zoom.us/j/88454238508

Board Members		Staff Members	
Dr. Shaun van Zyl	Board Chair	Megan Purcell	Executive Director
Helena Oosthoek	Vice-Chair	Laura Vanlerberg	Operations Lead
Mike Adams	Treasurer and Secretary	Kerry Stanley	Admin Support
Jo Ann Lamb	Board Director		
Greg Wanke	Board Director	**Guest:**	
Dr. Madeline Oosthuizen	Board Director	Harley Lee	BDO Accountant
Dr. Nerine Kleinhans - regrets	CSC Co-Chair		

Mission	Vision
To empower and support family physicians as they work to optimize the health and wellness of their patients.	Progressive, fulfilled, healthy family physicians who are empowered and equipped to practice optimal primary care in support of healthy communities across the East Kootenay.

DETAILED MEETING MINUTES	
Recorder	Kerry Stanley
Regrets	Nerine Kleinhans
Check in	Shaun van Zyl thanked everyone for joining
DECISION AREA	
Audit Review	• The engagement partner from BDO will now be Harley Lee. • The society's funds consist primarily of cash and GICs. There is an increase in cash over the last year. • Deferred revenue is the biggest liability for the Division. Refer to note 6 for additional details. • Statement of Operations shows the revenue increase over 2021. The increase in costs is based on events opening to be in person (events, meetings, travel, staff) and is likely to continue to increase. • The money returned does not show on the Statement of Operations. Shows are revenue recognized and liability for the amount to be repaid. • Status of the audit is almost complete, waiting on final sign off from management representation. • A draft letter was provided on internal and operation control matters. • The FRC has reviewed the documents prior and noted no concerns. • The information included on the Management Letter does not affect the audit but may help improve the operations. • The discrepancy in Accounts Payable is due to cheques not cashed. Some are outstanding from 2013 and not previously moved from this allocation. Funds that were still available were reallocated while expired accounts could not be changed in 2021.
ACTION ITEMS	
• Board to email response by June 16 at noon. • Laura will email final documents to Board.	
Next meeting	Sept 8 (TBD)
Adjourned	6:50 pm *Greg Wanke motioned to adjourn; All in favour*

EK Division Approval

Date: ____________________________________ Position:___________________________________

Name:___________________________________ Signature:__________________________________

East Kootenay
Division of Family Practice
A GPSC initiative

East Kootenay Division of Family Practice

BOARD MINUTES

September 15, 2022, 6:00 PM - 8:00 PM

https://us06web.zoom.us/j/88454238508

Board Members		**Staff Members**	
Dr. Shaun van Zyl	Board Chair	Megan Purcell	Executive Director
Helena Oosthoek	Vice-Chair	Laura Vanlerberg	Operations Lead
Mike Adams	Treasurer and Secretary (regrets)	Kerry Stanley	Administrative Support
Jo-Ann Lamb	Board Director (regrets)		
Greg Wanke	Board Director	**Guest:**	
Dr. Madeline Oosthuizen	Board Director		
Dr. Nerine Kleinhans	Board Director (regrets)		

Mission	**Vision**
To represent and empower primary care providers to lead and influence improvement in primary care.	Enable and support primary care providers as they work to optimize the health and care needs of our population and communities

DETAILED MEETING MINUTES	
Recorder	Kerry Stanley
Regrets	
Check in	Shaun van Zyl thanked everyone for joining and checked in with everyone
Additions to Agenda/Approval of Agenda	*Greg Wanke motioned to approve the Agenda; Seconded by Madeline Oosthuizen; All in favour*
CONSENT AGENDA	
1. May 2022 - EKDoFP Board Meeting [Draft] Minutes 2. June 2022 - EKDoFP Ad-Hoc Board Meeting [Draft] Minutes 3. Staff Report – Megan Purcell, Jacqui van Zyl 4. Initiative Progress Report – Megan Purcell 5. Regional Physician Representatives Committee (RPRC) Report 6. Operations Report – Laura Vanlerberg 7. Financials – Laura Vanlerberg	*Greg Wanke motioned to approve the Agenda; Seconded by Madeline Oosthuizen; All in favour*
DECISION AREA	
Board Member Nominations/Re-Elections	Dr. William (Billy) Brown was invited to be appointed into the upcoming vacant physician board role. He in actively involved in the PCN and has been practicing in Invermere as a physician for four years and providing locum coverage there for seven years prior. His documents will be circulated and signed, if approved. Dr. Brown is able to be appointed into the vacancy and added to the re-election list at the October AGM. *Shaun van Zyl motioned to accept Dr. William Brown's appointment into the vacant physician director role on the EK Division of Family Practice Board of Directors; Seconded by Greg Wanke; All in favour* *Madeline Oosthuizen motioned to accept Shaun van Zyl, Jo Ann Lamb, Greg Wanke and William Brown for re-election at the October AGM; Seconded by Helena Oosthoek. All in favour.*
AGM Agenda Approval	Two presentations were requested for the October AGM: Dr. Hale regarding environmental sustainability and Dr. Heilman regarding RTVS. *Madeline Oosthuizen motioned to accept the content of the AGM agenda as presented noting the timing may change; seconded by Helena Oosthoek; All in favour.* The cost for board members to attend the AGM and dinner will be covered by the Division.
Approval of Financials	The Project Lead for the Shared Care Orthopedic project has been hired. The PCN Management YTD fund balance is showing in red as all the PCN funding has not been received yet. The PCN funding comes directly from the Ministry and they take a while to reconcile last fiscal. Q2 Inpatient bridge funds will be paid after September 30.

	PCN Governance spending has increased from last year, but the fund is still underbudget. The funding for the Shared Care Maternity project was fairly generous and may be more than needed rather than being underbudget. Two meetings are still upcoming. *Madeline Oosthuizen motioned to approve the Q1 (April – June) financials as presented; Seconded by Greg Wanke; All in favour*
DISCUSSION AREA	
Questions and Comments from Consent Agenda	Locum funding is available; Invermere and Fernie have used some of their community assigned funds.
Business Support for Clinics Discussion of whether the Division should consider funding options like Cortico for clinics	A few East Kootenay clinics will be proceeding with Cortico. Some Divisions are paying for the ongoing costs for Cortico; it is unclear how this is being paid for in those Divisions. Cortico connects to Accuro only for the locally used EMRs. MedAccess has this ability built in, but this function is unaffordable to most clinics. Would clinics with alternate EMRs receive comparable funding? The PMA should include further direction on the funding for clinic costs. Clinic supports that Kimberley Medical has looked into include RRSP and financial management for the MOAs. A few requests have been received to help facilitate team clothing for clinics. FIGS has been suggested and provides group buying discount of 20% off based on an initial order of 75 sets or 150 pieces. Any purchase afterwards would receive the discount and can be ordered without Division support. All costs including name and logo would be an additional cost for the individual/clinic. The Division will proceed with providing clinics with FIGS catalogue and create an order and payment system.
PCN Update	Dr. Billy Brown and Dr. Jess Chiles attended an IDN PCN Governance conversations this morning, and are also attending a provincial GPSC engagement on the same topic tonight. Two options have been suggested, including a reorganization of responsibilities and roles of existing structure or to create a new entity responsible for running the PCN. A message that medical providers should be hired by clinics and allied supports hired by the Health Authority was emphasized. Additional feedback will be available following tonight's GPSC meeting.
Physician Engagement planning	Previous travelling Board meetings were well attended by at least 50% of local members. Should a community be invited to a board meeting via zoom and rotate through? Helps communicate directly with members. More meaningful conversation. Discuss at physician engagement session. Board will be sent invites and accept/decline as needed. Invites will be for members only, not NP, not PCN. What we're doing and advocating for then world café or group discussion. Physician survey: Comments about Division are helpful – shows we have room to grow. May have lost some ground during PCN. Reinforced that we are on the right track of support we are offering. Word clouds – what brings people here – enjoy region and burnout from work/life imbalance. Physician satisfaction, health and burnout have major negative shifts

	What can the Division do to help support changing this decline? Need more detailed check-in with each community for PCN future implementation, not the focus but will be able to take insight from these meetings. Frustration with Division on political position but members may not understand our funding structure. Political, but working within the system.
Board gathering at the AGM	A get together will be scheduled following the last speaker at the CME day pending availability from Copper Point.
Updates on Provincial Supports for family physicians overhead payments, etc.	Two funding streams have been announced with up to $25,000 per physician over four months available. The rate will be determined by physician time (including telehealth) as well as panel size and complexity. NTP contracts include $75,000 for overhead per year. Residents are concerns that there is no funding support after receiving this money for two years. This money is also causing an imbalance in payment for new physicians and long term physicians which needs to be resolved.
Kimberley Health Centre possible fundraising opportunity through the EK Foundation for Health	No organization or group has the ability or funds to make the third floor of the Kimberley Health Centre leasable, 20,000 sf. Brenna Baker with the East Kootenay Foundation for Health seemed interested in this being an achievable project as the Society has begun capital project work and has oversite of the Kimberley Health Centre. A meeting is scheduled for this society on October 12. No additional work is required at this time.
	A stat will be paid to Division staff for September 19 (Day of Mourning for the Queen) and Sept 30 (Truth and Reconciliation Day).
ACTION ITEMS	
• Kerry to email the Board members to confirm attendance and dietary requests for the AGM and CME Day. • Kerry to connect Andrea with Greg W and Shaun for locum funding information. • Consider inviting a community to each meeting and rotate through, start in the new year. • Megan to determine how other Divisions are funding Cortico. • Division to send FIGS catalogue and letter to each clinic. • Kerry will check if a room is available to meet after last presentation at the CME day and follow up by email. • Kerry to coordinate Board signing Madeline's card at AGM.	
Next meeting	November 17, 2022
Adjourned	8:23 pm *Greg Wanke motioned to adjourn; All in favour*

EK Division Approval

Date: ____________________________________ Position:___________________________________

Name:_________________________________ Signature:________________________________

Formerly the National Center for Nonprofit Boards

THE CONSENT AGENDA: A TOOL FOR IMPROVING GOVERNANCE

BoardSource wishes to thank Mary Carole Cotter, W.K. Kellogg Foundation; James P. Joseph, Arnold & Porter LLP; David Nygren, Mercer Delta Consulting; and James E. Orlikoff, Orlikoff & Associates, Inc., for sharing their professional insights and expertise on this document.

Information and guidance provided in this document is provided with the understanding that BoardSource is not engaged in rendering professional opinions. If such opinions are required, the services of an attorney should be sought.

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MEETING CHALLENGES, CHALLENGING MEETINGS

Nonprofit leaders have the daunting task of delivering on their missions — feeding the hungry and healing the sick, educating the young and entertaining the community, preserving the environment and protecting human rights, accrediting professionals and setting industry standards. With an abundance of obstacles and possibilities at every turn, boards need to spend their scarce time wisely.

Board meetings are the ultimate venue for executing the complementary responsibilities of oversight and strategy. Collectively, the board must satisfy legal requirements and provide programmatic, financial, and ethical oversight. As strategists, board members shape the future of the organization. Equally important — but often overlooked — board meetings bring together the governing body that is responsible for the organization's health and sustainability. As allies with the chief executive in pursuit of the mission, board members must be well informed about the opportunities and challenges facing the organization and ensure that the organization has appropriate strategies, plans, and resources to meet them.

As a practical matter, duly-called meetings are the main mechanism through which boards make *organizational* decisions. Often, meetings are the only time when the board as a whole gets together to execute its *governing* responsibilities. For these reasons, board meetings are precious times, indeed. More often than not, however, nonprofit board members find themselves in meetings that are filled with the least interesting and least challenging issues. Many board members and chief executives struggle to make board meetings valuable to the organization and the individuals in attendance.

A *consent agenda* can turn a board meeting into a meeting of the minds around the things that matter most. A consent agenda is a bundle of items that is voted on, without discussion, as a package. It differentiates between routine matters not needing explanation and more complex issues needing examination. While not difficult to use, a consent agenda requires discipline in working through the following seven steps:

1. Set the meeting agenda
2. Distribute materials in advance
3. Read materials in advance
4. Introduce the consent agenda at the meeting
5. Remove (if requested) an item from and accept the consent agenda
6. Approve the consent agenda
7. Document acceptance of the consent agenda

With a consent agenda, what might have taken an hour for the board to review, takes only five minutes. Because it promotes good time management, a consent agenda leaves room for the board to focus on issues of real importance to the organization and its future, such as the organization's image and brand, changing demographics of its constituents, or program opportunities created by new technology. This BoardSource white paper offers guidance on how to use consent agendas to improve board meetings and, in turn, the overall quality of governance.

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WHAT DOES — AND DOES NOT — BELONG ON A CONSENT AGENDA?

In setting the board meeting agenda, the board chair and chief executive recommend what items warrant full board discussion. While their best guess sets the agenda, all board members have an opportunity in the board meeting to "second guess" that preliminary decision and remove items from the consent agenda for discussion.

> **TIP BOX**
>
> To test whether an item should be included in the consent agenda, ask
>
> ☑ Is this item self-explanatory and uncontroversial? Or, does it contain an issue that warrants board discussion?
>
> ☑ Is this item "for information only"? Or, is it needed for another meeting agenda issue?
>
> ☑ Do we need to confirm a previously discussed issue? Or, do we need to continue the discussion?

COMMONLY FOUND ITEMS

Items commonly found on consent agendas include:

- Minutes of the previous meeting. There is no need to read the text of the minutes of a previous board meeting at a current one.

- Confirmation of a decision that has been discussed previously. Some decisions may need a final administrative touch before the board can vote on them. After such details are resolved, the board may vote on the item via consent agenda at the next meeting.

- Chief executive's report. To the extent that the chief executive does not have items other than those provided in a written memorandum to the board, the chief executive's report can be assigned to the consent agenda. However, chief executives who prefer to use a few minutes of the board meeting to draw attention to a particular issue outlined in the memorandum should exclude their report from the consent agenda.

- Committee reports. Committee reports often contain important information and sometimes recommendations for board approval or resolution. To the extent that such matters do not need discussion and are supported by written materials provided ahead of the board meeting, they may be better assigned to the consent agenda.

- Informational materials. To educate members about the organization, staff provides the board with reports and documents that do not require any action. These might include human resource policies, statistics on compensation levels in similar local organizations, a copy of the IRS Form 990 before it is filed, or a real estate analysis of the local market. However, if these materials relate to discussion items, they should be included as a part of that agenda item rather than placed on the consent agenda.

- Updated organizational documents. Organizational documents periodically need to be updated. Rather than waste meeting time, updates — such as typographical errors in a document that requires board approval, new dates or locations for board meetings, changes to the organization's name or address in legal documents, revisions to the bylaws after changing the title of the chief staff officer — may be added to the consent agenda.

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- Routine correspondence. The board may need to sign standard letters to donors, renew major vendor contracts (whose terms have already been renegotiated), or confirm a conventional action (such as opening a bank account) that requires board approval as stated in the bylaws.

INAPPROPRIATE AND QUESTIONABLE ITEMS

Consent agendas should be crafted with care since the items are not discussed by the board. **They should not be used to hide important issues or stifle difficult discussions.** The following items warrant close consideration when determining if they belong on the consent agenda:

- Audit. The board is responsible for hiring an auditor and overseeing that the auditor's recommendations are properly implemented. The auditor's report is a key financial document and should *never* become a consent agenda item. Ideally, the full board's consideration of the audit should include an opportunity to discuss the findings with the auditors without any staff present.

- Financial reports. On the one hand, if the financial report is uneventful, it may be appropriate to include it on the consent agenda. On the other hand, if it covers important topics, raises questions, or needs emphasis, it may be better handled as a separate item. Needless to say, consideration and approval of the annual budget should never be included in the consent agenda since it represents a major opportunity for the board to understand and discuss management's proposed resource allocations and operating plans.

  Deciding to put a financial report on the consent agenda may also be influenced by the financial acumen of all members of the board. Boards with only a few financially astute members should exclude financial reports from the consent agenda. This allows for a discussion of the financial reports to educate board members about the organization's financial health, thereby ensuring that they fulfill their fiduciary duties.

> **TIP BOX**
>
> Another way for the board to monitor financial performance — without having financial reports consume every board meeting — is to delegate certain duties to the finance committee, such as working closely with the financial staff and reviewing *monthly* financial statements in committee meetings. *Quarterly* financial reports may then be elevated to a special status and discussed thoroughly during full board meetings.
>
> While the finance committee may be charged with monitoring the financial performance, the full board is responsible for the financial health of the organization and should be directly involved in assessing financial matters, especially if the organization is undergoing change.

- Executive committee decisions. Even if an executive committee has authority to act on behalf of the board under certain circumstances, its decisions must still be confirmed by the full board. Executive committee decisions that are routine and procedural are ripe for a consent agenda. If the issue has broader implications — be it an emergency or a major strategic decision — the rest of the board needs to understand the background, rationale, and ramifications. These latter executive committee decisions should not be on the consent agenda; rather, they should be handled as separate discussion items, with the full board receiving appropriate information before confirming the decision.

TIP BOX

While executive committees operate in a myriad of ways, they are ultimately accountable to the full board. Executive committees sometimes overstep their authority and make decisions on behalf of the full board. This may happen when the committee meets regularly and, to save time during board meetings, presents decisions matter-of-factly to the rest of the board for approval. Or, by broadly defining what constitutes an emergency or unusual circumstance, the executive committee may usurp the full board's authority. Involving the board in the final confirmation of executive committee decisions sends a clear message that each board member bears responsibility for the organization.

SEVEN STEPS TO USING A CONSENT AGENDA

Consent agendas offer the opportunity to convert board meetings from boring recitations into active discourses by freeing up scarce meeting time for genuine board discussion of critical issues, emerging opportunities, and forward-looking plans. Chief executives and board members who use consent agendas speak glowingly of their impact on organizational decision making and board-staff solidarity. They appreciate the fact that their limited time is used well and that conversations in the boardroom are productive. The following seven steps outline how to use a consent agenda successfully.

1. Set the meeting agenda. Together, the board chair and the chief executive identify what issues should be at the heart of the meeting and what other items need to be addressed. They then assign routine reports to the consent agenda and create adequate time for more substantive discussions. This challenging but valuable exercise enables the board chair and chief executive to focus the board on organizational priorities.

2. Distribute materials in advance. All items included on the consent agenda must be supported by documents that enable board members to make informed decisions. The chief executive sends materials supporting items on the consent agenda to the board sufficiently in advance of the meeting to permit review. Committees and staff may also have to circulate memoranda summarizing committee actions.

3. Read materials in advance. Preparation is an absolute prerequisite for using a consent agenda. Board members must read materials ahead of the board meeting so that they are prepared to ask questions about items on the consent agenda or to vote their approval. While this may require additional effort from board members, it results in more productive meetings and therefore more satisfied and engaged board members.

TIP BOX

To ensure that the board carries out its fiduciary obligations, the chief executive may want to gently remind board members to pay particular attention to items on the consent agenda and encourage them to ask questions *in advance* of the meeting, especially if their questions are factual. A quick call to the appropriate person — the chief executive, lead staff person, board chair, or someone else — before the meeting can clarify small matters of fact. If their concerns are substantive, they should voice them at the start of the meeting. The item should then be removed from the consent agenda and added to the meeting as a discussion item.

4. Introduce the consent agenda at the meeting. The consent agenda is usually listed as the first item on the board meeting agenda (See Appendix: Sample Board Meeting Agenda). The

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board chair notes the items on the consent agenda and asks if any board member wishes for an item to be removed. This is the final moment for board members to raise their concerns.

5. Remove (if requested) an item from and accept the consent agenda. If a board member has a question, wants to discuss an item, or disagrees with a recommendation, he or she should request that the item be removed from the consent agenda. Without question or argument, the board chair should remove the item from the consent agenda and add it to the meeting agenda for discussion. If a board member needs to abstain from voting on a particular item in the consent agenda, he or she can make this explicit ahead of time and the item need not be removed.

6. Approve the consent agenda. If no one requests that an item be removed from the consent agenda, a simple unanimous yes vote is needed. The chair asks the board for a motion to approve the consent agenda in its entirety. After a motion and a second, the chair asks the board for its approval of the consent agenda. The board votes on the consent agenda items as a whole. The vote will, of necessity, be unanimous since any disagreement with an item should have been expressed earlier and the item removed from the consent agenda.

7. Document acceptance of the consent agenda. The minutes, circulated after the meeting, state that the consent agenda was approved unanimously and indicate which, if any, items were removed and addressed separately. All supporting materials should be saved with the agenda to demonstrate the information on which the board based its decision.

TIP BOX

- ☑ One way to remind board members that certain items on the consent agenda require board approval, and hence a vote, is to mark them “for approval.” This helps distinguish between items on the consent agenda that are informational from those that require board action.
- ☑ “Just a quick question” is not an option when using a consent agenda. Either an item is removed and discussed or it stays put. This places the burden of facilitation on the board chair to be disciplined about stopping discussion and removing items from the consent agenda.
- ☑ To help the board track decisions, the minutes should itemize specific resolutions included in the consent agenda. For example, the meeting minutes might read: “There being no objections, the consent agenda was moved, seconded, and unanimously approved. The consent agenda included the following resolutions: [approve minutes from Month, Day, Year meeting; approve filing of the IRS Form 990 as presented; etc.].” This helps ensure that the minutes are complete and prevents problems should the attachments become separated at a later date.

CHALLENGING MEETING PRACTICES

BREAKING WITH TRADITION

As a meeting management tool, a consent agenda is markedly different from traditional agendas that are highly standardized and structured. Rather than the “old business, new business” approach that emphasizes reports on past performance, a consent agenda energizes board meetings and creates space for deep and forward thinking on the organization’s most important challenges, be it assessing the impact of a particular program, identifying new sources of

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revenue, or examining the board's composition. A consent agenda also imposes different expectations on all parties. To be effective, it must be understood and accepted by everyone at the meeting.

Moving to a consent agenda may cause consternation because it requires a change from standard operating procedure and sometimes seems to minimize traditional board responsibilities and rituals. First, some board members (and lawyers) may worry that a consent agenda prevents the board from exercising its fiduciary duties. Nothing could be further from the truth. Used properly, consent agendas facilitate board focus on the things that matter most. A consent agenda is not an excuse to cover up important issues; rather, it is an invitation to explore them deeply.

Second, board meetings are often filled with oral presentations of committee updates as a way to showcase work done by committee chairs and members between meetings. Recognizing valuable work by volunteers encourages their continued participation, but the cost of spending board meeting time on purely symbolic matters is too high a price to pay. Instead, the chief executive and board chair should identify other ways to thank committee members for their hard work.

COLLABORATING FOR SUCCESS

Using a consent agenda requires true collaboration between the board and the chief executive. Both must do their homework in preparing for the meeting, from setting the agenda to providing materials to facilitating discussions. Chief executives rely on board meetings to handle mandatory business and to educate board members about the organization's programs. Astute executives treat meetings as valuable "kitchen cabinet" gatherings to engage smart, knowledgeable, passionate individuals around the issues that matter most to their organizations. The efficiencies of a consent agenda give executives more time to engage the board in thinking and talking about the organization's mission, programs, and impact.

Together, the board chair and chief executive need to think strategically about what contributions board members can make to issues facing the organization and how to present matters for their consideration. They need to be clear about the intended purpose of each item *not* on the consent agenda. It may be approval of a recommendation, guidance and advice, or brainstorming. Such clarity about the purpose of the item reduces the likelihood that board discussion will result in an extraneous task list for the chief executive or micromanagement by the board.

TIP BOX

Change is demanding. It requires open-mindedness and flexibility from those affected by the change. As with any new organizational process, the decision to adopt a consent agenda should be made thoughtfully and with a solid understanding of the ramifications of the change. The following steps can help the board adopt a consent agenda without major obstacles:

1. Discuss with the board the benefits of a consent agenda and get the board's support.
2. Create a cheat sheet on how a consent agenda works.
3. Outline criteria for what can and what cannot be included on the consent agenda.
4. Ease into the process. Start with obvious, clear items on the consent agenda.
5. Ask the board how the new meeting structure is working.
6. Fine tune meetings and materials as necessary.

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Because a consent agenda frees up meeting time for a different kind of discourse, it requires a different kind of meeting facilitation. The board chair may need to learn tips and techniques for facilitating less structured, more active group discussions. The board chair may need to approach meetings differently — as a focus group, as a debate about the pros and cons of an issue, as a creative idea-generating session, as a time to troubleshoot thorny problems. To make the most of these free-ranging discussions, the board chair will need to exert appropriate discipline without discouraging participation, or the benefits gained from the consent agenda may be lost.

TIP BOX

Meeting facilitation does not come naturally to all board chairs. The following techniques can help board chairs use an interactive approach to running meetings:

- ☑ Silent Starts. Before starting a major discussion, ask each board member to write down the most important question the board should consider on a sheet of paper. Collect and redistribute the responses. Then, have board members read each others' responses out loud.
- ☑ Counterpoints. Randomly assign two or three board members to make the most powerful arguments *against* the recommendation under consideration.
- ☑ Breakouts. Divide the board into small groups and have each group brainstorm questions, identify key issues, or propose alternatives to the issue at hand. Then, have each group present its conclusions to the full board.

THE ULTIMATE BENEFIT: BETTER BOARD PERFORMANCE

It's worth repeating: The main purpose of a consent agenda is to liberate board meetings from administrative details, repetitious discussions, and misdirected attention. The main benefit is better governance. Consent agendas allow the board to regularly dig deeper on strategic issues rather than take a superficial pass on a lot of issues. Traditional board meetings often focus on the past, learning about activities and results that occurred since the last meeting. Board members listen, ask for explanations, and seek assurance that staff has thought of everything. This leaves limited opportunity to focus on the future – how the community is changing, what programs will be most valuable, and ways the organization may need to evolve to best fulfill its mission.

The organization benefits from better decisions, more engaged board members, and greater impact when the chief executive and the board operate as strategic allies. The consent agenda removes one of the obstacles — limited time — to engaging the board meaningfully. With a consent agenda, the board is positioned to become an active participant in exploring the opportunities and challenges the organization faces today and in the future because routine business is handled efficiently. Board meetings become filled with open and robust debate around what matters most. Chief executives hear different perspectives about critical issues and in the process they can ensure the board is knowledgeable about, and supportive of, key initiatives. Board members, in turn, feel that their time is well spent; they feel valued and satisfied.

APPENDIX: SAMPLE BOARD MEETING AGENDA

Board of Directors Meeting
ABC Organization

Monday, January 2, 200X
1234 Main Street, Suite 56
City, ST 78910

<u>8:30 a.m. – 9:30 a.m. Full Board Executive Session</u>

- Chief Executive Assessment: Feedback and Approval of the 200X Process — TAB 1

<u>9:45 a.m. – 3:00 p.m. Board Meeting</u>

9:45 – 9:50 Welcome and Chair's Remarks

9:50 – 10:00 Consent Agenda

- Minutes of the December 1, 200X Meeting — TAB 2
- President's Report — TAB 3
- Planning and Development Task Force Update — TAB 4

10:00 – 2:15 Strategic Discussions: Presentations and Feedback

10:00 – 11:45 Strategic Plan: Measures of Success — TAB 5

[Noon — Buffet Lunch]

12:30 – 2:15 New Markets Strategy: Implementation Plan — TAB 6

2:15 – 2:45 Governance Committee: Discussion Items — TAB 7

- Bylaws
- Board Member Recruitment

2:45 – 3:00 Closing

AA	Advanced Access
ACE	Adverse Childhood Experiences
ACP	Advanced Care Plan
ACSC	Ambulatory Care Sensitive Condition Committee
AHPNS	After-Hours Palliative Nursing Service
ALC	Alternate Level of Care
AMF	Attachment Mechanism Funds
APA	American Physician Association
APP	Alternative Payment Plan
BCMA	BC Medical Association
BCPSQC	BC Patient Safety and Quality Council
CATS	Canadian Triage and Acuity Scale
CBT	Columbia Basin Trust
CDM	Chronic Disease Management
CEV	Clinically Extremely Vulnerable
CHC	Community Health Centre
CHSA	Community Health Services Area
CIHS	Community Integrated Health Services
CIR	Central Interior Rural
CMF	Complex medical conditions and/or frailty
CO	Central Okanagan
COP	Community of Practice
CSC	Collaborative Services Committee
CSDA	Community Service Delivery Area
CME	Continuing Medical Education
CPA	Common Program Agreement
CPD	Continuing Physician Development
CPSBC	College of Physicians and Surgeons of British Columbia
CYMHSU	Child and Youth Mental Health and Substance Use Collaborative
DoB	Doctors of BC
DoFP	Division of Family Practice
DSM	Diagnostic and Statistical Manual of Mental Disorders
DTO	Doctors Technology Office
EASE	Electronic Access to Specialist Expertise
EDD*	Equitable Distribution of Dissatisfaction
EKASS	East Kootenay Addictions
EMR	Electronic Medical Records
EOI	Expression of Interest
FEI	Facility Engagement Initiative
FFS	Fee For Service
FNHA	First Nations Health Authority
FP	Family Physician
FTE	Full Time Employment

GP / FP	General or Family Physician
GPSC	General Practice Services Committee
HA	Health Authority
HCIS	Home and Community Integrated services
HDC	Health Data Coalition
HLBC	HealthLinkBC
ICC	Integrated Care Coordinator
IHI	Institute for Healthcare Improvement
IMaST	Information Management and Supporting Technology working group
IHN	Integrated Health Network
IMG	International Medical Graduate
IMG (PRA)	International Medical Graduate
IMG (UBC)	International Medical Graduate
IMIT	Information Management Information Technology
IPCC	Integrated Primary and Community Care
IPRR	Interior Physician Recruitment and Retention (Network)
ISC	Inter Divisional Strategic Council
IWG	Incentive Working Group
JCC	Joint Collaborative Committee
JSC	Joint Standing Committee on Rural Issues
KB	Kootenay Boundary
LAT	Local Action Team
LEAP	Learning Essential Approaches to Palliative Care
LHA	Local Health Authority
LMDP	Leadership Management and Development Program
LRBC	Locums for Rural BC
LTC	Long Term Care
LOU	Letter of Understanding
MAPLe	Method of Assigning Priority Levels
MBMD	Millow Behavioral Medicine Diagnostic
MCFD	Ministry of Child and Family Development
MCI	Maternity Care Initiative
MHSU	Mental Health and Substance Use
MIRR	National Native Alcohol and Drug Abuse Program
MOA	Medical Office Assistant
MoH	Ministry of Health
MRC	Most Responsible Clinician
MRP	Most Responsible Physician
MSA	Medical Staff Association
MWSU	Mental Wellness and Substance Use
NACI	National Advisory Committee on Immunization
NGO	Non-Government Organizations
NP	Nurse Practitioner
OAT	Opioid Agonist Treatment
OPUS	Optimal Prescribing Update and Support
PACMapping	Primary Community Care Mapping

PAM	Patient Attachment Mechanism
PBF	Population Based Funding
PCCT	Primary & Community Care Transformation
PCH	Patient Care Home
PCHN	Primary Care Health Nurses
PCN	Patient Care Network
PDSA	Plan Do Study Act
PFCC	Patient and Family Centered Care
PHCSS	Primary Health Care and Specialist Services
PIA	Privacy Impact Assessment
PiC	Partners in Care
PITO	Physicians Information Technology Office
PLP	Personal Learning Plans
PMA	Provincial Master Agreement
PMA	Physician Master Agreement
PMH	Patient Medical Home
POC	Proof of Concept
POCT	Point of Care Testing
PPh	Polypharmacy
PPL	Professional Practice Leader
PQI	Physician Quality Improvement
PRA	Practice Ready Assessment
PSP	Practice Support Program
QI	Quality Improvement
RACE	Rapid Access to Consultative Expertise
RAP	Rapid Access to Psychiatry
RCCbc	Rural Coordination Centre of BC
RCI	Residential Care Initiative
Redesign	Health Authority Redesign
REEF	Rural Emergency Enhancement Funding
RLP	Rural Locum Program
RPRC	Regional Physicians' Representative Committee
RR	Rural & Remote
RRSC	Recruitment and Retention Steering Committee
RSON	Rural Surgical Obstetrics Network
SAC	Strategic Advisory Committee
SC	Shared Care
SCC	Shared Care Committee
Schol	Physician Leadership Training Scholarships
SCSP.	Specialised Community Service Program
SDOH	Social determinants of health
SET	Senior Executive team
SNO	Shuswap North Okanagan
SP	Specialist Physician
SOS	South Okanagan Similkameen Division
SSC	Specialist Services Committee

STEP	Short Term & Essential Practice
TBC	Team Based Care
TD	TeleDermatology
TH	Thompson
TiC	Transitions in Care
TOG	Target Operating Model
TOR	Terms of Reference
UPCC	Urgent Primary Care Centre
YT	Youth Transitions