GUIDELINES

SharedCare
Partners for Patients

Project Funding Guidelines

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SHARED CARE COMMITTEE OVERVIEW

Vision & Mandate

The Shared Care Committee (SCC) is one of four Joint Collaborative Committees (JCCs) representing a partnership between Doctors of BC and the Ministry of Health. All committees have their own distinct mandates, but work closely together in the development and alignment of initiatives to improve health outcomes and the patient journey through the health care system.

The SCC's mandate is to support family and specialist physicians, health care partners, patients, families and caregivers, to collaborate on health care improvement initiatives together.

With effective collaboration between family and specialist physicians and partners, Shared Care work sets the foundation for a culture of collegiality, innovation and team-based patient-centered care to ensure a coordinated care experience for all British Columbians.

Funding

DOCTORS OF BC	MINISTRY OF HEALTH

PMA
PHYSICIAN MASTER AGREEMENT

GPSC	SCC	SSC	JSC
GENERAL PRACTICE SERVICES COMMITTEE	SHARED CARE COMMITTEE	SPECIALIST SERVICES COMMITTEE	JOINT STANDING COMMITTEE ON RURAL ISSUES

Four joint collaborative committees

GUIDELINES

Lower per capita cost of care

Improved population health

Enhanced patient and provider experience
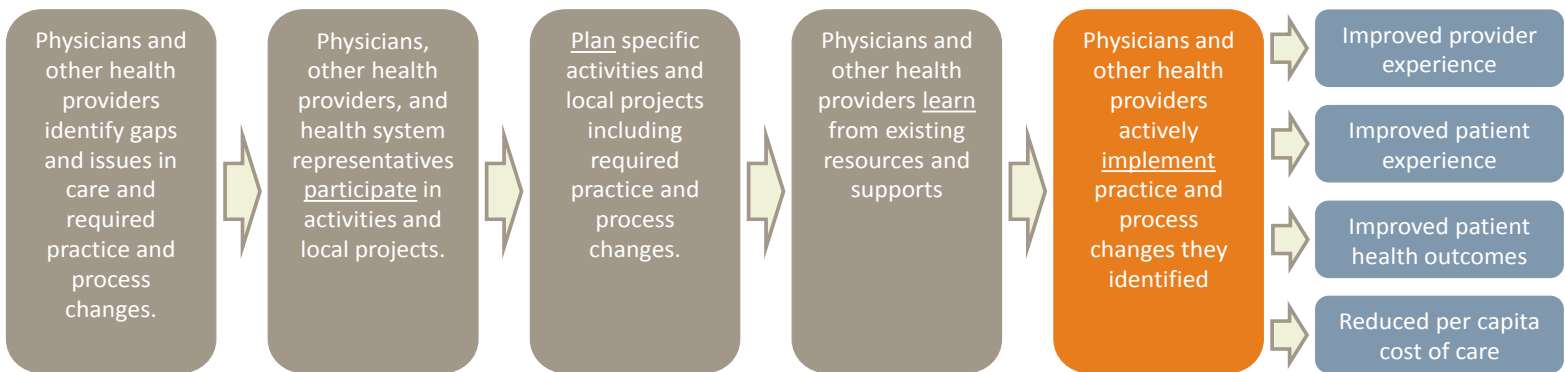
THE WORK OF THE SHARED CARE Committee is grounded in the principles of patient-centred care and the quality improvement methodologies of the Institute of Healthcare Improvement. In alignment with the Ministry of Health, the Shared Care Committee frames its efforts at system improvement around the Triple Aim Framework; improved patient and provider experience of care, improved health outcomes, and positive impact on efficiency and cost.

Physicians and other health providers identify gaps and issues in care and required practice and process changes.	Physicians, other health providers, and health system representatives participate in activities and local projects.	Plan specific activities and local projects including required practice and process changes.	Physicians and other health providers learn from existing resources and supports	Physicians and other health providers actively implement practice and process changes they identified		

Improved provider experience

Improved patient experience

Improved patient health outcomes

Reduced per capita cost of care

VALUES AND PRINCIPLES

Our values and principles should be clearly reflected in all projects, and will inform the Shared Care Committee's decision regarding partnership in a proposed project. The values and principles are:

Effective Engagement

Projects reflect the collective input and participation of all partners from development through to completion;

Projects have potential to link or align with Joint Collaborative Committees;

The Shared Care Committee is an active partner in supporting the development, implementation and evaluation of the work;

Shared Care projects should be driven by identified issues that are negatively affecting patient experience and outcomes. To consistently inform the patient perspective, patient partners should be an integral part of the project and engaged throughout the lifespan of the work.

Innovation

Participants agree to try new ideas, approaches and/or solutions, or collaborate to address issues with significant impact;

Focus on learning and adaptation, rather than success or failure;

Support solutions that have the potential to be leveraged broadly;

Promotes synergistic thinking.

Collaborative Culture Change

Supports collaboration for mutual benefit, shared priorities;

Builds FP – Specialist relationships around shared patient goals of care;

Supports provincial health system transformation priorities.

Supports building on successful work and lessons learned from other communities and projects

Measurable Improvement

Improvement goals are clearly identified;

Triple Aim Framework is applied to the measurement of improvement;

Aligns with the Shared Care Committee and Evaluation Frameworks;

Project leaders support two-way dialogue with the Shared Care Committee as projects progress regarding learnings, implications, and potential recommendations that may arise from the work.

SHARED CARE PROGRAMS OVERVIEW

Spread Successful Work	Collaborative Change & Innovation	Leadership & Sustainability	JCC Shared Initiatives
Online Learning Centre

SPREAD NETWORKS
• Adult Mental Health & Substance Use
• Chronic Pain
• Complex Care for Older Adults
• Maternity
• Palliative Care | Partners in Care / Transitions in Care

Surgical Support Strategy | Child & Youth Mental Health & Substance Use (CYMHSU) Community of Practice

RACE & eConsult

Teledermatology

Physician Leadership Scholarship | Health System Redesign

BC Physician Integration Program (BC PiP)

Quality Forum |

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

Since 2010, SCC's Partners in Care (PiC) and Transitions in Care (TiC) initiative has engaged Family Physicians (FPs), Specialists (SPs), FPs with Focused Practice, Health Authorities, and other health professionals, in over 170 community-based projects across the province.

PiC/TiC focuses on physician-led projects, to improve coordination of care for patients among providers (Partners in Care) and between care settings (Transitions in Care). As the PiC/TiC work has evolved over time, project teams have worked together to learn from each other and spread activities regionally or provincially. PiC/TiC projects also form the foundation of SCC's Spread Networks, which were initiated to bring together communities actively engaged in addressing the needs of priority populations.

Spread Networks

Spread Networks aim to build greater alignment across the system and facilitate the spread of positive improvements in practice. SCC supports the development and implementation of a 'Spread Network' model of care for several priority populations.

Communities joining a spread network will have the opportunity to share valuable lessons from their own experiences, as well as tools and resources that could benefit others. Communities approved for funding will receive centralized support and a spread toolkit including:

Resources and tools to support a collaborative approach to address identified issues and gaps.

Evaluation framework including needs-assessment and evaluation tools.

Coaching from a central team to guide and inform project activities.

Patient and provider surveys must be completed in the community as part the EOI process. The purpose of the surveys is to identify gaps and create a pre-project baseline to be compared to a post-project survey showing the improvements made as a result of the project.

Adult Mental Health & Substance Use Spread Network

The Adult Mental Health and Substance Use (AMHSU) Spread Network supports FP and Specialist-led partnerships to connect with other allied health care providers to identify community issues and develop strategies to create a more coordinated MHSU system of care.

The AHMSU Spread Network focuses on three adult age range populations:

Young adults (18-35yrs): youth transitioning into the adult care system

Middle-aged adults (36-55yrs): includes family/caregiver burnout involving anxiety and depression

Older adults (55-65yrs): high prevalence of underdiagnosed depression leading to a significant impact on physical health conditions

Chronic Pain Spread Network

The Chronic Pain Spread Network supports physicians to address chronic pain more effectively and to better meet patient needs in alignment with provincial strategies, and in consultation with Pain BC.

Communities engaged across BC are already doing great work in chronic pain care that includes:

Enhancing access to chronic pain care through new models of interdisciplinary care;

Linking patients, families and providers with patient self-management resources and support;

Enhancing skills and capacity for local physicians to provide chronic pain care and

Addressing the prevention and treatment of opioid use disorder.

Maternity Spread Network

The Maternity Spread Network supports the spread of successful work and an Inter-professional Collaborative Approach (IPC) to improve maternity care in BC. The Network brings communities together to share learnings, mentorship, and building of cross-provincial alignment, in consultation with Perinatal Services BC, the General Practice Services Committee's (GPSC) Maternity Working Group, the Joint Standing Committee for Rural Issues (JSC) Rural Obstetrical Surgical Networks and other JCC initiatives. The network is in the process of transitioning to a Community of Practice.

Maternity Spread Network projects focus on the following key areas of improvement:

Clarify and improve the maternity care pathway

Strengthen team-based care

Clarify roles and responsibilities, standardize care

Improve communication and referral between providers

Enhance patient self-management and access to perinatal education resources

Palliative Care Spread Network

The Palliative Care Spread Network aims to support and connect communities working toward the common goal of improving the local palliative care journey for patients, families, and caregivers - as well as for providers involved in their end-of-life care.

Communities are identifying gaps and creating solutions in the following areas :

- communication among providers, patients and families

- referrals between GPs and Palliative Care specialists

- provider education and resources

- awareness of community supports for patients, families and caregivers

Coordinating Complex Care for Older Adults Initiative

Older adults with complex health issues require significant levels of services which often include their family physician, specialist physicians, family caregivers, community health services and acute care.

Coordinating this care can be a significant challenge for patients, families and providers. Issues often arise relating to communication, roles and responsibilities, access to services, care plans, information sharing and more. Uncoordinated care is detrimental to patient outcomes, family and caregiver well-being, provider satisfaction and system costs. These challenges present several opportunities to improve how we provide more effective patient and family-centred care.

The Coordinating Complex Care for Older Adults Initiative supports communities to improve coordination of care for older adults with complex medical conditions in community settings, with particular emphasis on:

- Medication management

- Referral protocols and communication

- Coordinated care plans and responsibilities

These quality improvement activities are intended to align at the local level with Patient Medical Home and Primary Care Networks being implemented across BC through Divisions of Family Practice in partnership with regional health authorities.

WHAT DOES A PARTNERSHIP WITH SHARED CARE LOOK LIKE?

The Shared Care Committee offers active committee support for FP/specialist collaborative projects including:

PHYSICIAN ENGAGEMENT → PROJECT DEVELOPMENT → IMPLEMENTATION → EVALUATION

Supported projects provide opportunities to:

- identify and trial new, innovative solutions

- improve efficiency and reduce costs of care

- improve flow of care as patients move between family and specialist physicians, health services and care settings

- leverage results for province-wide spread.

Projects may vary widely in focus and activity, but the overall goals remain the same:

- to improve the experience of care for patients, families, caregivers and providers

- to enhance the coordination of care among health professionals, and;

- to support the development of team-based care models.

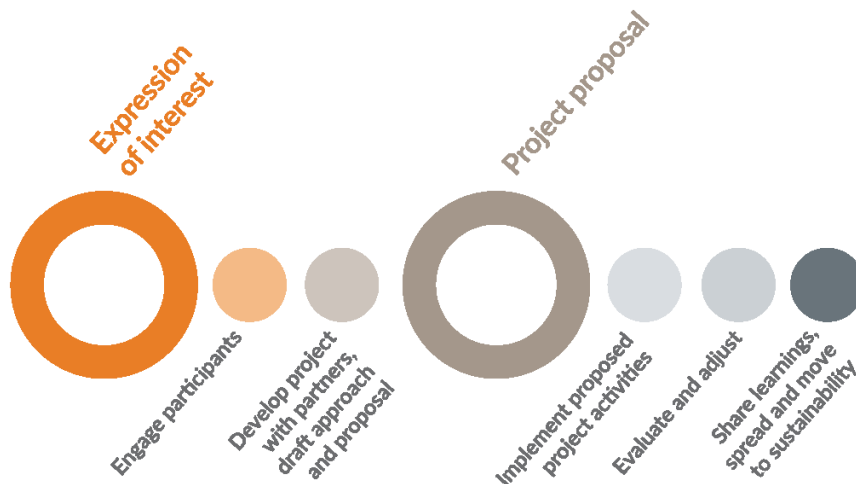Project activities contribute to a collegial, quality-focused health care culture at all levels.

Project Development Process

Shared Care initiatives are intended to be accessible to physicians in all settings, and to ensure this accessibility, the Shared Care Committee has developed a few streamlined steps for the process of proposal development.

Engage with your Shared Care Initiative Liaison: The Liaison will participate in development of the initial project idea to help identify related work for potential alignment, and coordinate the process of engaging the Shared Care Committee.

Identify the intended project improvements: Provide the patient, family and caregiver perspective to highlight the issue and purpose of the intended change. What is the issue or gap in care that needs to be addressed? What are the intended improvements and how will changes impact the care and experience of the patients and their families and caregivers? Ensure the identified issues or gaps in care are focused and concise.

Engage your partners: Collaboration is the focus of Shared Care. Ensure that relevant partners and organizations are willing to participate before moving forward, such as: patients, families, caregivers, family physicians, family physicians with focused practice, specialists and their respective specialty group, the Division of Family Practice and/or Medical Staff Association, allied health professionals, regional health authority, First Nations Health Authority and/or local First Nations.

Expression of interest

Engage participants

Develop project with partners, draft approach and proposal

Project proposal

Implement proposed project activities

Evaluate and adjust

Share learnings, spread and move to sustainability

Identify your project team: Physician leads (FP and specialist), Health authority, community organization, patient, family, and caregiver, and other partner representatives.

Identify the fund holder: Choose a willing fund holder from one of the partners to hold the project funds. Most commonly this is a physician-led organization, such as a Division of Family Practice or other organization.

Develop an Expression of Interest (EOI): Using the Project Funding Request Template, work with the Initiative Liaison to develop an EOI, outlining the project idea and funding needed to engage potential participants and develop the full project proposal. The Liaison will act as the liaison between the community and the Shared Care Committee in bringing the EOI forward to the committee, communicating their feedback, and facilitating funding transfers. If applying for funding to join a Spread Network, #6 and #7 will be combined into one Proposal.

Develop the project idea, proposal and budget: Utilizing EOI funding support from SCC, engage partners and others as appropriate to develop the full proposal using the Project Funding Request Template.

Proposal is presented to the committee: The Initiative Liaison will put forward the proposal to the Shared Care Committee, who will either respond by approving the proposal, or, in some cases may provide initial funding to begin work, while asking that changes or further investigations are incorporated. In some instances, the committee may decline to partner in a proposed project.

Execute Funds Transfer Agreement (FTA): Once committee approval is received, the SCC Initiative Liaison will facilitate the completion of a Funds Transfer Agreement, and funding to be released. Funding may be gated depending on the amount of funding approved.

Request additional funds and/or extension (if applicable): In some cases, additional time and/or resources are required to complete a project due to unforeseen circumstances. Work with the Initiative Liaison to identify needs and complete an Additional Funds Request (using the Project Funding Request Template) or Funding Agreement Extension Letter.

FUNDING PRIORITIES

The Shared Care Committee places priority on funding projects that:

align with the strategic goals of the Joint Collaborative Committees, the Ministry of Health, the Health Authorities: Provincial Services Health Authority; First Nations Health Authority; Interior Health Authority; Vancouver Island Health Authority; Fraser Health Authority; and Vancouver Coastal Health Authority.

are new or innovative approaches to identified issues that include the perspectives of patients, families, and caregivers;

collaborate with other communities embarking on similar work as appropriate – or with the health authority to prototype regional solutions where appropriate, to experience the benefits of collective impact;

are developed collaboratively with all partners including Indigenous communities, and are aligned with the community's health care priorities, including PCNs;

incorporate an agreed plan for the sustainability of successful solutions, and/or project deliverables that include identification of sustainability mechanisms;

have potential for spread and adaptation, recognizing that Shared Care is not a source of ongoing funding;

does not arise from an underfunded mandate of another organization or committee, such as a health authority;

has not been brought to other Joint Collaborative Committees for consideration, unless that committee recommended the proposal be submitted to Shared Care.

EXPRESSION OF INTEREST (EOI) DEVELOPMENT

The Expression of Interest (EOI) provides the opportunity to share a new project idea to the Shared Care Committee before significant work is undertaken.

Communities can apply for seed funding (up to $15,000) to develop a more fulsome project proposal, and for the Shared Care Committee to have early input into the work to be developed (i.e., recommendations for alignment with other work underway, and suggestions for partners or expertise that may assist in the development of the work).

The Project Funding Request Template (to be used when submitting an EOI, full Proposal, and Additional Funds Request) can be found HERE.

FULL PROPOSAL DEVELOPMENT

Through funding support of the EOI, a full project proposal and budget may be developed and submitted to the Shared Care Committee. The SCC Initiative Liaison will provide support and assistance in the development of the proposal and budget, and will present the proposal to the Committee.

Project Summary

a. The name of the project
b. The fund holder
c. The proposed length of the project
d. The total funds requested
e. The contact person

Background information and context

  a. A description of the current situation and gap analysis. Define the gap in care in terms of the patient and families. Patient journey mapping, surveys or interviews are useful tools to capture the issue from the patient and family perspective.
  b. Data: what data is available to illustrate the gap in care? (e.g. provider perspective, process data, etc.)
  c. Description of evidence or literature informing the project's approach.

Project Description

  a. A clear description of the approach and scope of work to be undertaken in a few brief paragraphs. This may include an outline of proposed project activities, PDSA cycles, specific solutions to be applied, or logic model/assumptions underlying the approach. (this is not expected to be a detailed project plan)

Engagement and project governance

  a. Names of the physician leads (family physician, family physician with focused practice and/or specialist)
  b. Additional physicians, and other members of the steering committee
  c. Physicians and allied health professionals engaged and/or participating
  d. Plans for patient/family/caregiver engagement and partnerships: Will patients be part of the steering committee? Working groups? How will patients stay involved during the project, and what kind of influence will they have over the work going forward (e.g. decision making, consultation, information, etc.)
  e. Outline of engagement activities to date, and methods for ongoing communication with key partners and stakeholders throughout the project, including Indigenous communities.

Expected outcomes and evaluation measures

  a. Improvement goals and how these will be measured, including:

      i. Process outcomes
      ii. Patient outcomes
      iii. Patient and provider experience
      iv. Cost savings or process efficiencies

Alignment

  a. How does this project align with the provincial health system priorities, including PCN.
  b. Does this project align with other key initiatives or priorities of the Joint Collaborative Committees and/or the health authority?
  c. Does this project involve an IT/virtual care component and if so, how does it align with work happening regionally and provincially? Who will be responsible for developing and maintaining the IT component? Projects that include a technology portion should demonstrate how they are leveraging, aligning, building upon and synchronizing with existing work across the province.
  d. Does this initiative reflect culturally-safe approaches and considerations?

Innovation or spread

a. Is the proposed project based on a new idea, an idea trialed successfully elsewhere, adapted from another solution, or complementary to other work supported by one of the joint Collaborative committees? Please provide details.

b. Does the project build on or link to work undertaken in the province by another organization (for example, bringing physician practices together to better serve a population, utilizing work developed by a health authority, university or other organization)? Please provide details.

c. Is the project adapting a successful prototype from another community? Please provide details.

d. Are there plans to spread this further in your community, if successful?

Risks

What are the anticipated risks to the project and what steps have/will be taken to mitigate these risks?

Sustainability Plan

As Shared Care provides one-time funding, are there agreed plans in place to sustain the project solution over the long term? Alternatively, how will sustainability strategies be identified and agreed between the project partners over the course of the work?

Gated Proposals

a. Proposals over $150,000 will commonly be gated; upon completion of identified milestones outlined in the proposal.

b. All Spread Network proposals will be gated. Up to $15,000 will be provided initially for the EOI.

Budget Guidelines

a. Physician compensation

   i. To ensure the project incorporates broad physician participation and engagement, at least 40% of the budget should be allocated to supporting physicians to participate in meetings and work outside of meetings.

   ii. If a project will utilize a lower percentage of the budget to support physician participation, please provide an explanation.

   iii. For general engagement meetings, funding will be provided for physicians to be compensated for their time where they are asked to present, work during the event, or attend during their clinic hours.

b. Project support

   i. Depending on the particulars of the project, funding for a project manager would be expected to be approximately 7-20 hours per week at a cost of $40-$65/hour. No more than 30% of the budget should be allocated to project management.

   ii. If a project requires more intensive project support, please provide details.

c. Administrative support and other costs

    i. Administrative costs of 10% of the budget may be included to pay for the fund holders' associated administrative costs (including administrative support for the project, Executive Director coordination and support, book keeping and accounting, contingency costs, other direct staff costs, etc.). No additional line items for administrative costs should be included in the proposal.

d. Evaluation (approximately 10% of the total budget)

    i. Each project should include appropriate provision for evaluation, including total costs for an evaluation professional, and costs associated with participant and data collection.

e. Information Technology (IT)

    i. Any costs for IT support should be identified, recognizing that the Shared Care Committee does not fund software development, licensing or other IT infrastructure.

f. Other costs may include:

    i. Meeting costs (e.g. food)
    ii. Event costs (e.g. catering, room rental). Please note that funding is not provided for physicians to attend CME accredited events.
    iii. Communications and marketing
    iv. Costs associated with PDSA cycles and process changes

g. In-kind supports should be identified, with approximate value
h. Participation in Conferences and Shared Care events (e.g. project and physician leads workshop, joint clinical committees showcase) etc.
i. A 10% contingency will be provided

j. Shared Care does not provide funding to:

    i. Reimburse clinical time or operational costs.
    ii. Compensate for capital costs, such as land, buildings, equipment, care packages, IT equipment, virtual care platforms etc.
    iii. Compensate organizations, such as health authorities, for costs of staff participation or costs they may incur from having taken part in Shared Care projects as part of their role.
    iv. Compensate Executive Directors
    v. Compensate/provide gifts for patient, family, and caregiver participation in Shared Care projects
    vi. Participate in clinical training and non-clinical training
    vii. Research studies
    viii. Alcoholic beverages
    ix. Sustain ongoing operation

The Project Funding Request Template (to be used when submitting an EOI, full Proposal, and Additional Funds Request) can be found HERE. The Budget Template can be found HERE.

REQUESTING ADDITIONAL FUNDS TO COMPLETE A PROJECT

It is expected that communities, for the most part, are able to complete their work within the funds that are approved by the Shared Care Committee. If, due to unforeseen circumstances, communities require additional funding to complete a project, communities can apply for additional funding.

Requests can be made when communities are nearing the end of their project when funds appear to be insufficient to complete the work or additional work is required/requested.

The process for requesting additional funding:

The Project Lead contacts their SCC Initiative Liaison to discuss the reason for requesting additional funds from the Shared Care Committee.

The Project Lead completes the SCC Project Funding Request template to identify the reason for requesting additional funds, the additional funding amount and the time frame anticipated. The Project Lead also creates a budget and work plan for the additional funds being requested and attaches it as appendices. The Project Lead submits these documents to their Initiative Liaison.

The request is brought forward to the SCC Co-Chairs for review. The Co-Chairs may choose to approve the funding request and inform the SCC of their decision at the next SCC meeting OR forward the request for decision to the full Committee.

If the request is approved, the Initiative Liaison and central Shared Care office will make arrangements for a Funds Transfer Agreement to be completed, and funding to be released.

The Project Funding Request Template (to be used when submitting an EOI, full Proposal, and Additional Funds Request) can be found HERE.

REQUESTING ADDITIONAL TIME TO COMPLETE A PROJECT

It is expected that communities, for the most part, are able to complete their work within the timeframe that is approved by the Shared Care Committee. If, due to unforeseen circumstances, communities require additional time to complete a project, communities can apply for a project extension.

Requests can be made when communities are nearing the end of their project when it appears that the project will not be completed by the approved end date as written in the Funds Transfer Agreement (FTA).

The process for requesting an extension:

The Project Lead contacts their SCC Initiative Liaison to discuss the reason for requesting an extension from the Shared Care Committee.

The Project Lead will work with their Initiative Liaison to develop a Funds Transfer Agreement Extension (FTA-E) letter. The FTA-E is a standardized letter agreement with an Appendix A summarizing the following:

a. Original FTA amount;
b. Funds remaining at the FTA expiration date;
c. Work proposed with remaining funds;
d. Desired outcomes of this work; and
e. Estimated completion date (this will become the new expiration date of the project term).

The Initiative Liaison and central Shared Care office will make arrangements for the FTA-E to be completed and executed.

The Funds Transfer Agreement Extension (FTA-E) letter can be found HERE.

THE ROLE OF THE PHYSICIAN LEADS IN SHARED CARE PROJECTS

The goal of the Shared Care Committee is to engage family and specialist physicians in opportunities that improve care for patients and contribute to a collaborative collegial culture. The role of the physician leads, therefore, is integral to the success of Shared Care projects.

The physician leads - Family Physician, Specialist, and/or FP with Focused Practice – are first and foremost champions for the project. The physician leads provide direction and leadership for the project lead, who works directly on their behalf to operationalize the activities of the project. Additionally, physician leads are critical to engagement of their colleagues, ensuring the project represents the interests and meets the need of the physician and health professional community.

Specifically, physician leads guide the project by:

- Championing the project amongst their colleagues to build interest and to ensure the project has the support and participation of the physician community;

- Continuously seeking feedback and perspectives from stakeholders such as allied health professionals and health authority leadership);

- Applying their clinical experience and knowledge to inform the project;

- Recruiting other physicians to join the steering/working group of the project;

- Liaising with other physicians to leverage and align their project with existing initiatives.

What does the commitment look like?

Most Shared Care projects are carried out over a period of 1–2 years.

Most commonly, the time commitments for participation are heaviest at the outset of the project, as engagement takes place and responsibilities are defined to ensure the project progresses as planned.

Once the project is underway, monthly or bi-monthly steering committee meetings are common, in addition to other commitments as agreed. Each project leadership group tailors these aspects to suit the needs of the work.

What supports are available to the physician leads?

The Shared Care Committee Initiative Liaison is a key support to physician leads in the following areas: project team staffing decisions, sharing information that could inform the project (such as similar work in other communities), identifying educational opportunities, and opportunities to present work at conferences, Shared Care Committee meetings and others.

Physician leads may also receive support to participate in leadership and QI training programs.

THE ROLE OF THE PROJECT LEAD IN SHARED CARE PROJECTS

The role of the Project Lead is to plan, implement, continuously improve, evaluate and close the project in collaboration with the Physician Leads, the local Shared Cared Steering Committee, and other key stakeholders* for the project. Project leads are accountable for overseeing and regularly reporting on the project scope, project team, resources, financials and outcomes of the project. Specific Project Lead functions include:

Planning

Develop a project Expression of Interest and/or full Proposal, work plan and budget

Identify, engage, and motivate stakeholders

Implementation

Develop a project management plan

Define and manage project scope according to the budget and timeline

Define, develop, and implement timelines, schedules, and activities for all project team meetings, physician engagement events, working groups, and focus groups etc.

Manage, monitor and revise project budget if necessary

Plan and implement Quality Improvement measures

Plan and implement human resource requirements

Develop and implement a communications plan to ensure that the Shared Care Committee, the Division of Family Practice, FPs, Specialists, and other stakeholders remain apprised of project activities and progress.

Identify potential risks and mitigation strategies

Identify and incorporate stakeholder expectations

Submit bi-monthly project status reports

Completion

Complete all phases of the project

Complete project evaluation

Complete project final report

*Other stakeholders to be involved in the project include, but are not limited to:

Patients, families, and caregivers

Ministry of Health

Regional Health Authority

First Nations Health Authority/Local First Nations

Local government

Community organizations

THE ROLE OF THE INITIATIVE LIAISON IN SHARED CARE PROJECTS

The role of the Initiative Liaison is to provide guidance and support of local project activities and act as liaison between the project team and the Shared Care Committee. The Initiative Liaison is accountable for overseeing and regularly reporting on the progress of projects within their region and/or portfolio. functions include:

- Provide **pre-project guidance** on the development of Expression of Interest (EOI), Proposal, budget, work plan, and engagement activities

- Arrange **execution of Funds Transfer Agreement (FTA)** and other related contracts/documents

- Collect, review and engage with Project Leads on **bi-monthly status reports** (every second month)

- Collect, review and engage with Project Leads on **final project report and evaluation report**, and reports on conclusion of project to the Shared Care Committee Provide written and/or verbal acknowledgement from the Shared Care Committee upon completion of the project

- Communicates with Project Leads about networking opportunities, tools and resources from other communities and organizations, as well as updates and communications from the Shared Care Committee

RESPONSIBILITY OF THE FUND HOLDER

The proposed fund holder should have the administrative capacity to hold funds on behalf of the stakeholders/partners and steering committee for the project. Where there is an interest in participating in a Shared Care project, but there is not an appropriate fund holder available, the Initiative Liaison will work with the community to identify appropriate alternatives.

LOCAL SHARED CARE STEERING COMMITTEES

For communities with three or more projects funded through Shared Care, it is recommended that an annual funding request be submitted to support community Steering Committees. The purpose of the Local Steering Committee is to provide advice and input to the development, progression and alignment of Shared Care projects to address the community gaps in care. Additionally, the Local Steering Committee will facilitate communications between community providers including FP's, SP's and the Health Authority. Local Shared Care Steering Committees must comprise:

- Two Co-chairs – FP & SP

- Additional Physicians – minimum one per project

- XX Health Authority (Senior Management or alternate)

- Shared Care Initiative Liaison

- Shared Care Project Lead(s)

- Patient and/or Family Caregiver

- Related Provincial Organizations

- Division of Family Practice Representative (optional)

The process for applying for Local Steering Committee funding is as follows:

i. The fund holder (typically a representative of the local Division of Family Practice) will complete and submit a *Local Shared Care Steering Committee Funding Request* to the Shared Care Initiative Liaison. A budget and Terms of Reference signed by the proposed Steering Committee Co-chairs will need to be attached.

ii. The funding request is submitted to the Shared Care Committee Co-chairs for review and approval.

iii. Once approval is received, the SCC Initiative Liaison and central Shared Care office will make arrangements for a *Funds Transfer Agreement* to be completed, and funding to be released.

iv. The Local Shared Care Steering Committee Funding Request form can be found HERE.

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