SharedCare

Partners for Patients

ANNUAL REPORT
2014/15

BRITISH COLUMBIA

doctors of bc

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MANDATE

The Shared Care Committee is a joint committee 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 address the growing need for coordination of patient care and best use of health care resources.

In addition to direct funding from the Physician Master Agreement, the Shared Care Committee works collaboratively with and receives project specific funding contributions from the General Practice Services Committee and the Specialist Services Committee.

For 2014/15, the Shared Care Committee allocated a budget of $21.8 Million comprised of:

- $6.5 Million in direct funding allocated in the Physician's Master Agreement
- $3.6 Million in prior years unspent
- $4.8 Million in prior years committed funding
- $6.9 Million in one-time funding from General Practice Services and Specialist Services Committees

Audited financial statements are attached as Appendix B (available September 2015)

ORGANIZATIONAL STRUCTURE

The Shared Care Committee is a joint committee of Doctors of BC and the Ministry of Health, each of which appoints four members. Sections of Emergency Medicine and Hospital Medicine, BC Health Authorities (including the First Nations Health Authority) and two patient representatives also participate on a regular basis. Details of the current membership and guest attendees are provided in Appendix A.

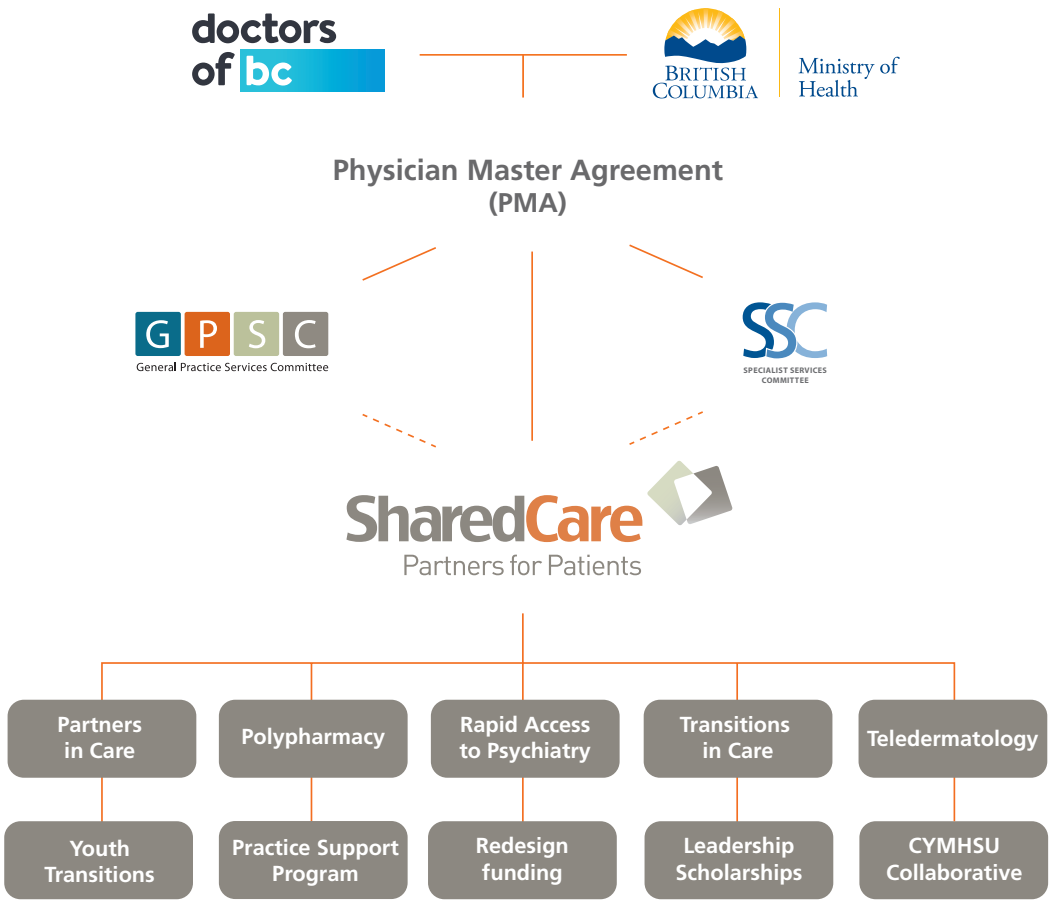
All Shared Care Committee decisions are made by consensus, with principles of sustainability and spread embedded in the work by:

- Using existing infrastructures to deliver the work
- Evaluating and sharing results of successful innovations and quality improvement learnings
- Using a community development approach that builds capacity for innovation, and develops collaborative relationships among health professionals within the community
- The provision of skilled staff as a supportive link between the committee and individual initiatives to monitor progress and support best possible outcomes

More information on Shared Care is available at **www.sharedcarebc.ca**

All Shared Care Committee decisions are made by consensus.

Shared Care Committee Structure



INITIATIVES

The relationship between family and specialist physicians, health professionals, patients and families is fundamental to the delivery of effective health care, especially for the most complex patient populations. Shared Care Committee initiatives help strengthen this relationship by providing a mechanism to build collaboration and collegiality to collectively address issues that matter most at a community level.

The spread of learnings, evaluation of quantitative and qualitative results, and increased opportunities for leadership and collaboration to improve care, all contribute to a collective impact integral to transforming the system at every level.

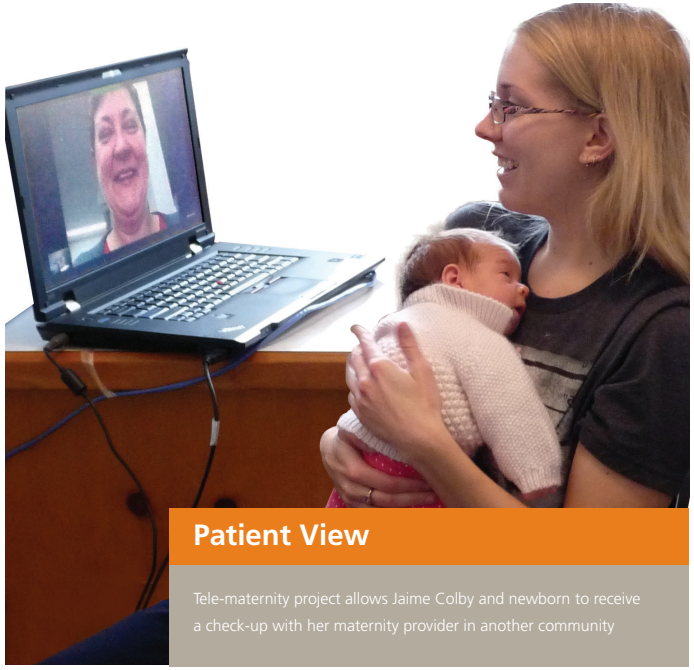
To facilitate this work, the Shared Care Committee supports a number of initiatives; all based on the application of the Triple Aim Improvement framework, and effective quality improvement methodologies. Currently there are approximately 125 active projects taking place across Shared Care initiatives, and 58 projects which have been completed to date.

Partners in Care

The Shared Care Committee's Partners in Care initiative comprises more than 40 collaborative projects by family and specialist physicians in communities throughout the province to implement and streamline referral and consult processes, shared care planning and re-referral criteria, diagnostic standards and communications, telephone advice protocols and more.

With funding from the committee, these physicians are developing locally appropriate solutions to challenges in both access and delivery of coordinated care for patients requiring both primary and specialist care.

Total expenditure 2014/15 $1,010,207



Patient View

Tele-maternity project allows Jaime Colby and newborn to receive a check-up with her maternity provider in another community

Rapid Access to Psychiatry

The Rapid Access to Psychiatry initiative began in March 2009, when two Vancouver psychiatrists began offering Group Medical Visits for their patient group. These formed the basis of an alternate model of care to expedite access to psychiatric assessment, effective intervention and follow-up for patients with mood disorders.

Evaluation of the model has demonstrated its effectiveness in improving access for patients – with psychiatrists able to see 4.5 times as many patients than with individual visits. Additionally, the psychiatrists found that many of their patients did well in a group setting. Evaluative research found that in 75% of cases, group visits are equally as effective as individual visits. The remaining 25% indicate that group visits are actually more effective with patients feeling supported by the other participants in the group.

The initiative has expanded to Langara College's Vancouver campus, where psychiatrists are now holding Group Medical Visits for patients with ADHD.

In 2014/15, based on the success of Rapid Access to Psychiatry and the Group Medical Visit, the Shared Care Committee forwarded a recommendation to the Specialist Services Committee to adjust the fees for Group Medical Visits to facilitate the wide adoption of this model for psychiatry.

Total expenditure 2014/15 $181,819

Transitions in Care

The Transitions in Care initiative focuses on improving care and bridging gaps between physicians and other health professionals as patients move between health care settings. The goal is to improve the coordination of care for patients and families across these transition points, where patients may be most vulnerable.

More than 20 individual projects, focused on priority patient populations, are trialling strategies to improve communications between providers, developing mechanisms to align care planning, and building capacity with patients and providers. Evaluations indicate patients and families are feeling more knowledgeable about their care, have a stronger sense of team work among their health care providers,and that many local strategies have been effective in addressing gaps and reducing acute exacerbations of health conditions that often result in emergency department visits, hospitalization or facility placement.

Total expenditures 2014/15 $1,870,922

Patient View

"One of the greatest benefits for me is that my doctors are really talking to each other."

Jack Swobaba - COPD patient with angina

Teledermatology

The Teledermatology initiative uses digital technology and a secure web-based system to improve access to dermatological consultation for family physicians in urban, rural and remote communities in BC. The aim is to reduce wait times for consultation – and the need for patients to travel to access specialist assessment.

A secure web-based system enables family physicians to send photographs of a patient's dermatological condition to a dermatologist for assessment. To date more than 800 family physicians have accessed the Teledermatology consultation service, and more than 2,000 consultations have been completed. More than 90% of patients found the process more convenient than travelling to another city for a dermatology consultation, 85% were satisfied with their consultation and 100% were comfortable with having photographs of their condition shared with a dermatologist via the secure website.

Throughout fiscal 2014 -15 the Teledermatology steering committee focused on physician engagement for program uptake, identification of program sustainability requirements and program evaluation. Teledermatology is now moving into its final phase with implementation of a sustainable structure to maintain access for physicians province-wide.

Total expenditure 2014/15 $206,405

Polypharmacy Risk Reduction

The Shared Care Polypharmacy Risk Reduction initiative supports family and specialist physicians to improve management of patients on multiple medications that may impact their safety and quality of life, especially for those who are elderly and frail.

In 2014-15, the Polypharmacy Risk Reduction initiative held ten engagement sessions for physicians and interdisciplinary care teams working in residential care facilities across BC, to provide training and resources to support them in undertaking review and adjustment of medication plans. Additionally, the initiative began working with acute care physicians caring for patients on medical units in four health regions, as well as hip fracture surgery patients at three hospitals in Vancouver and Victoria.

With the General Practice Services Committee preparing to launch their Residential Care Initiative, the Polypharmacy Risk Reduction initiative is aligned to facilitate the spread of proven solutions across the province. One such example is the Vancouver Division of Family Practice, which has initiated the implementation of a Mentored Medication project in Vancouver residential care facilities with support from the Polypharmacy Risk Reduction initiative.
A robust evaluation has been initiated to measure the impact of the initiative on care of frail seniors across the province.

Total expenditure 2014/15
$431,983

Physicians from across BC attending a recent *Train the Mentor* session

Child and Youth Mental Health and Substance Use Collaborative

The Child and Youth Mental Health and Substance Use Collaborative (the "Collaborative") is a cross system collaboration funded by the Shared Care Committee to increase timely access to integrated child and youth mental health and substance use services and supports throughout the province.

The Collaborative began in 2013 with eight Local Action Teams in the Interior region of BC. This unique collaborative model engages Local Action Teams who commit to improve areas of policy or practice that they identify and define during the process of engagement. The teams then make small tests of change in these areas and share results with others at regular "Learning Sessions". The Collaborative has spread rapidly from the Interior to other areas of the province. By March 2015 it had grown to 30 existing and emerging Local Action Teams in the Interior, Island, Fraser and Vancouver Coastal regions, reflecting recognition of the urgent need for improvement, and the effectiveness of the structured collaborative approach in engaging participation across services and community lines.

Participation includes youth and their families, Doctors of BC, three government ministries (Health, Children and Family Development, Education), Health Authorities (including First Nations), family and specialist physicians, schools, police, local government and community agencies – all partnering to address challenges and gaps identified in their communities, as well as provincially through system Working Groups.

In July 2014, the Child and Youth Mental Health and Substance Use Collaborative appeared before the Select Standing Committee on Children and Youth to describe the role and impact of the initiative, and in response to the Committee's strong interest in their work, agreed to regularly update them on the progress of the Collaborative.

In addition to improving community level dialogue and collaboration, in 2014/15 the Collaborative also accomplished the following:

- Development of a protocol for children, youth and their families presenting at Emergency Rooms. This includes improved guidelines, assessment tools, discharge safety and information for families, based on an extensive consultation process.
- Publication of eight articles on child and youth mental health and substance use, in collaboration with psychiatrist Dr. David Smith, which were featured in 22 newspapers across the province. 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.
- Development of an online 16-session targeted learning series to build capacity of pediatricians, general psychiatrics, ER physicians and GPs with specialized practices, as well as other health professionals. The learning series is scheduled to be launched in fall 2015.

Total expenditure 2014/15 $3,676,315

Youth Transitions

The Youth Transitions initiative was initiated to improve the transition from pediatric to adult care for youth and young adults with complex heath conditions, including cancer, chronic diseases, congenital defects and metabolic disorders of childhood. Approximately 1,700 youth are currently aging out of the pediatric system in BC annually, and this number is increasing.

The shift from pediatric to adult care can result in weakened relationships between patients and primary care physicians, and decreased access to community based health care resources. These can lead to exacerbations of illness, secondary illness or disability for patients. To better support these patients, the Youth Transitions initiative engaged patients, families and physicians in developing, piloting and evaluating effective transition resources for a more coordinated model of care for this vulnerable patient group.

In 2014/15 the Youth Transition Initiative successfully established the foundation to bridge the gaps in transition for youth from BC Children's Hospital to adult primary care. This includes a Medical Transfer Summary, an expedited referral process, fee code recommendations, and an algorithm for tracking and evaluation. The initiative is currently building its spread and sustainability plan as part of its final phase.

Total expenditure 2014/15 $0 *(carry-over funds from the prior year were utilized)*

Practice Support Program

The Shared Care Committee provides direction, support and funding to the Practice Support Program to provide training for physicians to improve shared clinical practice and enhance delivery of patient care.

In 2014/15, the Shared Care Committee supported the development and implementation of learning modules for musculo-skeletal care and treatment of chronic pain. These modules will be incorporated into physicians' electronic medical records systems, beginning in 2015/16

Total expenditure 2014/15 $541,707

Funding and Scholarships

Health System Redesign Funding

The committee supports physician participation in system redesign initiatives led by the BC health authorities. Funds are provided to compensate family physicians for time spent away from their practice as they participate to improve the delivery of primary and specialist care services delivered by health authorities.

Total expenditures 2014/15 $1,794,671

Physician Leadership Training Scholarship

In partnership with the Specialist Services Committee, Shared Care Committee offers scholarships to enable physicians to participate in leadership development activities, approved by the medical leadership in the health authorities. A maximum of $10,000 per physician is available to cover tuition fees and travel, and approximately 150 physicians took the opportunity to attend a range of quality improvement skills development and leadership training programs in 2014/15. Applications endorsed by the health authority are submitted to a subcommittee of Shared Care and Specialist Services members and staff for approval.

Total expenditures 2014/15 $237,205

Appendix A – 2014/15 Shared Care Committee Membership

Committee Members		
Dr. Gordon Hoag, Co-Chair	Pathologist	Doctors of BC
Ms. Marilyn Copes, Co-Chair	Senior Advisor, Health Services Policy and Quality Assurance Division	Ministry of Health
Dr. Shelley Ross	Family Physician	Doctors of BC
Mr. Kevin Brown	Executive Director, Health Human Resources Planning – Physicians	Ministry of Health
Dr. Ken Hughes	Orthopedic Surgeon	Doctors of BC
Ms. Michelle Lane	Executive Director, Acute and Provincial Services, Health Services Policy and Quality Assurance Division	Ministry of Health
Dr. George Watson	Family Physician	Doctors of BC
Dr. Garey Mazowita	Family Physician	Ministry of Health
Dr. Emiko Moniwa (alternate)	Psychiatrist	Doctors of BC

Participating Representatives

Ms. Jillianne Code	Patient	Patient Voices Network
Ms. Iris Kisch	Patient	Patient Voices Network
Dr. Shallen Letwin	Vice-President, Community Hospitals and Programs	Fraser Health Authority
Ms. Wendy Hansson (Mr. David Harrhy, alternate)	Vice-President, Community Integrated Health Services	Interior Health Authority
Ms. Candice Manahan (Mr. Ciro Panessa, alternate)	Executive Lead, Physician Quality	Northern Health Authority
Dr. David Robertson	Executive Medical Director	Vancouver Island Health Authority
Ms. Carol Park	Director, Primary Care Integration	Vancouver Coastal Health Authority
Ms. Pam Aikman	Provincial Director, Stroke Services BC	Provincial Health Services Authority
Dr. Shannon Waters	Director, Health Surveillance, Health Services	First Nations Health Authority
Dr. David Haughton	Emergency Physician	Section of Emergency Medicine, Doctors of BC
Dr. David Wilton	Hospitalist	Doctors of BC

Appendix B – Audited Financial Statements

Financial Statements of

SHARED CARE PROGRAMS

Year ended March 31, 2015

KPMG LLP
Chartered Accountants
Box 10426, 777 Dunsmuir Street
Vancouver BC V7Y 1K3

Telephone (604) 691-3000
Telefax (604) 691-3031
Internet www.kpmg.ca

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, 2015**,** 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, 2015 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.

Comparative Information

The financial statements of the Shared Care Programs as at and for the year ended March 31, 2014 are unaudited. Accordingly, we do not express an opinion on them.

KPMG LLP

Chartered Professional Accountants

September 16, 2015

Vancouver, Canada

SHARED CARE PROGRAMS

Statement of Financial Position

March 31, 2015, with comparative information for 2014

	2015	2014 (unaudited)
Assets		
Current assets:		
Cash	$ 11,948,879	$ 10,992,166
Accounts receivable	2,324,629	-
Due from British Columbia Medical Association (note 5)	-	14,716
Due from GPSC Collaboratives Program (note 5)	394,861	-
Due from Specialist Services Programs (note 5)	500,000	-
Prepaid expenses	510	-
	$ 15,168,879	$ 11,006,882
Liabilities and Net Assets		
Current liabilities:		
Accounts payable and accrued liabilities (note 5)	$ 1,006,961	$ 875,467
Due to British Columbia Medical Association (note 5)	86,263	-
Due to GPSC Collaboratives Program (note 5)	-	299,813
Due to Specialist Services Programs (note 5)	-	3,973
	1,093,224	1,179,253
Deferred contributions (note 4)	14,075,655	9,827,629
Net assets	-	-
	$ 15,168,879	$ 11,006,882

See accompanying notes to financial statements.

Approved on behalf of the Shared Care Committee:

Gordon Hoag — Committee Co-Chair

Marilyn Copes — Committee Co-Chair

September 16, 2015

SHARED CARE PROGRAMS

Statement of Operations and Changes in Net Assets

Year ended March 31, 2015, with comparative information for 2014

	Program Enablers	Partners in Care	Transitions in Care	Child and Youth Mental Health Collaborative	Polypharmacy	PRR Hip Fracture Project	Rapid Access to Psychiatry	Teledermatology	Scholarships	Redesign	Youth Transitions	Pain Collaborative	Special Projects	Total 2015	Total 2014
															(unaudited)
Revenue (note 4):															
Ministry of Health	$1,010,207	$1,732,009	$1,870,922	$ 3,661,635	$ 431,983	$ 1,683	$181,819	$ 206,405	$ 237,205	$1,794,671	$ 2,953	$ 358	$ 8,343	$11,140,193	$ 5,818,526
Expenses:															
Salaries and benefits	717,432	91,699	92,792	241,549	1,436	-	-	-	-	-	-	-	-	1,144,908	398,958
Office and communications	47,875	6,268	863	1,514	606	-	-	-	28	-	-	-	-	57,154	77,751
Meetings and conferences	145,924	12,992	16,296	164,590	237,081	-	4,548	12,128	61,261	-	2,953	358	-	658,131	379,756
Transfer to divisions of family practice	-	1,621,050	1,582,971	2,301,696	133,000	-	-	-	-	-	-	-	-	5,638,717	2,622,959
Transfer to health authorities	-	-	-	-	-	-	-	-	-	1,794,671	-	-	-	1,794,671	98,098
Other transfers	-	-	178,000	810,822	-	-	130,000	-	-	-	-	-	-	1,118,822	915,151
Special projects	-	-	-	-	-	1,683	-	-	-	-	-	-	8,343	10,026	1,177
Showcase	-	-	-	-	-	-	-	-	-	-	-	-	-	-	381,213
Professional fees	8,976	-	-	141,464	59,860	-	47,271	192,277	-	-	-	-	-	449,848	787,048
Education	-	-	-			-	-	-	175,916	-	-	-	-	175,916	66,415
Evaluation	-	-	-	-	-	-	-	2,000	-	-	-	-	-	2,000	-
Administration fees	90,000	-	-	-	-	-	-	-	-	-	-	-	-	90,000	90,000
	1,010,207	1,732,009	1,870,922	3,661,635	431,983	1,683	181,819	206,405	237,205	1,794,671	2,953	358	8,343	11,140,193	5,818,526
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, 2015, with comparative information for 2014

	2015	2014
		(unaudited)
Cash provided by:		
Operating activities:		
Excess of revenue over expenses	$ -	$ -
Change in deferred contributions	4,248,026	4,254,473
Change in non-cash operating working capital:		
Accounts receivable	(2,324,629)	6,398
Due from / to British Columbia Medical Association	100,979	246,020
Due from / to GPSC Collaboratives Program	(694,674)	142,339
Due from / to Specialist Services Programs	(503,973)	834,884
Prepaid expenses	(510)	1,500
Accounts payable and accrued liabilities	131,494	443,035
	956,713	5,928,649
Increase in cash	956,713	5,928,649
Cash, beginning of year	10,992,166	5,063,517
Cash, end of year	$ 11,948,879	$ 10,992,166

See accompanying notes to financial statements.

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 British Columbia Medical Association ("BCMA") 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), as well as expenses for the Evaluation working group. The 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.

(b) 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.

(c) 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.

(d) 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.

(e) 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.

(f) PRR Hip Fracture Project:

Partnering with the Specialist Services Committee ("SSC"), Hip Fracture Initiative, and Polypharmacy Risk Reduction, the PRR Hip Fracture Project is supporting family and specialist physicians to improve medication management, collaborative opportunities for caregivers, enhanced medication reviews and prevent adverse drug reaction for hip fracture patients.

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

(g) 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.

(h) 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.

(i) Scholarships:

The committee, in partnership with the SSC, offers scholarships for physicians for successful completion of leadership training approved by a health authority.

(j) Redesign:

The SCC 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.

(k) Youth Transitions:

This initiative aims to improve the transition from pediatric to adult care for youth and young adults (age 10 to 24) with chronic health conditions and/or disabilities.

(l) Pain Collaborative:

Environmental scan and needs assessment for a provincial collaborative initiative focused on pain.

(m) 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. This 15-month voluntary quality improvement initiative ran until December 2014.

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.

2. Agreements:

The Government of the Province of British Columbia (the "Government"), the Medical Services Commission of British Columbia ("MSC") and the BCMA 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 BCMA 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.

(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/to BCMA, due from/to Specialist Services Programs ("SSP"), and due from/to GPSC Collaboratives Program ("GPSC Collaboratives").

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. Significant items subject to such estimates and assumptions include provisions for contingencies. Actual results could differ from those estimates.

4. Deferred contributions:

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

	Program Enablers	Partners in Care	Transitions in Care	CYMH Collaboratives	Polypharmacy	PRR Hip Fracture project	Rapid Access to Psychiatry	Teledermatology	Scholarships	Subtotal carried forward
Balance, March 31, 2014 (unaudited)	$ -	$ 1,006,449	$ 1,366,237	$ 851,312	$ 682,590	$ -	$ 186,085	$ 347,201	$ 581,942	$ 5,021,816
Contributions received	818,729	749,852	1,621,278	1,046,230	233,276	-	-	146,419	-	4,615,784
Contribution receivable	-	-	-	-	-	-	-	-	-	-
Return of funds	-	-	-	-	-	-	-	-	-	-
Interest earned	-	31,721	23,585	38,522	18,423	-	1,001	4,492	5,308	123,052
Transfers (a)	576,271	2,443,849	627,985	2,890,082	1,184,134	232,956	13,916	(143,620)	(331,942)	7,493,631
Amounts recognized as revenue in the year	(1,010,207)	(1,732,009)	(1,870,922)	(3,661,635)	(431,983)	(1,683)	(181,819)	(206,405)	(237,205)	(9,333,868)
Balance, March 31, 2015	$ 384,793	$ 2,499,862	$ 1,768,163	$ 1,164,511	$ 1,686,440	$ 231,273	$ 19,183	$ 148,087	$ 18,103	$ 7,920,415

	Subtotal brought forward	Practice Support Program	Redesign	Youth Transitions	Pain Collaborative	Special Projects	Other Special Projects	Unallocated General	Total
Balance, March 31, 2014 (unaudited)	$ 5,021,816	$ 541,707	$ 1,830,557	$ -	$ -	$ 99,275	$ -	$ 2,334,274	$ 9,827,629
Contributions received	4,615,784	-	-	-	-	-	-	-	4,615,784
Contribution receivable	-	-	-	-	-	-	-	1,884,216	1,884,216
Return of funds	-	-	-	322,039	-	-	-	-	322,039
Interest earned	123,052	-	-	-	-	-	-	-	123,052
Transfers (a)	7,493,631	(208,559)	1,500,000	330,000	500,000	50,000	500,000	(1,721,944)	8,443,128
Amounts recognized as revenue in the year	(9,333,868)	-	(1,794,671)	(2,953)	(358)	(8,343)	-	-	(11,140,193)
Balance, March 31, 2015	$ 7,920,415	$ 333,148	$ 1,535,886	$ 649,086	$ 499,642	$ 140,932	$ 500,000	$ 2,496,546	$ 14,075,655

(a) Transfers represent amounts that have been directed by the funder to other programs either inside or outside the Program under the PMA.

5. Related party transactions and balances:

The Government and MSC have entered into a contract with the BCMA for the term of the PMA for the BCMA 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, 2015, the Program paid $90,000 (2014 - $90,000 (unaudited)) for services provided by the BCMA. As at March 31, 2015, $22,500 (2014 - $22,500 (unaudited)) remained payable to the BCMA relating to these administrative fees and is included in accounts payable and accrued liabilities.

As at March 31, 2015, the Program had a payable of $86,263 to the BCMA related to expenses paid by the BCMA on behalf of the Program. As at March 31, 2014, the Program had a receivable of $14,716 from the BCMA relating to funding allocated to the Program not yet received by the Program (unaudited).

As at March 31, 2015, the Program had a receivable of $394,861 from the GPSC Collaboratives relating to funding allocated to the Program not yet received by the Program. As at March 31, 2014, the Program had a payable of $299,813 to the GPSC Collaboratives relating to expenses paid by the GPSC Collaboratives on behalf of the Program (unaudited).

As at March 31, 2015, the Program had a receivable of $500,000 from the SSP relating to funding allocated to the Program not yet received by the Program. As at March 31, 2014, the Program had a payable of $3,973 to SSP related to expenses paid by the SSP on behalf of the Program (unaudited).

6. 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.