Divisions of Family Practice

A GPSC initiative

Administration Handbook

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British Columbia

G P S C
General Practice Services Committee

doctors of bc

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Introduction

This Administration Handbook is designed to provide local divisions with guidance regarding all administrative matters and to enable a division to operate effectively. It is intended primarily for the person who is responsible for the day-to-day operations of a division. The person filling this role can have the title of coordinator, executive director or executive lead, among others. We have referred to this role in this handbook as a coordinator for consistency.

For information about administrative matters not contained in this Administration Handbook, please contact the Business Systems Lead for the provincial Divisions team at 604.638.2895.

An Overview of the Initiative

Divisions of Family Practice are community-based organizations of family physicians working together to achieve common health care goals. The initiative was designed to improve patient care, increase family physicians' influence on health care delivery and policy, and increase professional satisfaction for physicians.

Launched in November 2008, Divisions of Family Practice is the first initiative of its kind in Canada. The Divisions initiative provides physicians with a stronger collective voice in their community while supporting them to improve their clinical practices and offer comprehensive patient services. The initiative is founded on the belief that communities are best served when they seek to improve the health of all residents in the region.

Divisions of Family Practice are key collaborators in a larger governance network including the regional health authorities, BC Ministry of Health (MoH), the BC Medical Association, and the General Practice Services Committee (GPSC). Partners from the community, from patient groups, or both may participate with a division when appropriate.

Divisions of Family Practice are sponsored by the GPSC, a joint committee of the MoH and the British Columbia Medical Association (BCMA).

A Division of Family Practice is formally structured as a not-for-profit society, with an elected board of directors. They contract or employ a division coordinator, and possibly other staff as needed and depending on available resources. Each division also has a physician lead, or chair, who represents the board and society as a whole publicly and with staff. All family physicians within the designated geographic area are potential members of the division.

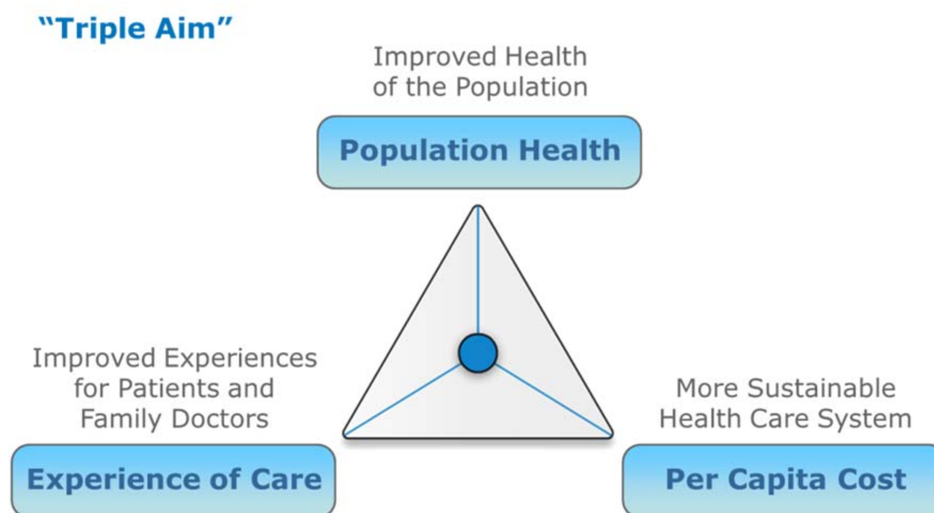
Philosophy of Divisions of Family Practice

At its core, Divisions of Family Practice is an initiative to strengthen the voice of family physicians and improve patient care at the community level. It is founded on commitments to working collaboratively to solve problems of local importance, building capacity at the local and regional level, and building relationships and trust with patients, communities, and other partners in provincial health care.

Triple Aim

The Divisions of Family Practice initiative is founded in the principles of the Triple Aim Initiative, a program of the Institute for Healthcare Improvement (www.ihi.org). The Triple Aim initiative helps health care organizations improve in three areas of focus: the individual experience of care for patients and doctors, the health of the population, and the economic viability of the health care system.

Divisions have the autonomy to use the local knowledge, experience, and understanding of their member physicians, to develop activities and initiatives that address these three key areas. New initiatives should always be measured against these aims.



Divisions work within some of the following areas:

Supports for member physicians' practices

- Providing supports for physician wellness, as identified by the board.
- Assisting with physician retention and recruitment planning and supports.
- Liaising with Practice Support Program staff to organize and host formal and informal networking opportunities.
- Supporting physician access to Continuing Medical Education.
- Assisting with clinical leadership and practice/system design support for members, the community and the region.
- Facilitating connections with family practice residents, nurse practitioners and medical students, and taking a leadership role in organizing and sustaining regular weekly medical staff rounds, journal clubs, and subspecialty interests within family medicine.

Supports member physicians in the community

- Promoting comprehensive primary health care including: chronic disease management; maternity care; complex care for people living with multiple chronic conditions including pain, anxiety and depression; mental health care; and end-of-life care. This primary care will be provided in collaboration with other health care providers as appropriate.
- Advocating for and building models of hospital care that foster continuity of inpatient care and effective information exchange during admissions and discharges, improved efficiency in response to sudden clinical deterioration or hospitalized patients, improved utilization and integration with the health care team, and increased collegial support for care of complex patients.
- Assisting with the coordination and quality of residential care.

Supports Public Use of Primary Health care resources

Divisions can help get information and education about primary health care services to the public. They can highlight innovative and continuous improvement activities through communications products including brochures, fact sheets, or other publications. These communication tools may include information on subjects such as:

- A full description of available primary health care services and the benefits of such services

- Scope of community hospital care services available for patients in the local health authority
- Assistance in finding primary care providers for unattached patients in the community
- Description of programs in place for providing comprehensive community care for complex and chronic patients
- Description of and contact information for maternity care
- Description of end-of-life care including in-hospital and community palliative and hospice care tools for end-of-life planning and advanced directives
- Description of residential care, home care supports and long-term care options
- Contact information for patient access to health services such as walk-in same-day access and after hours care (open or advanced access options)
- Education regarding appropriate use and access to urgent and emergency care
- Mental health and addictions services

Local Autonomy, Provincial Participation

Each Division of Family Practice is an integral part of the larger provincial network. While local autonomy is central to the Divisions approach, the ability of the initiative to have the greatest impact will come from the connections between and among divisions across the province.

Local Autonomy

The strength of the Divisions of Family Practice initiative comes from the ability of each division to operate autonomously to identify and respond to the needs and priorities of their members and patients.

Local divisions define their own governance, including board and committee structures, as well as how they want to manage the organization. How they expand the division and engage family physicians in their area is also determined at the local level.

Divisions can be agents of change in the health care system, promoting and facilitating quality primary care, collaboration, and sustainability in their communities. Once established, each division supports its community by developing locally appropriate health care programs and services based on priorities identified by the larger membership.

Divisions of Family Practice are also networked among themselves, both in geographic proximity and as a province-wide system. Divisions provide an opportunity to learn from what is being done in other communities around the province. They can gather and share information about events, successful initiatives, or promising developments in family practice.

Provincial Participation

The provincial Divisions team plays an important role in supporting local divisions, and strengthening the provincial network. As a central resource for all divisions, the provincial Divisions team undertakes initiatives that address common needs and goals, and save money through economies of scale, so that individual divisions can focus their resources on delivering results for local priorities.

There are significant advantages to be gained by participating in provincial undertakings. The provincial Divisions team can help achieve economies of scale by using provincial systems and technology that otherwise would be financially out of reach for most local divisions.

They provide access to topic specialists, such as lawyers and accountants, who can provide input into system development and initiative design. These professionals have experience working with health care stakeholders, and can share the lessons learned from working with other divisions and partners.

The provincial Division team will also help coordinate local divisions to build the case for continuing the funding for the initiative after 2012, when current funding expires.

Providing practical tools & business solutions

In a 2010 survey, division members gave a clear indication that they wanted more direction from the provincial Divisions team. In response, the provincial team has developed a suite of practical tools and business solutions to support the common needs of local and regional divisions. Local divisions are invited and encouraged to use these services.

Section 1 — The Provincial Divisions Team

The provincial Divisions team is committed to supporting the growth and development of all divisions in BC. It is a service and support centre for divisions, with expertise and resources available to assist with physician engagement, business systems, communications, and administration. As a Division coordinator it is important to know the people and support services that are available through the provincial Divisions team. It's just one more way to benefit from the learning and experience of the Divisions network.

Executive Lead

The Executive Lead of the Divisions of Family Practice oversees the provincial Divisions team. The Executive Lead is responsible for guiding the initiative. This is the person who creates the overall strategy of the Divisions of Family Practice and handles the majority of the interaction with members and partners.

Physician Engagement Leads

Each division is supported by a Physician Engagement Lead from the provincial Divisions team. The Physician Engagement Leads facilitate the development of local divisions, advise on member recruitment and engagement, and provide information to interested physicians on the Divisions initiative. coordinators can consult with their Physician Engagement Lead on issues including:

- Developing and understanding governance of the non-profit society.
- Planning and facilitating member and community engagement strategies.
- Hiring staff and human resources advice.

Business Systems Lead

The Business Systems Lead is responsible to help create and implement the operational infrastructure for Divisions of Family Practice. The Business Systems Lead is available to help coordinators manage their on-going operational needs, including organizational planning and development, identifying appropriate technologies and setting up systems, and establishing appropriate financial systems and procedures.

Financial systems and procedures

Customized systems are available to local divisions to assist with financial management. The provincial Divisions team has developed accounting structures, as well as procedures for funding transfers, funding renewals, and carry-over. Collaboration on accounting systems also allows the provincial Divisions team to track the financial development of overall initiative. This will be an important piece in 2012, as they make the case for additional funding for the initiative.

Technology support for Division communications

Effective communications is important. The provincial Divisions team has developed a number of technology-based projects to help track, plan and share information, including Divisions email, a membership database, dynamic website templates, forum and scheduling solutions, and hosting services.

Communications

The Communications department facilitates all aspects of communications, marketing, and branding for Divisions of Family Practice. It manages three levels of communications: provincial communications to partners and stakeholders, communications between divisions, and a division's communications to its members. The Communications department is available to help divisions develop communications plans, liaise with the media, website content, marketing materials, and membership and community engagement materials.

Branding tools & templates

Professional branding materials, including logos and templates are available to all divisions. Using these tools helps strengthen the recognition of the Divisions of Family Practice initiative locally and provincially. It strengthens the professional image and credibility of local divisions, and increases public confidence in the initiative by demonstrating the support of the Ministry of Health and the British Columbia Medical Association.

Administration

Working alongside the Physician Engagement Lead and Business System Lead, the provincial Divisions team provides administrative support from the

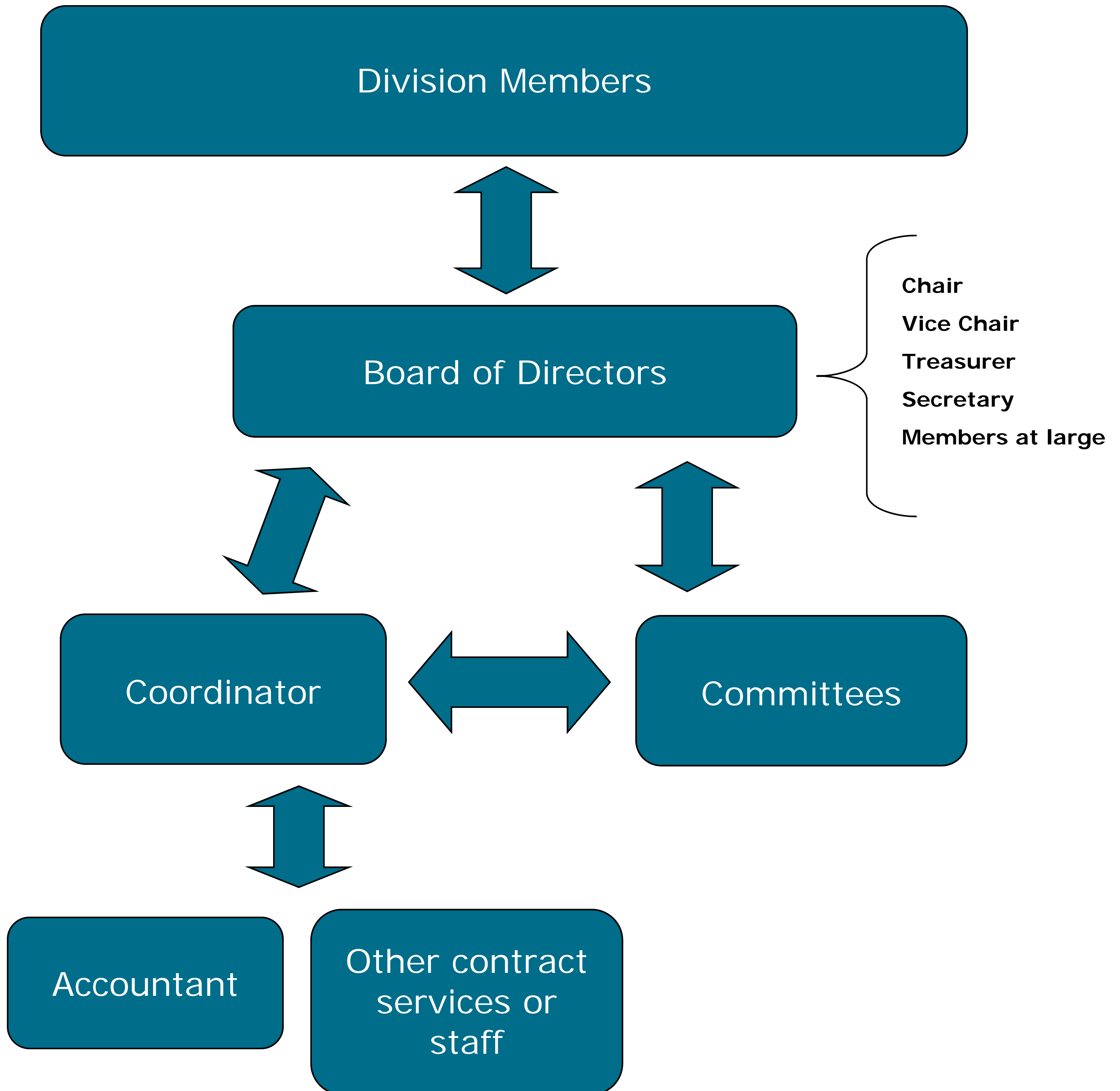
first steps of starting new divisions, through to the organization of the provincial network.

During the early development stage, the Administrative team assists with funding processes, brings together the necessary partners and stakeholders, manages the logistics for meetings, and distributes information and meeting materials.

Once a coordinator has been hired, the Administrative team provides training and one-on-one support for new coordinators on how to submit claims, preparation time, invoices, and sessional forms.

The provincial Divisions team is also responsible for organizing provincial events and workshops, and ensuring our stakeholders and partners are kept up to date on Division of Family Practice activities.

Structure of a Division



Section 2 – Board and Coordinator Roles

The roles of the board of directors and the coordinator are closely inter-connected. Having a clear understanding of the relationships and responsibilities of both parties is essential to the success of the division.

A. Role of the Board of Directors

The board of directors is primarily responsible for the governance of the division. It is responsible for setting and assessing the direction of the organization, and deciding what the division will do. The board is responsible for hiring and overseeing the coordinator.

Specific Responsibilities of the board:

Defining the vision
An organization's vision is its dream for its future. The board is responsible for ensuring that a clear vision is defined for the organization, and that members of the division are able to participate in developing that vision.

Setting the strategic direction
Effective planning leads an organization from its current reality toward its desired future; that is, its vision. Through the planning process, the board will set short and long-term goals that are aligned with the organization's mission, vision, values, goals, and policies. The board will support the coordinator to implement the strategic direction, and achieve the division's goals.

Approving the budget
The budget will be prepared by the coordinator and treasurer and presented to the board for approval. The budget should be aligned to reflect the priorities and goals set out by the division.

Focus on results
The board's focus should always be directed toward its mission and vision, and the results it desires to achieve. The first reference to the intended results of the division is in the Document of Intent, and the board can use this to describe results both for the division and for the community.

Committees
The board appoints and oversees committees as needed to meet the goals of the division. Committees take direction from, and act as advisory bodies to, the board. Committees can be struck to deal with operational issues such as human resources, policy, member engagement, or finance. The board may also choose to establish a Collaborative Services Committee to deal with more

complex issues. More information about Collaborative Services Committees is available in Section 8.

Advocates for members and patients
The board has a political role as an advocate for its constituents. Members place their trust in the board and expect them to provide strong leadership and to lobby for support of the organization's vision and goals. If communication with the public is particularly effective, patients will also see the division as an ally and advocate for better patient care.

Hires and evaluates the coordinator
It is the responsibility of the board to hire and oversee a coordinator to manage the staff, operations, and initiatives of the division. The board should have a predictable and mutually accepted approach to reviewing the performance of the coordinator. One approach, and a sample of potential questions, is described in Appendix F.

Fulfills the responsibilities of a society
It is the board's responsibility to meet the legal obligations of the *Society Act*. More information is available in Section 3: Responsibilities of a Society.

B. Role of the coordinator

The coordinator's overall role is to implement, maintain, and operate the division to achieve the goals set out by the board. Whereas the board establishes governance structures for the division, the coordinator manages the operations, administration, and staff. The coordinator reports directly to the board of directors, and receives support from the board chair. The coordinator may also be called an executive director or staff lead, as determined by the board.

Supporting the board & committees

The role of the coordinator at board meetings largely depends on how the board has defined the position. Some coordinators may be active participants in board meetings, while others may take notes and interact very little.

As a division grows, the coordinator will need to take a more active role in board discussion because of their detailed knowledge of programs, contracts, and needs of the division. The coordinator is also responsible to report to the board on the progress of the different areas of work in the division.

While the coordinator may be actively involved in discussions, they do not have a vote on the board. As a leader in the organization, the coordinator can assist the board in formulating motions, guide discussions, and keep the board members on track during discussions. They can also be an advisor who can support the board in making decisions, establishing and supporting committees, and developing a strategic plan.

The coordinator is also responsible for providing logistical and administrative support to the board and committees. This includes logistical details including selecting dates, locations, and catering for meetings; coordinating with board members; preparing the agenda and documents; as well as note-taking and distribution of minutes.

Administration

As the division is getting established, the coordinator will lead in developing administrative processes, and getting the organization up and running. In short, the coordinator is responsible for completing all of the tasks necessary to make the division a functional organization, including financial, banking and legal requirements for a non-profit organization.

The provincial Divisions team has resources and staff available to help coordinators take care of many of the administrative needs of local divisions. Working closely with the Physician Engagement Lead, Business Systems Lead,

and Administration team can help make sure that every division has a strong administrative foundation to work from.

Here are some of the early tasks that the coordinator may need to attend to:

- Develop and administer the division as a non-profit society.
- Set up bank account, signing officers, and other financial requirements.
- Develop infrastructure to receive and disburse division infrastructure dollars according to local needs and by agreement of the membership.

Data management

The early development of appropriate data use policies and procedures is also an important responsibility of the coordinator. The collection, storage and analysis of data must be managed in accordance with the Personal Information Privacy Act (PIPA) and such data stewardship policies as directed by the board.

Staffing

Additional staff may be engaged by the division to provide necessary functions or services. The coordinator is expected to provide leadership and direction to the staff according to the policies approved by the board. They will hire, supervise, support, and evaluate the staff working as part of the local division team. More information is available in Section 5 – Additional Staffing.

Putting plans into action

Divisions are results-driven organizations. As the leader of the local division staff team, the coordinator is called upon to be an activator and innovator, putting the plans, strategies and projects set by the board into action.

The coordinator is expected to provide guidance, facilitation and hands-on implementation support to the division for achievement of its community-identified goals. This will include preparing proposals, business cases, and detailed implementation plans, as well as supporting committees and task groups related to the division's work.

Tasked with managing and monitoring the projects and activities of the division, the coordinator will initiate and coordinate local data collection and community engagement processes to determine benchmarks and assess the scale of a problem, and provide long-term evaluation of the Division's initiatives.

Liaising closely with the provincial team and coordinator counterparts in the other divisions, the coordinator is expected to provide regular status updates for the division and provincial office, including achievements, issues, plans and support requirements.

Communicate and connect
The coordinator needs to be able to effectively connect and communicate with members, partners, and the community. He or she is the centre of the local network that will drive the success of the division.

The coordinator is there to facilitate the connection between members of the division and the board, and help the board effectively represent the voice of the members. The first step in building that connection will be developing and implementing the recruitment strategy. Help is available from the provincial Division team through the Physician Engagement Leads.

The provincial Division team can help the coordinator prepare a web site and other communications tools for the division. Once the tools are in place, the coordinator is responsible for maintaining content and keeping members informed and involved.

As the operational leader of the division, the coordinator needs to develop, maintain, and strengthen relationships with partners including the regional health authority and the Ministry of Health. They need to be able to build support from stakeholders and staff at different levels within participating organizations, and maintain effective working relationships to help achieve the goals set out by the board. This should include a network or functional, technical and subject matter experts in the community and across the province.

For more about connecting with partners see Section 9 – Division Initiatives.

C. Role of the board vs. coordinator

Activity	Lead
PLANNING	
Direct the process of planning	Board
Provide input to long range goals	Joint
Approve long range goals	Board
Formulate annual objectives	Coordinator
Approve annual objectives	Board
Prepare performance reports on achievement of goals and objectives	Coordinator
Monitor achievement of goals and objectives	Coordinator
PROGRAMMING	
Assess needs of members and partners	Joint
Oversee evaluation of services and programs	Board
Maintain program records; prepare program reports	Coordinator
Prepare preliminary budget	Coordinator
Finalize and approve budget	Board
See that expenditures are within budget during the year	Coordinator
Approve expenditures outside authorized budget	Board
PERSONNEL	
Employ coordinator (hire, train, support, dismiss)	Board
Direct work of the staff	Coordinator
Hire and discharge staff member(s)	Coordinator
Decision to add staff	Board
Settle discord among staff	Coordinator
COMMUNITY RELATIONS	
Explain organization to community	Board
Write news stories	Coordinator
Provide organization linkage with other organizations	Joint
BOARD COMMITTEES	
Appoint committee members	Board
Contact committee chair to urge him/her into action	Board
Promote attendance at board/committee meetings	Joint
Recruit new board members	Board
Plan agenda for board meetings	Joint
Take minutes at board meetings	Coordinator or staff
Plan and propose committee organization	Joint

Prepare exhibits, material, and proposals for board and committees	Coordinator
Sign legal documents	Board
Follow-up to insure implementation of board and committee decisions	Coordinator
Settle conflicts between committees	Board

Section 3 - Responsibilities of a Society

Divisions are incorporated as non-profit societies to provide the legal status necessary to sign contracts and to hold funds, in order to implement programs in their communities. Members of the provincial Divisions team support the division throughout this process, which includes developing the organizational structure and policies.

There are three main reasons to be a non-profit society:

- Many of the division's activities require a legal structure, such as hiring staff and signing service agreements. A non-profit society can serve the interests of its members and can enable a board to make decisions quickly and efficiently.
- Directors of the society are not personally or professionally liable for the society's actions, as the structure affords legal protection.
- Non-profit societies can recruit and engage community physicians, which creates a structured organization responsive to community needs.

Obligations of a society

Once a division has been formed, the division has legal obligations as a society. As societies, divisions are legally obligated to:

- Hold a meeting annually for all members at least every 15 months.
- Abide by the constitution and bylaws of the society and other laws governing societies.
- Send the Annual Report to Registrar of Corporations of BC.
- Report any changes in address or bylaw changes.
- File an annual corporate income tax return within six months of fiscal year-end.
- Abide by Personal Information Protection Act (PIPA).
- Make available a copy of bylaws and constitution to every member.
- Make available a copy of the financial statements to any person requesting them — a division may charge for producing these.

Financial requirements

The *Society Act* (Section 40) states that the board needs to approve any financial statements of the division with the signatures of two directors before the financial statements can be publicly circulated. The process can involve the board approving the financial statements before the annual general meeting (AGM), or asking the members to approve the financial statements at the AGM. If the members are not asked to approve the financial statements, then they are asked to receive the financial statements.

There can be discussion of elements of the financial statements, so members are usually encouraged to ask questions of the treasurer at the AGM. Openness with members is paramount, as the division belongs to them.

A. Maintaining Society Status

There are a number of important steps that each division has to take to maintain their status as a non-profit society.

- Annual Report (Form 11) - Must file an Annual Report each year within 30 days after each Annual General Meeting.
- Change in Address (Form 5) - Notice of every change of address of the society must be filed right away. The address must be a physical address.
- Change in Directors (Form 7) - Every change in directors, other than at an annual general meeting, must be filed immediately.
- Change in Constitution/Bylaws (Form 10) - Any change to the constitution and bylaws of a society must be filed with the registrar on a special resolution form.

Coordinators should review the document "Maintaining your BC society" available at www.bcregistryservices.gov.bc.ca (click on "Forms" button) for more details. Forms are available for download at www.fin.gov.bc.ca/registries.

B. The Annual General Meeting

The annual general meeting (AGM) is the time to present and report the division's achievements to the members. This should include a report on the finances and accounting of the division, as well as milestones and progress on projects over the past year. The AGM can be invigorating and social, and give you an opportunity to engage members more deeply in the division's projects.

The AGM needs to be held within 15 months of the previous AGM or of the date of incorporation.

There are a number of things that need to be done to prepare for the AGM, so it is important to start well in advance. It is a good idea to start planning the AGM at least three or four months prior to the AGM. Be prepared for it to take several planning meetings with the board to ensure that all the details are covered.

The *Society Act* requires that notice of the AGM be delivered to the members of the society in writing at least 14 days in advance. The notice needs to include the meeting's date, time, and location, as well as any special resolutions (i.e., changes to the bylaws). Contact the Business Systems Lead at 604.638.5269 for a sample of an AGM notice.

Notices can be sent by email, regular post, hand delivered, or faxed. It is also a good idea to post copy of the AGM notice in the physicians' lounge and any other areas that physicians frequent. If members attend regular medical education rounds at the hospital, ask the organizer to announce the AGM at rounds. This is a great way to catch a larger audience with an in-person announcement.

Contact the Communications department at 604.638.2840 for a copy of the Communications Toolkit, and refer to the Event Planning section for information on planning events.

Guideline for Planning an Annual General Meeting

Task	Lead	Timeline
Make arrangements for AGM location, food, speaker, etc.	Coordinator	Two months before AGM
Prepare any special resolutions for consideration by members	Board, Members, Coordinator	One month before AGM
chair gets ideas from staff, board, and writes up report on board activities	Chair, Board, Coordinator	One month before AGM (start asking for ideas two months before AGM)

Review policy re: rate of remuneration for board members. Prepare ordinary resolution	Board, Coordinator	One month before AGM
Request year-end financial statements from accountant	Coordinator, Treasurer	At year-end
Committees send draft reports to chair	Coordinator, committee chairs	One month before AGM
Financial statements reviewed and approved by the board	Board, Accountant, Coordinator	board meeting before AGM date
Send notice and extraordinary resolutions to members, candidates for the board, etc.	Board, Coordinator, others	At least 14 days before AGM date
Prepare board orientation manual, if new members are to be elected	Coordinator, board	1 week before AGM
Hold AGM	Coordinator, Board, Members	Date of AGM (probably 1-2 months after year end, depending on the ability of the Accountant to turn around financial statements)
Draft AGM minutes	Coordinator	1-2 weeks after AGM (file for next year)
Review AGM minutes and consider/implement decisions	Board, Members at the next AGM	First board meeting following the AGM
board orientation	Board, with support from Coordinator	First board meeting following the AGM (or at an extraordinary board meeting specifically for orientation)
Write report to Registrar of Companies of BC	Coordinator	Within 3 months of AGM

Section 4 —Division Administration

A. Important Documents and Procedures

The administration of a non-profit society requires that certain steps be taken, and documents filed. The coordinator is the keeper of this information, and is responsible to ensure that the division meets all of the legal requirements for a non-profit organization.

Document of Intent

The Document of Intent (DOI) is an aspirational document that is the foundation of all the work undertaken by a division. Coordinators need to be familiar with the DOI of their division and know where the original documents are kept. Contact the Business Systems Lead at 604.638.5269 for copies.

Constitution and Bylaws

The BC *Society Act* requires all registered organizations to have a constitution and bylaws that set out the rules that govern their activities. Coordinators need to be familiar with the constitution and bylaws of their Division and know where the original documents are kept. Contact the Business Systems Lead at 604.638.5269 for copies.

Any changes to the constitution and bylaws must be approved at an AGM, or an extraordinary general meeting. Approved changes must be filed with the Registrar of Corporations of BC in compliance with the *Society Act*.

Infrastructure Agreement

The Infrastructure Agreement sets out the funding agreement between the division and the BCMA. It is important to be familiar with the content of this document.

Policies

Each division has a responsibility to adopt policies that ensure the division has a plan to deal with privacy and other relevant issues. Coordinators and board members need to be familiar with the policies of their division. Policies should be sent to the Business Systems Lead as well. Refer to the Governance Handbook for more details.

Personal Information Protection Act (PIPA) and Privacy Officer

It is common for a division to appoint the coordinator as the privacy officer of the division. Contact the Business Systems Lead at 604.638.5269 to receive a copy of the Privacy package.

Business Number

A Business Number (BN) is a unique, nine-digit number that the Canada Revenue Agency will assign to a business (or other organization such as a charity) for tax matters related to business in Canada. Having a BN lets businesses and other organizations simplify their dealings with each other, as well as with all levels of the public sector. The business number is required to complete compilation services at the end of the fiscal year.

Divisions receive a business number through the incorporation process. If a division has been incorporated and the number is not delivered to the division, it can be requested from the CRA. The business number is the first nine digits of the GST/HST number.

More information is available in Appendix B: Getting a Business Number.

Business License

Licensing requirements vary from municipality to municipality. The master business license is the most common license required by businesses in BC. Some municipalities also require a municipal business license depending on the type of business being operated. Bylaws are generally available on municipality web sites, or by asking at City Hall to make sure all requirements are met.

WorkSafeBC

All employers in BC are required to register with WorkSafeBC under the *Workers Compensation Act*. Divisions are required to register as soon as they hire anyone on a permanent or contract basis. Application forms are available at www.worksafebc.ca/insurance.

Once the division is registered, WorkSafeBC will make an assessment and determine the amount, if any, of yearly premiums. The amount is determined by the industry and the number of workplace injuries your organization has had within the past three years.

WorkSafeBC can impose fines and penalties if there is a workplace accident and the employer has not registered. In addition, WorkSafeBC can order the organization to pay back premiums for the period of time it should have been registered but was not.

B. Insurance

Operating a non-profit society carries with it many responsibilities. Here are some key points to consider when deciding to purchasing insurance to protect the society and its directors and officers.

Directors and Officers Liability

Divisions are required to have liability insurance for the business aspects of the society that will provide financial protection to directors and officers for any claims arising from that relationship.

A directors and officers liability insurance policy covers a society's directors and officers for defense costs, settlements and judgments for claims by shareholders, customers, creditors, regulators, and other third parties for allegations of unpaid wages, mismanagement, negligence, misrepresentation, customer protection and privacy violations, and copyright infringement. As a general rule, the limit of liability should be equivalent to the assets of the society or the annual funding budget. A directors and officers liability insurance policy may cover contractors as well as directors.

Exclusions include claims that occurred before the policy was effective, dishonest acts, claims made by one director against another director, claims alleging bodily injury, property damage, mental anguish, and emotional distress.

Commercial General Liability

Most leases will require this coverage for a society in order to rent space. This covers the society against general business liabilities including any bodily injury, such as slip and fall, and property damage suffered by members of the public while on the premises. It also covers against personal injury such as libel and slander. A high limit is preferable, basically as much as the budget for insurance will allow. Please note, this is different from medical malpractice liability insurance.

Office Contents

Contents of a typical office include computers, laptops, filing cabinets, and office furniture. It is important to make sure that these items are all insured on a replacement costs basis so that the items will be replaced with brand new items if they are lost, damaged, or stolen. The total replacement cost of all office contents and equipment should be taken into account when choosing a limit of insurance to avoid additional expenses from being under-insured.

Leasehold Improvements

When renting office space, most leases typically make the tenant responsible for all improvements and renovations made to the space, even if the tenant did not have to pay for them at the start of the lease. As a result, most tenants are responsible for repairing or replacing any improvements that have

been done to their space following a fire or a water damage loss. This can amount to many thousands of dollars and it is critical to make sure any improvements are included in the limits chosen under your insurance policy.

Employment Practices Liability

For societies with employees, claims can arise from a variety of exposures including discrimination based on sex, age, illness, harassment, assault, demotion, unfair dismissals, and emotional distress at work. Employers face potential awards granted by both administrative tribunals and courts of law. This type of coverage can provide insurance to pay out for punitive damages and also provide access to a hotline for free legal advice when situations occur. It can usually be purchased as an extension to the directors and officers liability insurance.

C. Obtaining your Infrastructure Funding

For the initial infrastructure funding transfer to take effect, the following must be in place:

- Directors and officers liability insurance in place.
- A resolution by the board to manage the infrastructure funds of the division has been approved by the board.
- A bank account has been established and signing officers have signatures in place with the bank (at least two board members).
- A bookkeeper has been hired and software has been set up with the chart of accounts and is able to provide financial statements.
- The Infrastructure Agreement has been executed by the BCMA and the division.

When the above process has been completed, the treasurer will send the funds transfer letter to the provincial Divisions office. The coordinator will ensure that all submitted invoices are processed, and will not accept new invoices from the date of receiving the letter. The finance department will perform a reconciliation and then wire transfer the amount remaining directly into the division's bank account.

Once the funding transfer has been initiated, the BCMA will no longer provide financial services (this includes electronic funds transfers (EFTs) for sessional payments for meetings, financial statement data, payment of accounts payable, etc.). The ownership and responsibility for the financial position of the division will be controlled by the division itself.

The provincial Divisions team will remain available for any support and assistance required in establishing the books and records for divisions.

See the *Financial Systems Handbook* for more information.

D. Payment Processes

The BCMA will administer all payment processes of a division until the time that the division has completed the initial funds transfer process.

BCMA and Divisions of Family Practice Meeting Attendance and Claims

A meeting attendance list is required for each meeting. The following information is needed:

- A list of attendees, including MSP number
- Location
- Date
- Meeting start and finish time.

This will assist the internal payment process and can be emailed or faxed *following each meeting.* The Divisions of Family Practice provincial team has a standard attendance list template that should be used for meetings; contact the Project Coordinator at 604.638.2895 to receive a copy.

Meeting claims — Sessional payment form

Each physician participating in a division meeting can submit claims for attendance at division meetings on a sessional payment form (contact the Project Coordinator at 604.638.2895 to receive a copy) to the provincial Divisions office for payment. The form must be signed or approved by the lead physician before being submitted for processing.

Completed sessional forms should be forwarded by email or fax *within one month of the meeting date.*

Preparation Time Claims — Spreadsheet and Sessional Form

Use these forms when claiming time spent developing the division infrastructure. Lead physicians normally claim prep time for their extensive work in the development phase of the division.

A detailed record of time spent should include:

- Name and MSP number
- Dates worked
- Hours worked
- Brief description of work undertaken.

The spreadsheet of hours worked must then be summarized on one sessional form stating the range of dates, times (in 24-hour time), and total number of hours being claimed. Both the spreadsheet and sessional form need to be approved by the appropriate signatories before being emailed or faxed to the provincial Divisions office on a monthly basis.

Call the provincial Divisions team at 604-638-2895 (1-800-665-2262) with any questions.

Section 5 — Additional Staffing

It is important that the coordinator has the necessary support to ensure all work is undertaken effectively. Securing the services of an administrative assistant, a bookkeeper, or both can ensure the efforts of the coordinator are focused on the development of the division, and not on administrative or financial details.

The Physician Engagement Lead is also able to help coordinators with staffing and human resources matters.

Support Staff — When to Hire an Administrative Assistant and Bookkeeper

When a division meets regularly, a significant amount of time is required for logistics and administration. The administrative work of setting up and organizing meetings, processing sessional payments, and distributing information is more cost-effective if it is done by someone paid an administrative assistant rate, rather than a coordinator's rate of pay.

A bookkeeper is often engaged early in the development of a division. Contact the Physician Engagement Lead for information and support to hire a bookkeeper.

Alternative Support — Packaged Office Services

A packaged office service or virtual administrative assistant can provide the needed support before a division reaches the point where there is enough work to hire someone part-time. Packaged office services can help meet a project deadline, handle specific tasks, or provide support for a limited time each week.

Virtual assistants provide administrative support for their clients without having to be located in the client's office. Virtual assistants can be paid by the hour or by the job.

Services can include:

- Reception services
- Personal phone answering in your division's name (off-site call transfer services to your cell, home office, etc.) and voice mail
- Mail delivery and handling, and receiving courier packages
- Word processing, database management, and desktop publishing
- Bookkeeping
- Conference and meeting planning.

Section 6 – Communications and Branding

Effective communications results in the right message delivered to the right people at the right time and in the right way.

Communication is an important tool for building consensus and forming partnerships. It can help divisions manage change, both internally and with their partners and community.

Whether the division is promoting events or program, sharing experiences with other divisions and colleagues, or recruiting staff, members or volunteers, it all starts with a plan.

Coordinators can create a communication plan using the template found in the Communications Toolkit. The communications plan acts as a roadmap to identify:

- **What** you want to say.
- **Why** you need to say it.
- **Who** you want to say it to.
- **How** and where to best reach these people or groups.
- **When** to reach them and how frequently.
- And, most importantly, did the audience hear and understand the message?

Coordinators will find a more detailed collection of ideas and strategies in the Communication Toolkit. Again, contact the Communications department at 604.638.2840 to receive a copy.

A. Using the Divisions Logo

A consistent look for Divisions of Family Practice materials will help to ensure that the program is recognized locally and provincially as a collaborative effort to improve primary care in BC. The Communications department has created a Community Divisions Style Guide to provide clear direction on where and how to use the logo. Each Division receives the Style Guide with the logo materials.

Each division has an identity package designed specifically for its community. Divisions are encouraged to use these materials for all communications, such

as events, business cards, and board meeting agendas.

B. Division Websites

The Divisions of Family Practice website (www.divisionsbc.ca) facilitates communication and information-sharing both around the province and within communities that create a division.

The Communications department can provide information and support when the division is ready to start developing its web pages on the provincial website.

C. Working with Media

Interaction with media usually happens in one of two ways:

Proactive: when you contact the media in the hopes of getting a story or event covered. When you are making plans to approach media about a possible story or event, advise the Communications department. The Communications department can advise of other activities that may be related or perhaps in conflict with your story in the same timeframe.

Reactive: when a reporter contacts you for comment on a particular topic or idea. When a reporter contacts you, or perhaps requests a detailed interview:

- Ask the reporter about his/her deadline. Some stories are written for the next day, which generally means a 3 p.m. deadline on the same day as he/she is calling. This means the reporter needs to interview a spokesperson, research the topic, and write the story by 3 p.m., so time is extremely limited. Other stories may have longer deadlines, which might mean that you have more time.
- Contact the Communications department, who can help you identify spokespeople and key messages, and will help prepare information for the interview.

Section 7 — Recruitment and Engagement

Divisions of Family Practice is, at its core, a grassroots initiative to strengthen the voice of family physicians and improve patient care at the community level. The success of each local division relies on the effective recruitment and engagement of family physicians to take ownership of the vision and drive the initiatives.

The provincial Divisions team has resources and materials to support coordinators. Each division has a Physician Engagement Lead to help the coordinator recruit physician members and engage them in the division's activities.

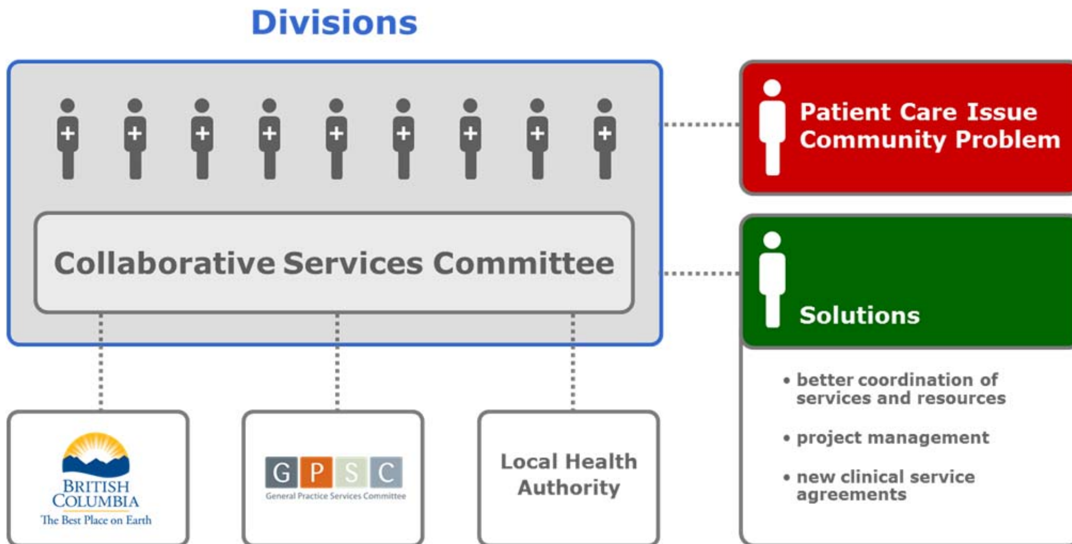
Coordinators can reference the document Division Initiatives, available through the Physician Engagement Leads for stories and examples of other divisions' activities. Case examples, including stories about member engagement, are also available at www.divisionsbc.ca.

Section 8 — Collaborative Services Committee

What is a Collaborative Services Committee?

A Collaborative Services Committee (CSC) is a local committee comprised of representatives of the division, the local health authority, and the GPSC. In many ways it is a local recreation of the GPSC. Division doctors work together as equal partners with the other representatives. The partners work collaboratively, discuss the issue, and develop solutions to address it.

The solution may be something that is resolved by better coordination of services and resources, it may require a small amount of project management and change management support, or it may require a new clinical service agreement. See the diagram below for a depiction of the structure of a CSC.



Does my Division Need a CSC?

A Collaborative Services Committee is formed when the board has confidence that it understands the issues important to its members and one of them is complex or involves patient care. A complex issue can't be solved by the physician community alone; the division needs support and, in many cases funding, from other partners. A division wouldn't need a CSC to discuss ordering stationery and medical supplies in bulk, but it would to consider changing how home care is allocated in the community. Any change to patient care will require involvement of the partners, as the discussion may change

how physicians work in a health authority facility or how physicians are compensated by the Ministry of Health.

How Do We Start a CSC?

When a division is ready to start a CSC, the Physician Engagement Lead from the provincial Divisions team will help with its formation. The Physician Engagement Lead will attend CSCs to help the partners understand and carry out the new way of working together. If the coordinator or board is uncertain if a CSC is needed for an issue, the Physician Engagement Lead is available for guidance.

Who Sits on a CSC?

A CSC is co-chaired by a physician from the division and someone from the health authority. One or two other doctors, one or two other health authority representatives, and a representative from the GPSC will make up the permanent membership of the CSC. There is also strong encouragement to add community and patient representation to a CSC, though it can take a few meetings to decide what kind of representation is needed.

Meeting attendance will be dictated by the topic under discussion. Other physicians leading issue-specific working groups and various people within the health authority will attend when their issue is on the agenda. As well, the board will invite community groups to inform or support the work under way. For example, to address the immunization of children it would make sense to ask a representative of the school board for input, but they would not attend when the issue in front of the CSC is the management of the frail elderly.

How Does a CSC Work?

The CSC is based on the principles of collaboration and co-design:

- Collaboration means listening to all the perspectives at the table, because there is an assumption that more information is better. There is a fundamental need to respect the knowledge and interests of every partner at the table.
- Co-design means that one partner cannot present a ready-made solution and demand it be given to them. In the context of the CSC, all partners will agree an issue is important, all partners offer what data they can to help make a good decision, and all partners contribute to the design of a solution that everyone agrees is likely to improve things.

- The CSC is *not* intended to replicate a negotiation table.
- A CSC operates by consensus, which means that everyone at the table supports a decision and understands how it was reached. This may mean that not everyone gets everything they want every time, but it does mean that there is wide support for what is decided by the group. This is relatively easy to achieve at a CSC because all solutions contain continuous quality improvement principles.
- Continuous quality improvement principles mean that any solution will be evaluated in a few months to see if it is working. If it isn't, then all the partners will work together and figure out how to make it better. Knowing that a solution isn't permanent and final makes it easier to agree with the group. At the first CSC the partners will work through a Terms of Reference template to help define this way of working together.

How Will a CSC Decide on Issues to Prioritize?

The guiding principle for all Divisions of Family Practice work is the Triple Aim:

- Improved experiences for both patients and family doctors.
- Improved population health.
- A more sustainable health care system.

Therefore, when considering issues to prioritize, encourage the board to evaluate the various issues using the Triple Aim:

- Will addressing this issue lead to better experiences with the medical system for both patients and physicians?
- Will improving this situation also improve the health of residents of our community?
- Will addressing this issue help to reduce costs and therefore create a more sustainable health care system?

What is the role of the coordinator at the CSC?

The role of the coordinator at the CSC will depend, in part, on each coordinator's relationship with their division. They will likely be responsible for ensuring minutes are taken and distributed, as well as other administrative aspects of running the meeting. However, the best way a coordinator can support their division is to ensure they understand the principles of the CSC, including collaboration, co-design, and the Triple Aim. This way, they can ensure that the board is collecting information from their members in a way that is compatible with the principles of the CSC.

Fundamentally, the coordinator needs to ensure that the doctors do not bring pre-determined solutions to the committee for discussion.

For example, consider the following two scenarios:

Scenario 1: ***"Our problem is that we don't have a clinic at Main and 3rd Street."***
By presenting this problem, the person implies that there is only one solution: a clinic at Main and 3rd Street. If the group decides that a clinic isn't feasible, then that person loses the only solution presented and neither collaboration nor co-design has occurred.

Scenario 2: ***"Our problem is that the area around Main Street is under-served for primary care and there are lots of young families."***
The problem presented in this manner offers lots of possible solutions. All partners will have knowledge that can be useful to designing a solution that is innovative, good for patients, and good for physicians.

The board will need to model collaboration and co-design to the CSC members, who will likely not understand why it is better than negotiation. They will need the coordinator's support to do this. Additional assistance is available by contacting the Physician Engagement Lead.

Debate vs. Dialogue

Debate	Dialogue
Assuming that there is one right answer (and you have it)	Assuming that others have pieces of the answer
Combative: attempting to prove the other side wrong	Collaborative: attempting to find common understanding
About winning	About finding common ground
Listening to find flaws	Listening to understand
Defending your assumptions	Bringing up your assumptions for inspection and discussion
Criticizing the other side's point of view	Re-examining all points of view
Defending one's views against others	Admitting that others' thinking can improve one's own
Searching for weaknesses and flaws in the other position	Searching for strengths and value in the other position
Seeking an outcome that agrees with your position	Discovering new possibilities and opportunities

Section 9 — Division Initiatives

Division initiatives, such as Hospital Care programs or Residential Care programs, are constantly evolving. The coordinator's role is to understand the current programs and any challenges they may have. They can work closely with the board members to improve the programs that are currently running.

As a division considers new programs, the coordinator will play an important role in connecting with partners, researching, sourcing, and providing information for the board to help in decision-making and program development. A comprehensive document, Division Initiatives, is available through the Physician Engagement Leads for review.

Division initiatives are generally between the division and one or more partners (e.g., the Ministry of Health, the local health authority, and/or a local community partner). Partner Agreements and Terms of Reference for these initiatives ensure that each partner understands and has agreed to the terms of the partnership.

Partner Agreements

A typical partner agreement outlines the scope of the project and the expectation on the deliverables from each partner. It outlines data that needs to be collected, the reporting schedule, and the obligations of each partner. Partner agreements are usually signed by the division lead physician and an authorized representative of the partner in the agreement.

The coordinator may be asked to review partner agreements and co-design the terms of the agreement on behalf of the division. The Physician Engagement Lead will sign off on the agreement, but much of the work to reach consensus will be facilitated by the coordinator.

It is also important that the coordinator understands the terms of each agreement and is able to communicate them to the board and to any members that ask. The coordinator is responsible for ensuring that the terms of each agreement are respected.

The division may already have Terms of Reference for one or more programs. It is important that the coordinator clearly understands the terms and obligations of the contract. They may be relied upon to explain or clarify elements of the Terms of Reference.

Each agreement spells out what kind of reporting the division needs to provide. It is the coordinator's responsibility to ensure each program runs smoothly and the Terms of Reference are being met by both the division and the partner organization(s).

Every agreement has a fixed term. As the Terms of Reference are set to expire, the coordinator may be asked to participate in the collaborative

process for the new agreement. They will need to be able to speak to the details and co-design the new Terms of Reference on behalf of the division.

Take time to read through each agreement and review each one on a regular basis to ensure the division fulfils its terms of the Terms of Reference.

Connecting with Partners

As it grows, the potential of the division to work with different partners will expand. Partners, as mentioned earlier, can include the local health authority, the Ministry of Health, community health service providers, or other non-profit organizations. It is important to build and maintain strong relationships with possible partners. Community partners will be key to supporting the division's work to improve the health of the residents in the community. Community partners may include:

- Health care organizations that support the health care goals of your community, e.g., Youth and Family Services, home care groups, etc.
- Patient advocacy organizations, e.g., Patient Voices Network (www.patientvoices.ca).
- Other non-profit organizations, e.g., Rotary Club, Scouts, and Girl Guides.
- Municipal groups.
- Local businesses, e.g., bicycle shops sponsoring a division's health-related activities, fitness centres offering reduced rates for patients who bring in a doctor's note, etc.

As the coordinator builds relationships with representatives of these groups they will find others who want to work with the division on specific projects. Community partners are great resources for helping a division understand some of the health care needs of the community that may not be immediately apparent to the board or members. They can also present opportunities that the division may not be aware of.

The coordinator will be the key contact with these partners on behalf of the division. Check with the mayor's office to see if there are regularly scheduled meetings focused on health care in the community. Many cities may have a Mayor's Health care Committee, which is a great way to network with key community health care partners.

Appendix A:

The following is an overview of documents or templates that are available through the Business Systems Lead (604.638.5269):

- Sample Documents, including:
    - Document of Intent
    - AGM notice
    - Funds Transfer Letter

- Templates:
    - Attendance list for meetings
    - Sessional payment forms

- Reference Folders:
    - Communications Toolkit, including:
        - Event Planning
        - Communication Plan
        - Ideas and strategies

    - Society Folder:
        - Constitution & bylaws
        - Policies

    - Privacy Package – information about the Personal Information Protection Act (PIPA)

- Division Initiatives – reference document

Appendix B: Getting A Business Number

Fill out the Business Consent form (RC-59) and have it signed by a board member. This form gives the CRA consent to deal with you as a representative of the division.

Send a list of your board members along with the RC-59. The list of board members will be located alongside the incorporation documents. Copy this list and include it with the form. The board member who signs the form ***must*** be on this same list of board members you include with the consent form.

Also include a letter from the board chair giving the CRA consent to release information to you, the coordinator.

One to two weeks after submitting the RC-59, call the CRA (1-800-959-5525) to confirm that they have received the form.

If the CRA has received the documents you can ask for the BN at this time. The CRA will inform you if all the documentation is correct.

Continue to check back if you do not obtain your BN on the first call. Not all situations are handled the same and additional information may be requested.

Once you obtain your business number, keep it with your incorporation documents for easy access.

The Canada Revenue Agency requests that all new registrations provide the name and the social insurance number of at least one owner/director of the business and the major business activity when registering.

Appendix C — Useful Links

Divisions of Family Practice	www.divisionsbc.ca
General Practice Services Committee	www.gpscbc.ca
BC Medical Association	www.bcma.org
Ministry of Health	www.gov.bc.ca/health/

Health Authorities

Vancouver Coastal Health	www.vch.ca
Fraser Health	www.fraserhealth.ca
Interior Health	www.interiorhealth.ca
Northern Health	www.northernhealth.ca
Vancouver Island Health	www.viha.ca

BC Registry Services	www.bcbusinessregistry.ca
Human Resources and Skill Development Canada	www.hrsdc.gc.ca
Societies Act of BC	www.bclaws.ca

Appendix D — Glossary

BCMA – British Columbia Medical Association. The BCMA is a voluntary association with over 11,000 members. The BCMA represents the collective view of the medical profession of BC. The BCMA negotiates for and on behalf of physicians for their compensation, sets medical service fee schedules, and is a division of the Canadian Medical Association.

CCFP – Certificant of the College of Family Physicians. Upon successful completion of both an approved training program and the Certification Examination in Family Medicine, a family physician is awarded Certification in Family Medicine and is able to use the designation CCFP

CPSBC – College of Physicians and Surgeons of British Columbia. The CPSBC oversees licensing and disciplining of physicians.

CSC – Collaborative Services Committee. See Section 8 for detailed information.

FPs4BC – Family Physicians for British Columbia. An initiative to attract and retain family physicians in BC. This program awarded significant funding to under-serviced areas to attract, recruit, and retain family physicians.

GP – General Practitioner.

GPMRP – General practitioner – most responsible physician. This is the GP who is the one most responsible for a given patient. This physician is typically the patient's family physician. If the patient does not have a family physician, the GPMRP is the GP "assigned" to be responsible for that patient when they are in need of medical care.

GPSC – General Practice Services Committee. The GPSC is a joint committee comprised of members from the BCMA, the society of General Practice (SGP) and the Ministry of Health. The GPSC was formed under the 2004 agreement between BC physicians and the provincial government. The committee has eight representatives (two from the SGP, two from the BCMA, and four from the Ministry of Health (MoH). The committee was formed to develop and implement strategies that allow for the optimum use of the cumulative total of $382 million designated within the 2004/2005 agreement to support improvements in primary care. Some of the initiatives of the GPSC include Divisions of Family Practice, Family Physicians for BC, Practice Support Program, and Full Service Family Physician Incentive Program.

HA – Health authority. There are currently five health authorities in BC: Northern Health, Interior Health, Vancouver Island Health Authority,

Vancouver Coastal Health, and Fraser Health. This structure, introduced in December 2001, modernized a complicated, confusing, and expensive health care system by merging the previous 52 health authorities into a streamlined governance and management model.

HCP – Hospital care physician. The HCP (or house doc) becomes the GPMRP for patients admitted into hospital without a family physician, or patients admitted to hospital who have a family physician, but their family physician does not have hospital privileges. The HCP remains the MRP for the length of the patient's stay in hospital.

IHN – Integrated Health Networks. IHNs link GPs/FPs with coexisting health authority and community resources. Its goal is to improve coordinated community care through an integrated team of providers wrapped around high-need priority patient populations. IHNs are designed to shift the patient experience from multiple, fractured services to a patient-centred experience that focuses on supporting the central role of the patient in staying healthy and managing their conditions.

MOA – Medical office assistant. Medical Office Assistants are an important part of the health care team, largely responsible for administrative functions.

MoH – Ministry of Health. The MoH is the provincial government body responsible for delivering health care to British Columbians.

MoU – Memorandum of understanding. The MoU is a document describing a bilateral or multilateral agreement between parties. It expresses a convergence of will between the parties, indicating an intended common line of action. It is often used in cases where parties either do not imply a legal commitment or in situations where the parties cannot create a legally enforceable agreement. It is a more formal alternative to a gentleman's agreement.

PITO – Physician Information Technology Office. PITO was set up by the BCMA and the BC government as part of the 2006-2012 Agreement. PITO was given $20 million (which annually increases to $24 million by 2012) in one-time funding to coordinate the implementation of IT products (mainly electronic medical records (EMR) systems) and services between GPs/FPs and vendors.

PSP – Practice Support Program. The PSP is a joint initiative between the BCMA, the MoH, and the local health authorities. PSP supports physicians and their office staff to implement practice enhancements in the areas of clinical work, practice management, and information management and technology. PSP supports evidence-based practice changes that have been shown to

improve patient care. The PSP develops learning modules and makes them available to physicians in small group learning sessions. There are currently four modules available: Advanced Access, Chronic Disease Management (CDM), Patient Self-management, and Mental Health.

SGP – Society of General Practitioners of BC. The SGP speaks for and represents the views of GP/FPs in BC. It represents GPs at the BCMA. There are two members of the SGP who sit on the GPSC. The SGP advocates for the GP role in primary care. It negotiates for improved funding through the GP Subsidiary Negotiation Committee and develops proposals to remunerate work done by GPs/FPs. It is also used to allocate negotiated funds.

Appendix E: Organization Evaluation

This list, adapted from "EFFECTIVE BOARD GOVERNANCE: A Handbook for Board members and Administrators of First Nations' boards," provides a useful framework for assessing the overall health of the Division and its processes.

		Yes	No
1.	The board provides a comprehensive orientation for new board members.	❑	❑
2.	The board encourages, supports and participates in ongoing training in governance.	❑	❑
3.	Board members are knowledgeable and well informed regarding the organization's programs and services.	❑	❑
4.	The board encourages and supports innovation and change.	❑	❑
5.	The board has a written mission statement which clearly defines the organization's purpose, and is the foundation for board decision-making.	❑	❑
6.	The board's written vision statement clearly describes the desired future for the organization and the community.	❑	❑
7.	The board annually approves organizational goals, consistent with its vision, which are regularly reviewed and discussed by the board and the coordinator.	❑	❑
8.	Additionally, the board sets annual board goals that list areas for board focus and improvement.	❑	❑
9.	The board's decisions and direction reflect a commitment to the organization's stated mission, vision and goals.	❑	❑

10. The board commits to the concept of the board as a corporate body. The board speaks with one voice. .... ❑ ❑
11. Board members understand that they do not have any individual powers, and that they cannot make decisions, or take action. .... ❑ ❑
12. Board members respect diversity and the opinions of others. .... ❑ ❑
13. The board subscribes to a board code of ethics that sets expectations for board member behaviour and conduct. .... ❑ ❑
14. Board meetings are conducted in a business-like manner according to established rules of order. .... ❑ ❑
15. Agenda topics for board and board committee meetings relate to governance, analysis and physician issues, not administrative issues. .... ❑ ❑
16. The board receives information (e.g., agendas, minutes, reports, etc.) in a timely fashion. .... ❑ ❑
17. Each board member is given the opportunity, and is encouraged, to express an opinion on any board matter under consideration. .... ❑ ❑
18. Disagreement and divergent opinions of board members are encouraged, and are perceived as a healthy and necessary aspect of board discussion. .... ❑ ❑
19. Minutes of board meetings clearly state board decisions and direction, and are distributed in a timely fashion. .... ❑ ❑
20. The board expects follow-up to board decisions, and checks to ensure that such follow-up occurs. .... ❑ ❑
21. The board is willing to directly face tough issues and make tough decisions. .... ❑ ❑
22. The board appoints the coordinator as the organization's lead staff person. .... ❑ ❑
23. The board's actions demonstrate its trust, confidence and support for the coordinator. .... ❑ ❑
24. The board has communicated its expectations for job performance, in writing, to the coordinator. .... ❑ ❑
25. The board and the coordinator meet regularly to review and discuss progress towards annually approved goals. .... ❑ ❑
26. The Division (or Physician) Lead and coordinator have an effective working relationship. .... ❑ ❑
27. The board and the coordinator work together as a team, and are perceived by staff and constituents to be effective in their ❑ ❑

respective roles. ....

28.	The board includes the coordinator in all board meetings and discussions.	❑	❑
29.	The board receives detailed and comprehensive information, reports, and advice from the coordinator, in a format easily understood by board members.	❑	❑
30.	For substantive issues, the board's communication with staff, and the staff's communication with the board, is through the coordinator.	❑	❑
31.	Board members do not direct staff activity, nor do they interfere in staff matters that are the jurisdiction of the coordinator.	❑	❑
32.	The board and coordinator both acknowledge staff successes. ...	❑	❑
33.	The board's policies are enabling, not restrictive.	❑	❑
34.	The board's policies provide clear direction.	❑	❑
35.	The board has clarified, in writing, the process and criteria for the development of the organization's annual budget.	❑	❑
36.	The organization's budget supports and is directly linked to redefined, board-approved goals.	❑	❑
37.	board members are knowledgeable about, and understand, their organization's budget.	❑	❑
38.	The board has a process in place for monitoring budget expenditures.	❑	❑
39.	The board's focus is on measurable results, and not solely on the activities and efforts of staff.	❑	❑
40.	The board supports the ongoing evaluation of the organization's programs, services and personnel.	❑	❑
41.	The board has a communications program.	❑	❑
42.	The board communicates information to its members and the public through a variety of methods.	❑	❑
43.	The board seeks input from its members on important matters affecting the organization.	❑	❑
45.	Members speak positively about the board, and the board's success in achieving desired results.	❑	❑
46.	The board is perceived as a strong advocate for family physicians and patient health.	❑	❑

47. The board conducts a board self-assessment with the goal of enhancing board effectiveness. .... ❑ ❑

Appendix F: Coordinator 360 Degree Evaluation

Every year, a 360-degree evaluation for the coordinator needs to be carried out by a member of the board who is seen as neutral. They may seek help from other board members if required.

The following is a list of potential questions that could be asked as part of an annual review.

Questions for board member (preferably the division lead)
Where are the coordinator's strengths and areas for improvement in supporting the board?
Where does the coordinator need support in managing and operating the division?
Do you have any significant concerns about the performance of the coordinator?

Questions for staff or contractors reporting to coordinator
Does the coordinator appropriately define work assignments and set expectations for performance?
Does the coordinator support you in achieving your goals?
How would you describe your working relationship with the coordinator?

Questions for division partner (Ministry, Health Authority or other community contact)
How would you describe your relationship with the coordinator?
Is the coordinator an able representative of the interests of the division?
Are there any areas you would recommend the board of the division offer additional support?
Do you have any significant concerns about the performance of the coordinator?