ANNUAL REPORT 2016

Shared Care Committee (SCC)

SharedCare
Partners for Patients

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Committee Background/History

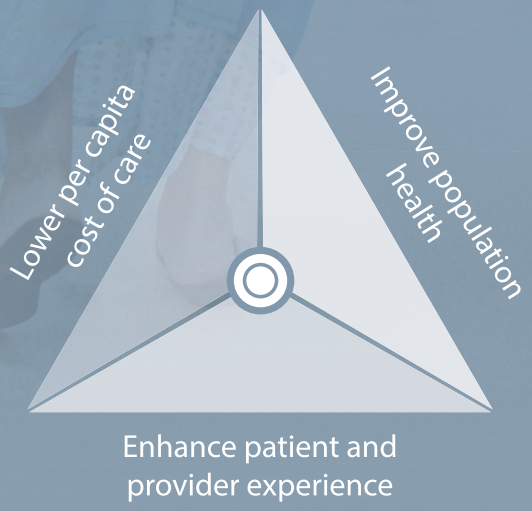
The Shared Care Committee (SCC) is one of four Joint Collaborative Committees of Doctors of BC and the Ministry of Health working to improve health outcomes and the patient journey through the health care system. The SCC was formed in 2006, per article 8.1 of the 2006 Physician Master Agreement between the Ministry of Health and Doctors of BC, to improve shared care between family and specialist physicians and other health providers.

The relationship between family and specialist physicians, and other health providers, is fundamental to the delivery of effective health care, especially for the most complex patient populations.

Shared Care Initiatives help build and strengthen this relationship by fostering mutual trust, respect, and awareness of provider responsibilities and expertise to maximize success of their quality improvement projects. With effective collaboration between family and specialist physicians and partners, Shared Care work sets the foundation for a culture of collegiality and team based care to ensure a coordinated experience for patients in BC's health care system.

Committee Mission/Vision/Mandate

THE WORK OF THE SHARED Care Committee is grounded in the principles of patient-centred care and the quality improvement methodologies of the Institute of Health care Improvement. In alignment with the Ministry of Health, the Shared Care Committee frames its efforts at system improvement around the three overarching goals outlined as the Triple Aim.



Shared Care Vision

Collaboration at all levels supports a coordinated care experience for patients and families

Mission

To engage family and specialist physicians in collaborative, team-based initiatives to improve the flow of patient care, trial innovative solutions and address inefficiencies and gaps in the health care system

Mandate

Develop recommendations to enable shared care and appropriate scopes of practice, and improve collaboration between family and specialist physicians and other health professionals to meet patient needs

Principles

Effective Engagement • Calculated Risk Taking • Enable Innovation • Foster Culture Change • Challenge the Status Quo

Co-chair's Message

2015-16 has been an active year for the Shared Care Committee, and the many initiatives with which it partners across the province. We've been pleased to see several of our initiatives achieve success and recognition – for example, four of our initiatives received awards this year celebrating innovation, team work, and leadership. These were; the Child and Youth Mental Health and Substance Use (CYMHSU) Collaborative; Rapid Access to Psychiatry; Northern Partners in Care, and a Partners in Care e-notification project. We've also seen the pioneering Rapid Access to Consultative Expertise (RACE) initiative beginning to spread across Canada, while continuing to be refined and adapted locally and regionally across the province.

System Change:

Our largest initiative, the Child and Youth Mental Health and Substance Use Collaborative, has now spread to 64 communities across the province and is now in its final year, with support from all of the Joint Collaborative Committees. Over 2,000 people are now working to achieve the 'tipping points' needed for a transformed system of care for young people with mental health and substance use issues.

Creating a Culture of Collaboration:

Physicians all across the province are working in partnership with Shared Care in their communities, and taking the initiative to lead improvements, trial innovative ideas, and build new relationships between family and specialist physicians, allied health providers, patients, community organizations and health authority leaders.

These local activities address issues of importance to patients and health providers, and at the same time contribute to the development of a culture of collaboration that provides a foundation for quality health care. Creating this collaborative culture – in addition to the specific care improvements achieved – cannot be overstated in its importance. What truly matters to patients and providers is the basis for achieving improvements within the Triple Aim Quality Improvement Framework, facilitating our collective ability to work together to improve the BC health care system.

As co-chairs, we would like to extend our thanks to the members of the committee for their engaged participation, and our sincere appreciation of the efforts of general practitioners and specialists across the province in providing leadership in health care transformation.

List of committee members

Shared Care Committee

Doctors of BC

Dr. Gordon Hoag, Co-Chair*

Dr. Ken Hughes*

Dr. Jiwei Li*

Dr. Emiko Moniwa (Alternate for **Dr Ken Hughes**)

Dr. Shelley Ross*

Dr. George Watson*

Ministry of Health

Ms. Marilyn Copes, Co-Chair*

Mr. Kevin Brown*

Ms. Michele Lane/Mr. Brendan Abbott*

Dr. Garey Mazowita*

Health Authorities

Dr. Charl Badenhorst, First Nations Health

Dr. Curtis Bell, Interior Health

Ms. Marie Hawkins, Fraser Health

Ms. Candice Manahan/Mr. Ciro Panessa, Northern Health

Ms. Carol Park, Vancouver Coastal Health

Ms. Pam Aikman Ramsay, Provincial Health Services

Dr. David Robertson, Island Health

Guests

Dr. Jillianne Code, Patient Partner

Dr. David Haughton, Section of Emergency Medicine

Ms. Iris Kisch, Patient Partner

Staff Support

Ms. Bethina Abrahams, Initiatives Lead, SCC

Ms. Lisa Despins, Communications Officer, SCC

Ms. Margaret English, Initiatives Lead, SCC

Ms. Nancy Falconer, Initiatives Lead, SCC

Ms. Alana Godin, Executive Lead, Joint Clinical Committees and Practice Support

Dr. Brenda Hefford, Executive Director, Practice Support & Quality

Ms. Katie Hill, Executive Lead, SCC

Ms. Salimah Lalli, Business Operations Analyst, SCC

Ms. Anne Marie Locas, Initiatives Lead, SCC

Ms. Angela Micco, Secretariat, Ministry of Health

Ms. Nikita Soares, Program Coordinator, SCC

Mr. Gary Sveinson, Initiatives Lead, SCC

Ms. Valerie Tregillus, Project Director, CYMHSU Collaborative

** Voting Member*

Performance: Year in Review

Child and Youth Mental Health and Substance Use (CYMHSU) Collaborative

Overview:

During 2015/16, the Child and Youth Mental Health and Substance Use (CYMHSU) Collaborative has continued to build momentum, with the number of communities involved significantly increasing over the past year with the establishment of new Local Action Teams (LATs). The Collaborative has made major inroads in reducing barriers at local, regional, and provincial levels, with LATs continuing to focus on local challenges in their communities, and eleven working groups tackling system barriers at the provincial level. As the Collaborative enters its final year, the focus remains on co-developing clear pathways to care locally, regionally and provincially, and collectively reaching the "tipping points" to confirm a transformed system of care now and in the future for children, youth, and families in BC.

Child and Youth Mental Health and Substance Use (CYMHSU) Collaborative

Results/Accomplishments:

- **Recognition:** The CYMHSU Collaborative won a national award from the *College of Family Physicians of Canada* and the *Canadian Psychiatric Association* in recognition of innovation and team-work.

- **Increased participation:** The number of Local Action Teams in BC communities increased from 24 to 64, and number of participants from 500 to over 2000.

- **Learning Session 7:** In March, 2016, the collaborative held its largest learning session to date, with over 500 attendees gathering to share successes, challenges, and innovative ideas for continued improvements. Dr Hedy Fry, MP for Vancouver Centre and past president of Doctors of BC, attended on behalf of Prime Minister Trudeau to share a message of support and encouragement for the Collaborative's continued work in leading change in BC.

- **Caring for Youth in crisis:** An ER Protocol has been developed for children, youth and their families presenting in the ER in crisis. The protocol includes improved guidelines, assessment tools, and discharge safety and information for families. Early testing and adoption of the protocol was successful in the Interior, and the protocol will be spread to hospitals in other regions in the coming year.

- **Physician Compensation:** Developed by the Physician Compensation Working Group and partners, a new blended payment model was successfully trialed for psychiatrists in the Interior. The new model will expand to all psychiatrists across BC in the coming year.

- **Fostering communication:** Information Sharing Guidelines have been developed to facilitate collaborative care between providers; these guidelines will be available to communities in early 2016.

- **Survey with over 900 psychiatrists in BC:** A survey was conducted to establish a baseline understanding of psychiatry practice in BC. The psychiatry workforce analysis will assist in the future planning and advocacy for psychiatry resources. Results will be available in 2016.

- **Media engagement:** Over the course of the year, there were a total of 46 newspaper and/or partner newsletter and website articles regarding the Collaborative, mostly featuring the work of Local Action Teams. These include a new eating disorders resource, events and activities for CYMH Day, and an article entitled 'Understanding Self-Harm which followed up on a previous series written by psychiatrist, Dr. David Smith. These and other activities and events are engaging local media to raise the profile and reduce stigma for mental health and substance use issues in communities.

- **Increasing skills and knowledge:** A new online 15 module learning series, "Learning Links" was developed and pilot tested to support pediatricians, general psychiatrics, ER physicians and GPs, as well as other professionals, to enhance their knowledge of various mental health topics. Learning Links is scheduled to be launched in fall 2016.

Budget spent: $5,804,965

(Middle) Cory Reid. Article published May 15, 2016 in the **Vancouver Sun**, ***Once plagued by PTSD and drug addiction, Corey Reid has a new role improving B.C.'s mental health system.***

Partners in Care and Transitions in Care (PiC/TiC)

Overview:

Community-driven activities: These continue to bring specialists and family physicians together to help streamline and bridge gaps in care for their patients. Evaluations consistently show improved care experiences for physicians and patients, especially through the creation—or repair—of productive collegial relationships. These are facilitated through a variety of activities, including continuing medical education, collaborative problem-solving to develop new models of care, refinement of referral and consultation processes, and networking. These opportunities have been recognized in national professional publications and very well received by physicians.

Technological applications: These are increasingly being used to facilitate specialist and primary care consultation and shared care, such as Rapid Access to Consultative Expertise (RACE), telematernity, videoconferencing, and linkages for mobile messaging. Successful prototype elements have been identified and are currently establishing strategies for broader spread and sustainability. RACE has been recognized as a leading practice by Accreditation Canada, and is currently partnering with the Canadian Foundation for Health care Improvement (CFHI) to support spread across Canada and internationally.

Team-based approach: Transitions in Care initiatives focus on a team-based approach to facilitate patient care across health settings. GP collaboration with specialists, allied health providers, and other partners aim to streamline residential care admissions; develop care conferencing models for complex seniors in the community; institute two-way communication for better hospital care, and coordinate hospital admission and discharge, among others.

(Right) Fran La Brash is grateful that visiting specialists reduce her family's need to travel to Penticton for care.

Results/Accomplishments:

- **Victoria:** Collaboration between GPs, Hospitalists, ED Physicians and health authority leaders resulted in the development of an electronic notification of admission, discharge and/or death to family physicians regarding their patients. With all partners involved, the two-way communication was created as a sustainable solution for easy spread region-wide.

- **Vancouver:** Another 'GP Notification of Hospital Admission' project in partnership with Providence Health Care and Vancouver Coastal Health, was recognized with the BEST Patient Safety & Quality Award from Providence Health.

- **South Okanagan:** Specialist Outreach Clinics provided a successful mechanism to improve care for rural patients, and support new family physicians in building clinical skills for local patient care. Telehealth enabled follow up appointments to improve access to specialist expertise, while reducing the impact of travel for rural patients and physicians.

- **Comox:** Family physicians, Obstetricians, Midwives and allied health providers worked collaboratively to align services for maternity care, with a focus on the needs of First Nations and first-time mothers. The partnership engaged community organizations, Island Health and Perinatal Services BC to improve care in a rural setting.

- **Northern BC:** Northern Partners in Care was awarded the Health and Wellness Innovator of the Year award for their Northern RACE Line, a line adapted from the provincial Providence RACE model as a regional resource for Northern BC.

Budget spent: $2,534,082 *(Partners in Care)*
$1,164,121 *(Transitions in Care)*

"To be able to drive change together is really exciting,"
says North Shore family physician, Dr Lisa Gaede.

Teledermatology

Overview:

With the shortage of dermatologists in BC, the Teledermatology Initiative supports the use of digital technology and the Internet to improve access to dermatological consults for family physicians across the province regarding their patients. This provides much needed access for physicians and their patients to dermatology expertise, especially in remote and isolated communities in BC, without the challenges of long wait times and significant travel. The Shared Care Committee is currently finalizing its recommendations for the long term sustainability of this initiative.

Results/Accomplishments:

- A midpoint evaluation report was commissioned and released in fall 2015. The report highlighted the program's growth across the province to now include 11 dermatologists, 1,100 referring clinicians, and 4,200 completed consults. Emergency department and hospital physicians have also begun accessing this service, demonstrating the effectiveness of this approach for both rural and urban settings.

- 94% of referring physicians received a report from the consulting dermatologist within 3 days, 75% within 24 hours.

Budget spent: $143,785

of referring physicians received a report from the consulting dermatologist within

within

Polypharmacy Risk Reduction Initiative (PPhRR)

Overview:

Since the roll out of the Residential Care Initiative (RCI), with the connection to Polypharmacy Risk Reduction (PPhRR) facilitated by the GPSC and SCC co-chairs, the PPhRR initiative has gained significant momentum in residential care across the province. With the Train the Mentor and Building Local Capacity and Sustainability approach, several new divisions have been engaged and others have been re-engaged in the context of the RCI. A number of local physicians have been recruited as faculty to facilitate workshops and develop local processes. Additionally, a strong collaboration has been established with the First Nations Health Authority, and PPhRR prototypes have been developed in Hartley Bay, Williams Lake, Powell River and Skidegate (Haida Gwaii).

In acute care, PPhRR is being prototyped in three medical units and three fractured hip surgical units across the province. This is in order to determine where the most effective improvements could be accomplished at each site based on 'patient medication journey mapping'. Further prototype sites are being engaged.

Results/Accomplishments:

- Polypharmacy Risk Reduction is currently spreading across the province, and is fully integrated into the GPSC's Residential Care Initiative for sustainability. To date, more than 25 Divisions of Family Practice have engaged and initiated plans to implement PPhRR with their residential care physicians.
- PPhRR has prototype work taking place in six acute care facilities, with plans to expand to eight in September.
- A provincial PPhRR evaluation plan was developed and is in the process of being implemented in acute and residential care. Early reports indicate that the initiative is making a significant impact.

Budget spent: $410,737

To date, more than 25 Divisions of Family Practice have engaged and initiated plans to implement PPhRR with their residential care physicians.

Rapid Access to Psychiatry

Overview:

The Rapid Access to Psychiatry (RAP) initiative, led by Dr Ron Remick, completed its prototyping work, and successfully transitioned to a sustainable independent program during this fiscal year. Recognizing the success of the model in increasing patient access to supportive psychiatric care, a revised fee for psychiatric group medical visits was implemented by the Medical Services Commission to more appropriately compensate psychiatrists providing this type of care for patients.

Results/Accomplishments:

- Dr. Ron Remick received the Dr. Nancy Hall Award for Leadership in Public Policy in recognition of leadership in advancing policy changes that make a difference in the lives of people living with mental illness and/or addictions.

- The RAP program has provided more than 6000 psychiatric consultations, at a cost of $500 per patient versus $3,500 (in a private practice setting). The number of consultations is 4.5 times greater than the number of patients seen by a psychiatrist in a traditional setting.

Budget spent: $ 144,047

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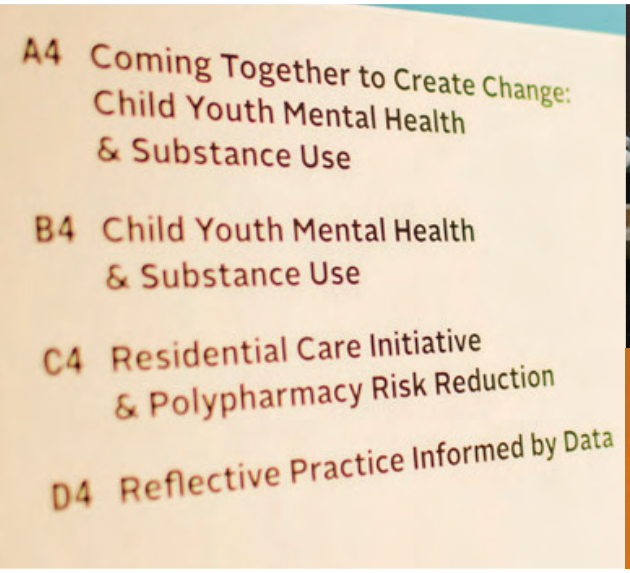
JCC Showcase

Overview:

The Shared Care Committee took the lead in planning and presenting the Joint Collaborative Committee Showcase on February 24th, 2016 in Vancouver. With active participation and support from GPSC and the Specialist Services Committee, the showcase was an opportunity to engage the broader health care quality improvement community and highlight the work of the three committees. Working in partnership with the BC Patient Safety and Quality Council, the showcase attracted 392 participants, including 74 family physicians, 79 specialist physicians, health authority and patient representatives, the Ministry of Health, and others. Three plenary and 28 concurrent sessions presented a wide range of topics and formats and drew a highly positive response from attendees. In addition, linking the showcase with the BC Quality Forum allowed almost 100 physicians to participate in the forum, a major goal for the BC Patient Safety and Quality Council.



The showcase attracted 392 participants, including 74 family physicians, 79 specialist physicians, health authority and patient representatives, the Ministry of Health, and others.

www.sharedcarebc.ca

SharedCare
Partners for Patients

Financial Statements of

SHARED CARE PROGRAMS

Year ended March 31, 2016

KPMG LLP
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Vancouver BC V7Y 1K3
Canada
Telephone (604) 691-3000
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INDEPENDENT AUDITORS' REPORT

To the Members of the Shared Care Committee

We have audited the accompanying financial statements of the Shared Care Programs, which comprises the statement of financial position as at March 31, 2016**,** the statements of operations and changes in net assets and cash flows for the year then ended, and notes, comprising a summary of significant accounting policies and other explanatory information.

Management's Responsibility 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 the financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on the financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform an audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the entity's preparation and fair presentation of the financial statements 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 entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of the Shared Care Programs as at March 31, 2016 and its results of operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

KPMG LLP

Chartered Professional Accountants

July 18, 2016

Vancouver, Canada

SHARED CARE PROGRAMS

Statement of Financial Position

March 31, 2016, with comparative information for 2015

		2016		2015
Assets				
Current assets:				
Cash	$	6,407,359	$	11,948,879
Accounts receivable		6,594,444		2,324,629
Due from GPSC Collaboratives Program (note 6(b))		64,768		394,861
Due from Specialist Services Programs (note 6(c))		91,631		500,000
Prepaid expenses		1,829		510
	$	13,160,031	$	15,168,879
Liabilities and Net Assets				
Current liabilities:				
Accounts payable and accrued liabilities (note 6(a)(i))	$	1,499,314	$	1,006,961
Due to Doctors of BC (note 6(a))		123,369		86,263
		1,622,683		1,093,224
Deferred contributions (note 5)		11,537,348		14,075,655
Net assets		-		-
	$	13,160,031	$	15,168,879

See accompanying notes to financial statements.

Approved on behalf of the Shared Care Committee:

Gordon Hoag — Committee Co-Chair

Marilyn Copas — Committee Co-Chair

SHARED CARE PROGRAMS

Statement of Operations and Changes in Net Assets

Year ended March 31, 2016, with comparative information for 2015

	2016	2015 (recast - note 4)
Revenue (note 5):	$ 14,804,745	$ 11,967,045
Expenses (schedule 1):		
Salaries and benefits	1,595,486	1,144,908
Office and communications	89,388	57,154
Meetings and conferences	970,274	658,131
Transfer to divisions of family practice	7,423,265	5,638,717
Transfer to health authorities	2,398,192	1,794,671
Other transfers	1,584,965	1,945,674
Special projects	-	10,026
Professional fees	307,039	449,848
Education	262,111	175,916
Evaluation	84,025	2,000
Administration fees (note 6(a)(i))	90,000	90,000
	14,804,745	11,967,045
Excess of revenue over expenses	-	-
Net assets, beginning and end of year	$ -	$ -

See accompanying notes to financial statements.

SHARED CARE PROGRAMS

Statement of Cash Flows

Year ended March 31, 2016, with comparative information for 2015

	2016	2015
Cash provided by:		
Operating activities:		
Excess of revenue over expenses	$ -	$ -
Change in deferred contributions	(2,538,307)	4,248,026
Change in non-cash operating working capital:		
Accounts receivable	(4,269,815)	(2,324,629)
Due from GPSC Collaboratives Program	330,093	(694,674)
Due from Specialist Services Programs	408,369	(503,973)
Prepaid expenses	(1,319)	(510)
Accounts payable and accrued liabilities	492,353	131,494
Due to Doctors of BC	37,106	100,979
Increase (decrease) in cash	(5,541,520)	956,713
Cash, beginning of year	11,948,879	10,992,166
Cash, end of year	$ 6,407,359	$ 11,948,879

See accompanying notes to financial statements.

SHARED CARE PROGRAMS

Notes to the Financial Statements

Year ended March 31, 2016

1. Operations and purpose of the Shared Care Programs:

The purpose of the Shared Care Programs (the "Program") is to improve shared care between general practitioners, specialist physicians and other healthcare professionals.

The financial statements of the Program include the funds and programs administered by the Doctors of BC on behalf of the Shared Care Committee ("SCC") under the 2014 Physician Master Agreement ("PMA") and the Joint Clinical Committees Administration Agreement.

The current programs within the Program are as follows:

(a) Program Enablers:

Program Enablers include costs for staff salaries and expenses, Doctors of BC administrative costs, communications and provincial engagement events (i.e. workshops).

(b) Working Groups:

The Evaluation working group is tasked with developing the evaluation framework for the SCC as well as providing guidance on all evaluation matters to both the SCC and its projects.

(c) Special Projects:

Call for Less Antipsychotics in Residential Care ("CLeAR") Project:

In June 2013, the BC Patient Safety & Quality Council (the Council), in partnership with the SCC, invited residential care facilities to join CLeAR. The initiative was considered very successful in improving collaboration among health professionals to reduce the use of antipsychotic medications. In 2015/16, the Council submitted a second request for $51,000 to expand uptake of CLeAR across the province. This was approved, and the first gate of funding was released in 2015/16, with the second gate anticipated for 2016/17. This quality improvement initiative will run until March 2017.

Local Engagement:

Funds held in this account are available for communities interested in participating in Shared Care work but do not have their own funds available to conduct the necessary physician engagement.

(d) Partners in Care:

This initiative comprises numerous joint efforts by family and specialist physicians in regions throughout British Columbia ("BC") to streamline: referral and consult processes, shared care planning and re-referral criteria, diagnostic standards and communications, telephone advice protocols, and other.

(e) Transitions in Care:

This initiative aims to address the various challenges of patient transition across care settings. Focused on finding local solutions to local problems, the initiative supports work in selected BC communities to improve the delivery of comprehensive, streamlined patient care.

1. Operations and purpose of the Shared Care Programs (continued):

(f) Child and Youth Mental Health Collaborative ("CYMH Collaborative"):

This is a large-scale provincial initiative. The CYMH Collaborative involves an unprecedented number of stakeholders - over 800 youth, parents, family doctors, specialists, three government ministries, RCMP, school counsellors, First Nations groups, and others - to work together to improve services for children and youth with mental health and substance use issues.

(g) Polypharmacy:

This initiative supports family and specialist physicians to improve management of patients on multiple medications that may impact their safety and quality of life, especially those who are elderly.

(h) Rapid Access to Psychiatry:

This initiative is involved around an alternate model of care to expedite the access to psychiatric assessment, effective intervention, and follow-up for patients with mood disorders.

(i) Teledermatology:

This initiative is using digital technology and aspects of the Internet to improve access to dermatological consults for family physicians in urban, remote, and isolated communities in BC.

(j) Scholarships:

The SCC, in partnership with the Specialist Services Committee, offers scholarships for physicians for successful completion of leadership training approved by a health authority.

(k) Redesign:

The SCC, in partnership with General Practice Services Committee and Specialist Services Committee, supports physician participation in system redesign initiatives led by the BC health authorities by providing funds to compensate family physicians for time spent participating in initiatives to improve the delivery of both primary and specialist care services.

2. Agreements:

The Government of the Province of British Columbia (the "Government"), the Medical Services Commission of British Columbia ("MSC") and the Doctors of BC entered into the PMA that is effective from April 1, 2014 to March 31, 2019.

The Joint Clinical Committee Administration Agreement is part of the PMA; it is intended to address those matters of unique interest and applicability to the SCC.

The SCC is a subcommittee of the General Practice Services Committee and the Specialist Services Committee, with equal representation from the Government and the Doctors of BC on the SCC. The SCC is responsible for the allocation of funds from the Government as outlined in the PMA.

3. Significant accounting policies:

(a) Basis of presentation:

The financial statements have been prepared by management in accordance with Canadian accounting standards for not-for-profit organizations in Part III of the CPA Canada Handbook - Accounting.

(b) Revenue recognition:

The Program follows the deferral method of accounting for contributions.

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. Externally restricted contributions are recognized as revenue in the year in which the related expenses are recognized, or the restrictions have been met.

(c) Financial instruments:

The Program's financial instruments include cash, accounts receivable, accounts payable and accrued liabilities, due from GPSC Collaboratives Program ("GPSC Collaboratives"), due from Specialist Services Programs ("Specialist Services"), and due to Doctors of BC.

Financial instruments are recorded at fair value on initial recognition and, other than investments in equity instruments that are quoted in an active market, are subsequently recorded at cost or amortized cost, unless management has elected to carry the instruments at fair value. The Program has not elected to carry any such financial instruments at fair value. Financial assets are assessed for impairment on an annual basis at the end of the fiscal year if there are indicators of impairment.

(d) Use of estimates:

The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

4. Recast of revenue and expense amounts:

During the year, it was determined that funding transfers to related entities should be recognized and presented on a gross basis on the Statement of Operations as the Program acts as a principal in the transactions. An adjustment was required to correct this presentation on a retroactive basis by recasting the comparative balances. This adjustment is immaterial to the financial statements as a whole. For the year ended March 31, 2015, total revenue and total expenses each increased by $826,852, with no impact on excess of revenue over expenses. There was also no impact on total deferred contributions and net assets as at March 31, 2015.

5. Deferred contributions:

Deferred contributions represent externally restricted funding received and are comprised of the following:

	Program Enablers	Working Groups	Special Projects	Partners in Care	Transitions in Care	CYMH Collaboratives	Polypharmacy	Rapid Access to Psychiatry	Teledermatology	Scholarships	Subtotal carried forward
Balance, beginning of year	$ 384,793	$ -	$ 640,932	$2,499,862	$1,768,163	$ 1,164,511	$ 1,686,440	$ 19,183	$ 148,087	$ 18,103	$ 8,330,074
Contributions from Government	-	-	-	-	-	-	-	-	-	-	-
Contributions receivable from Government	-	-	-	-	-	-	-	-	-	-	-
Contributions from other programs (notes 6(b)(i) and 6(c)	-	-	-	-	-	-	-	-	-	-	-
Receipt of unspent funds (note 6(a)(ii))	-	-	-	-	-	-	-	-	-	-	-
Interest earned	-	-	-	29,820	10,871	28,885	14,213	-	1,820	583	86,192
Budget allocations	2,100,207	200,000	(539,932)	1,450,138	861,837	5,675,489	(203,440)	180,817	101,913	231,897	10,058,926
Amounts recognized as revenue	(1,599,532)	(50,629)	(57,549)	(2,534,082)	(1,164,121)	(5,804,965)	(410,737)	(144,047)	(143,785)	(340,478)	(12,249,925)
Balance, beginning of year	$ 885,468	$ 149,371	$ 43,451	$1,445,738	$1,476,750	$ 1,063,920	$ 1,086,476	$ 55,953	$ 108,035	$ (89,895)	$ 6,225,267

Subtotal carried forward		Subtotal brought forward	Redesign	PSP & PSP Initiatives	Transfer for Committee Costs	PRR Hip Fracture project	Youth Transitions	Pain Collaborative	Unallocated General	2016	2015
											(Recast - Note 4)
$ 8,330,074	Balance, beginning of year	$ 8,330,074	$1,535,886	$ 333,148	$ -	$ 231,273	$ 649,086	$ 499,642	$2,496,546	$14,075,655	$ 9,827,629
-	Contributions from Government	-	-	-	-	-	-	-	-	-	4,615,784
-	Contributions receivable from Government	-	-	-	-	-	-	-	6,500,000	6,500,000	1,884,216
-	Contributions from other programs (notes 6(b)(i) and 6(c)	-	1,640,000	-	-	-	-	-	4,000,000	5,640,000	9,000,000
-	Receipt of unspent funds (note 6(a)(ii))	-	-	-	-	-	-	-	40,246	40,246	592,019
86,192	Interest earned	86,192	-	-	-	-	-	-	-	86,192	123,052
10,058,926	Budget allocations	10,058,926	700,000	(33,148)	180,000	(231,273)	(449,086)	(499,642)	(9,725,777)	-	-
(12,249,925)	Amounts recognized as revenue	(12,249,925)	(2,357,580)	(17,240)	(180,000)	-	-	-	-	(14,804,745)	(11,967,045)
$ 6,225,267	Balance, March 31, 2016	$ 6,225,267	$1,518,306	$ 282,760	$ -	$ -	$ 200,000	$ -	$3,311,015	$11,537,348	$ 14,075,655

6. Related party transactions and balances:

(a) Doctors of BC:

(i) Administration costs:

The Government and MSC have entered into a contract with Doctors of BC for the term of the PMA for Doctors of BC to administer the Program, the costs of which are to be recovered from the funding made available to the Program. During the year ended March 31, 2016, the Program paid $90,000 (2015 - $90,000) for services provided by the Doctors of BC. As at March 31, 2016, $22,500 (2015 - $22,500) remained payable to Doctors of BC relating to these administrative fees and is included in accounts payable and accrued liabilities.

(ii) Shared Care Committee costs:

During the year ended March 31, 2016, the Program provided $180,000 (2015 - $160,000) to Doctors of BC to pay for committee costs, and received $40,246 (2015 - $269,980) from Doctors of BC relating to unspent funds for committee costs from previous years.

As at March 31, 2016, the Program had a payable of $123,369 (2015 - $86,263) to Doctors of BC relating to expenses paid by Doctors of BC on behalf of the Program.

(b) GPSC Collaboratives:

(i) Contributions received:

During the year ended March 31, 2016, the Program received contributions of $2,000,000 (2015 - $4,000,000) for Shared Care initiatives and received contributions of $700,000 (2015 - $500,000) for Redesign.

(ii) Contributions provided:

During the year ended March 31, 2016, the Program provided contributions of $17,240 (2015 - $666,852) for PSP and PSP Initiatives.

As at March 31, 2016, the Program had a receivable of $64,768 (2015 - $394,861) from GPSC Collaboratives relating to funding allocated but not yet received.

(c) Specialist Services:

During the year ended March 31, 2016, the Program received contributions of $2,000,000 (2015 - $4,000,000) for Shared Care initiatives and received contributions of $940,000 (2015 - $500,000) for Redesign.

As at March 31, 2016, the Program had a receivable of $91,631 (2015 - $500,000) from Specialist Services relating to funding allocated but not yet received.

7. Financial risks:

The Program believes that it is not exposed to significant interest-rate, market, credit or cash flow risk arising from its financial instruments.

SHARED CARE PROGRAMS

(Funds and Programs Administered by Doctors of BC)

Schedule 1 - Expenses by Program

Year ended March 31, 2016

(a) Year ended March 31, 2016:

	Program Enablers	Working Groups	Special Projects	Partners in Care	Transitions in Care	CYMH Collaborative	Polypharmacy	Subtotal carried forward
Salaries and benefits	$ 1,134,259	$ -	$ 1,206	$ -	$ -	$ 409,411	$ 50,610	$ 1,595,486
Office and communications	39,790	-	19,718	482	-	24,300	5,068	89,358
Meetings and conferences	327,674	23,529	16,050	18,330	-	213,661	278,674	877,918
Transfer to divisions of family practice	-	-	3,575	2,432,114	1,164,121	3,812,834	32,879	7,445,523
Transfer to health authorities	-	-	-	-	-	40,612	-	40,612
Other transfers	-	-	17,000	-	-	1,226,678	-	1,243,678
Professional fees	7,809	2,100	-	83,156	-	47,581	33,306	173,952
Education	-	-	-	-	-	-	-	-
Evaluation	-	25,000	-	-	-	29,888	10,200	65,088
Administration fees	90,000	-	-	-	-	-	-	90,000
Total expenses	$ 1,599,532	$ 50,629	$ 57,549	$ 2,534,082	$ 1,164,121	$ 5,804,965	$ 410,737	$ 11,621,615

	Subtotal brought forward	Rapid Access to Psychiatry	Teledermatology	Scholarships	Redesign	PSP & PSP Initiatives	Transfer for Committee Costs	Total 2016
Salaries and benefits	$ 1,595,486	-	-	-	-	-	-	$ 1,595,486
Office and communications	89,358	-	-	30	-	-	-	89,388
Meetings and conferences	877,918	-	14,019	78,337	-	-	-	970,274
Transfer to divisions of family practice	7,445,523	-	(22,258)	-	-	-	-	7,423,265
Transfer to health authorities	40,612	-	-	-	2,357,580	-	-	2,398,192
Other transfers	1,243,678	144,047	-	-	-	17,240	180,000	1,584,965
Professional fees	173,952	-	133,087	-	-	-	-	307,039
Education	-	-	-	262,111	-	-	-	262,111
Evaluation	65,088	-	18,937	-	-	-	-	84,025
Administration fees	90,000	-	-	-	-	-	-	90,000
Total expenses	$ 11,621,615	$ 144,047	$ 143,785	$ 340,478	$ 2,357,580	$ 17,240	$ 180,000	$ 14,804,745

SHARED CARE PROGRAMS

(Funds and Programs Administered by Doctors of BC)

Schedule 1 - Expenses by Program (continued)

Year ended March 31, 2016

(b) Year ended March 31, 2015:

	Program Enablers	Special Projects	Partners in Care	Transitions in Care	CYMH Collaborative	Polypharmacy	Rapid Access to Psychiatry	Teledermatology	Subtotal carried forward
Salaries and benefits	$ 717,432	$ -	$ 91,699	$ 92,792	$ 241,549	$ 1,436	$ -	$ -	$ 1,144,908
Office and communications	47,875	-	6,268	863	1,514	606	-	-	57,126
Meetings and conferences	145,924	-	12,992	16,296	164,590	237,081	4,548	12,128	593,559
Transfer to divisions of family practice	-	-	1,621,050	1,582,971	2,301,696	133,000	-	-	5,638,717
Transfer to health authorities	-	-	-	-	-	-	-	-	-
Other transfers	-	-	-	178,000	810,822	-	130,000	-	1,118,822
Special projects	-	8,343	-	-	-	-	-	-	8,343
Professional fees	8,976	-	-	-	141,464	59,860	47,271	192,277	449,848
Education	-	-	-	-	-	-	-	-	-
Evaluation	-	-	-	-	-	-	-	2,000	2,000
Administration fees	90,000	-	-	-	-	-	-	-	90,000
Total expenses	$ 1,010,207	$ 8,343	$ 1,732,009	$ 1,870,922	$ 3,661,635	$ 431,983	$ 181,819	$ 206,405	$ 9,103,323

	Subtotal brought forward	Scholarships	Redesign	PSP & PSP Initiatives	PRR Hip Fracture Project	Youth Transitions	Pain Collaborative	Transfer for Committee Costs	Total 2015
Salaries and benefits	$ 1,144,908	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,144,908
Office and communications	57,126	28	-	-	-	-	-	-	57,154
Meetings and conferences	593,559	61,261	-	-	-	2,953	358	-	658,131
Transfer to divisions of family practice	5,638,717	-	-	-	-	-	-	-	5,638,717
Transfer to health authorities	-	-	1,794,671	-	-	-	-	-	1,794,671
Other transfers	1,118,822	-	-	666,852	-	-	-	160,000	1,945,674
Special projects	8,343	-	-	-	1,683	-	-	-	10,026
Professional fees	449,848	-	-	-	-	-	-	-	449,848
Education	-	175,916	-	-	-	-	-	-	175,916
Evaluation	2,000	-	-	-	-	-	-	-	2,000
Administration fees	90,000	-	-	-	-	-	-	-	90,000
Total expenses	$ 9,103,323	$ 237,205	$ 1,794,671	$ 666,852	$ 1,683	$ 2,953	$ 358	$ 160,000	$ 11,967,045