SharedCare
Partners for Patients

Shared Care Committee

Project Funding Toolkit

BRITISH COLUMBIA

doctors of bc

TABLE OF CONTENTS

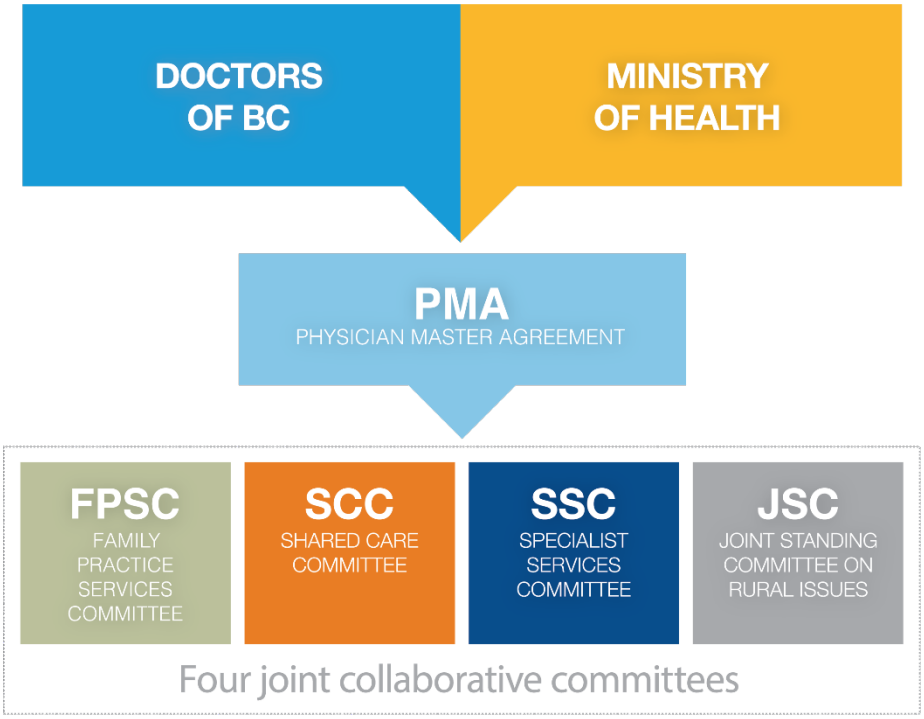
SHARED CARE COMMITTEE OVERVIEW

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.

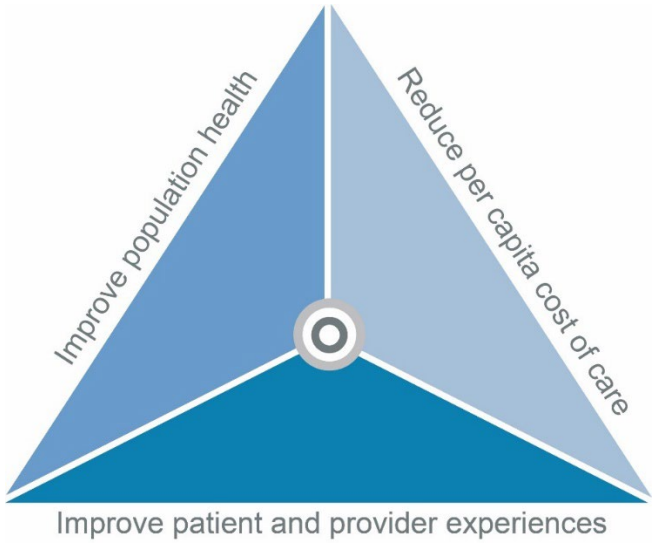
The SCC's mandate is to support family and specialist physicians, health care partners, patients, families, and caregivers, to collaborate on health care improvement initiatives together.

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.



Values and Principles

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.



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.

Effective Engagement | Innovation | Collaborative Culture Change | Measurable Improvement

Effective Engagement

- Physicians and other health providers identify gaps and issues in care and required practice and process changes.
- Physicians, health providers, and health system representatives plan specific activities/local projects and actively implement practice and process changes.
- Patient/caregiver partners are an integral part of the project and engaged throughout the lifespan of the work.
- Projects reflect the collective input and participation of all partners from development through to completion.

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.
- Solutions are supported that have the potential to be leveraged broadly.
- Promotes synergistic thinking.

Collaborative Culture Change

- Supports collaboration for mutual benefit, shared priorities.
- Builds sustainable physician relationships around shared 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.

Project Capacity

Taking on an improvement project takes time, expertise, and resources. While Shared

SHARED CARE FUNDING

Funding Overview

The Shared Care Committee offers active support for family physicians and specialists to collaborate on quality improvement projects through two main initiatives:

Partners in Care or Transitions in Care (PiC/TiC)	Networks
Projects co-led by family physicians and specialists to improve coordination of care among providers (PiC) and transitions between acute and community (TiC).	Bringing together communities actively engaged in addressing the needs of priority populations: • Adult Mental Health/Substance Use • Chronic Pain • Coordinating Complex Care for Older Adults (including Palliative Care) • Maternity Care
Objectives for funded Shared Care projects include: • Bridging care between acute and community • Improving communications and referrals • Increasing timely access to specialty care • Reducing wait-times for consultations • Improving patient care pathways	

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

Since 2010, SCC's Partners in Care (PiC) and Transitions in Care (TiC) initiative has engaged Family Physicians, Specialists, Family Physicians with Focused Practice, Health Authorities, and other health professionals, in over 200 community-based projects across the province.

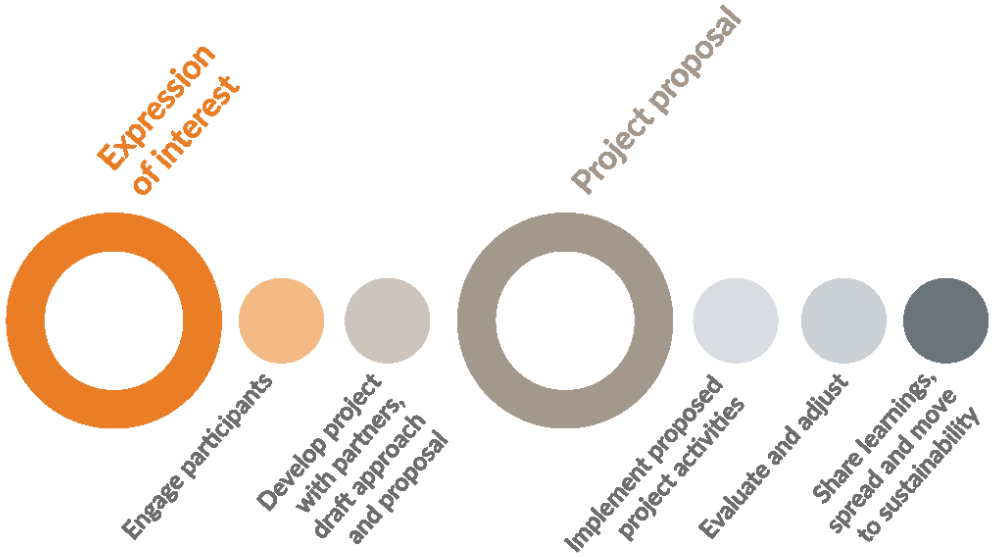
As the PiC/TiC work has evolved over time, project teams have worked together to learn from each other and spread activities regionally or provincially. PiC/TiC projects also formed the foundation of SCC's Networks, which were initiated to bring together communities actively engaged in addressing the needs of priority populations.

Supported projects provide opportunities to:

- identify and trial new, innovative solutions to gaps in care
- 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 spread of strategies and solutions
- engage in provincial initiatives

Both PiC/TiC and Network projects are developed through an Expression of Interest phase, and a Full Proposal Phase.

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 $25,000) 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).



All communities receiving funding 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 including:

- Resources and tools to support a collaborative approach to address common issues and gaps.
- Opportunities to liaise with other project leads working on Shared Care improvement projects
- Routine gatherings to learn and share resources
- Access and support to implement a shared measurement framework, as well as optional survey tools designed to capture the pre and post project community context
- Opportunities for guidance and information
- Potential to expand the work done in existing communities to newer ones

Through funding support of the EOI, a Full Project Proposal and budget may be developed and submitted to the Shared Care Committee. Regionally based SCC Initiative Liaisons will provide support and assistance in the development of the EOIs and proposals, and will present the these to the Committee on behalf of the applicant(s)

For a step-by-step guide to 'Applying for Funding' go to Appendix A.

Network Areas of Focus

Adult Mental Health & Substance Use Network

The Adult Mental Health and Substance Use (AMHSU) Network supports FP and SP-led partnerships to connect with other allied health care providers to identify community issues and develop strategies to create a more coordinated AMHSU system of care. For more information on the AMHSU Network please visit https://sharedcarebc.ca/our-work/spread-networks/mental-health-substance-use

Chronic Pain Network

The Chronic Pain 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. For more information on the Chronic Pain Network please visit https://sharedcarebc.ca/our-work/spread-networks/chronic-pain

Maternity Network

The Maternity 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 the emerging Perinatal Community of Practice, Perinatal Services BC, the Family Practice Services Committee's (FPSC) Maternity Working Group, the Joint Standing Committee for Rural Issues (JSC) Rural Obstetrical Surgical Networks and other JCC initiatives. The

network has now transitioned to a Community of Practice; however Shared Care continues to support improvement work within the theme of maternity. For more information on the Maternity Network please visit https://sharedcarebc.ca/our-work/spread-networks/maternity

Coordinating Complex Care for Older Adults Initiative (including Palliative Care)

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. These challenges present several opportunities to improve how we provide more effective patient and family-centred care.

Within the theme of Palliative Care, Shared Care looks 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.

For more information on the CCC network please visit https://sharedcarebc.ca/our-work/coordinating-complex-care-for-older-adults

Supplemental Funding Available

OPTIONAL - Local Shared Care Steering Committees ($20K)

For communities with two 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. The Shared Care Terms of Reference must be agreed to upon funding for a steering committee. Local Shared Care Steering Committees must be comprised of:

Two Co-chairs – FP & SP
Additional Physicians – minimum one per project
Health Authority Representation (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)

OPTIONAL – Sustainability Funding ($10K)

In order to provide the capability to check back on closed projects to ensure sustainability is efficient it is recommended that funding is provided 1-2 years after project close to:

- ensure the outcomes are still effectively addressing the original gap in care
- assess whether there have been any changes
- ensure sustainability is effective
- update any project resources

This opportunity to revisit a project and review the outcomes to ensure the solutions are still on track will enable Shared Care to assess the value of the project work and ensure that the outcomes are effective. It also allows for increased learning potentials for other SCC projects who want their work to be sustained. This has the potential to identify the requirement for remedial work and eliminate the opportunity for further issues.

To provide sustainability funding to review closed projects, a provision of up to $10K per project to be provided in a period between one and two years after a project closes. Application for these funds would be submitted by the fund holder after the project close and require a review process including approval from the SCC co-chairs.

PROJECT REPORTING REQUIREMENTS

SCC has a responsibility to ensure that projects receiving funding maintain consistent accountability throughout the project lifecycle. As noted in the Funds Transfer Agreement, it is the Fund Holder's responsibility to ensure that all required project reporting is completed, regardless of the presence of an active Project Lead/Manager.

Quarterly Reporting Requirements

- With a buffer of a minimum of 3 months after the start of the project, all projects funded through the Partners in Care/Transitions in Care (PiC/TiC) initiative or Networks are required to submit quarterly status and financial reports.
- Written reports, submitted through SCC's online reporting portal are required, regardless of whether activities have occurred for the relevant quarter. Verbal reports to the SCC liaison via a Steering Committee or other methodology are not considered fulfilment of the reporting requirement.
- The following are not required to submit to quarterly reports:
    - Steering Committees (end of year reporting only)
    - Expression of Interest projects (reporting is optional)

Process to collect reports

- On the last day of the quarter (June 30th, September 30th, December 31st and March 31st), a reporting reminder will be sent by the Quality Impact Project Officer to each project required to submit quarterly reports. Reporting is due on the 15th of the month following (July 15th, October 15th, January 15th, April 15th).
- All projects who have not submitted a quarterly report as of 2 weeks following the due date, will receive a reminder to submit. This reminder will be sent by the QI Project Officer.
- Discussion on projects that are consistently late (defined as more than 1 month late with reporting more than twice) will be referred to the Sr. Manager, Quality Impact.

Final Reports

EOI Completion Report: As your community works through the EOI, you may find that for a variety of reasons, you do not want to proceed to the submission of a full proposal. If this is the case, we would ask you to complete an EOI Completion Report, available on our funding guidelines webpage. In addition to the submission of this report, communities are requested to report on expenditures during the EOI phase and to return any unspent funds to Shared Care.

Final Report: Utilizing the Final Report template available through the Shared Care Learning Centre or via an Initiative Liaison, projects are required to submit a final report of their work within 3 months of project completion. Projects are encouraged to share draft final reports with their Initiative Liaison for feedback prior to finalization.

End of Project Physician Survey: Upon conclusion of the project, all physicians participating (defined as having received at least one sessional payment during the life of the project) should be survey regarding their experience.

EVALUATION

The Shared Care Committee has funded hundreds of Quality Improvement (QI) projects since the Committee's creation in 2011.

By supporting physician-led QI projects, the Shared Care Committee creates opportunities for family physicians and specialists to collaborate and directly apply their expertise and experience to specific issues and gaps in the health system.

With the aim of supporting high quality planning, implementation, monitoring and reporting processes, the Shared Care team has created a number of templates and tools for use by project teams. By offering a unified approach to evaluation and reporting, project teams will be better equipped to share their results and impacts in a way that can be effectively spread by the Shared Care team to key stakeholders, including the Shared Care Committee, the health authorities and the Ministry.

Shared Measurement

Central to this approach to evaluation is the adoption of Shared Measurement. Shared Measurement consists of an agreed upon set of Shared Measures related to the goals and objectives of the Shared Care Committee that can be used across the province to assess and compare local innovation projects and provincial initiatives. Implementation of this approach will facilitate the collection and reporting of data to highlight the collective impact of the Shared Care funded work.

At the project level, the Shared Measures can be integrated into an evaluation strategy as one component of the plan, or can standalone as the primary evaluative approach. Connect with your Initiative Liaison to find out more about how to integrate Shared Measures into your project and evaluation plan.

SUSTAINABILITY PLAN

Shared Care projects are quality initiatives designed to ensure that the project outcomes meet defined goals, and are self-sustaining or integrated into system processes for patient care.

As Shared Care provides one-time funding, communities must implement a sustainability plan to ensure the project implementation activities are sustained and updated as needed within the community on a long term basis. Additionally, projects should identify the funding and administrative plan to support operations. Another consideration would be confirming that long-term strategies are identified and agreed between the project partners over the course of the work.

The Shared Care Committee has defined sustainability as the following:

- When new ways of working and improved outcomes become the norm[1]
- Holding the gains and evolving as required – definitely not going back.[2]
- It's about paying attention:
    - The key to sustaining improvement is to focus on the daily work of frontline managers, supported by a high performance management system that prescribes standard tasks and responsibilities for managers at all levels of the organization.
    - Improvement alone is not enough.[3]

The guidelines development and utilization of Shared Measures in sustainability planning would be guided by the SCC process and follow the NHS identified aims:

1. Clarify what you are sustaining
2. Engage leaders
3. Involve and support front-line staff
4. Communicate the benefits of the improved process
5. Ensure the change is ready to be implemented and sustained
6. Embed the improved process
7. Build in ongoing measurement

[1] https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/NHS-Sustainability-Guide-2010.pdf
[2] NHS Institute for Innovation and Improvement 2005
[3] Scoville, R., K. Little, J. Rakover, K. Luther and K. Mate (2014). Sustaining Improvement. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. IHI Whitepaper. Cambridge, MA, Institute for Healthcare Improvement. Available at IHI.ORG.

Sample questionnaire themes to identify key gaps in terms of sustainability:

1. Process
    - Monitoring Progress
    - Adaptability
    - Credibility of Benefits
    - Benefits beyond helping patients
2. Staff
    - Training and involvement
    - Behaviours
    - Senior Leaders
    - Clinical Leaders
3. Organization
    - Infrastructure
    - Fits with goals and culture

APPENDIX A: APPLYING FOR SHARED CARE FUNDING

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 proposal development and applying for funding.

	Steps for Funding
Step 1	Engage with your Initiative Liaison
Step 2	Develop an Expression of Interest (EOI) and work with your Initiative Liaison to finalize EOI
Step 3	EOI submitted to Committee for Funding approval
Step 4	EOI approved. Sign 'Funds Transfer Agreement.' Funding released.
Step 5	Complete draft Full Proposal and work with your Initiative Liaison to finalize.
Step 6	Full Proposal is submitted to Committee for Funding Approval (Amount dependent on project)
Step 7	Complete and sign Funds Transfer Agreement after approval.

Project Development and Funding Process

Step 1: Engage with your Initiative Liaison

The Initiative 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 care gap that you are trying to address: Provide the patient, family and caregiver perspective to highlight the issue. What is the issue or gap in care that needs to be addressed? How would addressing this gap 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.

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. Some Divisions and other fund holders may have internal processes for project identification and approval, and early communication may support a streamlined application.

Step 2: Develop an Expression of Interest (EOI) – up to $25K

Using the Expression of Interest Template found on our Funding Guidelines webpage, 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 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 $25,000) as a precursor to developing 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 Liaison will present your draft proposal to the internal Shared Care team. Upon review and feedback, the liaison will work with the project team to make any changes necessary before the finalized EOI goes to the SCC for funding approval. This review process may be iterative as needed. This internal review can take up to 4 weeks.

Step 3: EOI submitted to Committee for Funding approval

EOI is presented to the Committee: The Initiative Liaison will put forward the EOI 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.

Step 4: EOI approved. Sign 'Funds Transfer Agreement'. Funding released.

Execute Funds Transfer Agreement (FTA): Once Committee approval is received, the Initiative Liaison will facilitate the completion of a Funds Transfer Agreement, and funding will be released.

Steps 5: Complete draft Full Proposal and work with your Initiative Liaison to finalize

Develop the project idea, proposal and budget: Upon EOI completion, projects may submit a full project 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. The Initiative Liaison will provide support and assistance in the development of the proposal and budget.

Feedback Implementation: The Initiative Liaison will present your draft full proposal to the internal Shared Care team. Upon review and feedback, the liaison will work with the project team to make any proposal changes and necessary before the finalized proposal goes to the SCC for funding approval. This review process may be iterative as needed. This internal review can take up to 4 weeks.

Gated Funding: If your proposal is requesting funding in excess of $100,000, funding will flow to the project in gates. Gates may be structured to sync with:

- Natural phases in the project appropriate for alignment with specific funding gates
- Anticipated milestones throughout the life cycle of the project
- Outcomes or measures associated with the natural phases of the project.

Step 6: Full Proposal is submitted to Committee for Funding Approval (Amount dependent on project)

As in Steps 3 & 4 (EOI), the following steps are required to reach funding approval:

1. Full proposal is presented to the Committee for funding approval

2. Execute 'Funds Transfer Agreement.' Funding released.

Applying for Local Steering Committee funding

Step 1: 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.

Step 2: The funding request is submitted to the Quality Impact Senior Manager Committee for review and approval.

Step 3: Once approval is received, the SCC Initiative Liaison and central Quality Impact office will make arrangements for a *Funds Transfer Agreement* to be completed, and funding to be released.

Step 4: The Local Shared Care Steering Committee Funding Request form can be found HERE.

APPENDIX B: DETAILED FORM INFORMATION – EXPRESSION OF INTEREST

Project Purpose/Summary (100 word maximum)

The summary should provide information on the gap/problem you are trying to address. How did your group identify this gap? Who was involved in identifying it and why is it a priority?

Shared Measures

Based on what you already know about the gap/problem, which Shared Measures would fit most with the proposed project (Note: these measures can be updated in the Full Proposal Stage)

☐ SCC1 - Improved patient care and health outcomes ☐ SCC2 - Improved patient ability to self-manage care ☐ SCC3 - Improvements in physician and other health provider coordination, flow of care and communication ☐ SCC4 - Improved patient transitions between provider and care environments	☐ SCC5 - Improvements in GP access to specialist consultations ☐ SCC6 - Improve timeliness of patient access to physician care ☐ SCC7 - Improvements in appropriateness of GP referrals to specialist physicians ☐ SCC8 - Improved per capita cost of care or improved sustainability

Patient Story

Grounding the work of health care system improvement in the patient journey is central to the approach of Shared Care. Please provide an (anonymized) story about how the problem/gap is impacting a patient/patients in your community.

Physician Leadership

Often, the spark for addressing a gap in case is identified by a physician. Provide information in this section of the form regarding what led the physician lead(s) to become interested in addressing the gap in care. Also, please address the issue of physician leadership capacity. Do/does the physician lead/s have the capacity to work on the project?

Activities & Engagement

Please describe what steps the project team will take to build toward the submission of a full proposal. Also address how the project team will engage with key stakeholders such as health authority representatives, Physician Quality Improvement (PQI) graduates, previous Shared Care project physician leads, and community specialists. How will the team engage the patient and family caregiver voice and capture the patient experience in planning? Which Indigenous communities and other diverse populations will be engaged in this project and in what capacity?

Participants

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. Health Authority contacts
d. Physicians and allied health professionals engaged and/or participating
e. Indigenous partners and patient partners
f. Project Manager/others

Budget Guidelines (applicable for both EOI & Proposal stages)

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.
    iv. Shared Care recognizes that in lieu of specialist participation in all projects, some will engage and have leadership from Family Physicians with a Focussed Practice. For budgeting purposes, please report budgets according to College membership (i.e., CCFP physicians to be budgeted within the FP line item; FRCPC to be budgeted within the SP line item).

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
    iii. care platforms etc.
    iv. Compensate organizations, such as health authorities, for costs of staff participation or costs they may
    v. incur from having taken part in Shared Care projects as part of their role.
    vi. Compensate Executive Directors

vii. Direct compensation for patient, family, and caregiver participation in Shared Care projects
viii. Participate in clinical training and non-clinical training
ix. Research studies
x. Alcoholic beverages
xi. Sustain long-term project operations

The EOI Funding Request Template and the Budget Template can be found on our Funding Guidelines webpage.

APPENDIX C: DETAILED FORM INFORMATION – FULL PROPOSAL

Project Summary (100 word maximum)

The summary should provide information an Executive Summary of the gap/problem you are trying to address and the activities you plan to undertake.

Project Aim Statement

An aim statement is the answer to the first question in the Model for Improvement, "What are we trying to accomplish?" (Institute for Healthcare Improvement, 2022)

Patient Story

Grounding the work of health care system improvement in the patient journey is central to the approach of Shared Care. Please provide an (anonymized) story about how the problem/gap is impacting a patient/patients in your community.

Activities & Engagement

Please describe what steps the project team will take to build toward the submission of a full proposal. Also address how the project team will engage with key stakeholders such as health authority representatives, Physician Quality Improvement (PQI) graduates, previous Shared Care project physician leads, and community specialists. How will the team engage the patient and family caregiver voice and capture the patient experience in planning? Which Indigenous communities and other diverse populations will be engaged in this project and in what capacity?

Shared Measures

Based on what you already know about the gap/problem, which Shared Measures would fit most with the proposed project (Note: these measures can be updated in the Full Proposal Stage)

☐ SCC1 - Improved patient care and health outcomes ☐ SCC2 - Improved patient ability to self-manage care ☐ SCC3 - Improvements in physician and other health provider coordination, flow of care and communication	☐ SCC5 - Improvements in GP access to specialist consultations ☐ SCC6 - Improve timeliness of patient access to physician care ☐ SCC7 - Improvements in appropriateness of GP referrals to specialist physicians ☐ SCC8 - Improved per capita cost of care or improved

☐ SCC4 - Improved patient transitions between provider and care environments	sustainability

Patient Populations

Please select the key patient populations who will benefit from the improvement work of the project.

Dimensions of Quality

Utilizing the Dimensions of Quality first published in 2009 by the BC Patient Safety & Quality Council, please identify the primary and secondary dimensions that the project will address. (What is Quality, 2022)

Quality is defined by seven dimensions that span the full continuum of care:

- **Respect**: honouring a person's choices, needs and values
- **Safety**: avoiding harm and fostering security
- **Accessibility**: ease with which health and wellness services are reached
- **Appropriateness**: care is specific to a person's or community's context
- **Effectiveness**: care is known to achieve intended outcomes
- **Equity**: fair distribution of services and benefits according to population need
- **Efficiency**: optimal and sustainable use of resources to yield maximum value

Engagement – Patient & Family Caregiver voice

The voice of patients and families in the shaping of health care improvements is vital. Patients and families can speak to their own, lived experience within the health system and frequently provide input to project discernment and implementation that is valuable and unique. For larger projects, contact the Patient Voices Network for information on inviting patient voices to your project table.

Indigenous Community Engagement

Shared Care Committee, as on of four Collaborative Committees have prioritized partnering with Indigenous communities and are committed to walking with First Nations, Metis, and Inuit peoples on our collective journey to ensure Indigenous patients have access to culturally safe health care in BC.

In an effort to align with the United Nations Declaration on the Rights of Indigenous peoples, The Truth and Reconciliation Commission, and British Columbia's In Plain Sight Report, we ground our journey in the meaningful relationships with continue to build with Indigenous communities, Elders and Knowledge Keepers, the Ministry of Health, and the First Nation Health Authority and BC's other health authorities.

There is no simple fix for the systemic racism that exists in health care but we are committed to adopting a process of constant learning, educating, and evolving.

Please reflect on the above in order to capture how Indigenous, First Nations, Metis, and Inuit peoples will be involved in shaping your improvement project.

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?

Barriers

Please identify if there are known risks or barriers to project implementation.

Sustainability

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

Governance

Identify if there is an action Steering Committee which will oversee the project. If not, what type of governance does the project plan to use to keep its work on track.

Participants

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 (as applicable)
c. Health Authority contacts
d. Physicians and allied health professionals engaged and/or participating
e. Indigenous partners and patient partners
f. Project Manager/others

Budget Guidelines (applicable for both EOI & Proposal stages)

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
   iii. care platforms etc.
   iv. Compensate organizations, such as health authorities, for costs of staff participation or costs they may
   v. incur from having taken part in Shared Care projects as part of their role.
   vi. Compensate Executive Directors
   vii. Direct compensation for patient, family, and caregiver participation in Shared Care projects
   viii. Participate in clinical training and non-clinical training
   ix. Research studies
   x. Alcoholic beverages
   xi. Sustain long-term project operations

The Project Funding Request Template and the Budget Template can be found on our Funding Guidelines webpage.

APPENDIX C: PROJECT MODIFICATIONS

Requesting Additional Funds to Complete a Project

It is expected that communities, for the most part, can 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. If additional funding is less than 20% of the overall project value, follow Option 1. For additional funding of greater than 20% of the overall project value, follow Option 2.

OPTION 1 – ADDITIONAL FUNDING LESS THAN 20% OF OVERALL PROJECT VALUE

Step 1: The Project Lead contacts their Initiative Liaison to discuss the reason for requesting additional funds from the Shared Care Committee.

Step 2: 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.

Step 3: 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.

OPTION 2 – ADDITIONAL FUNDING OVER 20% OF OVERALL PROJECT VALUE

Step 1: The Project Lead contacts their Initiative Liaison to discuss the reason for requesting additional funds from the Shared Care Committee.

Step 2: The Project Lead provides a minimum 5-7 page interim report summarizing the key deliverables, outcomes and progress that the project has made and the rationale for the additional funds request. The Project Lead also creates a budget and work plan for the additional funds being requested and attaches them as appendices. The Project Lead submits these documents to their Initiative Liaison.

Step 3: 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.

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). A maximum of 2 funding extensions are available as needed to projects.

The process for requesting an extension:

Step 1: The Project Lead contacts their Initiative Liaison to discuss the reason for requesting an extension from the Shared Care Committee.

Step 2: 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:

Step 3: The Initiative Liaison and central Shared Care office will make arrangements for the FTA-E to be completed and executed.

Step 4: If multiple FTA-E are requested and the project close date has changed from the original proposal, an internal review of the project objectives may be requested prior to any further extensions.

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

APPENDIX D: ROLES AND RESPONSIBLITIES

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 2–3 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 quarterly project status reports

Quarterly Reporting

A quarterly report is required to be submitted as per the Funds Transfer Agreement. The report requests a status update including status of the project, completed key activities, next steps and financial status update. In addition, how many physicians (differentiated by specialists and family physicians) have been paid at least one sessional payment for their involvement in the project is required. The Quarterly report is reviewed by

the Initiative Liaison as an opportunity to discuss and support the project. If a project is experiencing delays or major difficulties, additional reporting may be requested.

Completion

- Complete all phases of the project
- Complete project evaluation
- Complete project final report
- Facilitate the distribution, collection and submission of the Physician End of Project Survey

*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 **quarterly status reports**
- 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 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.

Reporting

SCC has a responsibility to ensure that projects receiving funding maintain consistent accountability throughout the project lifecycle. As noted in the Funds Transfer Agreement, it is the Fund Holder's responsibility to ensure that all required project reporting is completed, regardless of the presence of an active Project Lead/Manager.

Quarterly Reporting Requirements

- With a buffer of a minimum of 3 months after the start of the project, all projects funded through the Partners in Care/Transitions in Care (PiC/TiC) initiative or Networks are required to submit quarterly status and financial reports.
- Written reports, submitted through SCC's online reporting portal are required, regardless of whether activities have occurred for the relevant quarter. Verbal reports to the SCC liaison via a Steering Committee or other methodology are not considered fulfilment of the reporting requirement.
- The following are not required to submit to quarterly reports:
    - Steering Committees (end of year reporting only)
    - Expression of Interest projects (reporting is optional)

Process to collect reports

- On the last day of the quarter (June 30th, September 30th, December 31st and March 31st), a reporting reminder will be sent by the Quality Impact Project Officer to each project required to submit quarterly reports. Reporting is due on the 15th of the month following (July 15th, October 15th, January 15th, April 15th).
- All projects who have not submitted a quarterly report as of 2 weeks following the due date, will receive a reminder to submit. This reminder will be sent by the QI Project Officer.
- Discussion on projects that are consistently late (defined as more than 1 month late with reporting more than twice) will be referred to the Sr. Manager, Quality Impact.

Final Reports

EOI Completion Report: As your community works through the EOI, you may find that for a variety of reasons, you do not want to proceed to the submission of a full proposal. If this is the case, we would ask you to complete an EOI Completion Report, available on our funding guidelines webpage. In addition to the submission of this report, communities are requested to report on expenditures during the EOI phase and to return any unspent funds to Shared Care. Forms can be found on the Shared Care Learning Centre.

Final Report: Utilizing the Final Report template available through the Shared Care Learning Centre or via an Initiative Liaison, projects are required to submit a final report of their work within 3 months of project completion. Projects are encouraged to share draft final reports with their Initiative Liaison for feedback prior to finalization. Forms can be found on the Shared Care Learning Centre.

APPENDIX E: FREQUENTLY ASKED QUESTIONS

What is the difference between the EOI phase and Full proposal phase?

The focus of the EOI phase is stakeholder engagement and assessment of gaps in knowledge and / or resources. Time in the EOI phase is used to, and to develop a proposal inclusive of an evaluation plan a high level project plan, an evaluation plan that details the outcomes, measures and data collection strategies that will be used, and detailed budget.

Upon conclusion of the EOI, projects have the opportunity to apply for full project funding or make a decision not to proceed further.

Who can be a fund holder?

Most commonly this is a physician-led organization, such as a Division of Family Practice or other organization. Health Authorities, Non Profit Organizations, and PHSA agencies can also act as fundholder. Individuals, physicians or otherwise, are not able to act as fundholders.

Where can I find the deadlines for EOIs and proposals?

Submission deadlines are available on our website at https://sharedcarebc.ca/our-work/funding-guidelines

How do I engage physicians?

Each project should engage patients & families on some level throughout your project. There are various ways to engage the patient & family voice in your initiative:

- Patient journey mapping
- Patient focus group
- Surveys, interviews
- Participation on working group

Where do I engage physicians?

Physicians may be engaged in various ways including though the Divisions on Family Practice, Health Authorities, Medical Staff Associations, community clinics, and various specialist departments.

Can I hire an external evaluator?

External evaluators may be hired to support project work. Evaluation Each project should include appropriate provision for evaluation, including total costs for an evaluation professional, and costs associated with participant and data collection (approximately 10% of the total budget).

What IT components are funded?

Shared Care's current funding guidelines do not support funding for software development, licensing or other IT infrastructure. For questions related to IT funding, please speak to an Initiative Liaison.

What training can be compensated?

Through the Physician Leadership Scholarship Fund, physicians who are actively practicing in the Province of BC are eligible to receive up to $10,000 annually for leadership and quality improvement training. For more information on the Scholarship, go to https://sscbc.ca/physician-engagement/leadership-training-scholarship

In addition to the Scholarship program, health authorities across BC have partnered with the Specialist Services Committee to offer the Physician Quality Improvement program. For more information on the program, https://sscbc.ca/physician-engagement/quality-improvement-initiative

What patient compensation can be funded?

Based on the guidelines from the Patient Voices Network, patients who participate in Shared Care initiatives do so on a volunteer basis. However, patients may be reimbursed for expenses incurred as part of their participation.

Can I present this work at conferences?

Shared Care encourages projects to present at conferences, hospital rounds, and any other avenues that may be appropriate. Please contact your Initiative Liaison for potential funding opportunities.

How do I become a Shared Care Committee meeting member?

Doctors of BC has nearly 60 committees that focus on areas such as health, negotiations, economics, and public affairs. These committees are comprised of BC doctors who volunteer their time and association staff. Depending on the term of the existing Shared Care Committee members, recruitment will be listed on the following website - https://www.doctorsofbc.ca/about-us/governance-and-representation/committees/current-opportunities

What sustainability planning tools and resources are available to me?

Shared Care has created information on planning for sustainability which are available on the Shared Care Learning Centre.

How can I learn more about past projects?

All quality improvement projects supported by Shared Care and the Specialist Services Committee are viewable on the Shared Care Learning Centre's Project Directory.

Is it Research or Quality Improvement?

It's not always easy to distinguish research from QI. The table below will assist with identifying the key differences between research and QI. If further support is required, contact your Initiative Liaison

	Research	Quality Improvement
WHAT IS THE PURPOSE OF YOUR PROJECT?	To generate new knowledge, generalizable to the wider population.	To improve internal processes, practices or systems.
WHAT IS MY ROLE?	As a researcher, you are objective and attempt to isolate and remove personal bias (or disclose it) to support scientific rigor.	As a Team Lead for QI, you are often a part of the system you are trying to improve. Your subjective experience may have assisted in defining the problem you are trying to solve.
WHAT ARE YOU TRYING TO ACCOMPLISH?	To test a new practice, theory, intervention or device.	Bring about immediate positive change to a local practice setting.
HOW MANY PARTICIPANTS WILL YOU INCLUDE?	Typically, the research participants must reflect the total population that is being studied. (E.g. formal power analysis; interview saturation etc).	Will use a convenience sample of participants or data. Small sample, but large enough to observe change in specific measures.
HOW LONG DO YOU ANTICIPATE YOUR PROJECT WILL TAKE?	It will take considerable time. Sometimes years to collect data, report results and publish findings.	It will be done quickly, through rapid cycles of iterative change.
WHAT KIND OF TOOL/INSTRUMENT WILL YOU USE TO COLLECT DATA?	Valid & reliable instruments that measure concepts of interest.	Data collection tools that allow for easy recording of quick-cycle information.
HOW WILL YOU ANALYZE DATA?	With inferential statistics, descriptive statistics or qualitative methodology that can compare & contrast qualitative data.	With descriptive statistics that demonstrate change/trends (e.g., control chart).
WILL YOU BE ABLE TO VARY YOUR PROTOCOL DURING THE STUDY?	Design is tightly controlled in order to limit the effect of confounding variables on the variables of interest – essential to determine causality.	Design is flexible and nimble. Design will often be adapted to respond to the data. Ability to adapt is central to the Plan Do Study Act (PDSA) cycle.
WHO WILL MOST LIKELY BENEFIT FROM YOUR PROJECT?	There may not be any benefit to the research participants in the study. The generated knowledge is meant to have future benefits to the research population.	If process changes are trialed and then adopted, those directly working in and/or receiving services from the system will benefit from the project.
IS RESEARCH ETHICS APPROVAL REQUIRED?	Yes. Contact your facility Research Ethics Office if you are still uncertain if your project is research or QI.	No, but some institutions have QI ethics review processes.

WHAT DO YOU PLAN TO DO WITH YOUR FINDINGS?	Findings will be applied as widely as possible to increase the body of scientific knowledge, both through publication and presentation.	Apply learning and change practice in my setting immediately. Share locally and consider trialing spread to other locations.

Adapted by Facility Engagement Oct 2018 from Fraser Health "*Differentiation of Research, Quality Improvement and Program Evaluation*", Department of Evaluation and Research Services, March, 4, 2014.

What are the reporting requirements for a project?

Projects funded by Shared Care are required to submit quarterly status and financial reports as well as a final report.

How can I promote my project and implemented solutions?

There are numerous ways to promote the work of your project including publication, presenting at conferences or promoting your work within the context of the Divisions of Family Practice or Facility-based Medical Staff Associations. Shared Care communications staff would be pleased to discuss opportunities with you.

APPENDIX F: PHYSICIAN END OF PROJECT SURVEY

When to use this Survey

This required survey is to be answered by the physician leads & participants at the conclusion of the project.

Purpose

The responses to these questions can be aggregated across the province to establish a provincial snapshot related to the general physician experience of participating / leading a Shared Care project.

Participants

At a minimum, the Family and Specialist physician leads of a Shared Care project must complete this survey. Other physician participants, such as those on a Steering Committee or Working Group, are also welcome to participate.

Method

Please submit one collective response for each question. Questions can be administered via email or answered verbally during a project meeting and transcribed and submitted in the project's final report.

Results

Survey results should be submitted with the project's final report.

Survey Prompt

The purpose of this survey is to gather feedback from physicians at the conclusion of Shared Care projects. Results will be aggregated across the province to show the physician experience and impact of the projects.

Please take five minutes to answer this brief survey. Thank you for your time and participation in Shared Care.

Physician End of Project Survey

	Strongly Disagree	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*
1. This project improved the **coordination of care**[4] between family practice and specialist care (Shared Care mandate).	☐	☐	☐	☐	☐
2. Participating in this Shared Care project has **energized** me in my work.	☐	☐	☐	☐	☐
3. This project led to **improved provider experience.**[5]	☐	☐	☐	☐	☐
4. This project led to **improved patient experience.**[6]	☐	☐	☐	☐	☐
5. This project led **to improved population health.**[7]	☐	☐	☐	☐	☐
6. This project **reduced the per capita cost of care.**[8]	☐	☐	☐	☐	☐

[4] **Coordination of care** can be defined as "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of healthcare services."

[5] **Improved provider experience** is defined as engaging physicians to work with each other, the health care system and their communities, to lead and/or support quality improvement and the spread of effective innovations. **Physician engagement** is also considered a component of provider experience, and is defined as the active participation in the health system at the patient, organization and system level.

[6] **Improved patient experience** is a construct that includes the patient's entire journey through the health care system. It includes the ability to access healthcare services, the degree to which care is coordinated, and the safety of care. It also includes the degree to which care honours a person's choices, need and values including cultural safety and humility.

[7] **Improved population health** refers to improving patient outcomes by improving the quality of health services. Health of the population includes health conditions, health functioning and wellbeing.

[8] **Reduction in per capita cost of care** includes the development of a sustainable healthcare system, providing value or money, including measurable savings and improvements.