Public Works and Government Services Canada | Travaux publics et Services gouvernementaux Canada

**RETURN BIDS TO:**
**RETOURNER LES SOUMISSIONS À:**

**Bid Receiving - PWGSC / Réception des soumissions - TPSGC**
**Place du Portage, Phase III**
**Core 0B2 / Noyau 0B2**
**11 Laurier St.\11, rue Laurier**
**Gatineau, Québec K1A 0S5**
**Bid Fax: (613) 997-9776**

# REQUEST FOR PROPOSAL
# DEMANDE DE PROPOSITION

**Proposal To: Public Works and Government Services Canada**

We hereby offer to sell to Her Majesty the Queen in right of Canada, in accordance with the terms and conditions set out herein, referred to herein or attached hereto, the goods, services, and construction listed herein and on any attached sheets at the price(s) set out therefor.

**Proposition aux: Travaux Publics et Services Gouvernementaux Canada**

Nous offrons par la présente de vendre à Sa Majesté la Reine du chef du Canada, aux conditions énoncées ou incluses par référence dans la présente et aux annexes ci-jointes, les biens, services et construction énumérés ici sur toute feuille ci-annexée, au(x) prix indiqué(s).

**Comments - Commentaires**

THIS REQUIREMENT CONTAINS A SECURITY REQUIREMENT / DOCUMENT CONTIENT DES EXIGENCES RELATIVES À LA SÉCURITÉ

**Vendor/Firm Name and Address**
**Raison sociale et adresse du fournisseur/de l'entrepreneur**

**Issuing Office - Bureau de distribution**

Health Services Project Division (XF)/Division des projets de services de santé (XF)
Place du Portage, Phase III, 12C1
11 Laurier St./11 rue, Laurier
Gatineau
Gatineau
K1A 0S5

| | |
|---|---|
| **Title - Sujet** | |
| HEALTH CARE PROVIDERS | |
| **Solicitation No. - N° de l'invitation** | **Date** |
| W3931-13KM01/D | 2017-01-06 |
| **Client Reference No. - N° de référence du client** | |
| W3931-13KM01 | |
| **GETS Reference No. - N° de référence de SEAG** | |
| PW-$$XF-010-30704 | |
| **File No. - N° de dossier** | **CCC No./N° CCC - FMS No./N° VME** |
| 010xf.W3931-13KM01 | |
| **Solicitation Closes - L'invitation prend fin** | **Time Zone Fuseau horaire** |
| **at - à 02:00 PM** | Eastern Standard Time EST |
| **on - le 2017-02-17** | |
| **F.O.B. - F.A.B.** | |
| **Plant-Usine:** ☐ **Destination:** ☐ **Other-Autre:** ☐ | |
| **Address Enquiries to: - Adresser toutes questions à:** | **Buyer Id - Id de l'acheteur** |
| O'Sullivan, Patrick | 010xf |
| **Telephone No. - N° de téléphone** | **FAX No. - N° de FAX** |
| (819) 420-2233 ( ) | ( ) - |
| **Destination - of Goods, Services, and Construction:** **Destination - des biens, services et construction:** | |
| Specified Herein<br>Précisé dans les présentes | |

**Instructions: See Herein**

**Instructions: Voir aux présentes**

| | |
|---|---|
| **Delivery Required - Livraison exigée** | **Delivery Offered - Livraison proposée** |
| See Herein | |

**Vendor/Firm Name and Address**
**Raison sociale et adresse du fournisseur/de l'entrepreneur**

**Telephone No. - N° de téléphone**
**Facsimile No. - N° de télécopieur**

**Name and title of person authorized to sign on behalf of Vendor/Firm (type or print)**
**Nom et titre de la personne autorisée à signer au nom du fournisseur/ de l'entrepreneur (taper ou écrire en caractères d'imprimerie)**

**Signature** **Date**

Canada

**PLEASE REFER TO THE ATTACHMENT TO VIEW SOLICITATION W3931-13KM01/D**

# REQUEST FOR PROPOSAL

# FOR THE PROVISION OF HEALTH CARE PROVIDERS

# FOR THE DEPARTMENT OF NATIONAL DEFENCE, ROYAL CANADIAN MOUNTED POLICE AND VETERANS AFFAIRS CANADA

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## PART 1 - GENERAL INFORMATION

### 1.1 Introduction

The bid solicitation is divided into seven parts plus attachments and annexes, as follows:

Part 1 General Information: provides a general description of the requirement;

Part 2 Bidder Instructions: provides the instructions, clauses and conditions applicable to the bid solicitation;

Part 3 Bid Preparation Instructions: provides bidders with instructions on how to prepare their bid;

Part 4 Evaluation Procedures and Basis of Selection: indicates how the evaluation will be conducted, the evaluation criteria that must be addressed in the bid, and the basis of selection;

Part 5 Certifications and Additional Information: includes the certifications and additional information to be provided;

Part 6 Security, Financial and Other Requirements: includes specific requirements that must be addressed by bidders; and

Part 7 Resulting Contract Clauses: includes the clauses and conditions that will apply to any resulting contract.

The Annexes include the Statement of Work, the Basis of Payment, the Security Requirements Checklist, the Insurance Requirements, the Task Authorization Forms and the Performance Management Framework.

### 1.2 Summary

1.2.1 The Department of National Defence (DND), the Royal Canadian Mounted Police (RCMP) and Veterans Affairs Canada (VAC), require on an "as-and-when-requested" basis, the services of a Contractor to provide and manage Health Care Providers (HCPs) needed to supplement their workforces in delivering health care and health care support services to members, cadets, Veterans and applicants at various centres across Canada.

Canada intends to issue three competitive contracts (W3931-13KM01/001/XF for the DND, M7594-160563/001/XF for the RCMP and 51019-166001/001/XF for VAC) to the bidder achieving the highest combined rating of technical merit and price.

The Contracts will also include an option to acquire the Services for additional locations in any Canadian region or territory.

The term of the Contracts will be for a period of four years plus a 6 month estimated transition period, and options to extend the Contract by additional periods up to a maximum of eight years.

1.2.2 There are security requirements associated with this requirement. For additional information, consult Part 6 - Security, Financial and Other Requirements, and Part 7 - Resulting Contract Clauses. For more information on personnel and organization security screening or security

clauses, bidders should refer to the Industrial Security Program (ISP) of Public Works and Government Services Canada (http://ssi-iss.tpsgc-pwgsc.gc.ca/index-eng.html) website.

1.2.3 The requirement is subject to a preference for Canadian goods and/or services.

1.2.4 As per the Integrity Provisions under section 01 of Standard Instructions 2003 Goods or Services - Competitive Requirements, bidders must provide a list of all owners and/or Directors and other associated information as required. Refer to section 4.21 of the Supply Manual for additional information on the Integrity Provisions.

1.2.5 This bid solicitation is to establish contracts with task authorizations (TA) for the delivery of the requirement detailed in the bid solicitation, to the Identified Users across Canada, including areas subject to Comprehensive Land Claims Agreements.

1.2.6 This requirement is not set aside for Aboriginal businesses under the Procurement Strategy for Aboriginal Business (PSAB) but does contain a requirement for subcontracting with Aboriginal businesses.

1.2.7 The Federal Contractors Program (FCP) for employment equity applies to this procurement; see Part 5 - Certifications and Additional Information, Part 7 - Resulting Contract Clauses and Form 2 titled Federal Contractors Program for Employment Equity - Certification.

### 1.3 Conflict of Interest

Without limiting Canada's rights under article 18 of Standard Instructions 2003 - Goods or Services - Competitive Requirements the following private sector Company was engaged in the preparation of the solicitation:

Knowles Consultancy Services Inc., Hill International Inc. (in joint venture).

### 1.4 Debriefings

Bidders may request a debriefing on the results of the bid solicitation process. Bidders should make the request to the Contracting Authority within 15 working days from receipt of the results of the bid solicitation process. The debriefing may be in writing, by telephone or in person.

## PART 2 - BIDDER INSTRUCTIONS

### 2.1 Standard Instructions, Clauses and Conditions

All instructions, clauses and conditions identified in the bid solicitation by number, date and title are set out in the *Standard Acquisition Clauses and Conditions Manual* (https://buyandsell.gc.ca/policy-and-guidelines/standard-acquisition-clauses-and-conditions-manual) issued by Public Works and Government Services Canada.

Bidders who submit a bid agree to be bound by the instructions, clauses and conditions of the bid solicitation and accept the clauses and conditions of the resulting contracts.

The 2003 (2016-04-04) Standard Instructions - Goods or Services - Competitive Requirements, are incorporated by reference into and form part of the bid solicitation.

Subsection 5.4 of 2003, Standard Instructions - Goods or Services - Competitive Requirements, is amended as follows:

Delete: 60 days
Insert: 280 days

### 2.2 Submission of Bids

Bids must be submitted only to Public Works and Government Services Canada (PWGSC) Bid Receiving Unit by the date, time and place indicated on page 1 of the bid solicitation.

Due to the nature of the bid solicitation, bids transmitted by facsimile to PWGSC will not be accepted.

### 2.3 Former Public Servant

Contracts awarded to former public servants (FPS) in receipt of a pension or of a lump sum payment must bear the closest public scrutiny, and reflect fairness in the spending of public funds. In order to comply with Treasury Board policies and directives on contracts awarded to FPSs, bidders must provide the information required below before contract award. If the answer to the questions and, as applicable the information required have not been received by the time the evaluation of bids is completed, Canada will inform the Bidder of a time frame within which to provide the information. Failure to comply with Canada's request and meet the requirement within the prescribed time frame will render the bid non-responsive.

**Definitions**

For the purposes of this clause, "former public servant" is any former member of a department as defined in the *Financial Administration Act*, R.S., 1985, c. F-11, a former member of the Canadian Armed Forces or a former member of the Royal Canadian Mounted Police. A former public servant may be:

a. an individual;
b. an individual who has incorporated;
c. a partnership made of former public servants; or

d. a sole proprietorship or entity where the affected individual has a controlling or major interest in the entity.

"lump sum payment period" means the period measured in weeks of salary, for which payment has been made to facilitate the transition to retirement or to other employment as a result of the implementation of various programs to reduce the size of the Public Service. The lump sum payment period does not include the period of severance pay, which is measured in a like manner.

"pension" means a pension or annual allowance paid under the Public Service Superannuation Act (PSSA), R.S., 1985, c. P-36, and any increases paid pursuant to the Supplementary Retirement Benefits Act, R.S., 1985, c. S-24 as it affects the PSSA. It does not include pensions payable pursuant to the *Canadian Forces Superannuation Act*, R.S., 1985, c. C-17, the *Defence Services Pension Continuation Act*, 1970, c. D-3, the *Royal Canadian Mounted Police Pension Continuation Act* , 1970, c. R-10, and the *Royal Canadian Mounted Police Superannuation Act*, R.S., 1985, c. R-11, the *Members of Parliament Retiring Allowances Act*, R.S. 1985, c. M-5, and that portion of pension payable to the *Canada Pension Plan Act*, R.S., 1985, c. C-8.

**Former Public Servant in Receipt of a Pension**

As per the above definitions, is the Bidder a FPS in receipt of a pension? **Yes** ( ) **No** ( )
If so, the Bidder must provide the following information, for all FPSs in receipt of a pension, as applicable:

a. name of former public servant;
b. date of termination of employment or retirement from the Public Service.

By providing this information, Bidders agree that the successful Bidder's status, with respect to being a former public servant in receipt of a pension, will be reported on departmental websites as part of the published proactive disclosure reports in accordance with Contracting Policy Notice: 2012-2 and the Guidelines on the Proactive Disclosure of Contracts.

**Work Force Adjustment Directive**

Is the Bidder a FPS who received a lump sum payment pursuant to the terms of the Work Force Adjustment Directive? **Yes** ( ) **No** ( )

If so, the Bidder must provide the following information:

a. name of former public servant;
b. conditions of the lump sum payment incentive;
c. date of termination of employment;
d. amount of lump sum payment;
e. rate of pay on which lump sum payment is based;
f. period of lump sum payment including start date, end date and number of weeks;
g. number and amount (professional fees) of other contracts subject to the restrictions of a work force adjustment program.

For all contracts awarded during the lump sum payment period, the total amount of fees that may be paid to a FPS who received a lump sum payment is $5,000, including Applicable Taxes.

## 2.4 Enquiries - Bid Solicitation

All enquiries must be submitted in writing to the Contracting Authority no later than 10 calendar days before the bid closing date. Enquiries received after that time may not be answered.

Bidders should reference as accurately as possible the numbered item of the bid solicitation to which the enquiry relates. Care should be taken by Bidders to explain each question in sufficient detail in order to enable Canada to provide an accurate answer. Technical enquiries that are of a proprietary nature must be clearly marked "proprietary" at each relevant item. Items identified as “proprietary” will be treated as such except where Canada determines that the enquiry is not of a proprietary nature. Canada may edit the question(s) or may request that the Bidder do so, so that the proprietary nature of the question(s) is eliminated and the enquiry can be answered to all Bidders. Enquiries not submitted in a form that can be distributed to all Bidders may not be answered by Canada.

## 2.5 Applicable Laws

Any resulting contract must be interpreted and governed, and the relations between the parties determined, by the laws in force in Ontario.

Bidders may, at their discretion, substitute the applicable laws of a Canadian province or territory of their choice without affecting the validity of their bid, by deleting the name of the Canadian province or territory specified and inserting the name of the Canadian province or territory of their choice. If no change is made, it acknowledges that the applicable laws specified are acceptable to the Bidders.

## 2.6 Improvement of Requirement During Solicitation Period

Should bidders consider that the specifications or Statement of Work contained in the bid solicitation could be improved technically or technologically, bidders are invited to make suggestions, in writing, to the Contracting Authority named in the bid solicitation. Bidders must clearly outline the suggested improvement as well as the reason for the suggestion. Suggestions that do not restrict the level of competition nor favour a particular bidder will be given consideration provided they are submitted to the Contracting Authority at least 20 days before the bid closing date. Canada will have the right to accept or reject any or all suggestions.

## 2.7 Volumetric Data

The categories and locations data has been provided to Bidders to assist them in preparing their bids. The inclusion of this data in this bid solicitation does not represent a commitment by Canada that Canada's future usage of these categories or locations will be consistent with this data. It is provided purely for information purposes.

## PART 3 - BID PREPARATION INSTRUCTIONS

### 3.1 Bid Preparation Instructions

(a) **Copies of Bid:** Canada requests that Bidders provide their bid in separately bound sections as follows:

i. Section I: Technical Bid (10 hard copies, 10 soft copies on 10 separate USB keys)

ii. Section II: Financial Bid (3 hard copies, 10 soft copies on 10 separate USB keys)

iii. Section III: Certifications (3 hard copies, 10 soft copies on 10 separate USB keys)

If there is a discrepancy between the wording of the soft copy and the hard copy, the wording of the hard copy will have priority over the wording of the soft copy. However, if whole words, sentences, paragraphs or pages are not found in the hard copy but are found in the soft copy, the bidder will be asked if the missing words, sentences, paragraphs or pages were intended to be in the hard copy. If the bidders affirms that the missing parts were intended, the missing words, sentences, paragraphs or pages will be used in the evaluation. Prices must appear in the financial bid only. No prices must be indicated in any other section of the bid.

(b) **Format for Bid:** Canada requests that Bidders follow the format instructions described below in the preparation of their bid:

i. use 8.5 x 11 inch (216 mm x 279 mm) paper;

ii. use a numbering system that corresponds to the bid solicitation;

iii. include a title page at the front of each volume of the bid that includes the title, date, bid solicitation number, bidder's name and address and contact information of its representative; and

iv. include a table of contents.

(c) **Canada's Policy on Green Procurement:** In April 2006, Canada issued a policy directing federal departments and agencies to take the necessary steps to incorporate environmental considerations into the procurement process Policy on Green Procurement (http://www.tpsgc-pwgsc.gc.ca/ecologisation-greening/achats-procurement/politique-policy-eng.html). To assist Canada in reaching its objectives, Bidders are invited to:

i. use 8.5 x 11 inch (216 mm x 279 mm) paper containing fibre certified as originating from a sustainably-managed forest and containing minimum 30% recycled content; and

ii. use an environmentally-preferable format including black and white printing instead of colour printing, printing double sided/duplex, using staples or clips instead of cerlox, duotangs or binders.

(d) **Submission of Only One Bid:**

i. A Bidder, including related entities, will be permitted to submit only one bid in response to this bid solicitation. If a Bidder or any related entities participate in more than one bid (participating

means being part of the Bidder, not being a subcontractor), Canada will provide those Bidders with 2 working days to identify the single bid to be considered by Canada. Failure to meet this deadline will result in all the affected bids being declared non-responsive.

ii. For the purposes of this Article, regardless of the jurisdiction where any of the entities concerned is incorporated or otherwise formed as a matter of law (whether that entity Is a natural person, corporation, partnership, etc.), an entity will be considered to be **"related"** to a Bidder if:

(A) they are the same legal entity (i.e., the same natural person, corporation, partnership, limited liability partnership, etc.);

(B) they are "related persons" or "affiliated persons" according to the *Canada Income Tax Act;*

(C) the entities have now or in the two years before bid closing had a fiduciary relationship with one another (either as a result of an agency arrangement or any other form of fiduciary relationship); or

(D) the entities otherwise do not deal with one another at arm's length, or each of them does not deal at arm's length with the same third party.

iii. Individual members of a joint venture cannot participate in another bid, either by submitting a bid alone or by participating in another joint venture.

(e) **Joint Venture Experience:**

i. Where the Bidder is a joint venture with existing experience as that joint venture, it may submit the experience that it has obtained as that joint venture.

Example: A bidder is a joint venture consisting of members L and O. A bid solicitation requires that the bidder demonstrate experience providing maintenance and help desk services for a period of 24 months to a customer with at least 10,000 users. As a joint venture (consisting of members L and O), the bidder has previously done the work. This bidder can use this experience to meet the requirement. If member L obtained this experience while in a joint venture with a third party N, however, that experience cannot be used because the third party N is not part of the joint venture that is bidding.

ii. A joint venture bidder may rely on the experience of one of its members to meet any given technical criterion of this bid solicitation.

Example: A bidder is a joint venture consisting of members X, Y and Z. If a solicitation requires: (a) that the bidder have 3 years of experience providing maintenance service, and (b) that the bidder have 2 years of experience integrating hardware with complex networks, then each of these two requirements can be met by a different member of the joint venture. However, for a single criterion, such as the requirement for 3 years of experience providing maintenance services, the bidder cannot indicate that each of members X, Y and Z has one year of experience, totaling 3 years. Such a response would be declared non-responsive.

iii. Joint venture members cannot pool their abilities with other joint venture members to satisfy a single technical criterion of this bid solicitation. However, a joint venture member can pool its individual experience with the experience of the joint venture itself. Wherever substantiation of a criterion is required, the Bidder is requested to indicate which joint venture member

satisfies the requirement. If the Bidder has not identified which joint venture member satisfies the requirement, the Contracting Authority will provide an opportunity to the Bidder to submit this information during the evaluation period. If the Bidder does not submit this information within the period set by the Contracting Authority, its bid will be declared non-responsive.

Example: A bidder is a joint venture consisting of members A and B. If a bid solicitation requires that the bidder demonstrate experience providing resources for a minimum number of 100 billable days, the bidder may demonstrate that experience by submitting either:

- Contracts all signed by A;
- Contracts all signed by B; or
- Contracts all signed by A and B in joint venture, or
- Contracts signed by A and contracts signed by A and B in joint venture, or
- Contracts signed by B and contracts signed by A and B in joint venture.

That show in total 100 billable days.

iv. Any Bidder with questions regarding the way in which a joint venture bid will be evaluated should raise such questions through the Enquiries process as early as possible during the bid solicitation period.

### 3.2 Section I: Technical Bid

(a) In their technical bid, Bidders should demonstrate their understanding of the requirements contained in the bid solicitation and explain how they will meet these requirements. Bidders should demonstrate their capability and describe their approach in a thorough, concise and clear manner for carrying out the work.

(b) The technical bid should address clearly and in sufficient depth the points that are subject to the evaluation criteria against which the bid will be evaluated. Simply repeating the statement contained in the bid solicitation is not sufficient. In order to facilitate the evaluation of the bid, Canada requests that Bidders address and present topics in the order of the evaluation criteria under the same headings. To avoid duplication, Bidders may refer to different sections of their bids by identifying the specific paragraph and page number where the subject topic has already been addressed.

(c) The technical bid consists of the following:

i. Bid Submission Form: Bidders are requested to include the Bid Submission Form – Form 1 with their bids. It provides a common form in which bidders can provide information required for evaluation and contract award, such as a contact name and the Bidder's Procurement Business Number, etc. Using the form to provide this information is not mandatory, but it is recommended. If Canada determines that the information required by the Bid Submission Form is incomplete or requires correction, Canada will provide the Bidder with an opportunity to do so.

ii. **Customer Reference Contact Information:**

(A) The Bidder must provide customer references. The customer reference must each confirm, if requested by PWGSC, the facts identified in the Bidder's bid.

(B) For each customer reference, the Bidder must, at a minimum, provide the name and either the telephone number or e-mail address for a contact person. If only the telephone number is provided, it will be used to call to request the e-mail address and the reference check will be done by e-mail.

Bidders are also requested to include the title of the contact person. It is the sole responsibility of the Bidder to ensure that it provides a contact who is knowledgeable about the services the Bidder has provided to its customer and who is willing to act as a customer reference. Crown references will be accepted.

### 3.3 Section II: Financial Bid

(a) **Pricing:** Bidders must submit their financial bid in accordance with the Pricing Schedule detailed in Attachment 2 to Part 4. Unless otherwise indicated, bidders must include a single, firm, all-inclusive price, Applicable Taxes excluded, quoted in Canadian dollars in each cell requiring an entry in the pricing tables.

(b) **All Costs to be Included:** The financial bid must include all costs for the requirement described in the bid solicitation for the entire Contract Period.

### 3.4 Section III: Certifications

Bidders must submit the certifications and additional information required under Part 5.

## PART 4 - EVALUATION PROCEDURES AND BASIS OF SELECTION

### 4.1 Evaluation Procedures

4.1.1 Bids will be assessed in accordance with the entire requirement of the bid solicitation including the technical and financial evaluation criteria. There are several steps in the evaluation process, which are described below. Even though the evaluation and selection will be conducted in steps, the fact that Canada has proceeded to a later step does not mean that Canada has conclusively determined that the Bidder has successfully passed all the previous steps. Canada may conduct steps of the evaluation in parallel.

4.1.2 An evaluation team composed of representatives of the Client and PWGSC will evaluate the bids on behalf of Canada. Canada may hire any independent consultant, or use any Government resources, to evaluate any bid. Not all members of the evaluation team will necessarily participate in all aspects of the evaluation.

4.1.3 The evaluation team will determine first if there are two or more bids with a valid Canadian Content certification. In that event, the evaluation process will be limited to the bids with the certification; otherwise, all bids will be evaluated. If some of the bids with a valid certification are declared non-responsive, or are withdrawn, and less than two responsive bids with a valid certification remain, the evaluation will continue among those bids with a valid certification. If all bids with a valid certification are subsequently declared non-responsive, or are withdrawn, then all the other bids received will be evaluated.

4.1.4 Where Canada has made a final determination that a bid has failed any individual mandatory element of the RFP, including a technical evaluation pass mark, Canada reserves the right to not proceed further in the evaluation of the bid and may deem the bid non-responsive.

4.1.5 Canada has engaged Knowles Consultancy Services Inc., Hill International Inc. (in joint venture) as independent third-party fairness monitor to observe the whole procurement process, including the engagement process and the evaluation process, in order to provide an impartial opinion on the fairness, openness and transparency of each activity of the procurement process. The Fairness Monitor will not be part of the evaluation team, but will observe the evaluation of the bids with respect to Canada’s adherence to the evaluation process described in this bid solicitation.

4.1.6 In addition to any other time periods established in the bid solicitation:

(a) **Requests for Clarifications**: If Canada seeks clarification or verification from the Bidder about its bid, the Bidder will have 2 working days (or a longer period if specified in writing by the Contracting Authority) to provide the necessary information to Canada. Failure to meet this deadline may result in the bid being declared non-responsive.

(b) **Requests for Further Information:** If Canada requires additional information in order to do any of the following pursuant to the Section entitled "Conduct of Evaluation" in 2003, Standard Instructions - Goods or Services - Competitive Requirements:

i. verify any or all information provided by the Bidder in its bid; or

ii. contact any or all references supplied by the Bidder (e.g., references named in the résumés of individual resources) to verify and validate any information submitted by the Bidder,

the Bidder must provide the information requested by Canada within 2 working days of a request by the Contracting Authority.

(c) **Extension of Time:** If additional time is required by the Bidder, the Contracting Authority may grant an extension in his or her sole discretion.

### 4.2 Reference Checks

(a) For reference checks, Canada will conduct the reference check in writing by e-mail. Canada will send all e-mail reference check requests to contacts supplied by all the Bidders on the same day using the e-mail address provided in the bid. Canada will not award any points and/or a bidder will not meet the mandatory experience requirement (as applicable) unless the response is received within 5 working days of the date that Canada's e-mail was sent.

(b) On the third working day after sending out the reference check request, if Canada has not received a response, Canada will notify the Bidder by e-mail, to allow the Bidder to contact its reference directly to ensure that it responds to Canada within 5 working days. If the individual named by a Bidder is unavailable when required during the evaluation period, the Bidder may provide the name and e-mail address of an alternate contact person from the same customer. Bidders will only be provided with this opportunity once for each customer, and only if the originally named individual is unavailable to respond (i.e., the Bidder will not be provided with an opportunity to submit the name of an alternate contact person if the original contact person indicates that he or she is unwilling or unable to respond). The 5 working days will not be extended to provide additional time for the new contact to respond.

(c) Wherever information provided by a reference differs from the information supplied by the Bidder, the information supplied by the reference will be the information evaluated.

(d) Points will not be allocated and/or a bidder will not meet the mandatory experience requirement (as applicable) if (1) the reference customer states he or she is unable or unwilling to provide the information requested, or (2) the customer reference is not a customer of the Bidder itself (for example, the customer cannot be the customer of an affiliate of the Bidder instead of being a customer of the Bidder itself). Nor will points be allocated or a mandatory met if the customer is itself an affiliate or other entity that does not deal at arm's length with the Bidder.

(e) Whether or not to conduct reference checks is discretionary. However, if PWGSC chooses to conduct reference checks for any given rated or mandatory requirement, it will check the references for that requirement for all bidders who have not, at that point, been found non-responsive.

### 4.3 Two Step Bid Evaluation Process

**[Note to Bidders for subsections 4.3.1 to 4.3.8]:**

The two step processes, outlined below, involve preliminary evaluations of the technical and financial bids to help identify non-responsiveness and to provide a fair and transparent process for all Bidders to revise their bid subject to the conditions described herein. Through these two step processes, Canada wishes to obtain competitive and thoroughly assessed bids, as well as a fair process by permitting revisions, including administrative bidding errors by a Bidder against the mandatory elements as described herein.

Bidders will not be allowed to change the composition of the Bidder's team (i.e. a Bidder cannot add or withdraw any team members, including subcontractors, when submitting revised information). Any change to the composition of the Bidder will result in the bid being declared non-responsive.

### 4.3.1 Technical Bid Evaluation

Canada will conduct the evaluation of the Technical Bid in two steps.

4.3.1.1 Step 1 – Preliminary Technical Evaluation

A Preliminary Technical Evaluation will be conducted first in accordance with Attachment 1 to Part 4 – Technical Criteria.

4.3.1.2 Step 2 – Final Technical Evaluation

Final Technical Evaluation: Step 2 of the Technical Bid Evaluation will occur after Step 1. Where a bid has passed all the mandatory technical criteria, including point-rated criteria pass marks in the Preliminary Technical Evaluation, the evaluation team will affirm that the Preliminary Technical Evaluation conducted in Step 1 will be the Technical Bid Evaluation results for that bid. However, where a bid has failed one or more of the mandatory requirements in the Preliminary Technical Evaluation, including any point-rated criteria pass marks, or the Bidder added a bid condition, the second step will be conducted for that bid(s) as described below.

(a) Canada Provides Preliminary Technical Evaluation Result: Canada will only advise the Bidder as to which mandatory technical criteria or point-rated criteria pass mark it failed in the Preliminary Technical Evaluation. To ensure fairness to all Bidders, Canada will not provide a debriefing on their Preliminary Technical Evaluation results nor further detail on these evaluation results as part of Step 2.

(b) Bidder Submits Technical Bid Revision: The Bidder will be invited to submit a bid revision to its Technical Bid only, and/or remove any bid conditions if applicable, in response to the mandatory technical criteria and/or point-rated criteria pass marks identified as failed by Canada. Where the addition of such information will necessarily result in a change to the information it submitted in response to other mandatory or point-rated criteria as part of its Technical Bid, the Bidder must identify the affected criteria and only these adjustments should be made.

(c) Any other changes to the bid shall be considered new information and will not be considered by the evaluators in the Final Technical Evaluation unless the evaluation team determines, in accordance with the evaluation criteria, that it has a negative impact on any of the preliminary scores the evaluation team had assigned in the Preliminary Technical Evaluation. If this is the case, to preserve fairness amongst all Bidders and to ensure Canada is protected, the evaluators shall evaluate the applicable technical criteria in light of this new information and may reduce, but not increase, the score of any applicable point-rated criteria. This new score will be reflected in the Final Technical Evaluation result of Step 2.

(d) Technical Bid Evaluation Result: The bid revisions submitted by the Bidder in Step 2 will be used in the technical evaluation to determine whether or not the Bidder passed the mandatory technical criteria and the point-rated criteria pass marks. For the point-rated criteria, the new evaluated point score in Step 2 would not be used in the determination of the Bidder’s Technical Score. The technical evaluation score that would be used to determine the Technical Score would be the

evaluation score for that criterion as determined in the Preliminary Technical Evaluation in Step 1 (less any applicable technical criteria reductions as described in paragraph (c) above).

4.3.1.3 Additional Restrictions: Without limiting the foregoing, the Bidder must not make any changes to the Financial Bid as a result of any changes through its Technical Bid revision. Should the Bidder introduce changes to the Financial Bid through the above process, it will be given one opportunity to withdraw the financial changes. Failure to withdraw the changes will result in its bid being declared non-responsive and no longer considered by Canada.

**4.3.2 Financial Bid Evaluation**

Canada will conduct the evaluation of the Financial Bid in two steps.

4.3.2.1 Step 1 – Preliminary Evaluation of the Mandatory Financial Criteria

Canada will review and determine if the Mandatory Financial Criteria identified in Part 3, article 3.3, has been met.

4.3.2.2 Step 2 – Final Evaluation of the Financial Mandatory Criteria

Final Evaluation of the Financial Mandatory Criteria: Step 2 of the Financial Bid Evaluation will occur after Step 1. Where a bid has passed the Mandatory Financial Criteria, the financial evaluation team will affirm that the Preliminary Evaluation of the Mandatory Financial Criteria conducted in Step 1 will be the final Financial Bid Evaluation result for that bid for the Mandatory Financial Criteria. However, where a bid has failed the Preliminary Evaluation of the Mandatory Financial Criteria, the second step will be conducted for that bid as described below.

(a) Canada Provides Preliminary Evaluation of the Mandatory Financial Criteria Result: Canada will advise the Bidder that it failed the Mandatory Financial Criteria evaluation. To ensure fairness to all Bidders, Canada will not provide a debriefing on these evaluation results nor provide further details on these evaluation results.

(b) Bidder Submits Financial Bid Revision: The Bidder will be invited to re-submit a revision to their Financial Bid to revise elements in their Financial Bid in response to the Mandatory Financial Criteria.

(c) Financial Bid Evaluation Result: The bid revisions submitted by the Bidder in Step 2 will be used in the financial evaluation to determine whether or not the Bidder passed the mandatory financial criteria.

4.3.3 Additional Responsibilities for Steps 1 and 2 of the Technical and Financial Bid Evaluations

4.3.3.1 Bidders are and will remain solely responsible for the accuracy and completeness of their bids and Canada does not undertake, by reason of the Step 1 preliminary technical and financial mandatory criteria evaluations, any obligations or responsibility for identifying errors or omissions in bids submitted nor does Canada undertake to identify any or all such errors or omissions.

4.3.3.2 Bidders are and will remain solely responsible for ensuring consistency of the information submitted in their bids at all times. Without limiting the foregoing, Bidders are and will remain solely responsible for ensuring that any information provided in response to a preliminary technical or financial mandatory criteria evaluation is consistent with any other information

originally submitted in their bid in response to other requirements. Failure to do so may prejudice the evaluation of previously submitted information and/or render the bid non-responsive.

4.3.4 Bid revisions must follow the Bid Preparation Instructions (such as, for example, separating financial information from other information as required). Canada requests that Bidders clearly indicate, for each bid revision, which non-responsive requirement is being responded to.

4.3.5 Bid revisions must be submitted by email to the Contracting Authority within 2 business days (or longer period if specified in writing by the Contracting Authority). Failure to do so will result in the bid being deemed non-responsive and the bid will receive no further consideration.

4.3.6 The changes within any bid revision are at the Bidder's sole discretion and will be made solely by the Bidder. Canada will not provide information about any other bid or any information as to how a Bidder should prepare the content of its bid revision.

4.3.7 For those instances where a Bidder chooses not to submit additional or different information for a requirement identified as non-responsive or as having not achieved the minimum score for a point-rated criteria, the Bidder must submit a response indicating "No Change" for such requirement and the original response for that item will continue to apply. If a Bidder does not provide a "No Change" response, the Bidder shall be deemed to have provided a "No Change" response and the original bid response for that item shall continue to apply.

4.3.8 In addition to any other obligations contained in the resulting contract, the winning Bidder will be contractually obliged to provide all services described in its bid and bid revisions in responses to Attachment 1 to Part 4 – Technical Criteria in accordance with and at the prices contained in Attachment 2 to Part 4 – Pricing Schedule. After contract award, the Bidder selected by Canada must deliver the requested services in accordance with the Resulting Contract.

### 4.4 Technical Evaluation

#### 4.4.1 Mandatory Technical Criteria

Refer to Attachment 1 to Part 4.

#### 4.4.2 Point Rated Technical Criteria

Refer to Attachment 1 to Part 4. Point-rated technical criteria not addressed will be given a score of zero.

### 4.5 Financial Evaluation

Refer to Attachment 2 to Part 4.

### 4.6 Basis of Selection

4.6.1 Basis of Selection - Highest Combined Rating of Technical Merit (70%) and Price (30%)

4.6.1.1 To be declared responsive, a bid must:

a. comply with all the requirements of the bid solicitation;
b. meet all mandatory criteria; and
c. obtain the required minimum number of points specified in Attachment 1 to Part 4 for the point rated technical criteria.

4.6.1.2 Bids not meeting all the requirements detailed in sub-article 4.6.1.1 above will be declared non-responsive.

4.6.2 Neither the responsive bid obtaining the highest technical merit score, nor the one with the lowest evaluated price will necessarily be recommended for Contract award. The responsive bid with the highest combined rating of technical merit and price will be recommended for award of the contracts. The ratio will be 70% for technical merit and 30% for price. In the event two or more responsive bids have the same highest combined rating of technical merit and price, the responsive bid that obtained the highest overall score for all the point rated technical criteria detailed in Attachment 1 to Part 4 will be recommended for award of contracts.

4.6.3 The bidder's combined rating will be determined as follows:

Combined Rating (CR) = Technical Merit Score (TMS) + Pricing Score (PS)

4.6.4 To establish the TMS, the following formula will be used, rounded to two decimal places:

$$\text{Technical Merit Score (TMS)} = \frac{\text{Bidder's total number of points obtained}}{\text{Maximum number of points available}} \times 70$$

4.6.5 To establish the PS, one of two possible financial evaluation methods will apply. The first method, Method A, will be used if three or more bids are determined to be responsive. The second method, Method B, will be used if two bids are determined to be responsive.

4.6.5.1 Method A - 3 or more responsive bids:

(a) The evaluated price (EP), as determined using the table below, will be used to establish the median value of all responsive bids. The median will be calculated using the median function in Microsoft Excel, rounded to two decimal places.

| ITEM NO. | DESCRIPTION | TOTAL PRICE |
|---|---|---|
| **PRICING SCHEDULE A:** Initial Contract Period (From Contract Award date to March 31, 2020) | | |
| **1** | DND Streams 1-4 | $ - |
| **2** | DND Stream 5 | $ - |
| **3** | RCMP Streams 1-3 | $ - |
| **4** | VAC Streams 1-2 | $ - |
| **5** | Milestones and Fee | $ - |

| **PRICING SCHEDULE B:** Initial Contract Period (From April 1, 2020 to March 31, 2022) | | | |
|---|---|---|---|
| **6** | DND Streams 1-4 | $ | - |
| **7** | DND Stream 5 | $ | - |
| **8** | RCMP Streams 1-3 | $ | - |
| **9** | VAC Streams 1-2 | $ | - |
| **EVALUATED PRICE** | | $ | - |

(b) When an even number of responsive bids have been determined, an average of the middle two values will be used to calculate the median value. When an odd number of responsive bids have been determined, the middle value will be used to calculate the median value.

(c) Only bids with an evaluated price in the range that encompasses ±35% of the median value will be retained.

(d) The pricing score for those bids that are retained will be determined using the following formula, rounded to two decimal places:

$$\text{Pricing Score (PS)} = \frac{\text{Lowest Evaluated Price}}{\text{Bidder's Evaluated Price}} \times 30$$

4.6.5.2 Method B - 2 responsive bids:

(a) Each responsive bid will be prorated against the lowest evaluated price times 30.

(b) The evaluated price (EP) will be calculated in accordance with the table from sub-article 4.6.5.1 (a) above.

(c) The pricing score for each bid will be determined using the following formula, rounded to two decimal places:

$$\text{Pricing Score (PS)} = \frac{\text{Lowest Evaluated Price}}{\text{Bidder's Evaluated Price}} \times 30$$

4.6.6 The table below illustrates an example where three bids are declared responsive, and the selection of the contractor is determined by a 70/30 ratio of technical merit and price, respectively. The total number of points available is 135 and the lowest evaluated price is $45,000 (45).

## Basis of Selection - Highest Combined Rating Technical Merit (70%) and Price (30%)

| | | BIDDER 1 | BIDDER 2 | BIDDER 3 | BIDDER 4 |
|---|---|---|---|---|---|
| **Overall Technical Score** | | 115 | 89 | 92 | 125 |
| **Evaluated Price (Median = $52,500.00)** | | $55,000.00 | $50,000.00 | $45,000.00 | $75,000.00 |
| **Calculations** | **Technical Merit Score (TMS)** | (115/135) x 70 = 59.63 | (89/135) x 70 = 46.15 | (92/135) x 70 = 47.70 | (125/135) x 70 = 64.81 |
| | **Pricing Score (PS)** | (45/55) x 30 = 24.55 | (45/50) x 30 = 27 | (45/45) x 30 = 30 | Non-responsive:<br>Bid evaluated price higher than the median + 35% ($70,875.00) |
| **Combined Rating (CR)** | | 84.18 | 73.15 | 77.70 | N/A |
| **Overall Ranking** | | 1st | 3rd | 2nd | N/A |

## PART 5 – CERTIFICATIONS AND ADDITIONAL INFORMATION

Bidders must provide the required certifications and additional information to be awarded a contract.

The certifications provided by Bidders to Canada are subject to verification by Canada at all times. Unless specified otherwise, Canada will declare a bid non-responsive, or will declare a contractor in default if any certification made by the Bidder is found to be untrue, whether made knowingly or unknowingly, during the bid evaluation period or during the contract period.

The Contracting Authority will have the right to ask for additional information to verify the Bidder's certifications. Failure to comply and to cooperate with any request or requirement imposed by the Contracting Authority will render the bid non-responsive or constitute a default under the Contract.

### 5.1 Certifications Required with the Bid

Bidders must submit the following duly completed certifications as part of their bid.

#### 5.1.1 Declaration of Convicted Offences

As applicable, pursuant to subsection Declaration of Convicted Offences of section 01 of the Standard Instructions, the Bidder must provide with its bid, a completed Declaration Form (http://www.tpsgc-pwgsc.gc.ca/ci-if/declaration-eng.html), to be given further consideration in the procurement process.

### 5.2 Certifications Precedent to Contract Award and Additional Information

The certifications and additional information listed below should be submitted with the bid but may be submitted afterwards. If any of these required certifications or additional information is not completed and submitted as requested, the Contracting Authority will inform the Bidder of a time frame within which to provide the information. Failure to provide the certifications or the additional information listed below within the time frame specified will render the bid non-responsive.

#### 5.2.1 Integrity Provisions – List of Names

(a) Bidders who are incorporated, including those bidding as a joint venture, must provide a complete list of names of all individuals who are currently directors of the Bidder.

(b) Bidders bidding as sole proprietorship, as well as those bidding as a joint venture, must provide the name of the owner(s).

(c) Bidders bidding as societies, firms or partnerships do not need to provide lists of names.

#### 5.2.2 Canadian Content Certification

This procurement is conditionally limited to Canadian services.

Subject to the evaluation procedures contained in the bid solicitation, bidders acknowledge that only bids with a certification that the service offered is a Canadian service, as defined in clause A3050T, may be considered.

Failure to provide this certification completed with the bid will result in the service offered being treated as a non-Canadian service.

The Bidder certifies that:

( ) the service offered is a Canadian service as defined in paragraph 2 of clause A3050T.

5.2.2.1 *SACC Manual* clause A3050T (2014-11-27) Canadian Content Definition

### 5.2.3 Initiation of Security Clearances

The Bidder must provide evidence confirming it has initiated the process with the Canadian Industrial Security Directorate (CISD) in order to meet the Security Requirements identified in Part 6.

### 5.2.4 Federal Contractors Program for Employment Equity - Bid Certification

By submitting a bid, the Bidder certifies that the Bidder, and any of the Bidder's members if the Bidder is a Joint Venture, is not named on the Federal Contractors Program (FCP) for employment equity "FCP Limited Eligibility to Bid" list available at the bottom of the page of the Employment and Social Development Canada (ESDC) - Labour's website (http://www.esdc.gc.ca/en/jobs/workplace/human_rights/employment_equity/federal_contractor_program.page?&_ga=1.229006812.1158694905.1413548969#afed).

Canada will have the right to declare a bid non-responsive if the Bidder, or any member of the Bidder if the Bidder is a Joint Venture, appears on the “FCP Limited Eligibility to Bid” list at the time of contract award.

Canada will also have the right to terminate the Contract for default if a Contractor, or any member of the Contractor if the Contractor is a Joint Venture, appears on the “FCP Limited Eligibility to Bid” list during the period of the Contract.

The Bidder must provide the Contracting Authority with a completed Form 2 Federal Contractors Program for Employment Equity - Certification, before contract award. If the Bidder is a Joint Venture, the Bidder must provide the Contracting Authority with a completed annex Federal Contractors Program for Employment Equity - Certification, for each member of the Joint Venture.

## PART 6 - SECURITY, FINANCIAL AND OTHER REQUIREMENTS

### 6.1 Security Requirements

6.1.1 30 days before the Service Effective Date (SED), as defined in the Statement of Work, the following conditions must be met:

(a) the Bidder must hold a valid organization security clearance as indicated in Part 7 - Resulting Contract Clauses;

(b) the Bidder's proposed individuals requiring access to classified or protected information, assets or sensitive work site(s) must meet the security requirements as indicated in Part 7 - Resulting Contract Clauses; and

(c) the Bidder must provide the name of all individuals who will require access to classified or protected information, assets or sensitive work sites.

6.1.2 For additional information on security requirements, Bidders should refer to the Industrial Security Program (ISP) of Public Works and Government Services Canada (http://ssi-iss.tpsgc-pwgsc.gc.ca/index-eng.html) website.

### 6.2 Financial Capability

(a) SACC Manual clause A9033T (2012-07-16) Financial Capability applies, except that subsection 3 is deleted and replaced with the following: "If the Bidder is a subsidiary of another company, then any financial information required by the Contracting Authority in 1(a) to (f) must also be provided by each level of parent company, up to and including the ultimate parent company. The financial information of a parent company does not satisfy the requirement for the provision of the financial information of the Bidder; however, if the Bidder is a subsidiary of a company and, in the normal course of business, the required financial information is not generated separately for the subsidiary, the financial information of the parent company must be provided. If Canada determines that the Bidder is not financially capable but the parent company is, or if Canada is unable to perform a separate assessment of the Bidder's financial capability because its financial information has been combined with its parent's, Canada may, in its sole discretion, award the contract to the Bidder on the condition that one or more parent companies grant a performance guarantee to Canada."

(b) In the case of a joint venture bidder, each member of the joint venture must meet the financial capability requirements.

### 6.3 Insurance Requirements

The Bidder must provide a letter from an insurance broker or an insurance company licensed to operate in Canada stating that the Bidder, if awarded a contract as a result of the bid solicitation, can be insured in accordance with the Insurance Requirements specified in Annex D.

If the information is not provided in the bid, the Contracting Authority will so inform the Bidder and provide the Bidder with a time frame within which to meet the requirement. Failure to comply with the request of the Contracting Authority and meet the requirement within that time period will render the bid non-responsive.

## PART 7 - RESULTING CONTRACT CLAUSES

The following clauses and conditions apply to and form part of any contract resulting from the bid solicitation.

### 7.1 Statement of Work

The Contractor must perform the Work in accordance with the Statement of Work at Annex A.

#### 7.1.1 Optional Services

(a) **Option to Acquire HCP Services for Additional Locations**

The Contractor grants to Canada the irrevocable option to acquire HCP Services, as described in the Statement of Work, for additional locations across Canada.

Canada may exercise the option at any time, during the Contract Period, by sending a written notice to the Contractor. The options may only be exercised by the Contracting Authority, and will be evidenced, through a contract amendment.

The Contractor agrees to provide the services in accordance with the terms and conditions set forth herein. The Contractor agrees that, should the option be exercised by Canada, it will be paid in accordance with the applicable provisions as set out in Annex B – Basis of Payment.

(b) **Option to Acquire Additional HCP Categories of Service**

The Contractor grants to Canada the irrevocable option to acquire additional categories of HCP Services.

Canada may exercise the option at any time, during the Contract Period, by sending a written notice to the Contractor. The options may only be exercised by the Contracting Authority, and will be evidenced, through a contract amendment.

The Contractor agrees to provide the services in accordance with the terms and conditions set forth herein. The Contractor agrees that, should the option be exercised by Canada, it will be paid in accordance with the applicable provisions as set out in Annex B – Basis of Payment.

(c) If Canada decides to exercise any of the options mentioned above, the Contractor must not commence Work corresponding to the new categories and locations until the changes are evidenced through a Contract Amendment issued by the Contracting Authority and a Task Authorization authorized as per article 7.2.3 has been received by the Contractor. The Contractor acknowledges that any Work performed before the above two steps are completed will be done at the Contractor’s own risk.

### 7.2 Task Authorization

The Work or a portion of the Work to be performed under the Contract will be on an "as and when requested basis" using a Task Authorization (TA). The Work described in the TA must be in accordance with the scope of the Contract.

**[Note to Bidders for article 7.2]:**

All references to Departmental Procurement Authority (DPA) within this article apply to DND and RCMP only. For VAC, all references to Departmental Procurement Authority (DPA) within this article will be replaced with Departmental Technical Authority (DTA) upon Contract Award.

### 7.2.1 Task Authorization Form

7.2.1.1 The Departmental Procurement Authority (DPA) will provide the Contractor with a description of the task using the TA forms attached in Annex E. Both task authorization forms are referred to herein as TA Form.

7.2.1.2 The TA Form will contain as a minimum:

a. Contract number;
b. TA Form number;
c. task authorization period - start and finish date;
d. number of HCPs required;
e. HCP stream, occupational group, category and level;
f. HCP work location;
g. HCP language requirement;
h. applicable basis and method of payment;
i. estimated level of effort (LOE);
j. estimated total value of the task authorization;
k. identification of a full or part time requirement;
l. required work hours or schedule;
m. travel requirements;
n. other specific HCP requirements (e.g. On-call, weekend clinics, etc.);
o. security clearance level required;
p. a detailed description of the Work and deliverables, when applicable; and
q. a schedule indicating the required completion dates for the tasks or activities and the required delivery date for the deliverables, when applicable.

### 7.2.2 Contractor's Response

For any of the processes described below, the Contractor's response must contain, as a minimum, the information listed below for each resource proposed by the Contractor for the performance of the Work:

a. name of the proposed resource;
b. resumé of the proposed resource;
c. the necessary information and documents that demonstrate that the resource meets all the mandatory requirements specified in the applicable Task and Qualification Sheet (Appendix 11);
d. (specific to DND) completed Orientation Package - HCP Acknowledgement Form
e. completed HCP credentialing form;
f. confirmation that the resource meets the language requirements;
g. confirmation of the available start date of the resource;
h. confirmation of the application to obtain the HCP security clearance from the Canadian Industrial Security Directorate (CISD); and

i. (specific to RCMP) confirmation of the application to obtain the HCP security clearance from the RCMP Departmental Security Branch.

**7.2.2.1 Process for Routine Requests:**

(a) The Contractor must acknowledge receipt of the TA Form to the DPA via email or fax within 2 working days of receipt.

(b) The Contractor must provide the DPA a signed and dated response using the TA Form received from the DPA within the time period specified in the Statement of Work article titled Time To Provide.

**7.2.2.2 Process for Urgent Requests:**

(a) The Contractor must acknowledge receipt of the TA Form to the DPA via email or fax within 1 working day of receipt.

(b) The Contractor must provide the DPA a signed and dated response using the TA Form received from the DPA within the time period specified in the Statement of Work article titled Time To Provide.

**7.2.3 Authorization of the TA Form**

Authorization of the TA Form will be provided by the DPA only if the Contractor meets all the obligations detailed in article 7.2.2 and its sub-articles, as applicable.

(a) The authorized TA Form will be issued to the Contractor by fax or by e-mail as an attachment in MS Word, Excel or PDF format.

(b) Until the authorized TA Form has been received by the Contractor, the HCP must not commence Work. The Contractor acknowledges that any Work performed before an authorized TA Form has been received will be done at the Contractor's own risk.

**7.2.4 Position Request (PR)**

A Position Request (PR) is defined as a request for the Contractor to fill a position identified on the TA Form. A position is identified by its departmental position number on the TA Form.

**7.2.4.1 Filled and Unfilled PR**

(a) Specific to DND: The Contractor may not be able to fill a position for every TA Form sent to it by Canada. However, in addition to Canada's other rights to terminate the Contract, Canada may immediately, and without further notice, terminate the Contract, in whole or in part, for default, after the first year of the initial contract period, in accordance with the General Conditions, if the Contractor achieves a PR Filled % of less than 75% during a fiscal year (i.e. April 1 to March 31).

(a) Specific to RCMP: The Contractor may not be able to fill a position for every TA Form sent to it by Canada. However, in addition to Canada's other rights to terminate the Contract, Canada may immediately, and without further notice, terminate the Contract, in whole or in part, for default, after the first year of the initial contract period, in accordance with the General Conditions, if the

Contractor achieves a PR Filled % of less than 60% (for the second year of the initial contract period, 70% for any contract year thereafter) during a fiscal year (i.e. April 1 to March 31).

(a) Specific to VAC: The Contractor may not be able to fill a position for every TA Form sent to it by Canada. However, in addition to Canada's other rights to terminate the Contract, Canada may immediately, and without further notice, terminate the Contract, in whole or in part, for default, after the first year of the initial contract period, in accordance with the General Conditions, if the Contractor achieves a PR Filled % of less than 70% during a fiscal year (i.e. April 1 to March 31).

(b) To establish the PR Filled % for a fiscal year, the following formula will be used, rounded to two decimal places:

$$\text{PR Filled \%} = \frac{\text{Total \# of PRs filled}}{\text{Total \# of PRs filled + Total \# of PRs unfilled}}$$

(c) A PR is considered filled when the obligations, as detailed on the TA Form for that position, are met.

(d) A PR is considered unfilled when the obligations, as detailed on the TA Form for that position, are not met at the time the Time to Provide (TTP) for that position has expired. TTP is defined in the Statement of Work article titled Time to Provide.

(e) A PR will be measured as unfilled more than once if the Contractor is unable to fill a PR on the initial TA Form, and again on subsequent TA Forms for that same position.

### 7.2.5 Task Authorization Limit

The DPA may authorize any individual Task Authorization up to a limit of **(to be provided at Contract Award)**, applicable taxes included, inclusive of any revisions.

Any Task Authorization to be issued in excess of that limit must be authorized by the DPA and Contracting Authority before issuance.

### 7.2.6 Minimum Work Guarantee - All the Work - Task Authorizations

(a) In this clause, "Maximum Contract Value" means the amount specified in the "Limitation of Expenditure" clause set out in the Contract; and "Minimum Contract Value" means 5% of the Maximum Contract Value.

(b) Canada's obligation under the Contract is to request Work in the amount of the Minimum Contract Value or, at Canada's option, to pay the Contractor at the end of the Contract in accordance with sub-article (c) below. In consideration of such obligation, the Contractor agrees to stand in readiness throughout the Contract period to perform the Work described in the Contract. Canada's maximum liability for Work performed under the Contract must not exceed the Maximum Contract Value, unless an increase is authorized in writing by the Contracting Authority.

(c) In the event that Canada does not request Work in the amount of the Minimum Contract Value during the period of the Contract, Canada must pay the Contractor the difference between the Minimum Contract Value and the total cost of the Work requested.

(d) Canada will have no obligation to the Contractor under this clause if Canada terminates the Contract in whole or in part for default.

### 7.2.7 Task Authorization Status Reports

The Contractor must compile and maintain records on its provision of services to the federal government under authorized Task Authorizations issued under the Contract.

The Contractor must provide this data in accordance with the reporting requirements detailed below. If some data is not available, the reason must be indicated. If services are not provided during a given period, the Contractor must still provide a "nil" report.

The data must be submitted on a monthly basis to the DPA and the Contracting Authority.

The data must be submitted no later than 14 calendar days after the end of the reporting period.

**Reporting Requirement - Details**

A detailed and current record of all authorized tasks must be kept. This record must contain:

- **For each Task Authorization:**

  i. the Task Authorization number appearing on the TA form;
  ii. the date the task was authorized appearing on the TA form;
  iii. a title or a brief description of each authorized task;
  iv. the total estimated cost of the task (applicable tax extra) before any revisions appearing on the TA form;
  v. the following information appearing on the TA form must be included for each authorized revision, starting with revision 1, then 2, etc.:
     - the TA revision number;
     - the date the revision to the task was authorized;
     - the authorized increase or decrease ( applicable tax extra);
     - the total estimated cost of the task (applicable tax extra) after authorization of the revision;
  vi. the total cost incurred for the task (as last revised, as applicable), applicable tax extra;
  vii. the total cost incurred and invoiced for the task (as last revised, as applicable), applicable tax extra;
  viii. the total applicable tax amount invoiced;
  ix. the total amount paid, applicable tax included;
  x. the start and completion date of the task (as last revised, as applicable);
  xi. the date the HCP was requested for and the date the HCP was provided;
  xii. the status of each authorized task (as last revised, as applicable), and
  xiii. any additional data, as requested by the DPA or the CA.

- **For all Task Authorizations:**

  i. the sum (applicable tax extra) specified in clause 7.8.2 of the Contract (as last amended, as applicable);
  ii. the total cost incurred for all authorized tasks inclusive of any revisions, applicable tax extra;
  iii. the total cost incurred and invoiced for all authorized tasks inclusive of any revisions, applicable tax extra;

iv. the total applicable tax amount invoiced for all authorized tasks inclusive of any revisions; and
v. the total amount paid for all authorized tasks inclusive of any revisions, applicable tax extra.

### 7.3 Standard Clauses and Conditions

All clauses and conditions identified in the Contract by number, date and title are set out in the Standard Acquisition Clauses and Conditions Manual (https://buyandsell.gc.ca/policy-and-guidelines/standard-acquisition-clauses-and-conditions-manual) issued by Public Works and Government Services Canada.

#### 7.3.1 General Conditions

2035 (2016-04-04), General Conditions - Higher Complexity - Services, apply to and form part of the Contract.

#### 7.3.2 Supplemental General Conditions

4008 (2008-12-12), Personal Information, apply to and form part of the Contract.

### 7.4 Security Requirements (specific to DND)

The following security requirements apply and form part of the Contract.

7.4.1 The Contractor must, at all times during the performance of the Contract, hold a valid **Facility Security Clearance to the level of SECRET,** issued by the Canadian Industrial Security Directorate (CISD), Public Works and Government Services Canada (PWGSC)

7.4.2 The Contractor personnel requiring access to PROTECTED/CLASSIFIED information, assets or sensitive work site(s) **must EACH hold a valid RELIABILITY STATUS or SECRET clearance, as required**, granted or approved by CISD/ PWGSC.

7.4.3 The Contractor MUST NOT remove any PROTECTED/CLASSIFIED information or assets from the identified work site(s), and the Contractor must ensure that its personnel are made aware of and comply with this restriction.

7.4.4 Subcontracts which contain security requirements are NOT to be awarded without the prior written permission of CISD/ PWGSC.

7.4.5 The Contractor must comply with the provisions of the:

a. Security Requirements Check List and security guide (if applicable), attached at Annex C;

b. Industrial Security Manual (Latest Edition).

### 7.4 Security Requirements (specific to RCMP)

The following security requirements apply and form part of the Contract.

(a) **Security Requirements – CISD / PWGSC**

i. The Contractor must, at all times during the performance of the Contract, hold a valid *Designated Organization Screening* (DOS), issued by the Canadian Industrial Security Directorate (CISD), Public Works and Government Services Canada (PWGSC).

ii. The Contractor personnel requiring access to **PROTECTED** information, assets or *sensitive work site(s)* must **EACH** hold a valid **RELIABILITY STATUS**, granted or approved by CISD/PWGSC.

iii. The Contractor **MUST NOT** remove any **PROTECTED** information or assets from the identified work site(s), and the Contractor must ensure that its personnel are made aware of and comply with this restriction.

iv. Subcontracts, which contain security requirements, are **NOT** to be awarded without the prior written permission of CISD/PWGSC.

v. The Contractor must comply with the provisions of the:

(A) Security Requirements Check List and security guide (if applicable), attached at Annex C;

(B) Industrial Security Manual (Latest Edition).

(b) **Security Requirements – RCMP**

i. **General Security Requirements**

All contractors and sub-contractors employed on this contract must support the RCMP's security environment by complying with the directives described in this document.

(A) Physical access is restricted to those specific areas of RCMP facilities required to meet the contract's objectives.

(B) No Protected or Classified information or other assets will be removed from the RCMP facility without the approval of the Departmental representative or technical authority. If approved the transport and/or transmittal must comply with the security requirements identified in the RCMP's Transport and Transmittal Guide.

(C) Nothing above unclassified will be sent externally via Groupwise.

(D) Contractors will be issued a smart card, which is to be used only by the resource it is issued to.

(E) All work will be onsite at RCMP.

(F) Contractors must sign an AUP (Acceptable User Practices) and RCMP FORM 2871 to ensure the proper use of any IT EQUIPMENT.

(G) Restricted items such as cameras, mobile telephones, and audio/visual devices will be surrendered to the main security desk upon arrival at any RCMP facility unless prior written approval has been obtained.

(H) If applicable the contractor must hold a valid Document Safeguarding Capability (DSC).

(I) The information disclosed under this contract will be administered, maintained, and disposed of in accordance with RCMP Security Policies and the Policy on Government Security.

(J) The contractor will promptly notify the RCMP of any unauthorized use or disclosure of the information exchanged under this contract and will furnish the RCMP with details of the unauthorized use or disclosure.

(K) The contractor will be responsible for advising the RCMP of any changes in personnel security requirements. Ie: Cleared personnel leaving the company or no longer supporting the RCMP contract, new personnel requiring a clearance and personnel requiring clearance renewal.

(L) All contractor personnel will be required to obtain and maintain a personnel security clearance commensurate with the sensitivity of the work being performed throughout the life cycle of the contract (in accordance with the provisions of the SRCL).

(M) This requirement is limited to the level of RRS for RCMP.

(N) Work cannot commence for the contractor at RCMP until the RCMP clearance has been issued.

ii. **Personnel Security Requirements – RCMP Reliability Status (RRS)**

For contractors who require access to RCMP protected information, systems, assets and/or facilities. In this scenario, the RCMP wishes to conduct all checks required for obtaining an RRS. For PWGSC procurement purposes, this should be identified in the contractual documents.

Contractor personnel must submit to verification by the RCMP, prior to being granted access to Protected or Classified information, systems, assets and/or facilities. The RCMP reserves the right to deny access to any of the above to any contractor personnel, at any time.

When the RCMP identifies a requirement for RRS or a security clearance; the successful Contractor will submit the following to the RCMP:

(A) Form TBS 330-23

(B) Form TBS 330-60

(C) Form 1020 (Security Interview)

(D) Two pieces of photo identification (Birth Certificate and Driver's licence)

(E) Two sets of fingerprints

(F) Working Visa (where applicable)

(G) Two passport photographs

(H) Security Interview

The RCMP:

1. Will conduct personnel security screening checks above the Policy on Government Security requirements.

2. Is responsible for escorting requirements on its facilities or sites if applicable. RCMP reserves the right to request the use of an escort on its sites throughout this procurement if they so choose.

**7.4 Security Requirements (specific to VAC)**

The following security requirements apply and form part of the Contract.

7.4.1 The Contractor must, at all times during the performance of the Contract, hold a valid **Designated Organization Screening (DOS),** issued by the Canadian Industrial Security Directorate (CISD), Public Works and Government Services Canada (PWGSC).

7.4.2 The Contractor personnel requiring access to PROTECTED information, assets or sensitive work site(s) must EACH hold a valid **RELIABILITY STATUS**, granted or approved by CISD/PSPC.

7.4.3 The Contractor MUST NOT remove any PROTECTED information or assets from the identified work site(s), and the Contractor must ensure that its personnel are made aware of and comply with this restriction.

7.4.4 Subcontracts which contain security requirements are NOT to be awarded without the prior written permission of CISD/PSPC.

7.4.5 The Contractor must comply with the provisions of the:

a. Security Requirements Check List and security guide (if applicable), attached at Annex C;

b. Industrial Security Manual (Latest Edition).

## 7.5 Term of Contract

### 7.5.1 Period of the Contract (Contract Period)

The period of the Contract is from the date of Contract award to March 31, 2022 inclusive.

### 7.5.2 Option to Extend the Contract

The Contractor grants to Canada the irrevocable option to extend the term of the Contract by up to eight additional years under the same conditions. The length of each option period may vary. The Contractor agrees that, during the extended period of the Contract, it will be paid in accordance with the applicable provisions as set out in the Basis of Payment.

Canada may exercise this option at any time by sending a written notice to the Contractor at least 18 months before the expiry date of the Contract. The option may only be exercised by the Contracting Authority, and will be evidenced for administrative purposes only, through a contract amendment.

### 7.5.3 Comprehensive Land Claims Agreements (CLCAs) - Specific to DND only

(a) The Contract is subject to the following Comprehensive Land Claims Agreements:

i. Tlicho Land Claims Agreement
ii. Ta'an Kwach'an Council Final Agreement
iii. Kwanlin Dun First Nation Final Agreement

(b) The Contract with Task Authorizations is to establish the delivery of the requirement detailed under the Contract, to the Identified Users across Canada, including areas subject to Comprehensive Land Claims Agreements.

### 7.5.4 Delivery Points

Delivery of the requirement will be made to delivery point(s) specified at Attachment "X" of Annex B of the Contract.

## 7.6 Authorities

### 7.6.1 Contracting Authority

The Contracting Authority (CA) for the Contract is:

Name: Patrick O'Sullivan
Title*:* Supply Team Leader
Public Works and Government Services Canada
Acquisitions Branch
Directorate: Special Procurement Initiatives Directorate
Address*:* 11 Laurier Street, Gatineau, Quebec, K1A 0S5
Telephone: 819-420-2233
E-mail address: patrick.o'sullivan@pwgsc-tpsgc.gc.ca

The Contracting Authority is responsible for the management of the Contract and any changes to the Contract must be authorized in writing by the Contracting Authority. The Contractor must not perform Work in excess of or outside the scope of the Contract based on verbal or written requests or instructions from anybody other than the Contracting Authority.

### 7.6.2 Departmental Technical Authority (DTA)

The Department Technical Authority (DTA) for the Contract is listed below: **(to be provided at Contract Award)**

Name: _____
Title: _____
Organization: _____
Address: _____

Telephone: _____
Facsimile: _____
E-mail address: _____

### 7.6.3 Departmental Procurement Authority (DPA)

The DPA for the Contract is listed below: **(to be provided at Contract Award)**

Name: _____
Title: _____
Organization: _____
Address: _____

Telephone: _____
Facsimile: _____
E-mail address: _____

### 7.6.4 Task Managers (TM)

The list of TMs will be provided to the Contractor after Contract Award.

### 7.6.5 Contractor's Representative

Name: _____
Title: _____
Organization: _____
Address: _____

Telephone: _____
Facsimile: _____
E-mail address: _____

### 7.7 Proactive Disclosure of Contracts with Former Public Servants

By providing information on its status, with respect to being a former public servant in receipt of a *Public Service Superannuation Act* (PSSA) pension, the Contractor has agreed that this information

will be reported on departmental websites as part of the published proactive disclosure reports, in accordance with Contracting Policy Notice: 2012-2 of the Treasury Board Secretariat of Canada.

### 7.8 Payment

#### 7.8.1 Basis of Payment

The Contractor will be reimbursed for the costs reasonably and properly incurred in the performance of the Work specified in the authorized TA, in accordance with the Basis of Payment in Annex B, to the limitation of expenditure specified in the authorized TA.

Canada's liability to the Contractor under the authorized TA must not exceed the limitation of expenditure specified in the authorized TA. Customs duties are included and Applicable Taxes are extra.

No increase in the liability of Canada or in the price of the Work specified in the authorized TA resulting from any design changes, modifications or interpretations of the Work will be authorized or paid to the Contractor unless these design changes, modifications or interpretations have been authorized, in writing, by the Contracting Authority before their incorporation into the Work.

#### 7.8.2 Limitation of Expenditure

(a) Canada's total liability to the Contractor under the Contract must not exceed (**to be provided at Contract Award**). Customs duties are included and Applicable Taxes are extra.

(b) No increase in the total liability of Canada or in the price of the Work resulting from any design changes, modifications or interpretations of the Work, will be authorized or paid to the Contractor unless these design changes, modifications or interpretations have been approved, in writing, by the Contracting Authority before their incorporation into the Work. The Contractor must not perform any Work or provide any service that would result in Canada's total liability being exceeded before obtaining the written approval of the Contracting Authority. The Contractor must notify the Contracting Authority in writing as to the adequacy of this sum:

i. when it is 75 percent committed, or
ii. 4 months before the contract expiry date, or
iii. as soon as the Contractor considers that the contract funds provided are inadequate for the completion of the Work,

whichever comes first.

(c) If the notification is for inadequate contract funds, the Contractor must provide to the Contracting Authority a written estimate for the additional funds required. Provision of such information by the Contractor does not increase Canada's liability.

#### 7.8.3 Limitation of Expenditure for the Performance Incentive Fee

Canada’s total liability under this Contract for the Performance Incentive Fee (PIF) must not exceed the amounts shown in Annex F - Performance Management Framework, applicable taxes extra.

#### 7.8.4 Method of Payment – Authorized TA

One of the following methods will form part of the authorized TA:

(a) Single Payment

Canada will pay the Contractor upon completion and delivery of the Work in accordance with the payment provisions of the Contract if:

i. an accurate and complete invoice and any other documents required by the Contract have been submitted in accordance with the invoicing instructions provided in the Contract;
ii. all such documents have been verified by Canada; and,
iii. the Work delivered has been accepted by Canada.

(b) Monthly Payment

Canada will pay the Contractor on a monthly basis for Work performed during the month covered by the invoice in accordance with the payment provisions of the Contract if:

i. an accurate and complete invoice and any other documents required by the Contract have been submitted in accordance with the invoicing instructions provided in the Contract;
ii. all such documents have been verified by Canada; and,
iii. the Work performed has been accepted by Canada.

### 7.8.5 SACC Manual Clauses

SACC Manual clause A9117C (2007-11-30) T1204 - Direct Request by Customer Department applies
SACC Manual clause C2000C (2007-11-30) Taxes – Foreign –based Contractor applies
SACC manual clause C2605C (2008-05-12) Canadian Customs Duties and Sales Tax – Foreign-based Contractor applies
SACC Manual clause C0305C (2014-06-26) Cost Submission - Limitation of Expenditure or Ceiling Price
*SACC Manual* clause C0705C (2010-01-11) Discretionary Audit applies

## 7.9 Invoicing Instructions

The Contractor must submit invoices in accordance with the section entitled "Invoice Submission" of the general conditions. Invoices cannot be submitted until all Work identified in the invoice is completed.

(a) Each invoice must be supported by:

i. a copy of time sheets to support the time claimed;
ii. a copy of the release document and any other documents as specified in the Contract;
iii. a copy of the invoices, receipts, vouchers for all direct expenses, and all travel and living expenses;
iv. a copy of the monthly progress report.

(b) Invoices must be distributed as follows:

i. 1 copy must be forwarded to the following generic email address: **(To be provided at Contract Award)**; and

ii. Specific to DND: 1 electronic copy must be forwarded to the Departmental Procurement Authority identified under the section entitled “Authorities” of the Contract for certification and payment.
ii. Specific to RCMP: 1 electronic copy must be forwarded to the Departmental Technical Authority identified under the section entitled “Authorities” of the Contract for certification and payment.
ii. Specific to VAC: 1 electronic copy must be forwarded to the Departmental Technical Authority identified under the section entitled “Authorities” of the Contract for certification and payment.

### 7.10 Certifications and Additional Information

#### 7.10.1 Compliance

Unless specified otherwise, the continuous compliance with the certifications provided by the Contractor in its bid or precedent to contract award, and the ongoing cooperation in providing additional information are conditions of the Contract and failure to comply will constitute the Contractor in default. Certifications are subject to verification by Canada during the entire period of the Contract.

#### 7.10.2 Federal Contractors Program for Employment Equity - Default by the Contractor

The Contractor understands and agrees that, when an Agreement to Implement Employment Equity (AIEE) exists between the Contractor and Employment and Social Development Canada (ESDC)-Labour, the AIEE must remain valid during the entire period of the Contract. If the AIEE becomes invalid, the name of the Contractor will be added to the "FCP Limited Eligibility to Bid" list. The imposition of such a sanction by ESDC will constitute the Contractor in default as per the terms of the Contract.

#### 7.10.3 Canadian Content Certification

SACC Manual clause A3060C (2008-05-12) Canadian Content Certification.

### 7.11 Applicable Laws

The Contract must be interpreted and governed, and the relations between the parties determined, by the laws in force in _____.

### 7.12 Priority of Documents

If there is a discrepancy between the wording of any documents that appear on the list, the wording of the document that first appears on the list has priority over the wording of any document that subsequently appears on the list.

a. the Articles of Agreement;
b. the supplemental general conditions 4008 (2008-12-12);
c. the general conditions - Higher Complexity – Services, 2035 (2016-04-04);
d. Annex A, Statement of Work;
e. Annex B, Basis of Payment;
f. Annex C, Security Requirements Check List;

g. Annex D, Insurance Requirements;
h. the signed Task Authorizations (including all of its attachments, if any);
i. Annex F, Performance Measurement Framework;
j. the Contractor's bid dated _____, as amended on TBD.

### 7.13 Defence Contract (Specific to DND only)

*SACC Manual* clause A9006C (2012-07-16) Defence Contract
*SACC Manual* clause A9062C (2011-05-16) Canadian Forces Site Regulations

### 7.14 Foreign Nationals (Canadian Contractor or Foreign Contractor)

*SACC Manual* clause A2000C (2006-06-16) Foreign Nationals (Canadian Contractor)

or

*SACC Manual* clause A2001C (2006-06-16) Foreign Nationals (Foreign Contractor)

### 7.15 Insurance Requirements

The Contractor must comply with the insurance requirements specified in Annex D. The Contractor must maintain the required insurance coverage for the duration of the Contract. Compliance with the insurance requirements does not release the Contractor from or reduce its liability under the Contract.

The Contractor is responsible for deciding if additional insurance coverage is necessary to fulfill its obligation under the Contract and to ensure compliance with any applicable law. Any additional insurance coverage is at the Contractor's expense, and for its own benefit and protection.

The Contractor must forward to the Contracting Authority within 10 days after the date of award of the Contract, a Certificate of Insurance evidencing the insurance coverage and confirming that the insurance policy complying with the requirements is in force. For Canadian-based Contractors, coverage must be placed with an Insurer licensed to carry out business in Canada, however, for Foreign-based Contractors, coverage must be placed with an Insurer with an A.M. Best Rating no less than “A-”. The Contractor must, if requested by the Contracting Authority, forward to Canada a certified true copy of all applicable insurance policies.

### 7.16 Aboriginal Subcontracting Component

(a) The Aboriginal Subcontracting Component (ASC) is a mechanism designed to encourage the Contractor to contribute to and invest in the development and viability of Aboriginal businesses by procuring goods and services from qualified Aboriginal firms.

i. DND - The Contractor agrees to, on an annual basis, subcontract with one or more Aboriginal firms for the acquisition of goods and/or services valued at a minimum of $1,200,000.00.

i. RCMP - The Contractor agrees to, on an annual basis, subcontract with one or more Aboriginal firms for the acquisition of goods and/or services valued at a minimum of $75,000.00.

i. VAC - The Contractor agrees to, on an annual basis, subcontract with one or more Aboriginal firms for the acquisition of goods and/or services valued at a minimum of $75,000.00.

ii. To be considered an Aboriginal firm, the firm must meet the definition of an Aboriginal business, as defined under the Procurement Strategy for Aboriginal Business (PSAB).

iii. The range of goods or services subcontracted to the Aboriginal firm(s) is to be determined by the Contractor.

iv. The Contractor is solely responsible for the administration and maintenance of any contract(s) between itself and the Aboriginal firm(s).

(b) In support of the subcontracting component detailed above, the Contractor is required, within 30 calendar days of Contract Award, to submit an Aboriginal Subcontracting Plan to the Contracting Authority. The Aboriginal Subcontracting Plan should, as a minimum, include the following:

i. a description of how the Contractor plans to ensure that its subcontractor meets the definition of an Aboriginal business, as defined under PSAB;

ii. a description of how the Contractor plans to achieve the financial subcontracting component stated above;

iii. a description of how the Contractor plans to demonstrate that it has achieved the financial subcontracting component; and

iv. a corrective measures plan, in the event the Contractor does not achieve the financial subcontracting component in any given year. The corrective measures plan should detail how the Contractor will make up the deficiency in subcontracting the following year, taking into consideration relevant measures such as, but not limited to specialized training, career development, scholarships and community outreach to help local and Aboriginal communities in meeting their economic development needs. The Contractor is encouraged to reach out to Aboriginal businesses and communities.

### 7.17 Targeted Investment (TI)

A Targeted Investment (TI) is a mechanism designed to encourage the development of innovative and effective solutions to address unforeseen issues or deficiencies related to this requirement. The usage of a TI is not guaranteed – it will be used on an as-and-when-required basis. The process will be as follows:

(a) Canada will present the Contractor with a Targeted Investment requirement (through a description of the task using the Task Authorization form), which will include, at a minimum, the following elements:

i. a description of the problem;
ii. a description of the desired outcome;
iii. the method of payment; and
iv. the basis of payment.

(b) Within 30 calendar days from when Canada provided the Contractor with the TI requirement, the Contractor must provide Canada a detailed draft plan on how it intends to achieve the desired outcome detailed in the TI requirement. The draft plan must include a description of how Canada will objectively and quantifiably determine whether the desired outcome has been achieved, the proposed timeline, and a detailed price breakdown showing direct costs and any profit and overhead.

(c) If Canada does not approve the draft plan, Canada and the Contractor will work collaboratively to arrive at a mutually acceptable plan.

(d) Should the Contractor wish, it may submit a proposal for a TI for consideration by Canada. The proposal must include:

i. a description of the problem;
ii. a description of the desired outcome;
iii. a description of how Canada could objectively and quantifiably determine whether the desired outcome has been achieved;
iv. the proposed timeline; and
v. a detailed price breakdown showing direct costs and any profit and overhead.

(e) Approval of a TI, whether requested by Canada or proposed by the Contractor, remains at the discretion of Canada.

(f) The Contractor must not commence Work until Canada accepts and approves the plan, and authorizes the Task Authorization in accordance with the applicable provisions of article 7.2 Task Authorization. The Contractor acknowledges that any Work performed prior to Canada's authorization of the Task Authorization will be done at the Contractor's own risk.

### 7.18 Safeguarding Electronic Media

(a) Before using them on Canada's equipment or sending them to Canada, the Contractor must use a regularly updated product to scan electronically all electronic media used to perform the Work for computer viruses and other coding intended to cause malfunctions. The Contractor must notify Canada if any electronic media used for the Work are found to contain computer viruses or other coding intended to cause malfunctions.

(b) If magnetically recorded information or documentation is damaged or lost while in the Contractor's care or at any time before it is delivered to Canada in accordance with the Contract, including accidental erasure, the Contractor must immediately replace it at its own expense.

### 7.19 Dispute Resolution

(a) If a dispute arises out of, or in connection with this Contract, the parties agree to meet to pursue resolution through negotiation or other appropriate dispute resolution process before resorting to litigation.

(b) All information exchanged during this meeting or any subsequent dispute resolution process, shall be regarded as "without prejudice" communications for the purpose of settlement negotiations and shall be treated as confidential by the parties and their representatives, unless otherwise required by law. However, evidence that is independently admissible or discoverable shall not be rendered inadmissible or non-discoverable by virtue of its use during the dispute resolution process.

(c) The parties agree that the representatives selected to participate in the dispute resolution process will have the authority required to settle the dispute or will have a rapid means of obtaining the requisite authorization.

(d) These clauses shall not affect any of Canada’s rights of cancellation or termination contained in this Contract.

### 7.20 Representations and Warranties

The Contractor made statements regarding its experience and expertise in its bid that resulted in the award of the Contract and the issuance of TAs. The Contractor represents and warrants that all those statements are true and acknowledges that Canada relied on those statements in awarding the Contract and adding work to it through TAs. The Contractor also represents and warrants that it has, and all its resources and subcontractors that perform the Work have, and at all times during the Contract Period they will have, the skills, qualifications, expertise and experience necessary to perform and manage the Work in accordance with the Contract, and that the Contractor (and any resources or subcontractors it uses) has previously performed similar services for other customers.

### 7.21 Joint Venture Contractor

**[Note to Bidders:** This article will be deleted if the Bidder awarded the contract is not a joint venture. If the contractor is a joint venture, this clause will be completed with information provided in its bid.]

(a) The Contractor confirms that the name of the joint venture is _____ and that it is comprised of the following members: [list all the joint venture members named in the Contractor's original bid].

(b) With respect to the relationship among the members of the joint venture Contractor, each member agrees, represents and warrants (as applicable) that:

i. _____ has been appointed as the "representative member" of the joint venture Contractor and has full authority to act as agent for each member regarding all matters relating to the Contract;
ii. by giving notice to the representative member, Canada will be considered to have given notice to all the members of the joint venture Contractor; and
iii. all payments made by Canada to the representative member will act as a release by all the members.

(c) All the members agree that Canada may terminate the Contract in its discretion if there is a dispute among the members that, in Canada's opinion, affects the performance of the Work in any way.

(d) All the members are jointly and severally or solidarily liable for the performance of the entire Contract.

(e) The Contractor acknowledges that any change in the membership of the joint venture (i.e., a change in the number of members or the substitution of another legal entity for an existing member) constitutes an assignment and is subject to the assignment provisions of the General Conditions.

(f) The Contractor acknowledges that all security and controlled goods requirements in the Contract, if any, apply to each member of the joint venture Contractor.

(g) To witness their agreement with the terms and conditions of this Contract, Canada and the Contractor (by its agent, the Representative Member of the joint venture Contractor) have signed the cover page of this Contract. To witness that each member of the joint venture Contractor is a Party to this Contract and is jointly and severally and solidarily liable for the performance of all the Work, each member of the joint venture Contractor, including the Representative Member, has signed below.

**[Insert Full Legal Name of Representative Member]**

By its Authorized Signatory, _____

Print Name of Authorized Signatory: _____

Print Title of Authorized Signatory: _____

**[Insert Full Legal Name of Second Member]**

By its Authorized Signatory, _____

Print Name of Authorized Signatory: _____

Print Title of Authorized Signatory: _____

**[Insert Full Legal Name of Third Member** - add or subtract as many signature blocks as necessary so that each member of the Joint Venture is signing the Contract]

By its Authorized Signatory, _____

Print Name of Authorized Signatory: _____

Print Title of Authorized Signatory: _____

## ANNEX A1 STATEMENT OF WORK – DND

See attached.

## ANNEX A2 STATEMENT OF WORK – RCMP

See attached.

## ANNEX A3 STATEMENT OF WORK – VAC

See attached.

## ANNEX B BASIS OF PAYMENT

See attached.

## ANNEX C1 SECURITY REQUIREMENTS CHECK LIST (SRCL) – DND

See attached.

## ANNEX C2 SECURITY REQUIREMENTS CHECK LIST (SRCL) – RCMP

See attached.

## ANNEX C3 SECURITY REQUIREMENTS CHECK LIST (SRCL) – VAC

See attached.

## ANNEX D INSURANCE REQUIREMENTS

See attached.

## ANNEX E1 TASK AUTHORIZATION FORM – DND

See attached.

## ANNEX E2 TASK AUTHORIZATION FORM – RCMP

See attached.

## ANNEX E3 TASK AUTHORIZATION FORM – VAC

See attached.

## ANNEX F1 PERFORMANCE MEASUREMENT FRAMEWORK – DND

See attached.

## ANNEX F2 PERFORMANCE MEASUREMENT FRAMEWORK – RCMP

See attached.

## ANNEX F3 PERFORMANCE MEASUREMENT FRAMEWORK – VAC

See attached.

## ATTACHMENT 1 TO PART 4 TECHNICAL CRITERIA

See attached.

## ATTACHMENT 2 TO PART 4 PRICING SCHEDULE

The Bidder must complete the pricing schedules attached to the RFP and include it in its financial bid once completed. As a minimum, the Bidder must respond to these pricing schedules by including, in its financial bid for each of the periods specified below, its quoted Firm Fixed All-Inclusive Hourly Rate (in Canadian dollar) for each applicable HCP category and location. The rates should not include the applicable taxes.

Pricing Schedule A: Initial Contract Period (From Contract Award date to March 31, 2020) - see attached.

Pricing Schedule B: Initial Contract Period (From April 1, 2020 to March 31, 2022) - see attached.

**FORM 1**

| **BID SUBMISSION FORM** | | |
|---|---|---|
| **Bidder's full legal name**<br><br>***[Note to Bidders:** Bidders who are part of a corporate group should take care to identify the correct corporation as the Bidder.]* | | |
| **Authorized Representative of Bidder for evaluation purposes (e.g., clarifications)** | Name: | |
| | Title: | |
| | Address: | |
| | Telephone #: | |
| | Fax #: | |
| | Email: | |
| **Bidder's Procurement Business Number (PBN)**<br><br>*[see the Standard Instructions 2003]*<br><br>[***Note to Bidders:** Please ensure that the PBN you provide matches the legal name under which you have submitted your bid. If it does not, the Bidder will be determined based on the legal name provided, not based on the PBN, and the Bidder will be required to submit the PBN that matches the legal name of the Bidder.]* | | |
| **Jurisdiction of Contract**:<br><br>Province or Territory in Canada the Bidder wishes to be the legal jurisdiction applicable to any resulting contract (if other than as specified in solicitation) | | |
| **Former Public Servants**<br><br>See the Article in Part 2 of the bid solicitation entitled "Former Public Servant" for a definition of "Former Public Servant". | Is the Bidder a FPS in receipt of a pension as defined in the bid solicitation?<br><br>Yes ____ No ____<br><br>If yes, provide the information required by the Article in Part 2 entitled "Former Public Servant " | |

## BID SUBMISSION FORM

| | | |
|---|---|---|
| | Is the Bidder a FPS who received a lump sum payment under the terms of the terms of the Work Force Adjustment Directive?<br><br>Yes ____ No ____<br><br>If yes, provide the information required by the Article in Part 2 entitled "Former Public Servant " | |
| **Canadian Content Certification**<br><br>As described in the solicitation, bids with at least 80% Canadian content are being given a preference.<br><br>*[For the definition of Canadian goods and services, consult the PWGSC SACC clause A3050T]* | On behalf of the Bidder, by signing below, I confirm that *[check the box that applies]:* | |
| | At least 80 percent of the bid price consists of Canadian goods and services (as defined in the solicitation) | |
| | Less than 80 percent of the bid price consists of Canadian goods and services (as defined in the solicitation) | |
| **Security Clearance Level of Bidder**<br><br>**[include both the level and the date it was granted]**<br><br>[**Note to Bidders:** *Please ensure that the security clearance matches the legal name of the Bidder. If it does not, the security clearance is not valid for the Bidder.]* | | |

On behalf of the Bidder, by signing below, I confirm that I have read the entire bid solicitation including the documents incorporated by reference into the bid solicitation and I certify that:

1. The Bidder considers itself and its products able to meet all the mandatory requirements described in the bid solicitation;
2. This bid is valid for the period requested in the bid solicitation;
3. All the information provided in the bid is complete, true and accurate; and
4. If the Bidder is awarded a contract, it will accept all the terms and conditions set out in the resulting contract clauses included in the bid solicitation.

| | |
|---|---|
| **Signature of Authorized Representative of Bidder** | _____ |

**FORM 2**
**FEDERAL CONTRACTORS PROGRAM FOR EMPLOYMENT EQUITY – CERTIFICATION**

I, the Bidder, by submitting the present information to the Contracting Authority, certify that the information provided is true as of the date indicated below. The certifications provided to Canada are subject to verification at all times. I understand that Canada will declare a bid non-responsive, or will declare a contractor in default, if a certification is found to be untrue, whether during the bid evaluation period or during the contract period. Canada will have the right to ask for additional information to verify the Bidder's certifications. Failure to comply with any request or requirement imposed by Canada may render the bid non-responsive or constitute a default under the Contract.

For further information on the Federal Contractors Program for Employment and Social Development Canada (ESDC) - Labours' website.

Date:_____(YYYY/MM/DD) (If left blank, the date will be deemed to be the bid solicitation closing date.)

Complete both A and B.

A. Check only one of the following:

( ) A1. The Bidder certifies having no work force in Canada.

( ) A2. The Bidder certifies being a public sector employer.

( ) A3. The Bidder certifies being a federally regulated employer being subject to the *Employment Equity Act.*

( ) A4. The Bidder certifies having a combined work force in Canada of less than 100 employees (combined work force includes: permanent full-time, permanent part-time and temporary employees [temporary employees only includes those who have worked 12 weeks or more during a calendar year and who are not full-time students]).

A5. The Bidder has a combined workforce in Canada of 100 or more employees; and

( ) A5.1 The Bidder certifies already having a valid and current Agreement to Implement Employment Equity (AIEE) in place with ESDC -Labour.

OR

( ) A5.2. The Bidder certifies having submitted the Agreement to Implement Employment Equity (LAB1168) to ESDC -Labour. As this is a condition to contract award, proceed to completing the form Agreement to Implement Employment Equity (LAB1168), duly signing it, and transmit it to ESDC -Labour.

B. Check only one of the following:

( ) B1 The Bidder is not a Joint Venture.

OR

( ) B2. The Bidder is a Joint venture and each member of the Joint Venture must provide the Contracting Authority with a completed annex Federal Contractors Program for Employment Equity - Certification. (Refer to the Joint Venture section of the Standard Instructions).

# ANNEX A1

# STATEMENT OF WORK (SOW)
# FOR THE
# DEPARTMENT OF NATIONAL DEFENCE

APPENDICES

Appendix 1 - Glossary of Terminology

Appendix 2 - Canadian Forces Medical Clinic Model

Appendix 3 - Canadian Forces Dental Clinic Model

Appendix 4 - Canadian Forces Spectrum of Care

Appendix 5 - *CF Health Services Group Instructions:*

5020-20 Disclosure of Personal Health Information;

5020-25 Personal Health Information – Use;

5020-30 Personal Health Information – Access, Use and Disclosure;

5020-56 Privacy of Personal Information;

5020-68 - Sharing of Information Amongst Health Professionals;

6000-04 - Social Media - Protecting Information Assets;

*Defence Administrative Orders and Directives:*

1002-0 - Personal Information;

1002-1 - Requests under the Privacy Act for Personal Information;

1002-2 - Informal Requests for Personal Information;

1002-3 - Management of Personal Information;

*National Defence Security Orders and Directives (NDSOD):*

7010-01 Secure USB Memory Key – Instructions for Users;

7010-02 Fax Communication of Personal Health Information by Non-Secure Means;

7010-03 (PDF, 109 Kb) Access Control of Personal Health; and

Privacy Act, http://laws-lois.justice.gc.ca/eng/acts/p-21/.

Appendix 6 - DND CANFORGEN 039/08 CMP 018/08 131851Z FEB 08 – Disclosure of Medical/Social Work Info to Commanding Officers

Appendix 7 – CF H Svcs Group Instruction 4030-06 Providing Medical Advice in Support of Administrative or Disciplinary Proceedings

Appendix 8 - CF Health Service Group Instruction, 2000-09 Patient Safety

Appendix 9 - Defence Administrative Orders and Directives 6002-2 – Acceptable Use of the Internet, Defence Intranet, Computers and Other Information Systems

Appendix 10 – DND HCP Occupational Groups and Categories

Appendix 11 – DND HCP Qualification and Tasks

-General Instruction

-Stream 1

-Stream 2

-Stream 3

-Stream 4

-Stream 5

Appendix 12 – DND HCP Work Locations

Appendix 13 – DND HCP Requirement Forecast Plan

Appendix 14 – DND Deliverables Table

Appendix 15 - CF H Svcs Group Instruction 3120-06 Credentialing of Medical Branch Clinical Practitioners, DND 2523 Credentialing Information Form; and

-Deputy Surgeon General 02/12 - Credentialing of Health Care Personnel for Cadet Camps, DND 2558 Credentialing Information of Health Care Professionals for Cadet Camps Form;

Appendix 16 – DND Work Environment Orientation Package

Appendix 17 – List of Federal Government Holidays

Appendix 18 – Forms (Travel (to be provided at Contract Award), PA Supervisor Agreement)

Appendix 19 – List of Government Furnished Information (GFI)

Appendix 20 – PA Supervisory Agreement

## 1.0 INTRODUCTION

### 1.1 Purpose

The Department of National Defence (DND) has a requirement for a Contractor to provide and manage Health Care Providers (HCPs) needed to supplement its workforce in delivering health care and occupational health advice, consultation and screening services to Canadian Armed Forces (CAF) members and Cadets at various locations across Canada.

### 1.2 General Information

In Canada, CAF members' access health care services at Canadian Forces Health Services Centres (CF H Svcs Cs) and Canadian Forces Dental Detachments (CF Dent Dets) located within or near major military installations, referred to as CAF Bases.

1.2.1 Within each CF H Svcs C and CF Dent Det, the range of health care services varies based upon the department's planned military and civilian resources available. It is also based on the CAF members supported by the particular Base, or the CAF population served in that location.

1.2.2 The CAF provides comprehensive medical and dental care, supplemental health care, occupational health, preventive medicine, and health promotion to CAF members. The health care provided covers a broad range of health services, including health promotion, disease prevention, health maintenance, counselling, patient education, vaccination, diagnosis and treatment of acute and chronic illnesses, as well as facilitating referrals to tertiary care, which is the medical treatment provided at a specialist institution.

1.2.3 Generally, specialized health care, such as secondary, tertiary, quaternary, and long-term home care, as well as after-hours primary health care, are provided from civilian health care facilities. However, some specialized secondary health care services are provided at some locations through the CF H Svcs Cs and CF Dent Dets.

1.2.4 When specialized health care is not provided at CF H Svcs C or a CF Dent Det and is required for a CAF member, the attending physician may recommend an outside referral that is subject to approval by the Clinic's Senior Medical Authority (SMA) or the CF Dent Det's chain of command before the appointment is scheduled. A Clinic's SMA is an individual holding professional-technical authority over all aspects of health services, less dental services.

1.2.5 Health care benefits and services available to CAF members are defined and described in the Canadian Forces Spectrum of Care (CF SoC) (Appendix 4). Inclusions and exclusions apply everywhere in Canada, regardless of what health care services are covered by provincial health plans. The focus is not on equity with the provinces, but rather on operational benefit of having the right CAF member available for operations with the right level of health fitness.

1.2.6 The CF H Svcs Cs and CF Dent Dets are commanded by a Commanding Officer (CO) and a Dental Detachment Commander (Dent Det Comd) respectively. They are responsible for the overall delivery of in-garrison health care services within their designated geographical area, including any satellite clinics. Normally, the CF H Svcs C's clinical team lead and the Senior Medical Authority is the Base Surgeon.

1.2.7 The COs and Dent Det Comds are also responsible for the efficient and effective day-to-day operation of their organization, maintaining the Departmental standards and policies, identifying their medical and dental occupational group(s) shortages within their area of responsibility, and commencing the department's internal process to obtain additional Health Care Provider (HCP) support by initiating the request for staffing approval to the CF Health Service Group Headquarters.

1.2.8 Subsequently, if approved, the requirement for a HCP may be staffed through the Health Care Provider Contract (HCPC) to the Contractor via the Departmental Procurement Authority (DPA).

1.2.9 Physician Assistants (PAs) are included in HCPC. PAs currently practice across Canada in the CAF and are working in the public health care system in the Provinces of Manitoba, Ontario, New Brunswick and Alberta. Physician Assistants are regulated in Manitoba and New Brunswick by the respective provincial College of Physicians and Surgeons. In both Ontario and Alberta, the profession is not regulated; however, the Ontario Minister of Health has recommended that a mandatory registry be established, which would be governed by the College of Physicians and Surgeons of Ontario. In Alberta, a voluntary registry has been established for PAs under the College of Physicians and Surgeons of Alberta. PAs are permitted to practice, by way of delegation, under the Provincial Medical Act. PAs are represented by the Canadian Association of Physician Assistants, which formed in October 1999 as the "Canadian Academy of Physician Assistants".

1.2.10 The Canadian Forces have an integrated electronic health record, referred to as the Canadian Forces Health Information System (CFHIS). It is comprised of integrated applications supporting patient registration and scheduling, medical documentation, pharmacy, diagnostic imaging, laboratory and dental treatment.

## 1.3 Background

Given the identified shortage of personnel in health occupational groups in the DND, the requirement for the provision and management of additional HCPs are under Contract.

1.3.1 This is a recurring Contract requirement. The requirements for the provision and management of HCPs have been competed on two separate occasions.

1.3.2 In 2000, under the first procurement process, Med-Emerg International Inc. was the successful Bidder and awarded the Contract. Med-Emerg International Inc. provided and managed HCPs from March 1, 2001 to March 31, 2005.

1.3.3 Under the subsequent procurement process in 2004, Calian Ltd. was the successful Bidder and was awarded the Contract for the provision and management of HCPs.

1.3.4 The HCPC is intended to consolidate various previous contracts or staffing agreements for health care support services in the DND, including the health care services to Cadet Summer Training Centres (CSTCs), which are ly referred to as Cadet Camps.

**1.4 Departmental Authorities**

The Departmental Authorities (DAs) are responsible for the technical work and contract management activities inside the Department and are as follows:

a. Departmental Technical Authority (DTA);

(1) Task manager (TM); and

b. Departmental Procurement Authority (DPA).

1.4.1 The DTA is the representative of the DND, for whom the Work is being carried out under the Contract, and is responsible for all matters concerning the technical content of the Work under the Contract, including acceptance of the deliverables. Technical matters may be discussed with the DTA; however, the DTA has no authority to authorize changes to the scope of the Work. Changes to the scope of the Work must be made through a Contract amendment issued by the Contracting Authority.

1.4.1.1 The Task Manager (TM) is the manager at the DND Work Location. The TM is responsive to the DTA and the TM is responsible:

a. to manage the Work being carried out under Task Authorization;

c. to authorize temporary work location changes;

d. to advise HCPs of unexpected temporary closures to work location;

e. to authorize HCP overtime and on-call;

f. to request the DTA for approval for HCP Travel and Patient Site Visits;

g. for the scheduling of the clinic hours;

h. to determine the required HCP work hours necessary to cover the Clinic's hours of operation;

i. for the number of members seen by a HCP on a daily basis; and

j. for the scheduling of individual patients.

1.4.2 The DPA is the representative of the DND, responsible for all matters concerning the department's procurement and financial work under Contract, and for performing the department's Contract management activities such as:

a. administering the Task Authorization process;

b. validating the technical requirements against scope of the Work and the Contract for inclusion; and

c. verifying and processing the invoice for payment.

1.4.3 Contract administrative matters may be discussed with the DPA; however, the DPA has no authority to make changes to the Contract. Changes to the Contractor must be made through a Contract amendment issued by the Contracting Authority.

1.4.4 The DND will provide the DAs' names to the Contractor after Contract award.

## 1.5 Terminology

The Glossary of Terminology, which includes abbreviations and definitions, is found at Appendix 1 to Annex A - SOW DND.

## 2.0 APPLICABLE DOCUMENTS

The following list of applicable documents, in effect on the date of the Contract award, and including any subsequent amendments, revisions or bulletins until the expiry of the Contract, form part of the SOW:

a. CF Medical Clinic Model is found at Appendix 2 to Annex A – SOW DND;

b. CF Dental Clinic Model is found at Appendix 3 to Annex A – SOW DND;

c. CF Spectrum of Care (CF SoC) is found at Appendix 4 to Annex A – SOW DND;

d. CF Health Services Group Instructions are found at Appendix 5 to Annex A – SOW DND;

e. Privacy Act, at http://laws-lois.justice.gc.ca/eng/acts/p-21/;

f. DND CANFORGEN 039/08 CMP 018/08 131851Z FEB08 – Disclosure of Medical/Social Work Info to Commanding Officers, is found at Appendix 6 to Annex A – SOW DND;

g. CF Health Service Group Instruction, 4030-06 Providing Medical Advice in Support of Administrative or Disciplinary Proceedings is found at Appendix 7 to Annex A – SOW DND;

h. CF Health Service Group Instruction, 2000-04 Patient Safety is found at Appendix 8 to Annex A – SOW DND;

i. Defence Administrative Orders and Directives (DAOD) 6002-2 – Acceptable Use of the Internet, Defence Intranet, Computers and Other Information Systems is found at Appendix 9 to Annex A – SOW DND; and

j. the latest version of the Project Management Body of Knowledge (PMBOK) in effect at the time the Work and deliverables are required throughout the Contract period and found on the PMI official website.

2.1.1 The Contractor, the Contractor's Management Team (CMT), and the Contractor's HCPs must use or apply the applicable documents in the performance and delivery of the Work.

2.1.2 The DTA will provide the Contractor with the amendments, revisions and bulletins to the applicable documents. Amendments, revisions and bulletins become effective on the day of notice or the date specified in the notice, whichever comes later.

2.1.3 Should the DND reviews and revises the applicable documents, updated version will be provided to the Contractor.

2.1.4 The Contractor must distribute the amendments, revisions or bulletins to the CMT and HCPs by the end of the day following the day of notice or before the date specified in the notice, whichever comes later.

2.1.5 The Contractor must ensure that all subsequent Work provided, performed or delivered by the Contractor, the CMT and HCPs are in accordance with (IAW) any of the updated and revised amendments, revisions or bulletins.

## 3.0 SCOPE OF CONTRACT

The scope of work under the Contract includes:

a. the provision of HCPs, which mainly consists of: the recruiting; the verification of credentials and references; hiring; security clearance; and department introduction including the orientation package;

b. the management of the HCPs, which mainly consists of: retention; replacing or backfilling HCPs; account for hours worked by the HCP using the Timesheet Tool; credentialing; counselling; and discipline when necessary; and

c. the Contract Management activities, which mainly consist of:

    (1) the planning, organizing and scheduling work and deliverables to meet the required timelines or schedule; establishing processes or procedures to provide and manage HCPs; administration and management of timesheet tool;

    (2) invoicing; preparing and providing various project management plans and reports;

    (3) attending meetings; and

    (4) establishing and maintaining the Contractor organizational structure and management team to support providing all the Contract requirements and deliverables.

## 3.1 Contract Objectives

The objectives of the HCPC are to ensure that the DND obtains the required number of qualified HCPs needed to supplement their existing members and personnel in providing health care and in providing occupational health advice, consultation and screening services, as well as to administer and manage the required HCP resources.

## 3.2 Intended Use of Contract

The DND intends to use the HCPC when identified work force shortages occur because of one or a combination of the following circumstances:

a. to offset shortages caused by difficulties in recruiting and retaining military members or civilian personnel in health occupational groups;

b. when replacement of personnel is required as a result of operational deployments, training, extended leave, etc;

c. to supply HCPs when the Public Service staffing process has not been successful;

d. to act as a bridging mechanism while awaiting the Public Service staffing process to be completed; and

e. when urgent HCP requirements arise.

### 3.3 Contract Phases

Under the Contract there are three (3) Contract Phases defined as follows:

a. Start-Up Phase is the period from the date of Contract award to the Service Effective Date (SED), which will be approximately six (6) months. The Start-Up Phase is outside of the initial Contract period. The Contracting Authority (CA) will provide the Contractor with the duration of the phase on the Contract Award Date;

b. In-Service Phase starts on the SED, and includes the initial Contract period (48 months), as well as any of the option periods exercised, and will cease at the start date of the Out-Going Phase; and

c. Out-Going Phase is a period of approximately 12 months before the Contract expiry date. The CA will provide the Contractor with Out-Going Phase notification when the final option is exercised.

3.3.1 During the Start-Up Phase, the Contractor must set-up and prepare for providing all of the requirements and deliverables required in this phase and the subsequent phases. In addition, the Contractor must undertake any transition activities needed from the previous Contract, as well as carry out all provision type activities based on the Initial HCP Requirement Plan and DND 626 - Task Authorizations for the HCPs that are required at SED.

3.3.2 During the In-Service Phase, the Contractor must provide all requirements and deliverables required in this phase; some may have commenced in the Start-Up Phase but continue throughout this phase and the subsequent phase. In addition, the Contractor must carry out all provision and management activities based on terms and conditions of the Contract and on the Annual HCP Requirement Plan and DND 626 - Task Authorizations issued for recurrent requirements, and for any New HCP Requirements identified thereafter via DND 626 – Task Authorization.

3.3.3 During the Out-Going Phase, the Contractor must provide all requirements and deliverables required in this phase; some may have commenced in the Start-Up or In-Service Phases but continue throughout this phase. In addition, the Contractor must continue to manage the existing HCPs on DND 626 - Task Authorizations as well as provide and manage any New HCP requirements identified via DND 626 – Task Authorization process during this phase, and undertake the Out-Going Phase activities.

3.3.4 Any transition activities required between the previous and new Contract will be organized and coordinated through the CA.

3.3.5 The requirements and deliverables for all of the Contract Phases are stated in the Requirements Sections in the DND SOW.

## 3.4 HCP Work Streams

The DND HCP Work Streams are Streams 1 to 5 as follows:

a. Stream 1 - DND Medical Care;

b. Stream 2 - DND Dental Care;

c. Stream 3 - DND Specialist Health Care;

d. Stream 4 - DND Occupational Health Advice, Consultation and Screening; and

e. Stream 5 – DND Cadet Summer Training Centres.

3.4.1 Under Streams 1 and 2, the Work consists of providing primary medical and dental care to CAF members. Stream 3 provides secondary medical and dental care to CAF members. The Work conducted under these three (3) Streams mainly takes place in CF H Svcs Cs and CF Dent Dets.

3.4.2 Under Stream 4, the Work is conducted by clinicians but consists mainly of providing occupational health advice, consultation and screening activities. The outline of the work tasks and deliverables are identified under the specific occupational groups and categories on the applicable HCP Qualification and Task Sheet. The DND 626 - Task Authorization will include the detailed information on the specific tasks, deliverables and timelines or schedule. All Work conducted under this Stream is in a DND facility.

3.4.3 Under Steam 5, the Work consists of providing primary medical care, first aid, and emergency dental care services to the Cadet Instructor Cadre (CIC), CAF members and Cadet members at CSTCs. Health care is provided in Cadet Health Services Clinics co-located with the CSTCs, which could vary from buildings to tents in the field, and may be located on a CAF Base.

## 3.5 HCP Occupational Groups and Categories

The HCP Occupational Groups and Categories are found at Appendix 10 to Annex A - SOW DND, and are listed by Streams.

## 3.6 HCP Qualifications and Tasks

The HCP Qualifications and Tasks are found at Appendix 11 to Annex A - SOW DND, and include the specific work environment, education, experience, tasks and deliverables when applicable required for each Category.

3.6.1 As a minimum, all HCPs provided by the Contractor must meet all the mandatory requirements of the Contract, including the education and experience stated in the Qualifications and Task Sheets for the specific Occupational Group and Category.

3.6.2 Any HCPs who do not meet the mandatory requirements for credentials or experience but whom the Contractor believes have equivalent qualifications may be considered on an exception basis IAW DND policies and processes.

**3.7 Type of HCP Requests**

There are three (3) types of HCP Requests as follows:

a. New;

b. Recurring; and

c. Short-term.

3.7.1 A New HCP Request is defined as New HCP shortage identified that was not currently under a Task Authorization. A New HCP Request will also be either Recurring or Short-term.

3.7.2 A Recurring HCP Request is defined as a HCP requirement needed to fill a capability gap that lasts for, pertains to, or involves a period longer than 180 calendar days.

3.7.2.1 In the Annual Requirement Plan, a Recurring HCP Request is also defined as HCP requirements that were under Task Authorization in the current FY that continue to be required in the upcoming FY.

3.7.3 A Short-term HCP Request is defined as a HCP requirement needed to fill a capability gap that lasts for, pertains to, or involves a short period. For the purposes of the HCPC, the length of a short-term requirement is 180 calendar days or less.

**3.8 Priority of HCP Requests**

There are two (2) types of HCP Request priorities, which are as follows:

a. Routine; and

b. Urgent.

3.8.1 Routine is defined as a HCP Requirement that the priority to fill is a not Urgent.

3.8.2 Urgent is defined as a HCP Requirement that must be staffed as a priority over a Routine HCP Request, and therefore necessitates immediate action and attention.

3.8.3 Routine and Urgent HCP Requests can also be New, Recurring, and Short-term.

3.8.4 The priority of HCP Request can be applied under any of the HCP Work Streams.

**3.9 HCP Work Locations**

The HCP Work Locations are found at Appendix 12 to Annex A - SOW DND, and are listed by the Streams. For this Contract the work location can be either Regular or Temporary Work Locations.

3.9.1 Regular Work Locations is defined as the single permanent location defined on the DND 626 Task Authorization, at or from which the HCP ordinarily performs the Work of the position.

3.9.2 Temporary Work Locations is defined as the single location where the HCP is temporarily assigned to perform the Work of the position.

**3.10 Initial HCP Requirement Plan Definition**

The Initial HCP Requirement Plan is the estimated HCP Requirements that are required to start working at the SED. An example Plan is provided at Appendix 13 to Annex A – SOW DND for information purposes only, and does not represent a commitment by the DND that the Initial HCP Requirement Plan provided to the Contractor after Contract award will be the same.

3.10.1 The Initial HCP Requirement Plan starts with the Summary Page. The Summary Page lists categories down one side and locations across the top for all Streams, and all totals are a combination of Full Time and Part Time positions. It includes a total column across the bottom and on the right hand side. The totals across the bottom identify the number of positions that may be required per location and the total on the right identifies the total number of positions per category that may be required. Underneath the totals across the bottom are a number that represents the total estimated number of positions required to supplement the DND workforce.

3.10.2 Following the Summary Page are the HCP Work Stream breakdown tables. Each table represents the HCP Requirements for each of the Streams separately. The tables are not in addition to the Summary Page.

3.10.3 Each table is set up similarly to the Summary Page and represents only the Categories, Locations and totals of HCP Requirements for each Stream. These tables include three (3) columns per location:

a. one (1) for identifying Full-time positions required;

b. one (1) for identifying Part-time positions required; and

c. one (1) for identifying the combined number of weekly hours for the Part-time positions required.

3.10.4 Full-time is defined as work equal to 37.5 hours per week.

3.10.5 Part-time is defined as work less than 37.5 hours per week.

3.10.6 Overtime is defined as authorized time worked by the HCP in excess of 37.5 hours in a working week.

3.10.7 Extended hours is defined as all hours worked by the HCP beyond the LOE shown on TA Form, are considered extended hours, unless Overtime is pre-authorized on the TA Form.

3.10.8 Full-time and Part-time HCP Requirements can be New, Recurring or Short-Term.

### 3.11 Annual HCP Requirement Plan Definition

The Annual HCP Requirement Plan is the HCP Requirements that are required for the following Fiscal Year (FY), which starts on 1 April of every year. The DND compiles the Annual HCP Requirements in the third quarter (September to November) of each FY for organizational planning and budget purposes.

3.11.1 The Annual HCP Requirement Plan will consist of Work Stream Tables and two (2) lists that separately identify the Recurring HCP Requirements, and the New HCP Requirements. The Recurring and New HCP Requirement Lists are extracted from the Work Stream Tables for management purposes only, and are not to be considered as additional HCP Requirements.

### 3.12 Time to Provide

The Time to Provide (TTP) is defined as the period that starts when the DND 626 – Task Autorization Form (TA Form) is initially sent to the Contractor and ends on the required Work start date. The Contractor must submit its response to the DPA no later than 20 calendar days before the end of the TTP. During the Start-up Phase, in order to streamline the processing of the large volume of responses during this period, the Contractor should submit the response packages as they become available.

3.12.1 The end date of the TTP in the In-Service and Out-Going Phases are as follows:

a. for New HCP Requests with Routine priority: 60 calendar days from when the DND 626 TA Form is initially sent to the Contractor;

b. for New HCP Requests with Urgent priority: 21 calendar days from when the DND 626 TA Form is initially sent to the Contractor; and

c. for Recurring Annual HCP Requirements: 30 calendar days from when the Annual HCP Requirements Plan is sent to the Contractor.

d. an extension to the TTP may be authorized by the DTA, via the DPA, on a case-by-case basis.

**3.13 Temporary Change to HCP(s) Work Location(s) Within the Local DND Location(s)**

HCPs may be required to work at a Temporary Work Location from the Regular Work Location for various reasons such as; HCP shortages, vacancies, absences, temporary clinics closure, etc. Temporarily is defined as one (1) workday and up to 30 calendar days. For the purpose of the Contract, a Local DND Location, spans an area of 50 kilometers from the Regular Work Location using the most direct, safe and practical road.

3.13.1 When Temporary Change to a HCP Work Locations are required, the TM will provide the HCP and the DTA with written notification three (3) calendar days in advance of a temporary change to the Regular HCP Work Location.

3.13.2 The notice will contain the following information:

a. Task Authorization number;

b. name of HCP;

c. location name and address of the temporary work location;

d. reason for the change;

e. duration of change and the number of days; (from and to dates and total number of days);

f. required hours of work (7:00 am to 3:00 pm or 8:00 am to 4:00 pm, etc.);

g. required schedule, if part time (Monday, Wednesday and Friday, or Tuesday and Wednesday, etc.);

h. overtime involved - Yes/No; and

i. Point of Contact (POC) at the temporary work location (name, email address and telephone number).

3.13.3 Travel expenses to and from the temporary work location are not billable because it is considered the work place.

3.13.4 The DTA or the DPA will provide the written Temporary HCP Work Location notice, to the Contractor.

3.13.5 The Contractor must submit the Temporary HCP Work Location notice with their invoice, as this establishes the "authorization" for the change.

3.13.6 An amendment to the DND 626 – Task Authorization will not be issued for Temporary HCP Work Location within the Local DND Location.

**3.14 Temporary Change to HCP(s) Work Location(s) Outside Local DND Location(s) or Province of Work**

On occasion, DND may require HCPs to temporarily work outside the Local DND Location or Province of Work. The change in work location will be considered travel. Temporary, for this requirement, is defined as less than 30 calendar days. All Temporary HCP Work Locations outside the Local DND Location or Province of Work requires the approval of the DTA before the change can occur.

3.14.1 When Temporary Changes to HCP Work Locations outside the Local DND Location or Province of Work are required, the TM will request approval from the DTA seven (7) calendar days in advance.

3.14.2 The DTA will provide the Contractor with the written approval for the Temporary HCP Work Location Outside the Local DND Location or Province of Work. The written approval must contain the following information:

a. Task Authorization number;

b. name of HCP;

c. location name and address of the temporary work location;

d. reason for the change;

e. duration of change and the number of days. (from and to dates and total number of days);

f. required hours of work (7:00 am to 3:00 pm or 8:00 am to 4:00 pm, etc.);

g. overtime involved - Yes/No; and

h. Point of Contact (POC) at the temporary work location (name, email address and telephone number).

3.14.3 Temporary Changes to HCP(s) Work Location(s) outside the Local DND Location or Province of Work will be considered travel. The HCP Travel Request and Authorization process must be followed and is detailed under the SOW DND paragraph titled HCP Travel.

3.14.4 When the Temporary Change to a HCP work location is outside of the HCPs current Province of Work, the Contractor must ensure the HCP obtains the additional licenses and registration, when required.

3.14.5 The Contractor must submit the complete approval package, travel itinerary, claimable expenses and receipts with the invoice.

3.14.6 When a HCP is requested to travel and the travel requirement is not stated in the DND 626 – Task Authorization, the Task Authorization must be amended for the travel requirement before the travel for Temporary Changes to HCP(s) Work Location(s) Outside the Local DND Location or Province of Work is conducted.

**3.15 Temporary Closures to Work Location**

Temporary Closures to Work Location(s) may occur over the period of the Contract and closures can be expected or unexpected. Expected is defined as within the Department's control such as, repairs, scheduled maintenance, renovations, installation of new equipment(s), etc. Unexpected is defined as outside the control of the Department, such as flood, fire, equipment failure or shut down, power outages or extreme weather conditions, etc.

3.15.1 When a Temporary Closure to a Work Location is expected, the TM will advise the DTA. The DTA will advise the Contractor in writing, a minimum of seven (7) calendar days in advance, of any expected Temporary Closures, including the date(s) and duration of the closure, and the names of the HCPs affected by the temporary closure.

3.15.2 The Contractor must advise the affected HCPs of any expected Temporary Closures to Work Location(s) accordingly.

3.15.3 If unexpected Temporary Closures to a Work Location occur, the TM will advise the HCPs verbally and follow with the notice to the DTA and the DPA. The DTA or DPA will: advise the Contractor by email on the day of the closure; include the name(s) of the HCP(s) affected; and when known, advise the Contractor of the date and time the HCPs are to return to the work location.

3.15.4 The Contractor must contact the HCPs and advice the date and time they are to return to the work location.

3.15.5 The HCPs time during expected or unexpected Temporary Closures to Work Location closures are not billable hours.

### 3.16 Permanent Closures to Work Location

Permanent Closures to Work Location(s) may occur over the period of the Contract.

3.16.1 If a Permanent Closure to a Work Location is expected by the DND, the DTA will advise the Contractor in writing, a minimum of 60 calendar days in advance of the Permanent Closure.

3.16.2 The Permanent Closure to Work Location Notice will contain the following information:

a. date of the Notice;

b. work location closure date;

c. a list of the DND 626 – Task Authorizations affected by the work location closure; and

d. a list of the HCP Requirements that may be needed at other work locations, if applicable, and the anticipated start date(s).

3.16.3 The Contractor must advise the affected HCPs of Permanent Closures to Work Location(s).

3.16.4 If a list of HCP Requirements is provided to the Contractor, the DPA will issue New DND 626 – Task Authorizations accordingly for the Contractor's acceptance.

3.16.5 If HCPs are affected by a Permanent Closure to a Work Location, the conditions stipulated in the Contract article titled Cancellation of a DND 626 - Task Authorization will apply.

### 3.17 HCP Tele-Health Work

Tele-Health is defined as the delivery of health services via DND information technologies to CAF members at a distance from the Regular HCP Work Location. Tele-Health may include the practice of health care delivery, access to care, diagnosis, consultation, treatment, transfer of medical data, and education using DND interactive audio, video, or data communications.

### 3.18 HCP Patient Site Visits

A HCP Patient Site Visit is defined as a visit to a patient occurring outside of the CF H Svcs C and can be at a CAF member's home, barracks (may include ships), convalescent home, a local clinic, or a hospital, etc. Exceptional circumstances are determined on a case-by-case basis.

## 4.0 REQUIREMENTS

The Contract Requirements are detailed and described below.

**Part One - Start-Up Phase**

### 4.1 Contractor's Organization

The Contractor must set up its Organizational Structure to manage work, requirements, deliverables, and Task Authorizations related to all HCP requirements throughout all Phases of the Contract.

4.1.1 The Contractor's Organizational structure, number of team members, roles and responsibilities or function(s), and qualifications of the individual team members are the Contractor's responsibility.

### 4.2 Contractor's Work Location

The Contractor and Contractor's Management Team must work from its own site(s) throughout the duration of the Contract.

### 4.3 Contractor's Central Office

The Contractor must set up and manage a Contractor's Central Office (CCO) in Canada throughout the duration of the Contract.

4.3.1 The CCO must be the centralized point of contact for the CA, DTA and DPA for all Contract related communications such as, Task Authorizations, inquiries, issues or clarifications.

4.3.2 The CCO must be equipped to receive the Task Authorizations and general inquiries, via email, fax, and telephone and have the capability to conduct teleconferences, video conferences and web conferences.

4.3.3 The CCO must be available from Monday to Friday between the hours of 8:00am and 5:00pm, Eastern Standard Time (EST).

4.3.4 The CCO will not be required to be available on Federal Government Holidays or on civic and statutory holidays designated by the province in which the CCO is located.

4.3.5 The CCO must be capable, during work hours, of providing services to the DND in both of Canada's Official Languages (OL) – English and French. Bilingual means that the individual(s) must be able to read and communicate in clear language in oral and writing, using both official languages, without assistance and with minimal errors.

4.3.6 The Contractor must provide a CCO Set-Up Notification with a toll free telephone number, teleconference number, and an email address. Refer to Appendix 14, Deliverable 1.

4.3.7 The Contractor must provide the name, title, role and responsibility, and email address if different from the general email address, for point of contact personnel employed within the CCO. Refer to Appendix 14, Deliverable 2.

4.3.8 The Contractor must manage any CCO point of contact personnel changes without affecting the services required under the Contract and provide the name, title, role and responsibility, and email address if different from the general email address of any changes made to the CCO personnel within five (5) calendar days. Refer to Appendix 14, Deliverable 3.

4.3.9 The Contractor must ensure that the CCO personnel have the necessary experience or training required to be able to discharge their responsibilities.

4.3.10 Any associated training costs or travel expenses incurred in support of training their personnel are the Contractor's responsibility.

**4.4 Contractor's Management Team**

The Contractor must establish a Contractor's Management Team (CMT). The team composite may be different for each Phase of the Contract.

4.4.1 The name, title, role, summary of responsibilities, location and contact information for each member of the CMT must be confirmed at the initial Contract Kick-Off Meeting and must be based on the team composite described and proposed in the Contractor's bid. Refer to Appendix 14, Deliverable 2.

4.4.2 The Contractor must provide updated name, title, role and responsibility, and email address if different from the general email address, for any changes made to the CMT personnel, within two (2) working days of the change. Refer to Appendix 14, Deliverable 3.

4.4.3 The CMT must employ a minimum of one (1) person who is bilingual and capable of providing services to the DND in both of Canada's Official Languages (OL) – English and French. Bilingual means that the individual(s) must be able to read and communicate in clear language in oral and writing, using both official languages, without assistance and with minimal errors.

4.4.4 The Contractor must ensure that the CMT personnel have the necessary experience or training required to be able to discharge their responsibilities.

4.4.5 Any associated training costs or travel expenses incurred in support of training their personnel are the Contractor's responsibility.

**4.5 Contractor's Service Delivery Manager**

The Contractor must provide a dedicated Service Delivery Manager (SDM) as Lead for the CMT throughout the duration of the Contract.

4.5.1 The SDM position must be filled at all times, including periods when the SDM is absent for any reason.

4.5.2 The SDM will be the primary point of contact (POC) for the Contracting Authority (CA), the Departmental Technical Authority (DTA) and Departmental Procurement Authority (DPA).

4.5.3 The SDM must have the authority to plan, organize, coordinate, make decisions, direct, execute, implement, monitor, provide feedback, report, and manage all Work activities undertaken by the CMT in support of the Work associated with the provision and management of the HCPs.

4.5.4 The SDM must respond to any phone calls or emails from the CA, DTA or DPA within two (2) working days.

4.5.5 The SDM's name and contact information must be confirmed within five (5) calendar days after Contract award (ACA). Refer to Appendix 14, Deliverable 4.

4.5.6 As a minimum, the SDM must have the following qualifications and experience:

a. a University degree, or an acceptable combination of education and experience, such as:

   (1) a college certificate or college diploma; plus

   (2) seven (7) years' experience in a senior management role or position with direct responsibility for managing a multi-million-dollar contract, project or program;

b. seven (7) years' experience within the last 14 years in Project or Program Management;

c. five (5) years' experience within the last 10 years in managing employees;

d. three (3) years' experience within the last six (6) years in Contract Management; and

e. must be proficient in English.

4.5.7 The Contractor must provide a minimum of 30 calendar days' notice of the intent to permanently replace the SDM. Refer to Appendix 14, Deliverable 5.

4.5.8 Any proposed replacement SDM must meet the qualifications as outlined above and will be subject to the concurrence of the DTA.

**4.6 Deputy Service Delivery Manager**

The Contractor must provide a Deputy Service Delivery Manager (DSDM) as part of the CMT throughout the duration of the Contract.

4.6.1 The DSDM must replace and be available when the SDM is absent for any reason.

4.6.2 The DSDM's name and contact information must be confirmed five (5) calendar days ACA. Refer to Appendix 14, Deliverable 4.

4.6.3 As a minimum, the DSDM must have the following qualifications and experience:

a. University degree or an acceptable combination of education and experience, such as:

(1) college certificate or college diploma; plus

(2) five (5) years' experience in a senior management role or position with direct responsibility for managing a multi-million-dollar contract, project or program;

b. five (5) years' experience within the last 14 years in Project or Program Management;

c. four (4) years' experience within the last 10 years in managing employees;

d. two (2) years' experience within the last six (6) years in Contract Management; and

e. must be proficient in English.

4.6.4 The Contractor must provide a minimum of 15 calendar days' notice of the intent to permanently replace the DSDM. Refer to Appendix 14, Deliverable 6.

4.6.5 Any proposed replacement DSDM must meet the qualifications as outlined above and will be subject to the concurrence of the DTA.

**4.7 Contractor's Start-Up Plan**

The Contractor must develop and deliver a Draft within 14 calendar days ACA and Final Start-Up Plan. Refer to Appendix 14, Deliverables 7 and 8.

4.7.1 The Start-Up Plan can incorporate any Contractor start-up and set-up activities and practices but as a minimum, must include the following:

a. a list and description of Contractor start-up and set-up activities to be completed and the major milestones to be achieved during the Contract Start-Up Phase to allow for orderly and timely set up in order to fully meet all the SOW DND requirements before and at SED;

b. a high-level Work Breakdown Structure (WBS) in accordance with the PMBOK– current version and reflective of all the activities and sub-activities, the major milestones and deliverables;

c. a schedule in MS Project and IAW the PMBOK current version, which states the proposed timelines or timeframes for all activities and sub-activities related milestones, all dependencies, and the critical path; and

d. the Contractor's Senior Management structure for the Contract Start-Up Phase, including but not limited to: the Contractor's Start-Up Phase Management Team; any oversight committees; or working groups established by the Contractor, etc. The structure must indicate where participation is required or may be requested from the DTA, and what processes and procedures are recommended to ensure quick decision-making within the plan to facilitate the timely delivery of services.

4.7.2 The schedule will form the baseline on which the Contractor's performance will be monitored and measured by the DND.

4.7.3 The Contractor must revise and update within 10 calendar days the Draft Start-Up Plan if comments or recommendations are received from the DTA. Refer to Appendix 14, Deliverable 8.

4.7.4 Once the Start-Up Plan is approved by the DTA, it will be deemed the Final Start-Up Plan.

4.7.5 The Contractor must implement and carry out all start-up and set-up activities IAW the approved Start-Up Plan during the Start-Up Phase.

### 4.8 Contractor's Recruitment Plan

The Contractor must develop and deliver a Draft Recruitment Plan within 30 calendar days after Contract award. Refer to Appendix 14, Deliverables 9.

4.8.1 The Recruitment Plan must list and describe all the recruiting activities that will be completed in order to meet the Department's requirements for HCPs at the SED and throughout the duration of the Contract.

4.8.2 The Recruitment Plan, as a minimum, must include the following strategies and approach elements:

a. to recruit the initial HCPs required at SED; and new HCPs requirements after the SED and during the In-Service Phase;

b. to meet Cadet Summer Training Centre HCP requirements;

c. to meet short-term HCP requirements;

d. for urgent HCP requirements within the reduced Time To Provide timelines;

e. the pro-active recruitment strategies for HCP occupational groups and categories that:

(1) may require an additional 30 calendar days for the TTP;

(2) experience a higher requirement volume, including continuous and ongoing advertising activities;

f. the retention strategies to be used to retain HCPs and to minimize HCP turnover;

g. the replacement approach when HCPs are absent for an extended period of time;

h. the recruiting communications strategies for:

(1) promotional material development and distribution;

(2) communication channels, streams, and methodologies;

(3) advertising plans and marketing strategies; and

(4) Contractor's recruiting innovations.

4.8.3 The Contractor must revise and update within 20 calendar days the Recruitment Plan if comments or recommendations are received from the DTA. Refer to Appendix 14, Deliverable 10.

4.8.4 Once the Draft Recruitment Plan is approved by the DTA, it will be deemed the Final Recruitment Plan.

4.8.5 The Contractor must implement, and carry out all recruiting activities IAW the approved Final Recruitment Plan throughout the duration of the Contract.

4.8.6 If the Contractor's strategies and approach to recruitment change during the Contract period, the Contractor must update the Final Recruitment Plan, for DTA approval. Refer to Appendix 14, Deliverable 11.

**4.9 Contractor's Risk Management Plan**

The Contractor must develop and deliver a Draft Contractor's Risk Management Plan (CRMP) IAW the PMBOK-current version within 30 calendar days ACA. Refer to Appendix 14, Deliverables 12, 13 and 14.

4.9.1 The CRMP must detail and describe the procedures and methods to be used in identifying, analyzing, evaluating, tracking, reporting, and mitigating risk(s) throughout the duration of the Contract.

4.9.2 The CRMP, as a minimum, must describe and detail all the elements listed below:

a. Concept for Management of Risk;

b. Risk Prediction Methodology;

c. Risk Identification (Risk Factors);

d. Risk Analysis (Probabilities and Effects) and Risk Assessment;

e. Risk Response (Avoid, Transfer, Mitigate, and Accept);

f. Issue Review and Lessons Learned (LL) Analysis Methodology; and

g. Issue Report Methodology.

4.9.3 The CRMP must include a section for each phase of the Contract with identification of each of the phase's risks. Each of the sections must include:

a. an initial risk analysis and assessment;

b. identification of risks and if necessary a creation of Risk Breakdown Structure;

c. Qualitative Risk Analysis;

d. Quantitative Risk Analysis;

e. Risk Response Planning;

f. Risk Monitoring and Control; and

g. a feedback and lessons learned process.

4.9.4 The Contractor must revise and update, within 20 calendar days, the draft CRMP based on comments or recommendations received from the DTA. Refer to Appendix 14, Deliverable 13.

4.9.5 Once the draft CRMP is approved, the CRMP will be deemed the Final Contractor's Risk Management Plan (CRMP) and must be used to manage and mitigate the risks throughout the duration of the Contract.

4.9.6 The Contractor must update the Final CRMP for every Program Review Meeting (PRM). The version number and date must be annotated on each CRMP revision or update. Refer to Appendix 14, Deliverable 14.

4.9.7 The Final CRMP updates must include:

a. the identification of new risks;

b. ongoing risks;

c. any or all risk mitigation actions taken plus the associated costs;

d. all corrective actions taken;

e. outcomes to date;

f. detail(s) of all the potential issues or obstacles affecting the schedule timelines;

g. further recommended or suggested course(s) of action.

4.9.8 The Contractor must provide advance electronic copies of the current CRMP to the CA, the DTA and DPA, five (5) calendar days before each Progress Review Meeting (PRM). Refer to Appendix 14, Deliverable 15.

4.9.9 The Contractor must provide hard copies of the current CRMP to each attendee at the PRM. Refer to Appendix 14, Deliverable 16.

4.9.10 If any substantive risk(s) occur before the PRM reporting cycle, the Contractor must advise the DTA in writing within three (3) calendar days and must report these risks in the Monthly Program Report. Refer to Appendix 14, Deliverable 17.

## 4.10 Contractor's Management Plan

The Contractor must develop and deliver a Draft within 30 calendar days ACA, Final and an Updated Contractor's Management Plan (CMP). Refer to Appendix 14, Deliverables 18, 19 and 20.

4.10.1 The CMP must consolidate the entire Contractor's administrative and management processes, practices and procedures, and its supporting organizational structure used to manage all the Work, requirements and deliverables required under the Contract. The CMP must be used throughout the duration of the Contract.

4.10.2 The CMP, as a minimum, must describe and detail the Contractor's administrative and management processes, practices and procedures for the:

a. management of Work, requirements and deliverables required under the Contract;

b. schedule control and management during the Contract Start –Up Phase;

c. CCO and CMT Performance management and monitoring;

d. HCP management as it relates to recruitment, retention, credentialing, training, discipline and performance evaluation management and monitoring;

e. quality control;

f. risk reporting process;

g. media communications process;

h. Contract Change Management process to implement improvements or changes;

i. problem resolution;

j. HCPs time verification process (Timesheet Tool);

k. invoice processing including verifications and validations to detect errors; and

l. Contractor's internal and external lines of communication.

4.10.3 The Contractor must revise and update within 20 calendar days the CMP if comments or recommendations are received from the DTA. Refer to Appendix 14, Deliverable 19.

4.10.4 Once the Draft CMP is approved, the CMP will be deemed the Final Contractor's Management Plan (CMP) and must be used throughout the duration of the Contract.

4.10.5 The Contractor must ensure that it's administrative and management processes, practices and procedures are consistently applied across all locations by its personnel and IAW the approved Final CMP.

4.10.6 If the Contractor's administrative and management processes, practices and procedures change during the Contract period, the Contractor must update or revise the Final CMP for DTA approval. The version number and date must be annotated on each Final CMP revision or update. Refer to Appendix 14, Deliverable 20.

## 4.11 Contractor's Communication Packages

When the Contractor develops communications for recruitment purposes, for circulation to media organizations, the public, industry, educational institutes, etc.; the Contractor must submit the draft communication to the CA and the DTA, before publication, for their review and acceptance. Refer to Appendix 14, Deliverable 21.

4.11.1 When the draft is accepted, and approved by the CA and the DTA, the Contractor will receive a confirmation from the DTA.

4.11.2 All communications materials developed for circulation for recruitment purposes by the Contractor must be in English and French.

## 4.12 Probation

A 90 day probation period will apply to all newly contracted HCP. The probation period will begin on the first working day at the CAF clinic. If the TM is not satisfied with the services of the contracted HCP, the Contractor will have 14 calendar days to remedy the situation. If the situation cannot be resolved to the satisfaction of the TM, the contracted HCP will be removed and replaced at no cost to DND. Payment for HCPs who have performance issues shall cease upon termination of their Work under the contract.

## 4.13 HCP Professional Misconduct

Throughout the In-Service and Out-Going Phases, identification, investigation and management of HCP professional conduct and competency issues are a shared responsibility between the Contractor and the DND. The Contractor and the DND have a responsibility to report HCP Professional Misconduct IAW with the relevant provincial/territorial statute.

4.13.1 HCP professional performance shall be in accordance with standards set by the applicable licensing body as well as any additional standards imposed by the DND.

4.13.2 The DND will be responsible for identifying potential professional performance issues, determining whether the HCP's professional performance meets the applicable standard, imposing conditions or restrictions on the HCP's patient care privileges as necessary, and identifying any requirements for remediation of the HCP's clinical performance or professional conduct.

4.13.3 The Contractor will be responsible for the remediation of HCP professional performance issues and the determination and execution of any disciplinary measures.

4.13.4 In matters of HCP professional misconduct or incompetency, the Contractor and the DND will report to the HCP's licensing body IAW with the statutory requirements of the applicable province or territory.

**4.14 Issues, Challenges and Problem Resolution Process**

Throughout the duration of the Contract, the Contractor or the Contractor's HCPs must, as a preliminary step, contact the appropriate authority listed in SOW DND paragraph titled Departmental Authorities (DAs) to resolve any issues, challenges and problems at the lowest possible level.

4.14.1 Should the Contractor or the Contractor's HCP contact a DA that is not the responsible authority for the issue, challenge or problem, the Contractor or the Contractor's HCP will be re-directed to the appropriate authority.

4.14.2 The TM is the lowest level for issues, challenges or problems that are within the scope of TM's authority.

4.14.3 For issues, challenges or problems not resolved at the lowest level, the DTA is the authority for the technical content of the Work, requirements, and deliverables.

4.14.4 If the issue, challenges or problems cannot be resolved at the lowest possible level, the matter will be referred to the DTA and upward for resolution. If the issue cannot be resolved by the DA and CA levels, the matter will be escalated to the Executive Steering Committee.

**4.15 HCPC Lessons Learned**

The Contractor must develop and deliver a HCPC Lessons Learned (HCPC LL) document based on their lessons learned for the Start-Up and Out-Going Phases of the Contract; and on an annual basis for each year of the In-Service Phase of the Contract. Refer to Appendix 14, Deliverable 22 for the Start-up Phase, Deliverable 23 for the Annual and Deliverable 24 for the Out-Going Phase HCPC LL documents.

4.15.1 The intention is to have all stakeholders benefit and contribute to a formalized Lessons Learned (LL) process by implementing a formal HCPC LL Contract Management Activity process that ensures visibility and accountability using a feedback loop, and which minimizes the repetition of errors, improves service delivery, and results in positive and improved capability or requirements.

4.15.2 The HCPC LL document can incorporate any Contractor's Lessons Learned but as a minimum, must include the following information:

a. section for Observation/Issue, which states what the issue, problem, or difficulty was or the "what" part of the phase, activity, requirement or event. The Observation(s) or Issue(s) must be short, factual descriptions of what has occurred, and is used to describe either a positive or a negative event. Multiple observations of a similar nature may be combined into a single issue;

b. section for Discussion, which includes sufficient details surrounding the observation(s) or issue(s) to provide the reader with an understanding of the phase, activity, requirement or event without being part of the requirement. The details can include "who", "when", "why" and "where" statements;

c. section for Conclusion, which includes details on the overall impact of the observation(s) or issue(s);

d. section for Recommendations, which includes suggestions or recommendations on how the issue, problem or difficulty can be rectified, reduced or eliminated in the future; and

e. section for Point of Contact (POC), which identifies the appropriate office responsible for the matter based on the issue, problem or difficulty. The POC is the DTA for the technical content of the Work, requirements, and deliverables. The POC is the DPA for procurement and financial matters, administration of the Task Authorization and process, and departmental contract management activities. The POC for Contract, Contract obligations and requirements, and Contract Administration, including amendments; is the CA.

4.15.3 The DTA will track all HCPC LLs provided by the Contractor. The HCPC LLs will be provided for review and approval, to Program Governance via senior management stakeholder's committees. Refer to DND SOW Section titled Governance. Any HCPC LL approved for implementation, resulting in a change to the Contract obligations, requirements or deliverables will be brought to the attention of the Contracting Authority. Changes to the Contract can only be made through a contract amendment issued by the CA.

## 4.16 Timesheet Tool

The Contractor must have in operation a Timesheet Tool (TsT), which is accessible from the Contractor's website through a secure site to authorized users that hold various roles. The TsT is intended as a tool for:

a. HCPs to record their hours worked;

b. the TM to verify the HCP`s recorded hours; and

c. the DAs to validate the labour charges on the Contractor's invoice.

4.16.1 The Contractor must have the TsT ready for use 60 calendar days before the SED, and must provide a notification that the Timesheet Tool is setup and ready. Refer to Appendix 14, Deliverable 25.

4.16.2 The Contractor's TsT must be available to users as a minimum, from Monday to Friday, and between the hours of 7am and 6pm across all Canadian Time Zones.

4.16.3 Within five (5) calendar days of setup notification of the Timesheet Tool, the Contractor must conduct a TsT demonstration for the DAs at a DND location. The location and address will be provided to the Contractor after Contract Award. The demonstration must confirm that the TsT is ready for use and detail how the tool works from a user perspective. Refer to Appendix 14, Deliverable 26.

**4.17 Timesheet Tool Capabilities and Functionalities**

As a minimum, the Timesheet Tool must have the following capabilities and functionalities:

a. to allow HCPs to record their regular, overtime, on-call, and call-back hours worked;

b. to allow the TMs to review, validate and approve the HCP recorded hours;

c. to have an approval indicator that denotes that the recorded hours have been validated;

d. to set permissions control what users can see and do;

e. to allow for simultaneous access of users;

f. to allow for the storage of HCP timesheets and data;

g. to secure all data;

h. to enable reports to be generated from the TsT data and to be able to specify report filters to return the specific results wanted;

i. to enable queries to be conducted with the available fields in the TsT;

j. to allow for customization or modifications including: modifications of the field names; setting tasks, such as travel; and linking tasks to the timesheet;

k. to have a data back-up feature;

l. to allow the exporting of data; and

m. to have printing capabilities.

### 4.18 Timesheet Tool Setup

As a minimum, the timesheet tool setup must include the following data fields:

a. Task Authorization Number;

b. HCP location;

c. HCP surname;

d. HCP given name;

e. a separate field to be used by the HCP to input hours worked for each day of the week, including Saturday and Sunday, within the billing period;

f. sub-total regular hours worked. This field must reflect the total number of regular hours worked within the billing period;

g. total regular hours worked. This field must reflect the total number of hours worked to date on the DND 626 Task Authorization;

h. sub-total overtime hours worked. This field must reflect the total number of overtime hours worked within billing period;

i. total overtime hours worked. This field must reflect the total overtime hours worked to date on the DND 626 Task Authorization;

j. sub-total on-call hours worked. This field must reflect the total number of on-call hours worked within the billing period;

k. total on-call hours worked. This field must reflect the total of on-call hours worked to date on the DND 626 Task Authorization;

l. sub-total call-back hours worked. This field must reflect the total number of call-back hours worked within the billing period;

m. total call-back hours worked. This field must reflect the sub-total of call-back hours worked to date on the DND 626 Task Authorization;

n. remaining hours on the DND 626 Task Authorization. This field must reflect, in hours or days, the Level of Effort (LOE) remaining and IAW the DND 626 Task Authorization;

o. Travel. This section must reflect the from and to date fields that the HCP is on Travel Status within the billing period;

p. the approved travel DND 626 Authorization number; and

q. Approval Indicator. This field would identify for the Contractor: if the timesheet was approved or not approved by the TM; the name of the TM that has approved or not approved the timesheet; and must also have a Comment field for information to be inserted by the TM.

### 4.19 HCP Timesheet

As a minimum, the HCP timesheet must include the following data fields:

a. Task Authorization Number;

b. HCP location;

c. HCP name;

d. HCP given name;

e. a separate field to be used by the HCP to input hours worked for each day of the week, including Saturday and Sunday, within the billing period;

f. sub-total regular hours worked. This field must reflect the total number of regular hours worked within the billing period;

g. sub-total overtime hours worked. This field must reflect the total number of overtime hours worked within billing period;

h. sub-total on-call hours worked. This field must reflect the total number of on-call hours worked within the billing period;

i. sub-total call-back hours worked. This field must reflect the total number of call-back hours worked within the billing period;

j. remaining hours on the DND 626 Task Authorization. This field must reflect, in hours or days, the Level of Effort (LOE) remaining and IAW the DND 626 Task Authorization;

k. Travel. This section must reflect the from and to date fields that the HCP is on Travel Status within the billing period;

l. the approved travel DND 626 Authorization number; and

m. Approval Indicator. This field would identify for the Contractor: if the timesheet was approved or not approved by the TM; the name of the TM that has approved or not approved the timesheet; and must also have a Comment field for information to be inserted by the TM.

## 4.20 Timesheet Tool Account Creation Setup

The Contractor must create user accounts and initial passwords.

a. all accounts for the Contractor`s HCPs must be setup and provided before the HCP start date on the Task Authorization;

b. the Contractor must create a user account for the DAs and TMs before the Timesheet Tool demonstration. The number of DAs is estimated at 10 and the number of TM user accounts is estimated at three (3) positions per location (approximately 125 in total). The Contractor will be provided with the names of the DAs and TMs after Contract award;

c. throughout the Contract the Contractor must create new user accounts within seven (7) calendar days of receipt of the approved User Account Creation and Cancellation Request, provided to the Contractor from the DAs. New user accounts will only be requested and required when the assigned DAs and TMs change; and

d. the Contractor must delete old user accounts within seven (7) calendar days of the user change date that is stated on the User Account Creation and Cancellation Request provided to the Contractor from the DAs.

## 4.21 Timesheet Tool Account Permissions

The Contractor must set up specific TsT access permissions for the DAs and TMs.

a. the DAs must be given full user access: to view any HCP timesheet; to verify if TMs have approved the timesheet; for viewing data; and to generate reports based on the data found in the TsT;

b. the TMs must be given user access restricted to the information related only to HCPs on Task Authorizations at their location; and

c. the Contractor is responsible to ensure that HCPs do not have access to the timesheet approval field on the TsT.

### 4.22 Timesheet Tool User Help and Support

The Contractor must provide a Help and Support functionality for the TsT that, at a minimum, is available to authorized users, from Monday to Friday, between the hours of 7am and 6pm across all Canadian Time Zones, and that it is available by email, telephone or chat (may not be available on DWAN computer due to firewall).

### 4.23 Timesheet Tool Maintenance

The Contractor must conduct updates and maintenance of the TsT outside the working hours of 7am to 6pm across all Canadian Time Zones.

### 4.24 Timesheet Tool User Training and Manual

The Contractor's TsT must contain a computer-based training component and a User Manual, in both official languages. Refer to Appendix 14, Deliverable 25.

### 4.25 Initial HCP Requirements

The Contractor will be provided with the Initial HCP Requirement Plan and the associated DND 626 - Task Authorizations after Contract award at the Initial Kick-off Meeting.

4.25.1 On receipt of the DND 626 - Task Authorizations, the Contractor must follow the Task Authorization process detailed in the Contract. The Contractor must provide the DPA with the Task Authorization Response Packages for all DND 626s issued, no later than 20 calendar days prior to SED and all HCPs Requirements must start working on the SED, except for Stream 5.

4.25.2 All HCP Requirements that are identified after the Initial HCP Requirement Plan has been provided to the Contractor, and the HCP Requirement start dates are after the SED, are considered to be New HCP Requirements. The DPA provides New HCP Requirements to the Contractor, via a DND 626 - Task Authorization. The Contractor must follow the Task Authorization process detailed in the Contract. The TTP period will apply to all New DND 626 – Task Authorizations issued.

4.25.3 For the New HCP Requirements identified in the Annual HCP Requirement Plan, the Contractor must follow the Task Authorization process as detailed in the Contract.

### 4.26 Acceptable Delay

When the Contractor is not able to fill a DND 626 – Task Authorization in any of the Contract Phases, the Contractor must justify the delay in satisfying the requirement, in writing, to the DTA. The DTA will determine if the Contractor will be given an additional 30 calendar day period to fill, or if the DND 626 - Task Authorization will be cancelled. Refer to Appendix 14, Deliverable 27.

4.26.1 The Contractor may be given a written notice by the DPA for all approved requests. The DND 626 – Task Authorizations that are not filled will not remain open indefinitely. The DPA will provide the Contractor with the Cancellation of a Task Authorization Notice for DND 626 - Task Authorization, when the issued Task Authorization is cancelled because it was not filled.

**4.27 HCP Credentials**

Throughout the duration of the Contract, the Contractor must verify the HCP credentials before providing HCPs to the DND. The DND retains authority over the granting of patient care privileges.

4.27.1 The HCP credential verification process includes confirming with the respective regulatory or certifying organization that the HCP:

a. holds a valid license or certification;

b. has no restrictions or limitations against their license or certification and are in good standing; and

c. has no sanctions or past findings against their license or certificate.

4.27.2 If the HCP is the subject of an investigation, is involved in part of an investigation, has restrictions, limitations, sanctions or past findings against their license or certificate, the DND reserves the right to refuse the proposed HCP.

4.27.3 Throughout the duration of the Contract, including the Start-up Phase, when the Contractor provides any HCP, the Contractor must provide the DND 2523 Credential Information Form or the DND 2558 - Credentialing Information of Health Care Professionals for Cadet Camps. Example copies of the forms are found at Appendix 15 to Annex A – SOW DND.

4.27.4 The Contractor must use the Instructions for completion of the DND 2523 Credential Information Form or the DND 2558 - Credentialing Information of Health Care Professionals for Cadet Camps, and ensure that all sections are filled in as follows:

a. if any section is not applicable, such as SN or PRI, the acronym NA must be inserted;

b. under Member, the Contractor must check off “other” and insert “Contracted HCP under Contract # W3931-13KM01/001XF”;

c. photocopies of all required documentation must be provided by the Contractor;

d. the form must be signed and dated by the HCP; and

e. under the CO's signature block, the Contractor must strikeout the wording "CO's Signature/Signature du commandant" and insert the date and the signature of the contractor or its representative.

4.27.5 After the initial Credential Information Form is provided by the Contractor, and throughout the duration of the Contract thereafter, the Contractor must conduct and confirm verification of the HCPs' credentials every six (6) months.

4.27.6 Throughout the duration of the Contract, the Contractor must conduct the HCP re-verification process and confirm the status via the Credentialing Report, which is detailed under SOW DND paragraph titled Credentialing Report.

4.27.7 Throughout the duration of the Contract, if a HCP's responses to the attestations on the DND 2523 or 2558 change, if the HCP has had his/her license revoked for whatever reason, or should a HCP become subject of an investigation or involved in part of an investigation, the Contractor must notify, by telephone and follow up in an email, the DTA within the same business day or next business day if following a weekend. Refer to Appendix 14, Deliverable 28.

4.27.8 If a HCP has his/her license revoked, the DND 626 – Task Authorization will be cancelled immediately and the DND will not be held to the cancellation conditions in the Contract.

4.27.9 If the HCP becomes the subject of an investigation or is involved in part of an investigation, the DND reserves the right to determine if the DND 626 – Task Authorization will be cancelled or if the Contractor will be requested to replace the HCP.

### 4.28 Cadet Summer Training Centre HCP Security Requirement

Throughout the duration of the Contract, all HCPs provided for Stream 5 must successfully complete the Reliability Status Check (RS) as well as the Police Records Check (PRC)/Vulnerable Sector Screening (VSS) process. These documents are mandatory and necessary as the Work is conducted with youth.

### 4.29 HCP Language Requirements

Throughout the duration of the Contract, the Language requirement for the HCP will be specified in the DND 626 – Task Authorization as English, French or Bilingual (English and French).

4.29.1 The provided HCP must be able to read, communicate orally and in writing in the specified language(s) without assistance and with minimal errors.

**4.30 Contractor's Clinical Supervision of a Physician Assistant**

Throughout the duration of the Contract, when Physician Assistants are required by the DND, the Contractor must assign a HCP Physician to perform clinical supervision of the Physician Assistant.

4.30.1 The Contractor must provide a copy of the signed Supervisory Agreement between the HCP Physician and the Physician Assistant to enable the Physician Assistant to perform the delegated acts related to his Occupational Groups and Categories. Refer Appendix 14, Deliverable 29.

4.30.2 The Physician Assistant's delegated acts in the Supervisory Agreement must be in accordance with direction provided by the respective Physician provincial regulatory body.

4.30.3 Throughout the duration of the Contract, if the Contractor cannot assign a HCP Physician to perform the clinical supervision of a PA, DND may assign an alternate Physician on an exception basis IAW DND policies and processes.

**4.31 HCP Respiratory Mask Fitting**

Throughout the duration of the Contract, the Contractor is responsible to ensure that HCPs have been fit-tested with an N95 Mask Respirator, that they have a current Fit Test certification and that the fitting certification remains current, in accordance with the most current national standard (CSA Standards Z94.4). Current standard is for testing to be completed once every two (2) years. Refer to Appendix 14, Deliverables 30 and 31.

4.31.1 The Contractor must provide the DTA the Quantitative Fit Testing results for each HCP before their start date. Refer to Appendix 14, Deliverable 30. If a new hire does not have a current N-95 Mask Respirator fit certification at time of hire then a fit testing certification must be obtained within 60 calendar days of commencement of work with the DND/CAF.

4.31.2 The DTA will provide the Contractor with the name of manufacturers and model of the N95 Mask Respirators. The Contractor may use any manufacturer listed for the Mask Fit Test or a manufacturer of its choice as long as it complies with the Quantitative Fit Testing method IAW Canadian Standard stated above. At its discretion, the DND may provide assistance in providing the fit test to HCPs through the Base Fire Hall, when it is possible and at no cost.

4.31.3 The N-95 Mask Respirator fitting is only applicable to the HCPs working in CF H Svcs Cs and CF Dent Dets.

4.31.4 The Contractor must provide the DTA the Quantitative Fit Testing results upon each subsequent re-test. Refer to Appendix 14, Deliverable 31.

4.31.5 All costs associated with HCP N95 Mask fitting, including HCP time spent performing the fitting, are not billable to the DND.

### 4.32 HCP Workplace Hazardous Material Information System (WHMIS) Certification

Throughout the duration of the Contract, the Contractor must ensure that all HCPs have the Workplace Hazardous Material Information System (WHMIS) Certification that is issued by the Canadian Centre for Occupational Health and Safety.

4.32.1 All HCPs must successfully complete the Workplace Hazardous Materials Information System (WHMIS) for Workers training session provided by the Canadian Centre for Occupational Health and Safety. Alternate training that teaches WHMIS symbols and their meaning, the labels on products, and material safety data sheets may be acceptable as an equivalent if approved by the DTA.

4.32.2 The Contractor must provide a copy of the HCP WHMIS Certification with the Task Authorization response package. Refer to Appendix 14, Deliverable 32.

4.32.3 The Contractor must provide confirmation that all HCPs have taken the WHMIS Re-Certification via the annual WHMIS Re-Certification Report, which is detailed under SOW DND Paragraph HCP Certifications Report.

4.32.4 All WHMIS Certification or Re-certification costs, including HCPs time spent doing the training, are not billable to the DND.

### 4.33 HCP Basic Life Support (BLS) Certification

Throughout the duration of the Contract, the Contractor must ensure that all HCPs have the Certificate of Basic Life Support (BLS) for Health Care Provider or equivalent, such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required.

4.33.1 HCP Basic Life Support (BLS) Certification is only applicable to the HCPs working in streams 1, 2 and 5.

4.33.2 The Contractor must provide a copy of the BLS or equivalent Certification with the Task Authorization response package. Refer to Appendix 14, Deliverable 33.

4.33.3 The Contractor must provide confirmation that all required HCPs have taken the BLS or equivalent Re-Certification via the annual BLS Certification Report, which is detailed under SOW DND Paragraph titled HCP Certifications Report.

4.33.4 All BLS or equivalent Certification or Re-certification costs, including HCPs time spent doing the training, are not billable to the DND.

**Part Two - In-Service Phase**

### 4.34 Annual HCP Requirements

The Contractor will be provided with the Annual HCP Requirement Plan and the associated New DND 626 - Task Authorizations within the first seven (7) days of December each year.

4.34.1 For the Recurring HCP Requirements identified in the Annual HCP Requirement Plan, the Contractor must review the list and confirm via the Recurring HCP Task Authorization Confirmation Report within 30 calendar days from receipt whether the incumbent HCPs will continue to provide the services in the upcoming FY. Refer to Appendix 14, Deliverable 34.

4.34.2 On receipt of the DND 626 - Task Authorizations, the Contractor must follow the Task Authorization process detailed in the Contract. The Contractor must provide the Task Authorization Response Package to the DPA no later than 20 calendar days prior to HCP Start Date. Refer to Appendix 14, Deliverable 35

4.34.3 During the In-Service Phase, and after the Annual HCP Requirement Plan has been provided to the Contractor, any New HCP Requirements identified will be provided to the Contractor by the DPA via the DND 626 - Task Authorization(s).

4.34.4 For Stream 5 – DND Cadet Summer Training Centres, the specific annual CSTC dates, between the months of June and August, will be provided to the Contractor by means of a DND 626 – Task Authorization, once they have been confirmed.

### 4.35 HCP Orientation to the DND Work Environment

Throughout the duration of the Contract, the Contractor must provide all HCPs with the Orientation Package on the DND Work Environment. The Orientation Package is found at Appendix 16 to Annex A – SOW DND.

4.35.1 As part of the Task Authorization process, the Contractor must provide a signed copy of the Orientation Package - HCP Acknowledgement Form, which is included in the Orientation Package. The Orientation Package - HCP Acknowledgement Form is the confirmation that the HCP has received, read and understood the Orientation Package to the DND Work Environment and agrees to provide health care services in that environment. Refer to Appendix 14, Deliverable 36.

4.35.2 The Contractor may request a location site visit, when the HCP would like to see the facility before committing to working in a DND Environment. The Contractor must submit all Location Site Visit Requests to the DTA for approval.

## 4.36 HCP Incoming Clearance Activities

Throughout the duration of the Contract, all HCPs must undertake incoming clearance activities. Incoming clearance activities are completed by the HCP within the first two (2) weeks of their start date. These activities consist of:

a. obtaining a DND Base and building access pass or identification card. The TM will complete and provide the Building Pass Application Form to the HCP. The HCP must get the designated access pass or identification card from the DND Section responsible to assign the Base and building passes;

b. obtaining various DND Information Technology (IT) accounts and undertaking the DND associated training associated with obtaining these accounts. The TM will provide the specific accounts, required forms, associated training links and the organizations responsible for providing these accounts, to each HCP. The HCP must fill out and process the account requests. The various DND accounts are:

   (1) the Defence Wide Area Network (DWAN) account;

   (2) the Canadian Forces Health Information System (CFHIS); and

   (3) the Canadian Cadet Wide Area Network;

c. complying, throughout the duration of their Task Authorization, with the DND Acceptable Use policy as outlined in Appendix 9 - SOW DND - DAOD 6002-2 Acceptable Use of the Internet, Defence Intranet, Computers and Other Information Systems. Failure to comply with the acceptable use may result in cancellation of the Task Authorization;

d. obtaining a Public Key Infrastructure (PKI) Smartcard, which allows HCPs to access and transmit secure or confidential information when required in the performance of their Work. The TM will provide the HCP with the required PKI Request form, associated training links and the organization responsible for providing the PKI Card. The HCP must complete the Request Form and undertake the PKI Overview Computer-based training; and

e. reading and becoming familiar with the CF Health Services Group related information such as: standard operating procedures (SOPs) as it relates to Health Care and care and occupational health advice, consultation and screening services; and CF Health Group Instructions, Policies, Guidelines, and Standards. The TM is responsible to provide the HCP with all CF Health Services Group related

information. The HCP must read and apply the information in the performance of their Work throughout the duration of their Task Authorization.

### 4.37 HCP Contractor Identification

Throughout the In-Service and Out-Going Transition Phases, HCPs must be identifiable as a Contractor's resource.

4.37.1 HCPs must wear the Contractor's logo or tag at all times while performing the Work.

4.37.2 HCPs must include the designation of "Contractor" within their signature block when sending email or writing letters.

### 4.38 HCP Hours of Work

Throughout the In-Service and Out-Going Phases, HCPs must work between the core hours of 6am and 6pm local time, Monday to Friday (except for Stream 5 HCPs - CSTC).

4.38.1 The hours of work required will be stated in the DND 626 – Task Authorization Form.

4.38.2 HCPs will not be required to provide services on Federal Government Holidays (except for Stream 5 HCPs - CSTC) as listed at Appendix 17 to Annex A - SOW DND.

### 4.39 Extended hours

Extended hours are paid at the HCP hourly rate.

### 4.40 HCP Overtime

Throughout the duration of the Contract, HCPs may be required to work Overtime. When a HCP is required to work Overtime, it will be stated in the DND 626 – Task Authorization Form. Overtime work must be authorized in advance by the Task Manager.

4.40.1 The Contractor must submit the HCP Overtime Authorization with its invoice. Overtime is billable IAW the terms and conditions of the Contract. Refer to Appendix 14, Deliverable 37.

### 4.41 HCP On-Call

Throughout the In-Service and Out-Going Transition Phases, HCPs may be required to be On-Call. When a HCP is required to be on-call, it will be stated in the DND 626 – Task Authorization. On-Call is defined as, time scheduled by the TM, to carry a pager or cell phone and respond to calls outside the CF Health Service Centre's and CF Dent Det's hours.

4.41.1 When a HCP is requested to be On-Call and the On-Call requirement is not stated in the DND 626 – Task Authorization, the Task Authorization must be amended for the On-Call requirement before On-Call is worked.

4.41.2 Only one HCP per category and location at a time can be assigned to on-call duty and only when a military member or public servant is not available to cover the on-call period. The period for on-call duty cannot exceed 16 hours on days when the clinic is open, and 24 hours on weekend and Statutory holidays.

4.41.3 Every occurrence of On-Call must be authorized and provided in writing by the TM to the HCP the On-Call is scheduled.

4.41.4 The HCP must submit to the Contractor the written On-Call Authorization received from the TM, with their timesheet submission.

4.41.5 The Contractor must submit the On-Call Authorization and schedule with its invoice. On-Call is billable IAW the Annex B – Basis of Payment DND. Refer to Appendix 14, Deliverable 38.

**4.42 HCP Call-Back**

Throughout the In-Service and Out-Going Transition Phases, HCPs On-Call may be required to be Call-Back. Call-Back is defined as required to return to CF Health Service Centre or CF Dent Det to work as a result of the on-call task.

4.42.1 Every occurrence of Call-Back must be verified and approved in writing by the TM. The written approval will be provided to the HCP.

4.42.2 The HCP must submit to the Contractor the written Call-Back Authorization received from the TM, with their timesheet submission.

4.42.3 The Contractor must submit the Call-Back written approval of the HCP Call-Back hours worked with the invoice. Call-Back is billable IAW the Annex B – Basis of Payment DND. Refer to Appendix 14, Deliverable 39.

**4.43 HCP Tele-Health Work Requirements**

The Contractor's HCPs may be required to provide Tele-Health Work, which is also referred to as Telemedicine. The HCP will be provided access to the DND information technologies required to perform the Tele-Health Work.

4.43.1 The HCP may also use DND Video Conferencing for real-time patient-provider consultations and for provider-to-provider discussions.

4.43.2 When Tele-Health Work is required, it will be stated in the DND 626 – Task Authorization.

4.43.3 If Tele-Health Work is not stated on the DND 626 – Task Authorization, and becomes a requirement, the DPA will issue an amendment to the DND 626 – Task Authorization for the Contractor's acceptance.

4.43.4 If the Tele-Health Work is provided to a CAF member who is outside of the HCP's current Province of work, the Contractor must ensure the HCP obtains the required additional licenses and registration IAW the Province or Territory where the service will be received.

**4.44 HCP Patient Site Visits Requirement**

As part of a local CAF Health Team, on occasion and under exceptional circumstances, a HCP may be requested to conduct a Patient Site Visit.

4.44.1 Before a HCP Patient Site Visit occurs, and in accordance with the B Surg or CO's direction, the TM will obtain the written approval from the DTA. After the approval is obtained, the DTA will provide the Contractor with the written approval for the Patient Site Visit before the Patient Site Visit can occur.

4.44.2 The written approval must contain the following information:

a. Task Authorization number;

b. Clinic name and location;

c. name of the HCP who will conduct the Patient Site Visit(s);

d. reason for the Patient Site visit(s);

e. date(s) and time(s) of scheduled Patient Site Visit(s);

f. travel involved - Yes/No; (within or outside of the Local DND Location);

g. copies of the written authorizations from the B Surg or CO, if the Patient Site Visit is to be scheduled outside of clinic hours; and

h. overtime involved - Yes/No.

4.44.3 If a HCP Patient Site Visit is conducted outside of the CF H Svcs C's hours, or the regular work hours of the HCP, the HCP Overtime Request and Authorization process must be followed as detailed under the SOW DND Paragraph titled HCP Overtime.

4.44.4 When a HCP Patient Site Visit involves travel outside the Local DND Location, the HCP Travel Request and Authorization process must be followed as detailed under the SOW DND Paragraph titled HCP Travel.

4.44.5 The Contractor must submit the complete approval package, travel itinerary, claimable expenses and receipts with the invoice.

4.44.6 If the request for a HCP Patient Site Visit necessitates changes and updates to the original DND 626 – Task Authorization, the Contractor's HCP cannot conduct the HCP Patient Site Visit until the Contractor receives an approved DND 626 – Task Authorization amendment.

**4.45 HCP Travel**

Throughout the In-Service and Out-Going Phases, HCPs may be required to travel. When a HCP is required to travel, it will be stated in the DND 626 – Task Authorization.

4.45.1 When a HCP is requested to travel and the travel requirement is not stated in the DND 626 – Task Authorization, the Task Authorization must be amended for the travel requirement before the travel is conducted.

4.45.2 All travel must be pre-authorized by the DTA. The TM will provide the HCP Travel Request Form to the DTA for approval. If travel is approved, the TM will be notified and the HCP Travel Request Form will be provided to the DPA. The DPA will provide the Contractor with a separate DND 626 – Task Authorization for the travel for its acceptance along with the approved Travel Request Form.

4.45.3 The Contractor must make all travel arrangements and travel must be obtained and conducted in the most economical means available and IAW the Treasury Board Travel Directive. Refer to Appendix 19.

4.45.4 During the Travel period, all HCP's Labour time will be captured on the specific DND 626 -Travel Task Authorization. The HCP will enter the Travel dates on his TsT.

4.45.5 The Contractor must submit the HCP Travel Expenses with the original receipts with their invoice for re-imbursement IAW the conditions stated in the Contract. Refer to Appendix 14, Deliverable 40.

4.45.6 The DND 626 – Task Authorization for the HCP Travel requirement will be closed once the invoice for the HCP Travel has been paid.

**4.46 HCP Qualification Training**

Throughout the duration of the Contract, the Contractor is responsible for any HCP qualification training or training that is necessary for the HCP to maintain their specific qualifications and credentials such as re-training or re-certifications.

4.46.1 The HCPs training costs, travel costs associated with training, and time absent are not billable to DND.

4.46.2 The Contractor must provide the DPA with a minimum of 14 calendar days advance written notice when a HCP will be absent for training purposes that is for a period not to exceed 14 calendar days. The notice must contain the HCP name, Task Authorization number, name of training, and dates and duration of training.

4.46.3 If the training exceeds 14 calendar days, the conditions under DND SOW Paragraph titled HCP Long Term Absences article will apply.

**4.47 DND Unique Specialization Training**

Throughout the duration of the Contract, the Contractor is responsible for any required HCP training, re-training or certification costs, including any travel costs associated with the training.

4.47.1 Specialized Training that is unique to DND may not be accessible to the Contractor through a non-DND commercial supplier. On a case-by-case basis and at its discretion, the DND may offer DND specialization training billets or course billets to the Contractor for its HCPs.

4.47.2 If Specialized Training that is unique to DND is offered by DND to the Contractor, the costs charged to the Contractor will be the same costs per person as would be charged for a CAF member or civilian employee. Travel costs associated with the training and time absent are not to be billable to the DND.

**4.48 HCP Holidays**

Throughout the In-Service and Out-Going Phases, the Contractor must provide the TM with 14 calendar days written notice when a HCP is planning holidays for a period of 14 calendar days and 21 calendar days written notice when a HCP is planning holidays for a period greater than 14 calendar days. The TM is responsible to ensure that there is adequate staffing available to deliver the health services and may have to rearrange workload to accommodate the holiday period.

**4.49 HCP Short-Term Absences**

Throughout the In-Service and Out-Going Transition Phases, the Contractor must advise the TM in writing or by telephone when any of its HCPs will be absent from the work location for DND patient scheduling and workload management purposes. Short-term absence is defined as 21 calendar days or less.

**4.50 HCP Long Term Absences**

Throughout the In-Service and Out-Going Transition Phases, the Contractor must provide the DTA with 42 calendar days written notice when a HCP is planning to be absent for a period greater than 21 calendar days. The DTA may request that the Contractor replace the HCP or to deny some or all of the leave should the DND not have adequate staffing available to deliver the health services.

4.50.1 If the HCP absence is unplanned and the absence will be for a period greater than 21 calendar days, the Contractor must provide written notice to the DTA when advised by the HCP. The DTA may request that the Contractor temporarily replace the HCP.

4.50.2 When the HCP is replaced temporarily, the DND 626 – Task Authorization must be amended. The Contractor's replacement HCP must meet all the qualifications for the HCP category; must not be under another DND 626 – Task Authorization for same hours of work or schedule; and must not be a transferred HCP from another DND 626 – Task Authorization, creating another unfilled Task Authorization elsewhere, unless accepted by the DTA in some particular circumstances.

4.50.3 If the Contractor cannot provide a replacement HCP temporarily, the DND 626 – Task Authorization may be cancelled. If the DND 626 – Task Authorization is cancelled; a new DND 626 – Task Authorization may be issued to the Contractor by the DPA, the Time to Provide period detailed under the SOW DND Section titled Time to Provide will apply.

**4.51 HCP Departure While on a Task Authorization**

Throughout the In-Service and Out-Going Phases, the Contractor must provide 14 calendar days written notice to the DTA when a HCP is planning to vacate the position while on a Task Authorization. The Task Authorization will be cancelled and the Contractor may be provided a new DND 626 – Task Authorization.

**4.52 DND Cancellation of a Task Authorization**

Throughout the In-Service and Out-Going Phases, when the services of a HCP are no longer required the DPA will give the Contractor, a minimum of 14 calendar days written notice of a Cancellation of a Task Authorization. The minimum of 14 calendar day period is not required when a Task Authorization has been cancelled as a result of the Contractor not meeting the timeframe for the replacement of a HCP, for HCP Short term and Long Term Absence.

## 4.53 Personal Health Information

All HCPs have ethical, professional and legal responsibilities to maintain the confidentiality and privacy of patient health information obtained while providing care. The HCP must conduct their business accordingly to safeguard patient's privacy and health information confidentiality in accordance with Appendices 5, 6, 8 and 9 to Annex A – SOW DND.

4.53.1 In the event of suspected breaches involving personal health information, HCPs must immediately notify the TM. Immediately is defined as, "as soon as possible and on the same day".

4.53.2 All cases of a suspected breach of personal health information are investigated by the CF Health Services Group IAW with regulations listed at Appendices 5, 6, 8, 9 to Annex A – SOW DND.

4.53.3 The Contractor and HCP must cooperate with the identified CF Health Services Group Chief Privacy Officer (CPO). If a HCP is requested to participate in discussion or interviews or to provide a written statement, the HCP will be given the time to do so and time will be paid IAW the rate on the HCP's DND 626 – Task Authorization.

## 4.54 HCP Disclosure of Medical or Social Work Information to Commanding Officers

Throughout the duration of the Contract, and within the DND environment, HCPs provide health care to members and advise the chain of command. The HCP's responsibility to the chain of command is to sustain or restore service personnel or cadet members to operational or training effectiveness and deployability. In some circumstances, this will require them to report a service person's Medical Employment Limitations (MELs) or a Cadet member's Participation Limitations (PLs) to the chain of command.

4.54.1 The disclosure of information on members' MELs must follow by the DND CANFORGEN 039/08 CMP 018/08 131851Z FEB08 – Disclosure of Medical/Social Work Information to Commanding Officers, Appendix 6 to Annex A - SOW DND.

## 4.55 HCP Providing Medical Advice in Support of Administration or Disciplinary Proceedings

Throughout the In-Service and Out-Going Phases, HCPs may be asked by the member or by the member's Commanding Officer (CO) to intervene in career, administrative or disciplinary proceedings.

4.55.1 Except as otherwise provided for, in orders or directives (Court Martial, Civil Court or BOI), when HCPs are responding to these types of requests, the HCP must act IAW the process outlined in the CF Health Service Group Instruction, 4030-06 - Providing Medical Advice in Support of Administration or Disciplinary Proceedings found at Appendix 7 to Annex A – SOW DND.

4.55.2 Except as otherwise provided for, in orders or directives (Court Martial, Civil Court or BOI), when a HCP is requested to participate in career, administrative or disciplinary proceedings, the HCP will be given the time to do so and the time will be paid IAW the rate on the HCP's DND 626 – Task Authorization.

4.55.3 When a HCP participation in career, administrative or disciplinary proceedings involves travel outside the Local DND Location, the HCP Travel Request and Authorization process must be followed as detailed under the SOW DND Paragraph titled HCP Travel.

4.55.4 If the request for a HCP participation in career, administrative or disciplinary proceedings necessitates changes and updates to the original DND 626 – Task Authorization, the Contractor's HCP cannot conduct the HCP participation in career, administrative or disciplinary proceedings until the Contractor receives an approved DND 626 – Task Authorization amendment.

4.55.5 The Contractor must submit the complete approval package, travel itinerary, claimable expenses and receipts with the invoice.

**4.56 Patient Safety**

Throughout the In-Service and Out-Going Phases, HCPs must comply with the CF H Svcs Cs, Dent Det and Cadet health Services Clinic Patient Safety Policies while performing their Work. The Patient Safety Policies include the following: CF Health Service Group Instruction, 2000-04 Patient Safety, and is found at Appendix 8 to Annex A – SOW DND.

4.56.1 HCPs must engage in patient safety activities while performing their Work.

4.56.2 HCPs must report all patient safety incidents, both actual and potential incidents; to the Patient Safety Representative within the CF H Svcs C, CF Dent Det or Cadet health Services Clinic and IAW the DND processes in place at the time.

4.56.3 HCPs may be requested to participate in Patient Safety Activities that may include:

a. assistance with the analysis of patient safety incidents to determine what, how and why an incident occurred;

b. and implementation of recommendations to improve existing policies, procedures or processes and prevent the occurrence or recurrence of incidents; and

c. identification of potential risks and open communication with other members of the health care team to learn from incidents, continually improve, and supports a strong culture of patient safety.

4.56.4 When a HCP is requested to participate in Patient Safety Activities the HCP will be given the time to do so and the time will be paid IAW the rate on the HCP's DND 626 – Task Authorization.

## 4.57 HCP Participation in Clinical Quality Improvement and Quality Assurance

Throughout the In-Service and Out-Going Phases, HCPs are required to participate in continuous quality improvement IAW current CF H Svcs Group policies, which are currently under revision and will be part of the standard operating procedures (SOPs) provided.

4.57.1 HCP participation in continuous quality improvement may include:

a. responding to questionnaires, providing feedback, and participating in committees related to internal audits and external accreditation activities;

b. participation in as a member of a working group responsible to identify best practices, reduce waste and errors, and increase effectiveness of health care and service delivery;

c. conducting clinical quality assurance activities such as peer review chart audits, mortality and morbidity rounds or reviews, utilization reviews, etc.;

d. identification of strengths and challenges associated with current processes or practices to share best practices or identify areas of improvement respectively;

e. incorporation and adoption of recommended changes resulting from quality improvement activities into clinical or administrative tasks based on revised policy or procedure, or local direction from the senior administrative and/or senior medical/dental authority;

f. supporting the collection of metrics through the documentation of data, completion of electronic or paper forms, providing feedback, responding to questionnaires, etc.

4.57.2 When a HCP is requested to participate in Clinical Quality Improvement and Quality Assurance Activities, the HCP will be given the time to do so and the time will be paid IAW the rate on the HCP's DND 626 – Task Authorization.

## 4.58 HCP Participation in Collaborative Practice Approach

Throughout the In-Service and Out-Going Phases, HCPs must participate in the Collaborative Practice approach in the delivery of health care.

4.58.1 HCP Participation in Collaborative Practice Activities may include:

a. promoting collaborative practice amongst care providers and within functional programs; and attending functional program, intra-disciplinary, case conferences, and

b. case reviews, as well as meetings to discuss collaborative practices.

**4.59 HCP Recommended Referrals to External Providers**

Throughout the In-Service and Out-Going Phases, when the member's required health care is outside of the CF H Svcs C, CF Dent Det and Cadet Health Services Clinic's domain, HCPs may be required to make recommended Referrals to External Providers.

4.59.1 When a HCP makes a recommendation for health care to an external provider, on behalf of a member, their recommended referral must be on the current Federal Health Claims Processing Service (FHCPS) approved Provider List. The FHCPS External Providers List will be provided by the TM to the HCPs who are tasked with recommending referral to External Providers.

4.59.2 All HCP recommended referrals to External Providers, who are, themselves external providers, must be approved by the Clinic's Senior Medical Authority (SMA) before the appointment is scheduled.

4.59.3 All recommended referrals to External Providers made by the HCP must be at arm's length and have no perception of a personal nature or benefit. HCPs are to refrain from making recommended referrals to themselves, any relative, entity, organization, business, practice or partner with whom they are associated or affiliated.

4.59.4 The Base Surgeon may, on a case-by-case basis, approve a referral, in a remote or an under serviced area that have limited Providers, when the HCP recommends the external referral to themselves.

**4.60 Meetings**

The Contractor's appropriate CMT or CCO personnel must attend various meetings throughout the duration of the Contract.

4.60.1 The SDM or DSDM must attend all required meetings.

4.60.2 The Contractor must determine who from its CMT or CCO will be required to attend each type of meeting. The Contractor's personnel who are attending should be determined by the Agenda Items to be discussed and the Action Items Log (AIL).

4.60.3 The Contractor will be responsible for making all travel arrangements for their personnel attending meetings.

4.60.4 All Contractor or CMT and CCO personnel travel costs related to attending any of the required meetings will be borne by the Contractor and are not to be invoiced to the DND.

**4.61 Initial Kick-Off Meeting**

The Contractor will be required to attend an Initial Contract Kick-Off Meeting in the Start-up Phase, at a Government of Canada (GoC) facility. As a minimum, the Contractor's senior representative and SDM must attend this meeting and may include other Contractor's personnel it deems appropriate.

4.61.1 The Initial Contract Kick-off meeting must take place within 14 calendar days After Contract Award (ACA). The DTA will advise the Contractor of the date and address of the meeting.

4.61.2 The duration of the meeting is anticipated to be three (3) to five (5) calendar days.

4.61.3 This meeting will be co-chaired by the Contractor and DTA and will include, as a minimum, the following Agenda items:

a. review of the Contract including SOW;

b. an overview of the Contractor's Management Plan;

c. an overview of the Contractor's Organization;

d. an overview of the Contractor's Start-up Plan and Schedule;

e. an overview of the Contractor's Recruitment Strategy;

f. an overview of the Contractor's Risks and Risk Analysis and the methods or procedures by which the impact of these risks will be mitigated and managed;

g. confirmation of the names, title(s), roles and responsibilities plus contact information for the primary Points Of Contact (POC) for CCO and CMT personnel;

h. confirm at the Initial Contract Kick-Off Meeting, the CCO and CMT structure; and

i. other items.

4.61.4 The Agenda for the Initial Contract Kick-Off Meeting will be prepared by the DTA and provided to the Contractor by the DTA no less than five (5) calendar days before the meeting.

4.61.5 The minutes of the meetings will be prepared by the Chairs in accordance with the SOW DND Section titled Minutes of the Meetings and provided by the DTA to the Contractor and all attendees within seven (7) calendar days following the date of the meeting.

4.61.6 The minutes will be signed by the Chairs.

4.61.7 Should there be any action items resulting from the Initial Kick-off meeting, the DTA will prepare the Action Item Log (AIL) in accordance with the SOW DND Section titled Action Item Log (AIL). The AIL must be provided with the Minutes.

4.61.8 The contractor will coordinate responses to Action Items from the responsible parties and update the AIL.

4.61.9 All Action Items resulting from the Initial Contract Meeting must be responded to within 10 calendar days following the date of the meeting or by the date agreed upon at the Initial Contract Kick-Off Meeting.

4.61.10 The updated AIL will be distributed by the contractor to all attendees within 15 calendar days from the date of the meeting and will contain all responses for the Action Items assigned to all parties.

**4.62 Progress Review Meetings**

The Contractor must organize and hold Progress Review Meetings (PRMs) in the National Capital Region (NCR) as follows:

a. during the Start-up and Out-Going Phases on a monthly basis within the first 10 days of the month, unless agreed otherwise; and

b. during the In-Service Phase on a quarterly basis within the first 10 calendar days after the end of the quarter, unless agreed otherwise.

4.62.1 If agreed upon by the DTA in advance, the PRM may be held via videoconference or teleconference.

4.62.2 As a minimum, the SDM or DSDM must attend this meeting and may include other Contractor personnel it deems appropriate.

4.62.3 The PRMs will be co-chaired by the DTA and the Contractor.

4.62.4 The PRMs are anticipated to be half-day to two (2) full days (15 hours) in duration. The duration will be based on the Agenda items and Action Items to be discussed.

4.62.5 The DTA will prepare and distribute the PRM Agendas to all attendees a minimum of seven (7) calendar days before the meeting.

4.62.6 The Agenda will include:

a. the purpose of the meeting;

b. the location;

c. the date and estimated duration of the meeting;

d. the proposed list of topics and sub-topics to be discussed plus the time allocated to each discussion item; and

e. the name of the party and individual responsible for addressing each topic or sub-topic included.

4.62.7 The topics for presentation and discussion at PRMs may include:

a. opening remarks;

b. agenda review;

c. review of previous Minutes (if applicable);

d. current status or changes to the Contractor's Plans;

e. status on Contractor's Work and activities during the PRM period;

f. discussions on Contractor's Reports during the PRM period;

g. discussions review of Contractor's Performance;

h. problem or issue reviews and Lessons Learned (LL);

i. review of closed Action Items during the PRM period;

j. status of current Action Items;

k. new problem or issue areas and corrective measures or action plans;

l. new discussion Items;

m. plans for next reporting period;

n. round table discussion;

o. next meeting date; and

p. closing remarks.

4.62.8 The Contractor must provide its planned action(s) to address all discrepancies identified in the PRM in accordance with the time period and schedule agreed to at the PRM.

4.62.9 The Contractor must prepare the minutes of the PRM IAW the SOW DND Paragraph titled Minutes of Meetings.

4.62.10 The Contractor must correct any discrepancies noted in the minutes of the PRM within three (3) calendar days of the notification of the discrepancies by the DTA.

**4.63 Ad Hoc Meetings**

Ad Hoc Meetings are meetings that may be conducted when necessary to respond to urgent or unforeseen requirements, technical work, contract or program management activities or issues, and contractual obligations. Ad Hoc meetings are to be kept to a minimum and only take place if absolutely necessary.

4.63.1 Ad Hoc meetings can be requested by Canada or by the Contractor. The party requesting the Ad Hoc meeting may invite representatives as it deems appropriate.

4.63.2 The party requesting an Urgent Ad Hoc Meeting must provide the requested participants with a written notice one (1) working day prior to the meeting. The meeting should take place within two (2) working days of said notice.

4.63.3 The party requesting a Non-urgent Ad Hoc Meeting must provide the requested participants a minimum of five (5) working days written notice and the meeting will take place at a time agreed to by the parties.

4.63.4 Ad Hoc meetings must be held at a location that is mutually acceptable to the parties or by teleconference, videoconference or Web conference, if acceptable by all the parties.

4.63.5 The party requesting the Ad Hoc meeting must organize and chair the meeting as well as prepare and provide the Agenda. As a minimum, the Agenda must include:

a. the purpose of the meeting;

b. the location;

c. the date and estimated duration of the meeting;

d. the proposed list of topics and sub-topics to be discussed plus the time allocated to each discussion item; and

e. the name of the party and individual responsible for addressing each topic or sub-topic included.

4.63.6 The party who requested the Ad Hoc meeting will be responsible for the preparation and distribution of the Minutes IAW the SOW DND paragraph titled Minutes of Meetings, and the resulting Action Items Log and follow up actions IAW the SOW DND paragraph titled Action Item Log (AIL).

4.63.7 The costs associated with hosting the Ad Hoc Meetings will be borne by the party requesting the meeting.

4.63.8 All costs incurred in the attendance of Ad Hoc Meetings such as preparations and travel will be the responsibility of each of the parties required to participate in the meeting.

**4.64 Minutes of the Meetings**

Minutes of the Meetings will be required, throughout the duration of the Contract, for each meeting or review held, and must include and document all information required to provide an accurate record of the content of the meeting or review.

4.64.1 The minutes are prepared by the party indicated in the meeting paragraphs above. All parties are to indicate their required changes. Once approved by the parties, the responsible party will distribute copies of the Minutes to all the participants within seven (7) calendar days.

4.64.2 The Minutes must include, as a minimum, the following sections:

a. title page containing the title or purpose of the meeting, meeting number, date and location;

b. identification of the Contract number;

c. list of invitees' names, titles, and contact particulars (telephone and email addresses);

d. copy of the Agenda;

e. sections for: the Opening Remarks, Agenda Review, Review of Previous Minutes (if applicable), Open Discussion Items, New Discussion Items, and Review of Previous and New Action Items, Next Meeting, and Closing remarks;

f. a detailed summary of the proceedings, discussions, agreements or decisions reached or taken and by whom;

g. the AIL must be attached and include any responses provided from any of the attendees at the meeting; and

h. a signature page with spaces for the Contractor, the CA and the DTA, as applicable.

4.64.3 All Minutes prepared must be approved and signed before distribution by the Contractor and the CA or the DTA as applicable.

### 4.65 Action Item Log (AIL)

The AIL is the living document that details all Action Items related to all aspects of the Contract. The AIL is a follow-on document from the Initial Contract Kick-Off Meeting and runs for the duration of the contract.

4.65.1 The Contractor must prepare and maintain the AIL commencing with receipt of the AIL from the CA after the Initial Kick-off Meeting. Refer to Appendix 14, Deliverable 41.

4.65.2 The AIL must provide a consolidated list of all actions to be taken, and by each party.

4.65.3 The AIL must include, as a minimum, the following sections:

a. serial number;

b. item;

c. description of the action to be taken;

d. cross-reference to the minutes;

e. indication of the person who is responsible for action;

f. estimated target date for completion of action; and

g. Status Indicator on whether the Action Item is open or closed.

4.65.4 All Action items will remain open until there is a decision recorded in Minutes of Meetings to close the item.

4.65.5 The updated version of the AIL must be distributed by the Contractor with meeting minutes to all participants. Refer to Appendix 14, Deliverable 42.

### 4.66 Reports

The Contractor must prepare and provide various reports throughout the duration of the Contract.

### 4.67 Start-Up Phase Report

During the Start-Up Phase of the Contract, the Contractor must prepare and deliver monthly Start-Up Phase Status Reports. Refer to Appendix 14, Deliverable 43.

4.67.1 The report must show all Work undertaken, including Work in progress, against the Start-Up schedule and must:

a. present an overview of all activities that have taken place in the reported period, those planned but that have not taken place in the reported period, and those that are planned for the following period; and

b. address the activities including all scheduled events or milestones, conducted activities, major accomplishment, non-conducted planned activities and missed schedule activities, including reasons for delays, current status of problems, action items taken or planned to resolve, impacts, impacts to the schedule, forecasted problems, recommendations or solutions to any issues or problems, and planned activities for the following period.

**4.68 Task Authorization Status Report**

The Contractor must prepare and deliver a Task Authorization Status Report monthly, commencing after the Initial Kick-Off Meeting for the duration of the Contract. Refer to Appendix 14, Deliverable 44.

4.68.1 The reporting requirement details are specified in the Contract article titled Task Authorization Status Report – Contracts with Task Authorizations of the Contract.

**4.69 HCP Credentialing Report**

The Contractor must prepare and deliver an Initial Credentialing Report prior to the SED and for each six (6) months thereafter for the duration of the Contract. Refer to Appendix 14, Deliverables 45 and 46.

4.69.1 The report, as a minimum, must include the following information for each HCP:

a. the Task Authorization number;

b. the location;

c. the occupation category;

d. the HCP name;

e. the Credential type (e.g. licence, insurance, registration, certification, education, etc.);

f. the credential description (e.g., name, regulatory body, level of education, etc.)

g. status (e.g. confirmed, pending, expired, etc.); and

h. expiry date.

## 4.70 HCP Travel Report

Throughout the duration of the Contract, the Contractor must prepare and deliver a monthly HCP Travel Report. Refer to Appendix 14, Deliverable 47.

4.70.1 The report is to be provided with the invoice but should be able to be generated through the Timesheet Tool. The report, as a minimum, must list:

a. every HCP authorized to travel under the Contract; and

b. include for each HCP the following distinct data elements:

(1) DND 626 Task Authorization number;

(2) province;

(3) location;

(4) occupation and category;

(5) HCP surname;

(6) HCP given name;

(7) HCP start date;

(8) Task Authorization period (period of travel);

(9) status (fulltime or part-time); and

(10) total DND 626 Task Authorization travel amount;

(11) total travel costs expended during the reporting period; and

(12) total accumulated travel costs incurred to date.

## 4.71 HCP Labour, Overtime, On-Call and Call-Back Report

Throughout the duration of the Contract, the Contractor must prepare and deliver a monthly HCP Labour, Overtime, On-Call and Call-Back Report. Refer to Appendix 14, Deliverable 48.

4.71.1 The report is to be provided with the invoice but should be able to be generated through the Timesheet Tool. The report, as a minimum, must include:

a. every HCP authorized to perform Work under the Contract;

b. DND 626 Task Authorization number;

c. location;

d. occupation and category;

e. level of education (when applicable);

f. HCP surname;

g. HCP given name;

h. HCP start date;

i. DND 626 Task Authorization end date;

j. Level of Effort (LOE), which is authorized hours worked per week, for each of regular hours and overtime worked during the current month;

k. average LOE per HCP;

l. On-Call hours worked during the period;

m. Call-Back hours worked during the period;

n. total cost for current month;

o. total costs incurred over duration of Contract; and

p. total Task Authorization authorized value.

**4.72 Recurring HCP Task Authorization Confirmation Report**

Throughout the duration of the Contract, the Contractor must prepare and deliver an Annual Recurring HCP Task Authorization Confirmation Report. Refer to Appendix 14, Deliverable 49.

4.72.1 The report, as a minimum, must include:

a. all HCPs who have committed to continuing on the recurring Task Authorization;

b. DND 626 Task Authorization number;

c. location;

d. occupation and category;

e. HCP surname;

f. HCP given name;

g. HCP start date;

h. DND 626 Task Authorization end date; and

i. Level of Effort (LOE), which is authorized hours worked per week, for each of regular hours and overtime worked during the current month.

**4.73 HCP Certifications Report**

Throughout the duration of the Contract, the Contractor must prepare and deliver an Annual N95 Mask Fit Test; WHMIS Certification; and BLS Certification Report. Refer to Appendix 14, Deliverable 50.

4.73.1 The report, as a minimum, must include the following information:

a. DND 626 Task Authorization number;

b. location;

c. occupation and category;

d. HCP surname;

e. HCP given name;

f. HCP start date;

g. Quantitative Fit Test Results;

h. Quantitative Fit Test Results effective date;

i. Quantitative Fit Test Results expiry date;

j. HCP WHMIS Certification date;

k. HCP WHMIS Certification expiry date;

l. HCP BLS Certification date; and

m. HCP BLS Certification expiry date.

**Phase Three – Out-Going Phase**

### 4.74 Out-Going Phase Plan

The Contractor must develop and deliver a Draft Out-Going Phase Plan at the Out-Going phase kick-off meeting and Final Out-Going Phase Plan that will outline out-going activities and will propose timings for the range of Deliverables listed below. Refer to Appendix 14, Deliverables 51 and 52.

4.74.1 The Out-Going Phase Plan can incorporate any out-going activities and practices but as a minimum, must include the following:

a. a list and description of Contractor out-going activities to be completed and the major milestones to be achieved during the Out-Going Phase to allow for orderly and timely transition and fully meet all the SOW DND requirements;

b. a schedule, which states the proposed timelines or timeframes for all activities and sub-activities related milestones, all dependencies, and the critical path; and

c. the Contractor's Senior Management structure for the Contract Out-Going Phase, including but not limited to: the Contractor's Out-Going Phase Management Team. The structure must indicate where participation is required or may be requested from the DTA, and what processes and procedures are recommended to ensure quick decision-making within the plan to facilitate the timely delivery of services.

4.74.2 The Contractor must revise and update within 10 calendar days the Draft Out-Going Phase Plan if comments or recommendations are received from the DTA. Refer to Appendix 14, Deliverable 52.

4.74.3 Once the Out-Going Phase Plan is approved by the DTA, it will be deemed the Final Out-Going Phase Plan.

4.74.4 The Contractor must implement and carry out all out-going activities IAW the approved Out-Going Phase Plan during the Out-Going Phase.

### 4.75 Out-Going Phase Kick-Off Meeting

The Contractor will be required to attend an Out-Going Phase Kick-Off Meeting in the Out-Going Phase, at a Government of Canada (GoC) facility. As a minimum, the Contractor's senior representative and SDM must attend this meeting and may include other Contractor's personnel it deems appropriate.

4.75.1 The Out-Going Phase Kick-Off Meeting must take place within 30 calendar days after the Contractor has been officially notified of the commencement of the Out-Going Phase by the CA. The DTA will advise the Contractor of the date and address of the meeting.

4.75.2 The duration of the meeting is anticipated to be one (1) to two (2) calendar days

4.75.3 This meeting will be co-chaired by the Contractor and DTA and will include, as a minimum, the following Agenda items:

a. an review of the Contractor's Out-Going Plan and Schedule;

b. an review of the Contractor's Risks and Risk Analysis and the methods or procedures by which the impact of these risks were mitigated and managed;

c. confirm at the Out-Going Phase Kick-Off Meeting, the CCO and CMT structure; and

d. other items.

4.75.4 The Agenda for the Out-Going Phase Kick-Off Meeting will be prepared by the DTA and provided to the Contractor by the DTA no less than five (5) calendar days before the meeting.

4.75.5 The minutes of the meetings will be prepared by the Chairs in accordance with the SOW DND Section titled Minutes of the Meetings and provided by the DTA to the Contractor and all attendees within seven (7) calendar days following the date of the meeting.

4.75.6 The minutes will be signed by the Chairs.

4.75.7 Should there be any action items resulting from the Out-Going Phase Kick-Off Meeting, the DTA will prepare the Action Item Log (AIL) in accordance with the SOW DND Section titled Action Item Log (AIL). The AIL must be provided with the Minutes.

4.75.8 The contractor will coordinate responses to Action Items from the responsible parties and update the AIL.

4.75.9 All Action Items resulting from the Out-Going Phase Kick-Off Meeting must be responded to within 10 calendar days following the date of the meeting or by the date agreed upon at the Out-Going Phase Kick-Off Meeting.

4.75.10 The updated AIL will be distributed by the contractor to all attendees within 15 calendar days from the date of the meeting and will contain all responses for the Action Items assigned to all parties

### 4.76 Out-Going Phase Contract Summary Reports

During the Out-Going Phase, the Contractor may be requested to:

a. provide Contract summary reports such as but not limited to:

   (1) reports generated through the Timesheet Tool;

   (2) Final HCP Certifications Report;

   (3) Final HCP Labour, Overtime, On-Call and Call-Back Report;

   (4) Final HCP Travel Report; and

   (5) Final HCP Credentialing Report;

b. export data electronically from the Timesheet Tool for accounting purposes, retention and audit requirements; and

c. provide Final Lessons Learned documents.

**4.77 Final Progress Review Meeting**

During the Out-Going Phase, the Contractor and its appropriate personnel must attend a Final Progress Review (FPR) meeting at a Government of Canada facility. The purpose of the FPR meeting will be to perform a complete review of all of the contractual and SOW DND requirements, deliverables, remaining or outstanding PRM Action Items, and to discuss the Contractor's final invoice, to ensure all Contractual obligations are completed and the Contract can be closed.

4.77.1 The FPR meeting will take place no more than 30 and no less than 20 calendar days before the Contract expiry date. The CA will advise the Contractor of the date and address of the meeting. As a minimum, the Contractor's senior representative and SDM must attend this meeting and may include other Contractor personnel, as it deems appropriate.

4.77.2 The meeting duration is anticipated to be approximately three (3) to five (5) calendar days.

4.77.3 This meeting will be co-chaired by the CA and DTA and will include, as a minimum, the following Agenda items for review and discussion:

a. contractual and SOW DND requirements and deliverables;

b. remaining or outstanding PRM Action Items;

c. Contractor's Out-Going Phase activities;

d. Contractor's closing invoice; and

e. other items.

4.77.4 The Agenda for the FPR Meeting will be prepared and provided by the DTA to the Contractor, no less than seven (7) calendar days before the meeting.

4.77.5 The minutes of the Meeting will be prepared by the Chairs in accordance with the SOW DND paragraph titled Minutes of Meetings and provided by the DTA to the Contractor and all attendees within seven (7) calendar days following the date of the meeting.

4.77.6 The minutes will be signed by the Chairs and the Contractor.

4.77.7 Should there be any action items resulting from the FPRM, the DTA will prepare the Action Item Log (AIL) in accordance with the SOW DND paragraph titled Action Item Log (AIL). The AIL must be provided with the Minutes.

4.77.8 The DTA will coordinate responses to Action Items from the responsible parties and update the AIL.

4.77.9 All Action Items resulting from the FPR Meeting must be responded to and closed before the Contract expiry date.

## 5.0 PROGRAM GOVERNANCE

### 5.1 Governance Framework

The Governance Framework outlines governance for the delivery of the Health Service Program, a major service delivery initiative established to support the Canadian Forces Health Service delivery in Canada and includes the management of the Health Care Provider Contract (HCPC).

5.1.1 The Program Governance Framework describes and details the processes of interaction and decision making amongst the senior management stakeholders in the departments. Additionally, it describes and details the mandate, roles and responsibilities of the two distinct levels of Senior Management and Executive Committees that provide direction to the Contract Management Team (CA, DTA, and DPA), who are responsible for the HCPC management functions and activities at the working level.

5.1.1.1 The Governance Framework is listed below:

5.1.1.2 Two (2) distinct levels of senior management stakeholder's committees have been established: Senior Management Oversight Committee; and the Executive Steering Committee.

## 5.2 Senior Management Oversight Committee

The Senior Management Oversight Committee is responsible for monitoring the delivery of the Health Service Program and validation that the HCPC meets program objectives and goals. This includes monitoring Contractor Performance, monitoring risks, quality and schedule, and resolving issues or addressing concerns or problems that cannot be resolved within the authorities at the working level. As a minimum, the Senior Management Oversight Committee meets twice a year.

## 5.3 Executive Steering Committee

The Executive Steering Committee is the key body within the governance structure that is responsible for the business issues associated with the delivery of the Health Service Program that are essential to ensuring the delivery of the program. This includes providing strategic direction, making policy and resourcing decisions, and assessing requests for changes to the scope of the program and the related changes to the Contract that is not within the authority of the Senior Management Oversight Committee. The Executive Steering Committee meets once annually.

5.3.1 The Contractor must provide representatives, when requested, at the Senior Director and Senior Executive levels for the Senior Management Oversight and Executives Steering Committees, respectively. These two (2) representatives must not be the same person.

5.3.2 The Contractor's representatives must participate, when requested, as board members and have the authority to make decisions and carry out action items in regards to Contractor`s Contract management including performance, provision and delivery of the required services and improvement of those services.

## 6.0 DELIVERABLES

The Contractor must prepare and provide all Deliverables in the consolidated table, found in Appendix 14 to Annex A – SOW DND.

6.1.1 The Table specifies:

a. the deliverable number;

b. the SOW DND reference paragraph;

c. the required delivery dates;

d. the delivery format (electronic or paper); and

e. to whom the deliverables are to be provided.

6.1.2 All Deliverables are to be in English only.

6.1.3 The Contractor must ensure that all Deliverables have a cover page and that the cover page indicate the Deliverable number, Deliverable name, whether it is an original submission or re-submission, draft or final version (if applicable), and the date in the format of DD-MM-YYYY.

6.1.4 All Deliverables must:

a. be formatted to fit on Letter size paper (8.5" x 11") unless doing so makes the content illegible, in which case, larger size paper may be used;

b. be provided in Microsoft Office format;

c. be legible and suitable for reproduction;

d. not be password protected; and

e. have pages numbered sequentially.

6.1.5 The process for approval of deliverables is as follows:

a. the DTA will acknowledge receipt of all Deliverables within five (5) calendar days after receipt;

b. within 20 calendar days of receipt, the DTA will review all Deliverables;

c. the DTA will advise the Contractor, via e-mail, if the Deliverable has been approved or rejected;

d. if the Deliverable is rejected by the DTA, a notice of the deficiency(ies) will be provided;

e. the Contractor must address the deficiency(ies) noted and resubmit the corrected deliverable within ten (10) calendar days from the date of notification; and

f. the DTA will have an additional 14 calendar days to review and approve or reject the resubmitted Deliverable.

## 7.0 GOVERNMENT FURNISHED RESOURCES

Government Furnished Resources (GFR) are Canada-owned Government Furnished Equipment (GFE), Government Supplied Material (GSM), and Government Furnished Information (GFI) that the DND will make available for use by the Contractor or Contractor's HCPs.

7.1.1 All GFE, GSM and GFI provided to the Contractor or to the Contractor's HCPs in support of performing the Work under the Contract, will be provided to the Contractor, free of charge.

7.1.2 The Contractor's HCPs must ensure that any GFE or GSM provided are returned in satisfactory condition, subject to normal wear and tear, to the DND upon completion of the Work under the DND 626 Task Authorization.

7.1.3 Cost recovery action will be taken IAW the Contract for any GFE or GSM lost or damaged, subject to normal wear and tear.

7.1.4 The DND will provide each HCP with the following GFE:

a. all office related equipment necessary to support HCP tasks such as office space, desk, chair, telephone with unlimited access for health care related business purposes only, computer with DWAN and CFHIS access, printer access, access to filing cabinet with locking capability (if required), etc.; and

b. all medical equipment required to perform HCP tasks such as examination beds, sterilized tools and equipment, dental suite, diagnostic equipment, therapeutic devices, exercise equipment, etc.

7.1.5 The DND will provide the following GSM for each HCP:

a. all office related supplies required to perform HCP tasks such as pens, paper, forms, prescription pads, etc.; and

b. all medical or dental consumables used in the completion of HCP tasks such as bandages, needles, sharps containers, dressings, braces, splints, orthotics, masks, etc.

7.1.6 Any HCP ergonomic equipment, specialized equipment or material requested, are the responsibility of the Contractor

7.1.7 The DND will provide certain required forms to the Contractor at Appendix 18 to Annex A – SOW DND and Appendix 20 to Annex A – SOW DND.

7.1.8 GFI provided to the Contractor or to the Contractor's HCPs will be as per Appendix 19 to Annex A – SOW DND.

## APPENDIX 1 TO ANNEX A1

## GLOSSARY OF TERMINOLOGY

## APPENDIX 1 – GLOSSARY OF TERMINOLOGY

| PART 1 - ACRONYMS | |
|---|---|
| ACA | After Contract Award |
| AIL | Action Items Log |
| BLS | Basic Life Support |
| B Surg | Base Surgeon |
| CA | Contracting Authority (PSPC) |
| CAF | Canadian Armed Forces |
| CAF SoC | Canadian Armed Forces Spectrum of Care |
| CCO | Contractor`s Central Office |
| CCO Net | Canadian Cadet Wide Area Network |
| CAF | Canadian Armed Forces |
| CF Dent Dets | Canadian Forces Dental Detachments |
| CFHIS | Canadian Forces Health Information System |
| CF H Svcs Cs | Canadian Forces Health Services Centres |
| CIC | Cadet Instructor Cadre |
| CMP | Contractor's Management Plan |
| CMT | Contractor Management Team |
| CO | Commanding Officer |
| CPO | Chief Privacy Officer |
| CPR/AED | Cardio-pulmonary Resuscitation/Automated External Defibrillator |
| CRMP | Contractor's Risk Management Plan |
| CTC/CSTC | Cadet Training Centre/ Cadet Summer Training Centre |
| DAs | Department Authorities |
| DAOD | Defence Administrative Orders and Directives |
| DND | Department of National Defence |
| DPA | Departmental Procurement Authority |
| DSDM | Deputy Service Delivery Manager |
| DTA | Departmental Technical Authority |
| DWAN | Defence Wide Area Network |
| EST | Eastern Standard Time |
| FHCPS | Federal Health Claims Processing Service |
| FOC | Free of Charge |
| FPR | Final Progress Review |
| GFE | Government Furnished Equipment |
| GFI | Government Furnished Information |
| GFR | Government Furnished Resources |
| GoC | Government of Canada |
| GSM | Government Supplied Material |
| HCP (s) | Health Care Provider (s) |
| HCPC | Health Care Provider Contract |
| HSS | Health Services Support |

| | |
|---|---|
| IAW | In accordance with |
| IT | Information Technology |
| KPI | Key Performance Indicator |
| LL | Lessons Learned |
| LOE | Level of Effort |
| MEL(s) | Medical Employment Limitation(s) |
| MS | Microsoft |
| NA | Not applicable |
| NCR | National Capital Region |
| NDSOD | National Defence Security Orders and Directives |
| NDA | National Defence Act |
| NJC | National Joint Council |
| NPF | New Position Filled |
| NPU | New Positions Unfilled |
| OHC | Occupational Health Care Program |
| OHSB | Occupational Health and Safety Branch |
| OL | Official Languages |
| OPIs | Offices of Primary Interest |
| PA(s) | Physician Assistant(s) |
| PEB | Performance Evaluation Board |
| PET | Performance Evaluation Team |
| PHA | Periodic Health Assessment |
| PIF | Performance Incentive Fee |
| PKI | Public Key Infrastructure |
| PM | Performance Monitors |
| PMBOK | Project Management Body of Knowledge |
| PMF | Performance Management Framework |
| POC | Point of Contact |
| PRC | Police Records Check |
| PRI | Personal Record Identifier |
| PRM(s) | Progress Review Meeting(s) |
| PS | Public Service |
| RS | Reliability Status Check |
| QMP | Quality Management Plan |
| QR&Os | Queen's Regulations and Orders |
| RDD | Required Delivery Date |
| RFP | Request for Proposal |
| RMP | Risk Management Plan |
| RPF | Recurring Position Filled |
| RPU | Recurring Positions Unfilled |
| SAP Score | Semi-Annual Performance Score |
| SDM | Service Delivery Manager |
| SED | Service Effective Date |
| SMA | Senior Medical Authority |
| SN | Service Number |

| | |
|---|---|
| SOPs | Standard operating procedures |
| SOW | Statement of Work |
| TA | Task Authorization |
| TM(s) | Task Manager(s) |
| TOC | Table of Contents |
| TsT | Timesheet Tool |
| TTP | Time to Provide |
| VSS | Vulnerable Sector Screening |
| WBS | Work Breakdown Structure |
| WHMIS | Workplace Hazardous Material Information System |

| PART 2 - DEFINITIONS | |
|---|---|
| Canadian Forces Health Information System | The Canadian Forces electronic health record that is comprised of integrated applications supporting patient registration and scheduling, clinical notes, order entry, and results review, pharmacy, laboratory, diagnostic imaging, and dental treatment. |
| Certified Practitioner | Clinical practitioners whose occupation is not a regulated health profession, but has a national, provincial, or territorial certification to practice process. |
| CF Clinics | Medical or Dental units and detachments |
| CAF Drug Benefit List | Identified in the CAF Spectrum of Care document, the CAF Drug Benefit List identifies both prescription and non-prescription drugs available to CAF members. The medications on this list must generally be proven to provide a therapeutic effect. Other products, such as selected medical devices or supplies may also be included as Drug Benefits if there is evidence available to support their therapeutic value. The CAF Drug Benefit List is reviewed and updated on a routine basis by CF Health Services. |
| CAF Member | Those individuals identified by DND as eligible for health benefits and services at public expense. While predominately Regular Force and Reserve Force members CAF member in the contract also includes other eligible individuals such as Cadets, Foreign Service members, and Foreign Service dependants. |
| CAF Spectrum of Care Document | This document outlines the health care benefits and services available to CAF members. |
| Clinical Administration | Work that consists of providing medical advice and consultation by undertaking tasks or activities in a non-clinical environment that does not involve providing patient care. The tasks may include, but are not limited to: reviewing medical Periodic Health Assessments, reviewing and providing advice, assessment or professional opinions on specific medical cases (case reviews), assessing and determining assignments of medical categories and employment restrictions, policy development, etc. |
| Continuity of care | The CF Health Services is responsible for delivering integrated and coordinated health care services that are responsive to the CAF member's needs. Using a continuous health care record, the process involves the CAF member and an interdisciplinary health care team, with support from the CF members' chain-of-command. Continuity of care includes continuity of health care |

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| | provider, where practicable and ensuring seamless and efficient transition of the CAF member from one health care provider to another when required. |
| Extended hours | Hours worked by the HCP beyond the LOE shown on the TA Form when Overtime is not pre-authorized on the TA Form. Extended hours are paid at the HCP normal hourly rate. |
| Facility Operator | A facility operator is the organization who operates a facility where one or more HCPs practise. |
| Health Services Support | All activities necessary to provide health care to a given population. |
| Lessons Learned | Lessons learned means the adding of value to an existing body of knowledge, or seeking to correct deficiencies in areas of concepts, process, policy, doctrine, training, equipment, requirements, deliverables, or organizations, by providing feedback and follow-on action. |
| Level of effort (LOE) | The LOE is the number of hours the HCP is required to work, per week, as identified on the TA Form. |
| In-garrison health care | At home health care and services is referred to as in-garrison. In garrison care consists of all health care provided to CAF members and other entitled persons in Canada. It is inclusive of pre and post deployment activities, field training, and work on the ranges. It is exclusive of operations and exercises, and when the ships are away from a Canadian port. Patients that are repatriated from operations and exercises are considered to be under in-garrison care. |
| Medical Boards | A specific and detailed military medical administrative process of health assessment of service members, to accurately determine employability. |
| Out-patient care | Not requiring admittance to clinic/hospital overnight |
| Personal Health Information | Medical, dental or psychosocial information about an identifiable individual that is recorded in any form. |
| Personal information | Personal information is defined by section 3 of the Privacy Act, and includes personal health information. |
| Program Manager | The program manager has oversight of the purpose and status of the projects in a program and can use this oversight to support project-level activity to ensure the program goals are met by providing a decision-making capacity that cannot be achieved at project level or by providing the project manager with a program perspective when required, or as a sounding board for ideas and approaches to solving project issues that have program impacts. In a program there is a need to identify and |

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| | manage cross-project dependencies and often the project management office (PMO) may not have sufficient insight of the risk, issues, requirements, design or solution to be able to usefully manage these. The program manager may be well placed to provide this insight by actively seeking out such information from the project managers although in large and/or complex projects, a specific role may be required. |
| Project Manager | A project manager is the person responsible for accomplishing the project objectives. Key project management responsibilities include<br><br>• defining and communicating project objectives that are clear, useful and attainable<br>• procuring the project requirements like workforce, required information, various agreements and material or technology needed to accomplish project objectives<br>• managing the constraints of the project management triangle, which are cost, time, scope and quality<br><br>A project manager is a client representative and has to determine and implement the exact needs of the client, based on knowledge of the organization they are representing. An expertise is required in the domain the Project Managers are working to efficiently handle all the aspects of the project. The ability to adapt to the various internal procedures of the client and to form close links with the nominated representatives, is essential in ensuring that the key issues of cost, time, quality and above all, client satisfaction, can be realized. |
| Regulated Health Professions | Clinical practitioners whose occupation is a health regulated profession. In Canada, the regulation of health professions is under provincial/ territorial jurisdiction with each province/territory individually legislating the credentialing requirements for each profession. |
| Routine request | Routine request are HCP requirements that the priority to fill is a not Urgent |
| Secondary care | Secondary care is the health care services provided by medical specialists and other health professionals who generally do not have first contact with patients, for example, cardiologists, urologists and dermatologists. |
| Senior Medical Authority | The generic term utilized in the CF Clinic Model which is applicable to an individual at any level within the health care organization holding Professional-Technical authority |

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| | over all aspects of health services, less dental support. |
| Service Effective Date | Start date of the In-Service phase. The first day of work for the HCP on the initial HCP Requirement Plan. |
| Short-term HCP requirement | Short term requirements are those planned requirements where the duration of the Task Authorization is 180 calendar days or less. |
| Sick Parade | A pre-defined period of time during which CAF members and other eligible personnel may present, without an appointment for assessment of health concerns over not greater than 48 hours duration. |
| Spectrum of Care | A formal document that defines and describes the health care benefits and services, medical and dental, that are available for CAF members and other eligible persons. These services are provided at no cost to the CF member. |
| Recurring Requirement List | HCP requirement that is already under Task Authorization and are planned to be further extended for a defined period of time. |
| Task Authorization | Authorization to the Contractor to provide HCP and details task requirements. |
| Tertiary Care | Tertiary care is specialized consultative health care, usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment, such as a tertiary referral hospital. |
| Tertiary settings | Usually regional hospitals or provincial health science centres that house sophisticated diagnostic equipment and perform complex therapeutic procedures that require advance expertise by medical and nursing specialists. |
| Urgent request | Urgent requirements are HCP Requirement that must be staffed as a priority over a Routine HCP Request, and therefore necessitates immediate action and attention must be filled in less time than that allowed for the routine requirements. |

## APPENDIX 2 TO ANNEX A1

## THE CANADIAN FORCES MEDICAL CLINIC


# The Canadian Forces Medical Clinic

## LIST OF EFFECTIVE PAGES

Insert latest changed pages, dispose of superseded pages in accordance with applicable orders.

Dates of issue for original and changed pages are:

| | | | |
|---|---|---|---|
| Original | 0 | Change | 3 |
| Change | 1 | Change | 4 |
| Change | 2 | Change | 5 |

Zero in Change No. Column indicates an original page. Total number of pages in this publication is XXX consisting of the following:

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# PREFACE

1. **Background**. The Canadian Forces Health Services (CFHS) is mandated to provide the health services support (HSS) necessary to sustain a multi-purpose, deployable, combat capable force across the full spectrum of military scenarios. As an outcome of legislation, policy and military efficiency, the CF Member has their health protected, promoted and restored in accordance with the principles expressed in the Canada Health Act, to levels of accessibility and quality of health care delivery that are comparable to those afforded to Canadians, in general. HSS commences and normally concludes with in-garrison HSS capabilities.

2. **Purpose**. The purpose of this publication is to provide doctrine for the CF's principle in-garrison HSS capability - the CF Medical Clinic. This publication should be read:

   a. As a sequel to B-GJ-005-410/FP-000 Health Services Support to Canadian Forces Operations;

   b. In conjunction with other CF in-garrison primary health care system documentation available on the CFHS web site; and

   c. With the understanding that CF doctrine is the fundamental principle by which the CF guides its actions in support of objectives. It is authoritative but requires judgment in application. While doctrine is guidance and not mandatory, departure from guidance should normally be undertaken only after doctrine has been considered in light of the particular circumstances of an operation, and the doctrine is found to be wanting in some respect. Such a departure should be taken as an indicator that the doctrine itself requires amendment.

3. **Scope**

   a. This publication provides a description of the CF Medical Clinic Model including an overview of how the Model was developed. It presents the principles and concepts that underlie CF in-garrison primary health care and specific details about how that care should be delivered.

   b. This publication is divided into four parts. The first Part describes the CF philosophy of health care, leadership of the CF Medical Clinic and the Professional Technical Network. The second Part details the departmental structure of the CF Medical Clinic Model, including the components that bring the aspects of the Model together and those supports within the Model that will enable its functioning. The third Part details each of the five types of CF Medical Clinic. The fourth Part provides the description of how the performance of the CF Medical Clinic will be measured.

4. **Compliance**. The content of this publication is in compliance with Canadian law and Government of Canada and Department of National Defence policies.

5. **Precedence**. Commander Canadian Forces Health Services Group (Comd CF H Svcs Gp) is responsible for the development and maintenance of CFHS doctrine. The Comd CF H Svcs Gp exercises this responsibility through the CF Doctrine Board with cross-environmental support derived through the CFHS Doctrine Forum. If conflicts arise between the contents of this publication and the contents of single-service publications, this publication will take precedence unless the Chief of the Defence Staff, in consultation with the Commanders of Commands, provides more current and specific guidance.

# FOREWORD

1. Health care is, at its very essence, serving people. Members of the Canadian Forces Health Services (CFHS) have undertaken a career in the service of the CF Member. Since 2000, the CFHS has undertaken an extensive process of self-examination, of both internal and external consultation, and of renewal. This process has been extremely challenging, and has at times been difficult and painful. However, the goal of all aspects of the Rx 2000 renewal process has been the same – to better serve the CF and its members.

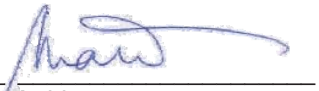
2. The Primary Care Renewal Initiative (PCRI) has been a key component of this renewal process. The delivery of primary care services to the CF Member is critical to maintaining operational readiness, and to maintaining the essential trust between the CF Member and their health care system. The development and implementation of PCRI have exemplified the strengths of the CFHS, and have also borrowed best practices from the Canadian civilian health sector.

3. From its earliest beginnings, PCRI has called upon the experience and expertise of serving members of the CFHS. It has also enlisted the advice of leading experts in the civilian health care sector. These inputs have been combined in an extensive and painstaking process of concept development, review, trial, evaluation and adjustment to arrive at the PCRI concept now ready for implementation across the CF. At all points in this process, the guiding principle has been “What is right for the CF Member?”.

4. The PCRI Clinic Model outlined in this document represents the culmination of literally years of work by all ranks and military occupations within the CFHS. The Model itself stresses teamwork, and the pooling of talents and resources in support of the patient and of the CF mission. Throughout its development, this teamwork was constantly in evidence. The result has been the development of a system that is patient focused, and which allows all members of the health care team to grow as professionals and to apply their skills to their maximum extent in the care of the CF Member. It stresses respect; respect for the patient, respect for the CF mission, and mutual respect amongst all members of the health care team.

5. Health care in Canada is changing and the PCRI Model will allow the CFHS to be in the vanguard of that change. We are extremely proud of the contribution of all members of the CFHS involved in the development of this PCRI Clinic Model. They have consistently acted with flexibility, openness, and with the best interests of the CF Member at heart. The result is a model that will achieve the dual purposes of allowing CF health care personnel to achieve professional fulfillment, and of providing the best possible primary care services to the CF.

S. Cameron
Colonel
Surgeon General



L. Mathieu
Major-General
Director General Health Services/
Commander CF Health Services Group

PART A - THE CANADIAN FORCES MEDICAL CLINIC

CHAPTER A-1

# INTRODUCTION

## A-101. IN-GARRISON HEALTH SERVICES IN THE CANADIAN FORCES

1. The Canadian Forces (CF) is responsible for the provision of in-garrison medical and dental care to its Regular Force personnel, to its entitled Reserve Force personnel and to other entitled personnel on 37 installations across Canada and abroad. The CF is legally responsible for providing health care and services to the entitled CF Member under the Queen's Regulations and Orders (QR and Os) for the Canadian Forces. QR and Os stipulate that medical and dental care shall be provided at public i.e., Government of Canada (GOC) expense to Canada's military personnel. This responsibility is part of the GOC's responsibility for the Canadian military as set out in *The Constitution Act*.

**Note**: *The Canada Health Act* specifically excludes the full-time CF Member from its definition of insured persons for whom health services are provided under provincial health care insurance plans.

2. Health care and services to the CF Member are provided in two distinct contexts: at home, which is referred to as in-garrison, and on deployed operations. Quality health care is provided to the CF Member anytime, anywhere, from in-garrison clinics to ships at sea.

3. In Canada, the CF Member receives non-emergency outpatient medical and dental care at/through CF Health Services (CFHS) medical and dental clinics at CF installations across Canada and abroad. Usually, more specialized health care as well as after hours primary health care are provided in civilian health care facilities. Health services support (HSS) is provided when and where required on deployed operations through a variety of arrangements. Arrangements may include full service by the CFHS, by purchased local services, in partnership with other military health services or combinations of the aforementioned.

4. The CF Member is entitled to receive the same care and publicly funded benefits and services that Canadians receive under their provincial health care plan. Service in the CF is an inherently dangerous way of life. In return for their commitment to serve Canada with unlimited liability, the CF Member must be provided with health care comparable to that that is provided to Canadians, in general, but tailored to meet their unique needs.

5. The CFHS is tasked to ensure the delivery of comprehensive medical and dental care, supplemental health care, occupational health, preventive medicine and health promotion services anytime, anywhere. A range of specific health services is provided within each of these broad domains of care. More information is provided in the CF Spectrum of Care document.

## A-102. DEVELOPMENT OF A NEW CANADIAN FORCES MEDICAL CLINIC MODEL

1. The provision of health care in the 21st Century holds many challenges for the CF. It not only encompasses aspects unique to the CF environment but other challenges shared by the civilian health care sector such as shortages of qualified clinical personnel.

2. In January 1999, the Chief of Defence Staff (CDS) tasked the Chief of Review Services (CRS) to conduct a review of the provision of in-garrison health care to the CF Member. The CRS team was specifically asked to examine continuity of health care and the administration of Temporary Medical Categories. The CRS report identified significant problems related to the

management and delivery of CF in-garrison health care and offered a series of recommendations to address the perceived deficiencies. Some of the comments and observations about the CFHS made in the CRS report centered on the following:

a. Lack of continuity of care;

b. Substantial regional differences in the provision of health care at CF installations across Canada;

c. Lack of strategic direction and low morale;

d. Too many clinicians performing strictly administrative functions;

e. Lack of on-going quality improvement programs;

f. Deficiencies in the management of health records;

g. Lack of accountability amongst providers; and

h. CF Member concerns about the access to and timeliness of health care.

3. The CDS subsequently convened a Task Force comprised principally of CF health care professionals to develop an action plan to deal with the CRS recommendations. A key recommendation stemming from the CDS Task Force was the requirement to create a project to address the problems identified by the CRS and the Task Force. Defence Services Program (DSP) Project 00000297, entitled Rx 2000, was established.

4. The Rx2000 mandate is to initiate corrective action to ensure a high standard of health care for the CF Member - anywhere, anytime. It is a proactive, multifaceted reform project that aims at repositioning the CF health care system to be patient-focused, accessible and capable of meeting the needs of the CF Member and the CF operational chains-of-command at home and abroad while respecting the five principles of the Canada Health Act. To achieve this, Rx 2000 organized change activities into four CF health care reform streams.

a. To build a health care delivery structure that will ensure continuity of health care to the CF Member and other entitled personnel.

b. To implement an accountability framework for the renewed CF health care system as a single corporate entity under the leadership of the Director General Health Services (DGHS).

c. To establish programs for the mitigation of preventable injuries and illnesses thereby protecting the CF Member and meeting the requirements of CF operations.

d. To develop a human resources framework to ensure sustainability of the CFHS.

5. In addressing the first of these four overarching objectives of Rx2000, the CF Primary Care Renewal Initiative (PCRI) was created to be the focal point for improving Continuity of Care, and for developing the associated management structure and administrative framework to sustain these improvements.

6. The CFHS Primary Health Care Model was developed through a series of working groups and advisory committee meetings held between November 2000 and March 2001, involving a total of 140 CFHS personnel. The Model was refined following the report produced by the Canadian College of Health Service Executives on the subject of the management structure of in-garrison health care in the CF.

7. The concepts were operationalized and, through the PCRI Trial Plan the pilot phase, commenced in June 2002 at CF clinics located in:

a. Esquimalt;

b. Edmonton;

c. Kingston; and

d. Bagotville

8. In July 2002, Hollander Analytical Services was selected to conduct an independent evaluation of PCRI to ensure that the planned changes would achieve the objectives of PCRI. The evaluation and the methodology used by Hollander was developed following consultation with CFHS staff.

9. The Hollander Evaluation represents a significant consultation effort with the key stakeholder groups across the CF. Close to 300 interviews and numerous focus groups were conducted with CF members, the operational chains-of-command and frontline CFHS personnel.

10. The Hollander Evaluation report was completed in November 2003 and it confirmed that the new CF Medical Clinic Model was sound. However, specific changes to the Model were recommended to improve the delivery of care to the CF Member. The majority of these changes have been incorporated into the new CF Medical Clinic Model. The following also significantly influenced the development of the Model especially in the area of occupational health and operational medicine:

a. The CF Surgeon General Working Group on Collaborative Practice; (See Annex A for details)

b. Two Working Groups held by the DGHS Executive Committee in July and October 2003 specifically focused on the way ahead for Primary Health Care Renewal in the CF; and

c. Decisions made by the Primary Care Renewal Steering Committee[1].

[1] The PCRI Steering Committee was formed to provide oversight of the development of the new CF Medical Clinic Model and its implementation. (See Terms of Reference at Annex B)

## CHAPTER A-2

# ROLE OF THE CANADIAN FORCES MEDICAL CLINIC

### A-201. CANADIAN FORCES MEDICAL CLINIC MISSION, VISION AND VALUES

1. The Canadian Forces (CF) Medical Clinic must support the broader mission and vision of the CF and the CF Health Services (CFHS). In support of these superior missions, the CF Medical Clinic is mandated to meet the individual health care needs of the CF Member in an appropriate, responsive, and timely manner, while supporting the CF operational chains-of-command. In essence, the CF Medical Clinic mission is based on the following two objectives:

   a. Sustaining high-quality health care in an ever-changing environment; and

   b. Enhancing support to the CF operational chains-of-command.

2. The CF Medical Clinic is responsible for the provision of in-garrison health services to the CF Regular Force member, the entitled CF Reserve Force member and other entitled personnel. It is also responsible for ensuring that appropriate continuing professional education and training opportunities are provided to CFHS personnel.

3. The CF Medical Clinic does not deploy as a unit. However, it does have a role, through its Operations and Training element, in ensuring that CFHS personnel are prepared and fit to participate on deployed operations, from both a military and clinical perspective.

4. The CF Medical Clinic is staffed in accordance with their Position Charter document based on generic templates but adjusted to take into account local operational and patient needs.

5. The vision for in-garrison health care services is:

   *"The CF Medical Clinic is patient-centered and focuses on the long-term health of the CF Member and the CF community, using an interdisciplinary team of health care providers working together to improve patient care and support to CF operations. The CF Medical Clinic promotes an environment that understands and respects the professional skills, knowledge and responsibilities of CFHS clinical providers. The CF Medical Clinic will promote standardization while meeting the unique local needs of the CF."*

6. The CF Medical Clinic staff is also expected to adhere to the values of the CFHS, which include:

   a. Caring – We have empathy for our patients, whose welfare is our foremost concern. Compassion is always evident as we share with them the responsibility for their health;

   b. Our People – We support, promote and encourage the professional and personal development of our people;

   c. Teamwork – We are a multidisciplinary team that works together, guided by the best interests of those we serve;

   d. Professional Excellence – We master the skills of our disciplines, learn continuously and base our judgments on scientific evidence and the best interests of those we serve;

   e. Communication – We listen to, understand and inform our patients, our people, the CF and the public;

f. Accountability – We take responsibility for our actions, decisions, and behaviour; and

g. Military ethos – Our uniformed personnel continuously develop and excel as loyal and dedicated members of the CF.

## A-202. ETHICS

1. Members of Canada's Defence Team are expected to consistently perform their duties to the highest ethical standards. To provide guidance on ethics, the Department of National Defence (DND) developed the Defence Ethics Program. It is a comprehensive values-based ethics program put in place to meet the needs of the DND at both the individual and the organizational levels. The aim and primary focus of the Defence Ethics Program is to foster the practice of ethics in the workplace and on operations.

2. The Statement of Defence Ethics is the heart of the Defence Ethics Program. It is a public statement of commitment to ethical principles and obligations, and consists of a declaration of who is bound by it, a set of three ethical principles, and a list of six core ethical obligations. See http://armyonline.kingston.mil.ca/CLS/D42586.asp for full details.

3. Clinicians are also bound by the ethical considerations of their respective professions. Adherence to the various professional codes of ethics is essential.

## A-203. PROFESSIONAL EXCELLENCE

1. The CF must be constantly adapting to changing realities in the strategic and operational milieu in which it operates. Two key ongoing themes affecting the CF Medical Clinic are:

a. The increasingly diverse capabilities required to support CF objectives; and

b. The need to remain interoperable with Canada's allies and a continuing commitment to keep abreast of best practices in the delivery of health care to the CF Member, both in-garrison and on deployed operations.

2. The CFHS must undergo analogous transformations to meet new and ever-changing needs of the CF. For their part; CFHS personnel must master the skills of their discipline, learn continuously and base their judgments on contemporary scientific evidence and the best interests of those they serve.

3. The CFHS leadership believes that it is important to achieve excellence in the areas of operational medicine and occupational health. Delivering this operational support to CF units must be a top priority of everyone who works at the CF Medical Clinic, although the primary responsibility for this support rests upon the clinical staff. For this reason, CFHS personnel must be actively and routinely engaged in the CFHS Maintenance of Clinical Skills Program (MCSP) activities. In addition, a critical role for Medical Officers is to make regular visits to operational units. MCSP activities and visits to operational units should be given the same priority as the requirement to deliver routine day-to-day health care and health services within the CF Medical Clinic.

## A-204. DEFINING HEALTH AND HEALTH PROMOTION

1. The CF accepts the World Health Organization (WHO) endorsed definitions of health and health promotion, with the addition of spiritual well-being. The following are the CF definitions of health and health promotion.

a. **Health**

*"A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."*

b. **Health Promotion**

*"Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, social, mental and spiritual well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living.*

*Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being".*

## A-205. DEFINING PRIMARY HEALTH CARE

1. In the civilian environment, primary health care is usually defined as a set of universally accessible first-level services that promote health, prevent disease and provide diagnostic, curative, rehabilitative and supportive services. In a primary health care model, health is conceived quite broadly to include the health of the individual, their family and their broader community. Primary health care also incorporates the notion of population health that looks at the broader determinants of health such as the environment and inequalities in health status. A widely accepted definition of primary health care is that of the WHO as articulated in the Declaration of Alma-Ata, which states that:

*"Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."*

2. The term primary health care refers to a broad, comprehensive approach to health and health care. The term primary care refers to a narrower definition of health care, typically a physician working alone in their office providing medical care to their patients. It is important to realize that the CF Model of Care is principally a primary health care model. The unique aspects of the definition of primary health care in the CF are:

a. The CF provides a significant occupational health and support to operations component to its care delivery;

b. The CF Member's family members do not normally receive health care services from the CFHS; and

c. The CF Member only receives care while in the CF; the range of services does not cover the CF Member from birth to death.

## CHAPTER A-3

# THE CANADIAN FORCES MEDICAL CLINIC PHILOSOPHY OF CARE

### A-301. THE CANADIAN FORCES HEALTH CARE COVENANT

1. The Department of National Defence (DND) and the Canadian Forces (CF) are obligated to provide the CF Member with the best health care possible. This can best be achieved if there is a clear understanding of the expectations and responsibilities of the CF Member and the CF Medical Clinic staff.

2. The following are the terms of the health care covenant, referred to as “Our Contract With You”, between the CF Member and the CF Medical Clinic staff.

a. As a patient, the CF Member can expect to:

(1) Be treated with respect at all times;

(2) Have the privacy of their health information respected;

(3) Be involved in decisions about their care and treatment;

(4) Include their family members in decisions about their care where appropriate;

(5) Be fully informed about all aspects of their care;

(6) See a physician, when desired;

(7) Know who is providing their care;

(8) Request a second opinion, should they desire;

(9) Have religious and cultural beliefs respected;

(10) Be treated in the official language of their choice;

(11) Have access to their personal health record; and

(12) Have a second medical staff member, of their gender, present during an examination or treatment, where appropriate.

b. Health care providers at the CF Medical Clinic can expect the CF Member to:

(1) Communicate openly and honestly with their health care providers about their health concerns;

(2) Raise any concerns about their health care with their health care providers;

(3) Participate actively in decisions about their health care;

(4) Carry out treatment recommendations;

(5) Attend all scheduled appointments;

(6) Treat health care providers with respect;

(7) Inform their direct supervisor of their medical employment limitations;

(8) Utilize CF medical facilities whenever possible; and

(9) Inform CF medical authorities of any medical care received outside of CF medical facilities.

## A-302. HEALTH CARE OBJECTIVES

1. **General**. The CF Medical Clinic has two principal objectives:

a. Sustaining high-quality health care in an ever-changing environment; and

b. Enhancing support to the CF operational chains-of-command.

2. **Putting Patients First - Sustaining High Quality Health Care in An Ever-changing Environment**

a. Sustaining high-quality health care is based upon the following principles:

(1) Adhering to clinical best practices;

(2) Optimizing Continuity of Care;

(3) Instituting acceptable waiting times;

(4) Providing access to a comprehensive spectrum of care;

(5) Creating a user-friendly health care system;

(6) Promoting continuous learning;

(7) Fostering continuous quality improvement; and

(8) Ensuring excellence in health record keeping.

b. The CFHS must provide quality patient-centered care, based on clinical best practices, for the CF Member, that meets their unique needs anytime, anywhere. Included in quality health care are such elements as waiting times, the spectrum of care, standardization, ease of use, and accessibility. Standardization is the best way to address regional/sector inconsistencies and with a highly mobile population standardization will make it easier for the CF Member to access and utilize the health care system. These quality health criteria will be achieved through a health services infrastructure and delivery system that responds to the health needs of the CF Member as well as to the need of the CF to maximize readiness and employability.

3. **Enhancing Support to the Operational Chains-of-Command**

a. Enhancing support to the operational chains-of-command has several subcomponents including:

(1) Clearly defined communication protocols between the Clinic staff and the Operators;

(2) Greater involvement of CFHS staff in Base occupational health, and operations and training activities, such as having MOs spend the equivalent of approximately one day per week at mutually agreed upon times, with local units;

(3) Ensuring that there are sufficient numbers of CFHS clinical personnel with the appropriate occupational health and operational medicine qualifications; and

(4) Timely response to the Operator's requests/queries.

b. Support to the operational chains-of-command is of utmost importance as this is the foundation of a military medical force. As a general rule within the CFHS context, the increase in the available CF workforce for deployment is a most significant variable to enhancement of operational requirements. In addition, there must be greater involvement of the Clinic staff in Base operations and training activities. There is a critical requirement for sufficient numbers of personnel with the appropriate occupational health and occupational medicine qualifications to meet operational requirements. There is an absolute need for core clinic staff to allow occupational health and occupational medicine tasks to be carried out without degrading the health care services provided at the CF Medical Clinic. Inherent in support to the operational chains-of-command is the fostering of an environment that values stakeholder input, promotes the health and well-being of the CF Member, and responds to the operational needs of the CF.

c. With regard to the requirement for civilian clinicians to also be knowledgeable about occupational health and support to CF operations, the following distinction is made:

(1) **Canadian Forces Clinicians** - need to be involved in the activities of operational and training units on their Base.

(2) **Civilian Clinicians** - need to understand the activities being conducted on the Base.

d. CF Commanders have special and unique responsibilities for the health of their troops. The CFHS must provide a Continuum of Care, from a high quality in-garrison care system in Canada, through appropriate selection of personnel for deployed operations and military tasks, to the provision of high quality care under demanding and austere conditions normally associated with deployed operations. CF commanders require expert medical advice to assist them in discharging their responsibilities. There is a requirement for CF health care professionals to exercise control, on behalf of CF Commanders, over the professional and technical aspects of health care.

e. The CFHS leadership believes that it is important to achieve excellence in the areas of operational medicine and occupational health. Delivering this support to CF units is a top priority of everyone who works at the CF Medical Clinic. The primary responsibility for this support rests upon the CF health care providers. For this reason the requirement for CFHS personnel to be actively engaged in Maintenance of Clinical Skills Program activities and, specifically MOs, to make visits to operational units is given the same priority as the requirement to deliver the routine day-to-day health care and health services within the CF Medical Clinic.

## A-303. THE TRIAD OF TRUST

1. Trust is an essential ingredient in successful human relationships. This is particularly true in the context of the patient/health care provider relationship. The issue of Medical Confidentiality epitomizes the need for trust.

2. A civilian health care interaction occurs where the patient and health care provider meet with the common goal of preventing or resolving a clinical problem. The location where this interface takes place is the area where exchanges of confidential health information occur and where trust between the patient and health care provider is developed. As a rule, this interface is well established in the civilian health care environment and confidentiality is well protected. In most jurisdictions in Canada, Medical Confidentiality between patient and physician is further strengthened by provincial or territorial statute. Transgressions are considered acts of professional misconduct. Their respective governing bodies similarly regulate non-physician health care providers.

3. A CF health care interaction has a third legitimate and necessary element to the interface relationship, namely the CF Member's chain-of-command. The connectivity of Patient, responsible Physician and Commander is referred to as the Triad of Trust. This is the make or break point for the trusting relationship and the area where the needs of each element of the Triad are articulated.

4. The CF Member's chain-of-command has the ultimate responsibility for the health of the CF Member. It must leverage every opportunity to prevent injuries and optimize recovery. To achieve optimal recovery, the CF Member's chain-of-command must be willing and able to provide a supportive service environment and ensure the CF Member is not tasked to a situation that may aggravate their health condition(s). The CF Member's chain-of-command requires accurate and timely information about the medical limitations of the CF Member that impacts both their deployability and employability. CF commanders rely on the CFHS for this information.

5. The CF Member needs to be assured that their health information will be protected and that their chain-of-command will provide an employment situation that is respectful of any medical employment limitation(s) that may exist. The CF Member's health care provider needs assurances that their cooperation with the CF Member's chain-of-command is indeed in the best interest of the CF Member and that confidentiality and the patient/health care provider relationship will be preserved. Finally, the CF Member's chain-of-command needs information that will allow it to provide an optimum employment situation for the CF Member recovering from serious injury or disease. The only way this three-way relationship will work is if all elements understand and respect the needs of each other.

6. Several CF initiatives have attempted to resolve the interface issues and enhance the Triad of Trust. In particular, the Chief of Defence Staff (CDS) released a CANFORGEN message in February 2000 that described the role of the Physician with respect to the release of medical information to non-medical persons in the chain-of-command.[1] In brief, it stated that any employment limitation(s) that has been assigned to the CF Member because of a medical or psychosocial condition, as well as the prognosis of that condition, would be fully described and explained to the CF Member's Commanding Officer (CO) through appropriate means. It further explained that the CF Member's specific diagnosis and treatment, and any other information obtained during a medical or psychosocial examination or interview, will not be disclosed to or discussed with the CO or any non-medical personnel, unless the subject CF Member has provided formal consent.

[1] CANFORGEN 026/00 ADMHRMIL 016 181430Z FEB

## A-304. CONTINUITY OF CARE

1. **The Civilian Definition of Continuity of Care**. Continuity of care is the degree to which a series of discrete health care events are coherent, connected and consistent with the patient's health care needs. Continuity has three dimensions.

   a. **Informational**. The accessibility and use of all relevant medical information from the past to make the most appropriate current care decisions for each individual.

   b. **Relational**. One of the most important features of a successful primary health care system is when a patient can establish an ongoing relationship with a trusted care provider who can provide a link from the past to the current situation and also from the current to the future situation.

   c. **Integration and Management of the Clinical Situation**. Continuity is achieved when care from multiple providers is delivered in a coordinated and timely fashion such that outcomes are optimized and such that the patient feels secure and confident that providers are not working at cross-purposes or without all of the information they require.

2. **The Canadian Forces Definition of Continuity of Care**. The CFHS is responsible for delivering integrated and coordinated health care services that are responsive to the CF Member's needs. Using a continuous health care record, the process involves the CF Member and an interdisciplinary health care team, with support from the CF Member's chain-of-command. Continuity of Care includes continuity of health care provider, where practicable and ensuring seamless and efficient transition of the CF Member from one health care provider to another when required.

3. **Applying Continuity of Care to the Canadian Forces**. One of the vital pillars of CF health care reform, Continuity of Care is intended to address the need to create a caring, responsive and coordinated process by which all health services provided to the CF Member are integrated. To accomplish this, the Continuity of Care process must involve the CF Member, an interdisciplinary health care team, the CF Member's chain-of-command, and must be supported by a continuous, comprehensive health record. Continuity of Care includes continuity of provider where practicable, a seamless efficient transition of the CF Member from one care provider to another, and from the in-garrison setting to deployed operations. The CF Medical Clinic provides Continuity of Care by rostering the CF Member to a team of providers, and by having a CF/Civilian health care provider mix. The civilian component provides stability and the CF component provides the in-garrison to deployed operations transition.

4. **Three Perspectives on Canadian Forces Continuity of Care**. Successfully achieving Continuity of Care in the CF means satisfying three different perspectives on the issue.

   a. **The Canadian Forces Member's Perspective**. Continuity has occurred when the CF Member perceives that their health care provider knows what has happened to them before, that the various health care providers currently involved in their health care agree on a management plan and that a provider who knows about them will care for them in the future. Ultimately, although the CF Member's individual experiences can be aggregated to the group level, the unit of measurement for Continuity of Care is fundamentally the individual. Continuity of Care is thus not solely an attribute of providers or organizations; it is how the CF Member personally experiences the coordination and integration of their health care.

   b. **The Health Care Provider's Perspective**. From the perspective of the health care provider, Continuity of Care has occurred when they perceive that they have sufficient knowledge about the CF Member to effectively apply their professional judgement and make decisions. Furthermore, Continuity of Care occurs when individual providers are

confident that other health care providers who will work in collaboration with them will know, understand, and respect their input.

c. **The Chain-of-Command's Perspective**. Continuity of Care has occurred when the CF Member's chain-of-command is confident that their personnel are receiving high quality integrated health care and that information on the health status of CF Members and units is being provided to their respective chains-of-command in accordance with existing policies to maximize operational effectiveness.

5. **The Central Role of the Physician in Continuity of Care**. In order to ensure Continuity of Care, the CF Member must have the opportunity to establish a trusting relationship with their Physician. Implicit in this statement is the fact the CF Member, unless operational demands or other workload factors dictate otherwise, must be able to consult their Physician whenever they wish to do so. Lastly, the Collaborative Practice structure established at the CF Medical Clinic must ensure that information flows so that the Physician can continuously integrate the CF Member's health situation and, in collaboration with the CF Member, make well-informed health care decisions.

## A-305. A DEFINED SPECTRUM OF CARE

1. The CF Spectrum of Care refers to the health care benefits and services, both medical and dental, which are available and publicly funded for the CF Member. The CF Spectrum of Care includes comprehensive benefits such as physician and hospital services, supplemental benefits such as medications and vision care, occupational health benefits, preventive medicine benefits, health promotion benefits, and dental benefits. The CF Spectrum of Care document can be found on the CFHS website.

## A-306. PROMOTING PATIENT-CENTERED CARE

1. The guiding principles underlying patient-centered health care are:

a. Putting the patient at the forefront of service design; and

b. Decentralizing decision-making and the delivery of services to sub-units and work teams so as to foster a patient perspective.

2. The goal is to interpret and analyze proposed change through the eyes of the patient in the context of what a patient would ask, such as:

a. How does this improve my care and/or make it more convenient?

b. Have I already been asked this question or had this procedure done by another provider?

c. Was I greeted courteously?

d. How long is the wait for sick parade?

e. Was my appointment time respected?

f. Was I adequately prepared for my procedure?

g. Is the clinic open during lunch hour?

3. A patient-centered model ensures that the approach to the organization of activities and expenditures of resources are directed at achieving the most efficient and effective delivery of health care.

4. The CF Medical Clinic supports patient-centered care through the following:

a. Patient-satisfaction surveys;

b. Collaborative Practice and the associated case conferencing; and

c. The CF Health Record.

## A-307. OPTIMIZATION OF SELF-CARE

1. The CFHS believes that patient empowerment and optimization of self-care are important for the CF Member and the CF as an organization. The essential feature of empowerment is that the CF Member assumes a shared responsibility for managing their health. To do this, the CF Member must have sufficient information to fully understand their health condition(s) and their treatment options. It then becomes incumbent upon the CF Medical Clinic health care providers to ensure the CF Member is provided with or directed to the information required to make informed choices.

## A-308. THE CANADIAN FORCES MEMBER'S FAMILY

1. Consistent with the Department of National Defence's legal mandate, the CF Member's family receives health care from the civilian health care system in the province or territory where they are located. By exception, the CF Medical Clinic may be mandated to provide dependent care by direction of the Minister of National Defence.

2. Although the CF, for the most part, has no mandate to provide direct health care services to the CF Member's family, a number of services are in place to support the CF Member's family. The Military Family Resource Centres located at Bases across Canada and in Europe offer the CF Member's family quality of life programs and crisis intervention services. The Canadian Forces Member Assistance Program, coordinated by the CFHS, provides confidential psychological and emotional support for the CF Member and their family on a voluntary short-term basis to help with a wide variety of concerns, including:

a. Marital and family;

b. Personal and emotional;

c. Work-related, including harassment and sexual assault;

d. Interpersonal relations;

e. Stress and burn-out; and

f. Substance abuse.

3. The CF also recognizes that involvement of family members may be a necessary and appropriate part of the management the CF Member's health problems. The CF provides social work services to the CF Member and their family members, and will include family members in group therapy sessions when it is deemed in the best interests of the CF Member.

## A-309. CF CHARACTERISTICS THAT AFFECT PRIMARY HEALTH CARE DELIVERY

1. There are numerous CF traditions, policies and practices that impacted the development of the CF in-garrison primary health care system. These CF-unique characteristics present both challenges and opportunities in regard to how services can be structured compared to primary health care models in the civilian environment.

2. The CF-unique characteristics include.

a. **Sick Parade as a Tool for the Assessment of the Canadian Forces Member's Fitness for Duty**. Sick parade is a predefined period when the CF Member may present, without appointment, for assessment of health concerns of less than 48 hours duration. However, many CF members use sick parade for health concerns which have been present for well over 48 hours duration. Such use of sick parade detracts from optimal continuity of care. Nevertheless, there are many historical, cultural, demographic and occupational /operational factors that affect how and when the CF Member accesses health care. All of these factors need to be taken into account as the CFHS strives to encourage the CF Member to use scheduled appointments for their health care needs whenever possible.

b. **Requirement for Canadian Forces Health Services Personnel to be Deployable**. The CF Member is required to maintain a level of medical, dental and physical fitness consistent with their role on deployed operations. In support of this requirement, regular medical and dental examinations and other occupational health and safety assessments are mandated by policy and are an integral part of the delivery of health services in the CF.

c. **Company Doctor Role of the Canadian Forces Medical Officer.** The CF Medical Officer (MO) functions as company doctor in regard to matters of occupational health, operational support, public health and health promotion. The CF MO also has direct links and responsibilities to the operational chains-of-command. This does not preclude the need for the CF MO to advocate on behalf of their patient.

d. **Balancing the Dual Role.** For health care professionals, the two principal objectives of the CF Medical Clinic can sometimes be difficult to balance. It is akin to being both a Patient Advocate and a Company Doctor at the same time. In the role of a Patient Advocate, health care professionals must directly support the CF Member, and the CF Member must trust that their health care needs are of prime concern to the clinicians. On the other hand, Commanding Officers are tasked to carry out a mission. They must be secure in the knowledge that their personnel are medically and psychologically fit to take part in the mission. In the role of a Company Doctor, health care professionals must support the Commanding Officer by apprising them of personnel who have specific employment limitations. This imposes significant obligations upon the CF physician i.e., Medical Officer (MO) to ensure that the CF Member meets the medical fitness standards required for the specific tasks they may be assigned. Thus, the MO plays a vital role in matters such as occupational health, operational support, public health, health prevention and promotion. To accomplish this, the MO has direct links and responsibilities to the CF Member's chain-of-command.

e. **Reliance on Civilian Sector for Most Secondary and Tertiary Care**. The CFHS does not provide the full range of health services at CF installations. Hospital services, most specialist services and many diagnostic and therapeutic services are provided as required off the Base using contractual agreements. Arrangements for third party billings have been made that also apply to the use of off-Base medical clinics and General Practitioner services during evenings and weekends.

f. **Complexity of Canadian Forces Health Records**. The maintenance of health records is more complex in the CF compared to the civilian environment. This complexity is attributed to the following realities.

(1) The CF Member is transferred from one Base to another quite regularly. Records must be moved frequently and record management must be developed to incorporate a higher inflow and outflow of records than may be the case in the civilian environment.

(2) Records, or copies of records, accompany the CF Member when they go on deployed operations. Upon return, the records, complete with all of the new information from the deployed operation, must be reintegrated into the in-garrison health records.

(3) Accuracy and completeness of health records is critical. They are often the basis for adjudicating claims for disability pensions and other benefits. Sometimes claims may be made decades after a particular incident or activity. The health record is therefore an important legal, historical document.

## A-310. KEY FEATURES OF EFFECTIVE CANADIAN FORCES PRIMARY HEALTH CARE

1. There is broad based agreement on the characteristics of good primary health care systems. Characteristics applicable to the CF include.

a. **Effectiveness**. The ability to maintain or improve health.

b. **Efficiency**. The cost of services and resources required for managing a health problem or care episode.

c. **Accessibility**. Promptness and ability to visit a primary health care provider and ease of accessing specialized care and diagnostic and therapeutic services.

d. **Continuity**. The CFHS is responsible for ensuring a caring, responsive and coordinated process by which health services provided to the CF Member are integrated.

e. **Quality**. The total appropriateness and suitability of care as perceived by patients and professionals, including compliance with clinical guidelines and best practices.

f. **Responsiveness**. Consideration of and respect for the expectations and preferences of patients, health care providers and the chains-of-command.

g. **Accountability**. Accountability refers to taking responsibility for actions, decisions and behaviour. The CF Medical Clinic Model envisions clear accountability mechanisms between the CF Medical Clinic and its enrolled population and between the CF Medical Clinic and the CFHS leadership.

2. In addition to the general features listed above, Hollander Analytical Services suggests that there are 18 characteristics that one would find in the ideal primary health care model, although they are not aware of any system in Canada that fulfills all of these characteristics. The 17 applicable characteristics plus two characteristics unique to the CF and relevant comments are listed below. This structure is seen as a helpful tool for ongoing evolution of the CF Model of Care.

| | PRIMARY HEALTH CARE | THE CF MODEL OF CARE |
|---|---|---|
| 1. | Provide a comprehensive range of primary health care services via one stop access. | The CF provides a comprehensive basket of services referred to as the CF Spectrum of Care. The CF Spectrum of Care includes comprehensive benefits such as physician and hospital services, supplemental benefits such as medications and vision care, occupational health benefits, preventive medicine benefits, health promotion benefits, and dental benefits.<br><br>The CF Member is able to use a one stop shopping approach to access most of their health care needs. By virtue of their relationship with their primary health care team and the linkages between the CF primary health care team and local community health care resources, the CF Member has access through their local CF Medical Clinic to all required health care and health services. |
| 2. | Ensure access to a comprehensive range of health services. | The CF Member has access to the full spectrum of health care services that would be available to most Canadians. This includes primary health care services available to the majority of Canadians through the provincial health care system, as well as supplemental benefits similar to those available in an employer health plan. |
| 3. | Appropriate access to services 24 hours per day, seven days per week (24/7) including discipline specific on-call coverage. | During normal working hours from Monday to Friday, CF members obtain health services from a network of on-Base clinics across Canada. After hours, members are provided with a health card that facilitates access to civilian providers and institutions. When circumstances dictate, Clinic medical staff will provide on-call services, and weekend or after hours clinics. Additionally, the CF provides 24/7 access to tele-triage services via the CF Health Information Line, a toll-free service contracted to a civilian firm. |
| 4. | Discipline specific learning, collaboration and support. | The CF Medical Clinic Model mandates regular intra-disciplinary meetings. These meetings are intended to maximize learning, collaboration and support among clinicians of the same profession, regardless of where they are currently employed in the CF Medical Clinic.<br><br>There are discipline-specific Practice Leaders at the local CF Medical Clinic who are supported and guided through the CF Surgeon General's Professional Technical Network. The Practice Leaders are responsible for organizing regular inter-disciplinary meetings. |

| | PRIMARY HEALTH CARE | THE CF MODEL OF CARE |
|---|---|---|
| 5. | Interdisciplinary, Collaborative Practice teams. | The CF Surgeon General and all CF clinical Practice Leaders believe that successfully integrating the skill sets of various health care providers will lead to improved care, more efficient care and a better work environment. To this end, the CF Medical Clinic Model is centered on the Care Delivery Unit (CDU), an interdisciplinary, highly collaborative team of health care professionals that is, in turn, focused upon the needs of the CF Member and support to CF operations. Regular case conferencing occurs, which also fosters collaborative practice.<br><br>Professional collaboration is not only an opportunity to provide the CF Member with better and more complete services than could be delivered by any one professional acting independently; it also gives professionals the opportunity to learn from each other. |
| 6. | Population rostered to practice teams. | A CF roster is a list detailing the Base's Regular Force and Reserve Force units and the specific CDU to which they are assigned. The CF Medical Clinic model requires that the CF Member be rostered to a specific CDU staffed with a core team of primary health care providers.<br><br>Rostering an entire CF unit to a CDU facilitates a seamless transition when deploying the unit or a portion of the unit. The CF medical staff who normally deploy with the unit are layered into the CF unit's CDU when in-garrison. This process greatly enhances continuity of care while maintaining a close affiliation between the Unit and the CDU clinical staff. |
| 7. | Client-centered Care | A patient-centered model ensures that the approach to the organization of activities and expenditures of resources are directed at achieving the most efficient and effective delivery of health care for the patient.<br><br>The CF Medical Clinic model supports patient-centered care through the use of the collaborative practice approach and the associated case conferencing that ensures that a wide range of skills and knowledge is brought together and focused on the patient. The CF Health Care Covenant embodies the fundamental spirit of patient-centered care.<br><br>Where operational circumstances dictate, the CF Member may actually receive health care more expeditiously than would be the case in the civilian sector.<br><br>Additionally, standardized Patient Satisfaction surveys are carried out annually to measure the degree to which patients feel their care has been centered on their needs. |

| | PRIMARY HEALTH CARE | THE CF MODEL OF CARE |
|---|---|---|
| 8. | Access to a timely, integrated, continuous health record. | Continuity of care is the degree to which a series of discrete health care events are coherent, connected and consistent with the patient's health care needs. Informational continuity is one of the three dimensions of continuity of care and refers to the accessibility and use of all relevant health care information from the past to make the most appropriate care decisions with each patient.<br><br>The Canadian Forces Health Information System and Electronic Health Record support the delivery of optimal, seamless care and will ensure that patients feel secure and confident that providers are working collaboratively and have the information they require.<br><br>Pending full implementation of the electronic health record, the CF will maintain the comprehensive, integrated medical file, referred to as the CF 2034, on each CF member. The CF 2034 contains all relevant medical information captured on the member from date of enrolment to date of release. Qualified health records staff within the clinics maintains the records in accordance with national directives. |
| 9. | Continuity of care provider. | Continuity of care is one of the most vital pillars of Rx 2000. It is intended to address the need to create a caring, responsive and coordinated process by which all health services provided to the CF Member are integrated. The continuity of care process involves the CF Member, an interdisciplinary health care team, the CF Member's chain-of-command, and is supported by a continuous, comprehensive health record. Continuity of care includes continuity of provider where practicable and a seamless efficient transition of the CF Member from one care provider to another, when required. This applies to both in-garrison settings and deployed operations. The CF Medical Clinic provides continuity of care by rostering the CF Member to a team of providers, and by having a CF/Civilian care provider mix. The civilian component provides stability and the CF component provides the in-garrison to deployed operations transition.<br><br>The CF Model of Care represents a shift in emphasis away from sick parade towards scheduled appointments. This is an intentional change in the way care is provided so that the CF Member has the opportunity to develop a professional relationship with their primary care provider and receive the significant health benefits associated with improved continuity of care. |

| | PRIMARY HEALTH CARE | THE CF MODEL OF CARE |
|---|---|---|
| 10. | Accountability to funders, clients and community, including families. | Fiscal responsibility and accountability has been introduced through the approval of transparent business plans and processes, utilizing the Balanced Score Card approach. Measuring clinic performance is an integral aspect of the Medical Clinic model.<br><br>The Canadian Council on Health Services Accreditation (CCHSA) carries out regular, independent accreditation surveys of the CF Medical Clinics. The accreditation process includes reviews of accountability to clients and the broader community, including the CF Member's family. Staff Assistance Visits supplement accreditation activity by focusing more on military medicine, support to CF operations, and financial accountability of the CF Medical Clinic. |
| 11. | Citizen participation in planning, delivery and evaluation of care services. | In addition to the care provided to the CF Member, the CFHS agrees that outside stakeholder participation in primary health care is important and that, for the CFHS, this would include the following groups:<br><br>• The CF Member's family;<br>• Other Base personnel involved in care or support services e.g. Padres, Military Family Resource Center, etc.<br>• The operational unit commanders on the Base;<br>• The local civilian medical clinics and hospitals; and<br>• The local civilian community.<br><br>To this end and consistent with the requirements of the CCHSA, the CFHS and the CF Medical Clinic will work to rapidly evolve the concept of the local Leadership and Partnership Committee to ensure that the various stakeholders identified above have input into, and are kept apprised of, ongoing developments. |
| 12. | Health Promotion and Illness Prevention | All CFHS clinical staffs contribute to varying degrees to health promotion activities through patient/client education in the areas of modification of lifestyle, exercise and fitness, nutrition and weight control and stress management. The Strengthening the Forces Program has employees of the Canadian Forces Personnel Support Agency delivering health promotion programs to the CF Member under the professional technical direction of the local CF Senior Medical Authority and with oversight by the CF H Svcs Gp HQ Forces Health Protection staff.<br><br>Other illness prevention activities include Preventive Medicine, immunization, travel health advice, and a myriad of other activities. |

| | PRIMARY HEALTH CARE | THE CF MODEL OF CARE |
|---|---|---|
| 13. | Continuous quality review and improvement. | The CF Model of Care supports Continuous Quality Improvement through the use of:<br><br>• Quality teams;<br>• A risk management framework;<br>• Clinical pathways;<br>• Evidence-based clinical and management practices;<br>• Management Information System Guidelines;<br>• Performance Indicators, both clinical and managerial;<br>• Independent accreditation; and<br>• Staff Assistance Visits |
| 14. | Coordination of care including linkage to community and social services. | CFHS believes that coordinated care is achieved when care is timely and delivered in such a way that patients and providers feel secure and confident that providers are working collaboratively and with all of the information they require.<br><br>The CF Model of Care enhances health care coordination by placing the patient at the center of all health care decisions and using a team-based care-delivery approach that emphasizes a seamless flow of information and care responsibilities. The involvement of the Primary Care Nurse and the Case Manager in the management of care for those patients with complex needs, and the inclusion of a robust Mental Health department in the CF Medical Clinic Model are key components to ensuring that the CF Member who is most in need of well-coordinated care will receive it. |
| 15. | First point of contact | CF Medical Clinic reception staffs are formally trained to have a high level of customer service skills. The reception staffs ensure that the CF Member is directed to the appropriate primary care provider, and that the required information is communicated in a timely and secure manner to the primary care provider. |
| 16. | Adoption of a population health perspective | At the CF Medical Clinic and National levels, population health is concretely addressed by the:<br><br>• Analyzing the health status of CF Members through various means such as the Health and Lifestyle Information Survey;<br>• Forces Health Protection epidemiological initiatives;<br>• Providing occupational health support to specific population groups within the military such as aircrew and divers;<br>• Identification of high risk activities by the Primary Care Nurse, Community Health Nurse and the Physician;<br>• Identification of vulnerable groups such as those requiring case management; and<br>• Collection and analysis of health indicator information |

| | PRIMARY HEALTH CARE | THE CF MODEL OF CARE |
|---|---|---|
| 17. | Optimizing Self-care | The CF is committed to the principle of the CF Member playing an active role in their health and health care.<br><br>The CF Return to Work program embodies many of the principles of optimization of self-care. |
| 18. | Occupational Health and Support to Operations | One of the underlying principles of the CF Model of Care is that it requires sufficient numbers of CFHS clinical personnel with the appropriate occupational health and operational medicine qualifications to meet the unique and special needs of the rostered population and their unit commanders.<br><br>The requirement for Civilian clinicians to be knowledgeable about occupational health and support to the CF operation is supported by a robust orientation program for these clinicians that includes, to the extent possible, familiarization training with the operational units on the Base.<br><br>Support to the CF operational chains-of-command is one of the major objectives of the CF Medical Clinic Model and is achieved through the following:<br><br>• Clearly defined communication protocols between Clinic staff and the operators;<br>• Greater involvement of CFHS staff in Base operations and training activities;<br>• Ensuring that there are sufficient numbers of CFHS clinical personnel with the appropriate occupational health and operational medicine qualifications; and<br><br>Additionally, the Medical Officer weekly schedules reflect the requirement for Medical Officers to routinely visit the operational and training units on Base and, where appropriate, to participate in unit activities. |

| | PRIMARY HEALTH CARE | THE CF MODEL OF CARE |
|---|---|---|
| 19. | Professional Development | By virtue of the nature of the professionals it employs and the profound responsibilities assumed by these professionals, the CFHS has a significant responsibility to ensure that clinicians are provided with the necessary professional development and training opportunities required to meet their responsibilities.<br><br>There are five components to professional development supported by the CF:<br><br>• Maintenance of Clinical Skills Program;<br>• Occupational Training;<br>• Continuing Professional Education (CPE);<br>• Intra-disciplinary meetings; and<br>• Regular involvement with operational units.<br><br>With respect to the extent to which Civilian clinicians need to be knowledgeable about occupational health and support to CF operations, the following distinction is made:<br><br>• CF Clinicians - need to be involved in the activities of operational and training units on the Base.<br><br>• Civilian Clinicians - need to understand the activities being conducted on the Base. |

**Figure A-3-1, Characteristics of Primary Health Care Relevant to the Canadian Forces**

## CHAPTER A-4

# LEADERSHIP OF THE CANADIAN FORCES MEDICAL CLINIC

### A-401. COMMAND AND CONTROL OF CF MEDICAL CLINICS

1. The Commander Canadian Forces Health Services Group (Comd CF H Svcs Gp) exercises command over all CF Health Services (CFHS) units, including all CF Medical Clinics designated as such. To affect local command and control, the Comd CF H Svcs Gp will appoint an officer to be the Commanding Officer (CO) of each CFHS Unit. By appointment and specific designation, the CO will be empowered with the powers of a CO in accordance with Queens Regulations and Orders for the Canadian Forces. Each CO is responsible and accountable either directly to Comd CF H Svcs Gp, or to a subordinate CFHS formation-level Commander i.e., H Svcs Gp Comd for the efficient and effective command, control and management of their unit.

### A-402. GOVERNANCE OVERVIEW

1. Governance refers to the exercise of authority, direction and control of an organization in order to ensure its mandate is achieved. Governance also often includes the communication channels into, out of, and within an organization that allow representatives of all of the key stakeholders to be meaningfully engaged and to participate in the major decisions affecting the organization. It is the means by which the leaders of an organization are accountable to those whose lives are most affected by the decisions of the leaders.

2. Governance, from the CF Medical Clinic perspective, is intended to answer very specifically the following questions:

- Who is in charge of What;
- Who sets the direction and the parameters within which the direction is to be pursued;
- Who makes decisions about What;
- Who sets performance indicators, monitors progress and evaluates Results; and
- Who is accountable to Whom for What?

### A-403. THE GOVERNANCE MODEL

1. Providing health services to the CF Member and supporting the CF Member's chain-of-command is a common objective exercised by command and staff personnel at three levels within the CFHS, national-level i.e., CF H Svcs Gp HQ, formation-level i.e., the H Svcs Gp HQ, and tactical-level i.e., the CF Medical Clinic. Role clarity is important at each level of the organization in order to eliminate confusion and maximize performance.

2. The role of the CF Medical Clinic is to deliver health services to the CF Member and support the CF Member's chain-of-command. The role of the CFHS Formation-level HQ is to address how CFHS internal resources, contractors and civilian partners can best meet CF needs. The CFHS National-level HQ defines the type and scope of health services that can best meet the CF Member's needs, the standards for these services, and provides the resources required. The CF Medical Clinic, the CFHS Formation-level HQ, and the CFHS National-level HQ each have a specific mandate, set of responsibilities and organizational structure.

3. The CF Medical Clinic role is to meet the health care needs of the CF Member and those of the CF, i.e., corporate requirements. In doing so, the CF Medical Clinic executes the plans, policies and procedures approved by its CFHS Formation-level HQ and the CF H Svcs Gp HQ. Certain CF medical clinics also have regional i.e., sector responsibilities to detachment sites in their geographic region/sector. The CF Medical Clinic with regional/sector responsibilities is

responsible for care delivery or coordination of care delivery for the CF Member at their designated detachment sites, and for coordination and continuity of service for the CF units/formations it directly supports. From the CF Medical Clinic perspective, the essence is do it, measure it and improve it.

4. The CFHS Formation-level HQ role is to support their CF Medical Clinics as they carry out their roles of meeting the health care needs of the CF Member and those of the CF. In doing so, the CFHS Formation-level HQ is the Management Unit that supports the cluster of CF medical clinics in their CFHS formation and executes plans, policies and procedures approved by CF H Svcs Gp HQ. The CFHS Formation-level HQ integrates the strategies established by CF H Svcs Gp HQ with CF operations. Within the overall direction set by the Comd CF H Svcs Gp, through CF H Svcs Gp HQ planning and policy and standard setting processes, CFHS formation-level managers have the responsibility to plan and allocate CFHS resources, including professional and technical resources, to achieve the mandated in-garrison health care and health services in their Formation. At the CFHS Formation-level HQ, the essence is how it gets done, who will do it, and how can we integrate the best practices and skills of our personnel.

5. Similar to the CF Medical Clinic and the CFHS Formation-level HQ, the CF H Svcs Gp HQ role is to meet the health care needs of the CF Member and those of the CF. In doing so, the CF H Svcs Gp HQ supports the CF Medical Clinic and the CFHS Formation, and manages all health services as an integrated system. The operating principle at CF H Svcs Gp HQ is deciding what is to be done, to what standard, and integrating best practices and skills of all personnel.

## A-404. A DYNAMIC LEADERSHIP TEAM

1. The CF Medical Clinic Manager, Base Surgeon and Clinic Warrant Officer are the CF Medical Clinic leadership team, with shared responsibility and accountability for the successful operation of their Clinic. The requirement for an effective, synergistic relationship between the CFHS chain-of-command, the CFHS Professional Technical (Prof Tech) Network, and the HQ staff at each organizational level within the CFHS is critical. Fundamental to this essential requirement and paramount to the successful execution of the medical mission at the CF Medical Clinic, is the dynamic partnership that must exist between the Clinic Manager, Base Surgeon and Clinic Warrant Officer. Although clear Terms of Reference and opportunities to participate together in leadership training exercises can support the establishment of an effective relationship, they cannot replace the essential ingredients of a shared professional commitment to doing what is best for the CF Member and the CF Member's chain-of-command. Effective leadership and mentoring from their respective CFHS Formation-level HQ superiors contributes to the success of the dynamic leadership team.

## A-405. THE CLINIC MANAGER

1. The CO of the CF Medical Clinic, designated a CFHS Unit, is known as the Clinic Manager (CM). The CM is responsible for the overall delivery of health care and health service programs within the designated geographical area of their Clinic, including detachment sites. The CM is also responsible for their Clinic's efficient and effective day-to-day operation and for maintaining accreditation standards. The responsibility for providing leadership and expertise in the overall planning, coordination, implementation and evaluation of all programs and services provided to the CF Member in their designated area of responsibility, is within the CM's scope of responsibilities. In addition, the CM is accountable for the successful and fiscally responsible operation of their Clinic.

2. The CM creates the organizational culture and environment whereby the Clinical Team, led by the Base Surgeon, works at achieving the CFHS objective of providing quality care and service to the CF Member and support to the CF Member's chain-of-command.

3. The CM takes a leadership role in embodying the Comd CF H Svcs Gp vision, mission and values and encourages the same from all their Clinic's staff.

4. The CM is under the direct supervision of their CFHS Formation Commander, but is also responsive to the supported Base and Unit chains-of-command, and to CF H Svcs Gp HQ Deputy Chief of Staff for Health Services Delivery. During periods when the Clinic Manager is away, the Base Surgeon will normally be assigned the Acting Clinic Manger role.

## A-406. THE BASE SURGEON

1. The Base Surgeon is responsible to ensure high-quality clinical care and services are provided to the CF Member. To this end, the Base Surgeon provides Prof Tech oversight of all clinical activities required for efficient and effective delivery of health care services at the Clinic, including its detachments.

2. The Base Surgeon advises local commanders on all health matters affecting the supported Unit/Base/Formation. The Base Surgeon coordinates, through a multidisciplinary approach, the clinical programs, primary and specialist, and associated medical administrative processes related to the delivery of health care in the Clinic.

3. The Base Surgeon is also responsible to ensure that the clinical staff maintain the professional standards of clinical practice and approved processes are followed for all clinical programs and services. The Base Surgeon promotes the CFHS vision and values and leads the Clinical Team towards that vision.

4. The Base Surgeon may designate one of the senior Medical Officers to be the Deputy Base Surgeon. The role of the Deputy Base Surgeon is to assist the Base Surgeon in fulfilling the prof tech and administrative duties. Generic Terms of Reference for the Deputy Base Surgeon position are available on the CFHS website.

## A-407. THE ROLE OF THE CLINIC WARRANT OFFICER

1. The CF Medical Clinic Warrant Officer has both a leadership and a clinical role in the Clinic. The leadership role is in the context of being a member of the Clinic's leadership team and working collaboratively with the CM and the Base Surgeon to provide the vision and day-to-day guidance for the Clinic's staff. The clinical role is fulfilled through regular employment as a Physician Assistant within a Care Delivery Unit.

2. The Clinic Warrant Officer's time will be divided equally between the leadership and clinical roles. Some of the specific tasks in each of these roles are listed below.

a. **Leadership and Administrative Role**

(1) Advising the Base Surgeon on CFHS Non-Commissioned Member (NCM) standards of practice;

(2) Advising the CM on organizational issues of culture, morale, dress, deportment and discipline, etc.;

(3) Liaising with Career Managers, their immediate superior CFHS headquarters and Base staff on matters of personnel development and the Clinic's performance;

(4) Mentoring the Clinic's NCMs; and

(5) Overseeing the Clinic's NCM performance evaluation process.

b. **Clinical Role**. Maintaining clinical excellence across their scope of practice by:

(1) Providing direct patient care to the CF Member presenting to the Clinic;

(2) Participating in other clinical activities in accordance with the CFHS Maintenance of Clinical Skills Program; and

(3) Serving as the Clinic's Physician Assistant and Medical Technician Practice Leader.

## A-408. CANADIAN FORCES HEALTH SERVICES GROUP CHAIN-OF-COMMAND

1. **Commander Canadian Forces Health Services Group**. The Comd CF H Svcs Gp is ultimately accountable for the delivery of health care in the CF and to force generate trained CFHS personnel in support of the CF mission. To best exercise this accountability and authority, a unified CFHS chain-of-command was approved in 2001 into which most CFHS personnel are assigned. Individual CFHS units report to the Comd CF H Svcs Gp either through a CFHS formation-level command i.e., the H Svcs Gp or directly to the national-level command i.e., CF H Svcs Gp through the Deputy Commander (DComd) CF H Svcs Gp. The Comd CF H Svcs Gp has the powers of a Commander of a Command and reports to the Assistant Deputy Minister Human Resources (Military) (ADM HR (Mil)) at the national-level i.e., National Defence Headquarters (NDHQ). Commanders of subordinate CFHS formations have the powers of a Formation Commander. Commanders of subordinate CFHS units have the powers of a Commanding Officer.

2. **Commander Canadian Forces Health Services Group Staff**. The Comd CF H Svcs Gp is supported at the national-level by a robust staff of subject matter experts, including the Prof Tech Networks for the CF medical and dental services, which assist the Comd in discharging his/her duties. The CF H Svcs Gp HQ operates as a matrix organization. Certain functional staffs, such as Health Services Delivery and Forces Health Protection, bypass the CFHS formation-level HQ when directing clinical activities specifically related to the delivery of health services or health protection. Although the CF Medical Clinic does not report to the matrix staffs from a command and control perspective, the CF Medical Clinic is, however, responsive to them. The CF H Svcs Gp HQ staffs provide advice and guidance to the Comd and his/her subordinate HQs/units but the CF H Svcs Gp HQ staffs have no formal command authority. Command authority rests with the Comd and is exercised on a day-to-day basis by the DComd CF H Svcs Gp.

3. **Clinics Reporting To Regular Force Field Ambulances**. At Bases that have a Regular Force Field Ambulance, Medical Officers (MO) will be preferentially assigned a Unit affiliation and leadership role in the Field Ambulance. It is anticipated that the Field Ambulance leadership role will preclude the MO from taking on any additional leadership responsibilities within the CF Medical Clinic structure. At these sites, the CF Medical Clinic Care Delivery Unit (CDU) may be led either by an MO who has not been assigned a Field Ambulance position, or in one of the following ways:

a. The Primary Care Services Manager directly supervises the CDU staff; or

b. The Primary Care Nurse in the CDU becomes the administrative and management leader, while a civilian physician acts as the Senior Medical Authority of the CDU.

4. **Clinics with Formation-level Responsibilities**. The three CF Type V Medical Clinics (Esquimalt, Ottawa and Halifax) commanded by a Lieutenant-Colonel report directly to the DComd CF H Svcs Gp. In addition to their responsibility to provide direct patient care to personnel in their geographic area of responsibility, they must also provide health services support to the formation-based or national-level HQ that they support. Also, they must perform all of the personnel management i.e., G1 functions, and planning and preparation functions in

support of operations i.e., G3 functions of a CFHS formation-level HQ. To that end, additional personnel to assist with the command, control and administration of personnel and resources have been added to these units.

## A-409. RELATIONSHIP TO THE OPERATIONAL CHAINS-OF-COMMAND

1. Fundamental to providing quality health services is the need to support the CF operational chains-of-command. The operational chains-of-command must have confidence that the CF Member's health care needs are being looked after and that they are receiving the information that they need to accomplish their mission. Specifically, the Senior Medical Authority must ensure that the clinicians under their responsibility provide accurate and timely information to the CF Member's chain-of-command in keeping with the policies on confidentiality of medical information. The CFHS Command Authority must ensure that the clinicians under their command are given every opportunity to meet the demands of the CF operational chains-of-command and that the health care needs of the organizations they support are being met. Where difficulties arise, they are to seek the appropriate assistance from a higher authority within the CFHS chain-of-command.

## CHAPTER A-5

# THE PROFESSIONAL TECHNICAL NETWORK

### A-501. OVERVIEW OF THE PROFESSIONAL TECHNICAL NETWORK

1. The Professional Technical (Prof Tech) Network is the professional accountability structure through which the Canadian Forces (CF) Surgeon General ensures that the CF medical services are meeting a high clinical and professional standard. The Prof Tech Network also provides an interconnected support framework for medical clinicians that promotes continuous learning and allows for timely response to the needs of the CF operational chains-of-command.

2. In order to understand the functioning of the Prof Tech Network within any given CF Medical Clinic, it is helpful to understand the overall structure of the Network. Further amplification of this subject can be found at Annex C.

### A-502. SENIOR MEDICAL AUTHORITY

1. Senior Medical Authority (SMA) is the generic term applicable at any level to the individual holding Prof Tech authority over all aspects of health services, less dental support. This individual is also the person responsible for provision of medical advice to the supported Commander(s). At the highest level i.e., the CF, the SMA is the CF Surgeon General. For each of the three CF Environments, the Senior Medical Authority is the Environmental Chief of Staff Medical Advisor. For a Formation-based Command, it is the Formation Surgeon. At Base level it is the Base Surgeon. For a deployed Joint Task Force it is the Joint Task Force Surgeon.

**Note:** While the SMA is normally a Medical Officer (MO), the term may also be used to refer to a Nurse Practitioner (NP), Physician Assistant (PA) or Medical Technician (Med Tech) where that person is the best-qualified individual either integral to or in support of a particular CF element. One obvious example of this is the PA on the crew of a submarine or frigate; another would be the senior Med Tech at the CF Type I or Type II Medical Clinic without a MO. In extenuating circumstances, it may be appropriate to designate a civilian physician as the SMA on a temporary basis.

### A-503. PRACTICE LEADERS

1. Practice Leader (PL) is the generic term applicable at any level to the individual from any given health service discipline, such as Nursing, Pharmacy, Physiotherapy, Laboratory Technician, Diagnostic Imaging Technician, Med Tech, etc., who is the technical authority at that level for their discipline. PLs are responsible for identifying and resolving discipline-specific Prof Tech issues. They will provide advice on maintenance of clinical skills activities, continuing professional education and other aspects of training and employment of personnel within their discipline.

2. At Base level, the PL will also usually be the overall team leader for that service, although this is not necessarily true of those disciplines such as Nursing whose practitioners work in more than one element of the CF Medical Clinic.

3. The Prof Tech Network also requires that PLs be designated at formation and environmental command levels. These individuals will be selected by the corresponding SMA in consultation with the National Practice Leader for that discipline. PL appointments at these levels are secondary duty appointments. Normally an individual appointed as a PL for a given CF Environmental Command will also be the CFHS Formation-level PL for their discipline and the

Base-level PL at the Base where they work. PLs may be civilians, although at higher levels efforts should be made to maximize use of CFHS personnel in this role.

## A504. NATIONAL-LEVEL STAFFS

1. The final key component of the Prof Tech Network is the National-level i.e., central staffs of subject matter experts. These include the National-level PLs, particularly for the clinical specialties, and also CF and civilian experts in the fields of Forces Health Protection, Operational Medicine, Medical Policy development and Medical Standards application.

2. To ensure the timeliest support, Prof Tech issues that require the advice of the National-level expert staffs should be raised quickly to that level, with intermediate levels of the Prof Tech Network being kept informed of both the query and the response. This imperative must be tempered, however, with the need to avoid burdening the national-level staffs with innumerable minor questions. Particularly to be avoided is the asking of essentially the same question by different Bases at different times, each unaware of the fact that someone else has already asked. Appropriate informing of offices of collateral interest on all communications will help avoid this. Further, those originating questions should check with their next higher-level of the Prof Tech Network to confirm whether or not direction or guidance has already been issued on the topic before raising an issue to the National-level staff.

## A-505. PROFESSIONAL TECHNICAL NETWORKING AT BASE LEVEL

1. The Base Surgeon has broad responsibility for all Prof Tech aspects of health care on their Base, and Bases supported by any of their Clinic's detachments. The Base Surgeon implements, and monitors compliance with, clinical policy and guidance originating from National-level staffs and from superior levels of the Prof Tech Network. The Base Surgeon provides feedback up the Prof Tech Network on the impact of Prof Tech policies.

2. The Base Surgeon is the local standard of practice authority for both CF and civilian providers, and as such must review the qualifications and skills of civilian clinical personnel before such persons are hired. Should the Base Surgeon have reason to doubt either the technical or ethical conduct of any practitioner, they should consult in confidence with their Formation Surgeon, who has the authority to temporarily restrict the scope of practice of any clinical person, although they have no power over a professional's license to practise. While the Base Surgeon cannot direct the imposition of administrative career sanctions such as Recorded Warning or Counselling and Probation, their clear representation to their Clinic Manager (CM) of the need for such intervention will be given significant weight.

3. The Base Surgeon acts as a mentor to their MOs, and advises all practitioners on the special CF context and demands present at their particular base. They must work with Base-level PLs and their CM to ensure that clinical skills of all personnel are optimized, and that planned Maintenance of Clinical Skills Program activities respect the guidelines and are undertaken in the spirit of promoting operational readiness. Continuing Professional Education activities can be somewhat broader in content but must nonetheless be of benefit to the provider and the CF.

4. The Base Surgeon has overall responsibility for the provision of accurate, timely and clear medical advice to the chains-of-command they support. They will normally be the individual to whom the local Commander turns when he or she feels there has been any problem with information flow.

5. The Base Surgeon is the key to successful management of patient complaints. All issues raised to the Base Surgeon must be carefully considered in the context of Medical Services Instruction CF 3000-003, and in the recognition that the longer complaints are left unaddressed, the more difficult it will be to reach a fair and satisfactory resolution for all concerned.

6. The Base Surgeon needs the support of their PLs in carrying out their responsibilities, and should consult with them frequently. In this way, patient care will be improved, and work satisfaction of all health care providers will be supported. Interdisciplinary meetings, both for continuous learning purposes and to address current issues, must be a regular feature of professional life at the CF Medical Clinic.

## A-506. SCOPES OF PRACTICE

1. It is fundamental to the functioning of the CF Medical Clinic that all clinical practitioners operate within their profession's accepted scope of practice. Indeed, all practitioners have an ethical duty to ensure that their actions remain within their scope of practice; and the SMA must satisfy themselves that this is the case.

2. Where scopes of practice may have areas of overlap, such as is the case for Physician Assistants, Nurse Practitioners and to some extent General Duty Medical Officers, the potential exists for one profession to feel their skills are not being fully exploited, and that they themselves are not respected as professionals. The SMA must be alert to such sensitivities and take steps to ensure that all concerned are aware of each other's capabilities. Clinical pathways are one tool that may be used to ease these tensions in managing conditions relevant to a particular Base or to the CF as a whole. A commitment to Collaborative Practice will further limit conflicts arising from overlapping scopes of practice.

## A-507. DISPUTE RESOLUTION

1. For Base-level disputes of a Prof Tech nature involving two or more PLs, the Base Surgeon is the Prof Tech authority. For issues where a PL is not satisfied with the position taken by the Base Surgeon, the issue should be raised to CFHS formation-level for adjudication, and subsequently to the Environmental Command level if the CFHS formation-level response is felt by any party to be insufficient.

2. The final authority for all health services Prof Tech issues, less dental, rests with the CF Surgeon General who has wide latitude to decide with whom to consult before reaching a decision. For issues of broad concern, involving several clinical disciplines, the CF Surgeon General's Practice Leaders Forum will normally be involved. However, for single discipline issues the CF Surgeon General may consult only with the National Practice Leader of that discipline. The CF Surgeon General, prior to issuing direction on a clinical issue, may also undertake consultation external to the CF.

3. Regardless of level, the SMA must weigh issues on the basis of the best interests of the patient and the CF, evidence-based principles and consistency in policy application and interpretation prior to providing Prof Tech direction.

4. Where the Base Surgeon and CM are in conflict over an issue and cannot resolve it locally, either must raise it party to the next higher-level, where the CFHS Formation Commander and the CFHS Formation Surgeon will discuss the appropriate response. While Command Authority rests with the CM and the CFHS Formation Commander, it could be perceived that the Base Surgeon cannot win such a dispute. In fact it is clear that the CFHS chain-of-command exists to support and facilitate the Prof Tech Network in providing clinical care. Viewed in this way, the moral authority of the Base Surgeon is considerable since it is based on their command of clinical knowledge applied in support of the CF Member.

## A508. AUTHORITY TO PERFORM PERIODIC HEALTH ASSESSMENTS, GRANT MEDICAL EMPLOYMENT LIMITATIONS AND AWARD SICK LEAVE

1. The Table at Figure A-5-1delineates the authorities of various practitioners to conduct Periodic Health Assessments (PHAs), award sick leave, and to impose medical employment limitations, whether through a period of light duties documented on a CF 2018 or through a temporary or permanent medical category change.

2. The Table at Figure A-5-1 includes the CF Surgeon General approved guidelines for regarding the degree of authority that may be devolved by the Base Surgeon to health care professionals in their Clinic in terms of assigning medical employment limitations and awarding sick leave. It should be noted that the table contains the upper limits of this authority.

3. The Base Surgeon is responsible for ensuring that individuals are capable of properly exercising any authority that they may be granted within the limits prescribed in the table below.

| Profession | PHA | Light Duties | Excused Duty | Sick Leave | Temporary Category | Permanent Category |
|---|---|---|---|---|---|---|
| Medical Officer (MO) | X | X | X | X | X | X |
| Civilian Physician | X | X | X | X | X | X |
| Nurse Practitioner (NP) | X | Up to 14 days + one extension. | X | See footnote[1] | See Footnote[2] | |
| Physiotherapist | | Up to 14 days + one extension. | X | | | |
| Physician Assistant (PA) | X | Up to 14 days + one extension. | X | | See Footnote[2] | |
| Medical Technician | | Up to 5 days. | X | | | |

**Figure A-5-1, Authorities to Perform Periodic Health Assessments Grant Medical Employment Limitations and Award Sick Leave**

[1] QR & Os state that only a physician, either military or civilian, can grant sick leave. Nevertheless, there are occasions when in the conduct of their normal duties NPs may decide that a period of sick leave should be prescribed for a CF member. Until QR&Os can be amended, Base Surgeons may elect to create a process whereby NP recommendations for up to 14 days sick leave are counter-signed by a physician.

[2] CF members should not normally be booked for a medical appointment with either a PA or an NP where it is anticipated that there will be a requirement for a change of medical category. The only exception to this rule is for specifically identified self-limiting medical conditions, such as pregnancy. The list of conditions for which PAs and NPs may assign a Temporary Category is contained in their respective Scope of Practice Guidelines found on the CFHS website. It is also recognized that during the course of conducting a routine PHA, it may become clear to the PA or NP that a change in category is warranted. In these instances, the PA or NP should complete the Temporary Category Medical documentation, but it must be counter-signed by a physician before being sent to the local approving authority.

## PART B – THE CANADIAN FORCES MEDICAL CLINIC MODEL

## CHAPTER B-1

# OVERVIEW OF THE CANADIAN FORCES MEDICAL CLINIC MODEL

### B-101. A CARE CONTINUUM

1. **General**. The provision of health services to the Canadian Forces (CF) Member encompasses all aspects of their care from their date of enrolment to their date of release, including transitioning the CF Member to other health care resources upon release. To facilitate coordination, The CF Medical Clinic staff must either provide or coordinate the full range of health services, including pre-hospital care, primary care, specialist services, hospitalization, rehabilitation, and when necessary, palliative care. Delivering this broad range of services in a coordinated approach supports the concept of a Care Continuum.

2. **Pre Medical Treatment Facility Care**. Consistency with best-practice identified in the civilian health care sector has the CF Health Services (CFHS) moving away from current practices to the provision of emergency medical care prior to casualty presentation at a medical treatment facility (MTF) through a layered system of response utilizing Military Police (MP), Department of National Defence (DND)/CF Fire Fighters, and where appropriate, CF ambulance i.e., medical evacuation resources. To facilitate emergency medical care prior to casualty presentation at the MTF and to enhance its in-garrison First Response capability, the CF will provide standardized Emergency Medical Responder (EMR) training to all DND/CF Fire Fighters and MP personnel.

### B-102. DEPARTMENTAL STRUCTURE

1. The CF Medical Clinic has been organized into a departmental structure that best supports the provision of health care services and support to the CF operational chains-of-command. The departments include:

   a. Primary Care Services;

   b. Diagnostic and Therapeutic Services;

   c. Mental Health Services;

   d. Support Services;

   e. In-Patient and Surgical Services (only at select CF Type V Medical Clinics); and

   f. Operations and Training.

2. The departmental structure is a functional structure i.e., at smaller sites, two or more departments may be combined under one manager. A first-line manager who reports directly to the Clinic Manager (CM) leads the Department.

### B-103. PROFESSIONAL MANAGEMENT

1. At the CF Medical Clinic level, the administrative responsibility for health services has shifted from the Base Surgeon, whose primary area of responsibility and expertise is that of Professional Technical (Prof Tech) leadership, to the Clinic Manager (CM) and a team of intermediate-level managers whose primary skill set is the administration of health care services.

2. The intermediate-level manager's major responsibility is to facilitate quality patient care. They must directly support the Clinical Team to ensure the delivery of safe, competent, ethical and coordinated patient care within their respective Department. Managers at the CF Medical Clinic enable the clinical professionals to carry out their complex roles while fostering professional growth and maintenance of clinical skills. Intermediate-level managers must create a practice environment that supports their staffs' ability to interact in ways that deepen collegial relationships and create a strong sense of team.

3. All managers at the CF Medical Clinic must understand that their principal function is to be an enabler, supporting the delivery of direct patient care by clinicians. In this context, it should be far more common for the Manager to be "taking away" administrative tasks from clinicians rather than assigning such tasks. Terms of Reference for managers must be clearly written to reflect this fact and the CM must ensure that their Clinic only employs managers who understand this fundamental principle and act accordingly.

4. In order to strengthen management competencies at all levels within the CF Medical Clinic, educational initiatives have been implemented and mentoring programs established. A key component of the CF Medical Clinic Model is the requirement for the CM to achieve and maintain Certified Health Executive status through the Canadian College of Health Services Executives.

5. The CM reports through the CFHS chain-of-command to the Commander CF Health Services Group (Comd CF H Svcs Gp), but also needs to maintain communication with the other CF chains-of-command on their Base to ensure that the services provided support operational needs. The Base Surgeon reports to the CFHS chain-of-command via the CM, and to the CF Surgeon General through the Prof Tech Network.

## B-104. ROLE OF DEPARTMENTAL MANAGERS

1. **Primary Care Services Manager**. The Primary Care Services Manager's scope of responsibilities may include:

a. Appointment scheduling, on and off site;

b. Case management services;

c. Comprehensive care planning;

d. Comprehensive primary care services provided on-site, including on-call clinician;

e. Consideration, when applicable, of care to transient population;

f. Coordination of access to off site health services;

g. Immunization clinic and individualized health promotion programs;

h. Managing at least one CDU; and

i. Urgent care services provided during normal service delivery hours.

**Note:** At the CF Type IV Medical Clinic, a civilian manager typically fills the role of Primary Care Services Manager (PCSM) whereas a Major Nursing Officer may fill this role at the CF Type V Medical Clinic.

2. **Diagnostic and Therapeutic Services Manager.** The Diagnostic and Therapeutic Services Manager's (DTSM's) scope of responsibilities may include:

a. Diagnostic Imaging services provided on site;

b. Laboratory services provided on site;

c. Ophthalmology/Ears, Nose and Throat services provided on site;

d. Pharmacy services;

e. Physiotherapy services provided on site;

f. Community Health Nurse services provided on site;

g. Administrative requirements of the Preventive Medicine Service; and

h. Specialist services provided on-site.

**Note:** At the small CF Type IV Medical Clinic, the PRIMARY CARE SERVICES MANAGER and DTSM roles are combined. The combined function may be designated Clinical Services Manager. At the larger CF Type IV Medical Clinic and at the CF Type V Medical Clinic, a civilian manager fills the role of DTSM.

3. **Support Services Manager**. The Support Services Manager's scope of responsibilities may include:

a. Facility management;

b. Financial management;

c. Logistic support;

d. Health Records management;

e. Human Resources management, CF, civilian employee and contracted;

f. Information Management/Information Technology services;

h. Clinic Orderly Room services;

i. Safety programs in conjunction with the supporting Base;

j. Security services.

**Note:** At the CF Type III Medical Clinic and the CF Type IV Medical Clinic, an experienced Captain Health Care Administrator (HCA) normally fills this role. At the CF Type V Medical Clinic an experience Major HCA normally fills this role.

4. **Mental Health Services Manager**

a. In settings where Mental Health (MH) services are sufficiently large, a separate MH Manager and administrative support structure may exist. At smaller CF medical clinics and those that do not have an on-site Operational Trauma and Stress Support Centre program, the MH team will have a Team Leader. The MH Team Leader reports to the DTSM administratively and to the Base Surgeon for Prof Tech matters.

b. Prof Tech leadership is provided in accordance with the provisions of the CFHS Professional Technical Concept Paper. When applied to the interdisciplinary MH care delivery system this identifies a need for two overarching Prof Tech leaders. One leader is responsible for the Prof Tech aspects of the Psychosocial Service and one is responsible for the Prof Tech aspects of the MH Services in the CF Medical Clinic where both services exist. The CF Medical Clinic will also have identified Practice Leaders for each of the MH disciplines existing therein. Programs that comprise MH Services may have program leaders whose function is to provide Prof Tech oversight of the more specialized care provided by their program. In this way, a network of clinical leadership exists to support the care provided by MH practitioners.

## B-105. THE ROLE OF TEAM LEADERS

1. Where there is a small group of individuals working together in a department, it may be appropriate to designate one of them as the team leader. Normally the person designated as the Team Leader for a section will also act in the capacity of Practice Leader for their discipline.

2. The Team Leader plays a pivotal role in the delivery of health care. They are in a unique position of managing resources, people, material and time, to promote the delivery of quality health care. In addition to managing the current status, they are also able to challenge it by identifying opportunities for process improvement, implementing those improvements and then sustaining the benefits gained.

3. The CF as a learning organization realizes that leaders need to become coaches who draw upon the experience, insight and intelligence of their colleagues. Team leaders are viewed as facilitators who encourage and empower their staff to solve problems and make decisions. To achieve this, the Team Leader needs skills in the areas of emotional intelligence, personnel management and process thinking.

## CHAPTER B-2

# Pre-Hospital Care Services

### B-201. INTRODUCTION AND OVERVIEW

1. The CRS review of in-garrison health care services in 1999 found that there were inconsistencies and deficiencies in the provision of pre-hospital medical emergency care across the CF. The CRS review stated that the Surgeon General should have overall responsibility for ensuring that CF members have access to pre-hospital care comparable to the average Canadian.

2. The CF EMS System is not a stand-alone structure. In fact, wherever possible, the CF will be utilizing existing civilian 911 and EMS Systems for the provision of pre-hospital care. However, if the response times or the level of care provided by the civilian system are judged to not meet the standard referred to above, then the system will be augmented with CF EMS resources to ensure an acceptable standard is achieved. CF Medical Clinic personnel need to be familiar with all aspects of pre-hospital care response and the EMS System, including disaster response.

3. The provision of pre-hospital medical emergency care to CF members is through a layered system of response utilizing CF Military Police (MP), DND/CF Fire Fighters, and where appropriate, CF medical ambulance resources. This arrangement has been formalized through a Service Level Arrangement (SLA) between the CFFM/CFPM and the DGHS. The SLA confirms that the Surg Gen is the authority on all medical matters as it pertains to pre-hospital care for medical first response by non-medical MOC personnel. Non CFHS personnel involved in pre-hospital care must adhere to all medical directives and instructions that may be issued by the Surgeon General in order to ensure appropriateness and consistency of medical emergency care at all levels within the EMS System.

### B-202. TRAINING.

1. The CFHS is providing standardized Emergency Medical Responder (EMR) training to all DND/CF Fire Fighters in accordance with the Paramedic Association of Canada (PAC) National Occupational Competency Profiles (NOCP). Additionally, Military Police training is in accordance with the RCMP Emergency Medical Responder Training Program. This training will be provided through a train-the-trainer system that will see national EMR Master Instructor Trainers located regionally and an Instructor Trainer with a number of Instructors located on each Base. These instructors will be responsible for training both Fire Fighters and Military Police. Training and MCSP will be coordinated through the HS Del Quality Improvement Section. This coordination is designed to ensure consistent training and MCSP, as well as the provision of patient care consistent with evolving best practice. This structure will not remove the authority or responsibility of B Surgs to monitor patient care services within their areas of responsibility. It will however, prevent unnecessary involvement and workload by B Surgs and local clinical personnel in the strategic monitoring and planning of pre-hospital care training and MCSP.

**B-203. EQUIPMENT**.

1. EMR equipment in police cruisers and firefighting vehicles; and medical emergency equipment in ambulances is now being standardized across the CF. Automated External Defibrillator (AED) equipment has now become commonplace in both the medical professional and layperson arenas within North America. AEDs are now found on all ambulances, virtually all designated EMR vehicles, and in many police vehicles across Canada. To follow best practice and remain consistent with the care available to the average Canadian, AEDs are being procured by the CF. Additionally, CF EMS communications are being made compatible with civilian communication systems to ensure effective interoperability.

## CHAPTER B-3

# PRIMARY CARE SERVICES

### B-301. OVERVIEW AND ORGANIZATIONAL STRUCTURE

1. The Primary Care Services Manager(PRIMARY CARE SERVICES MANAGER) reports directly to the Clinic Manager (CM). Primary Care Services include the Care Delivery Units, the Urgent Care Service, the Case Management Service and the Community Health Nurse. Each Care Delivery Unit is under the leadership of a Medical Officer (MO).

### B-302. THE CARE DELIVERY UNIT

1. At the core of the CF Model of Care is the Care Delivery Unit (CDU). The CDU is an interdisciplinary team of Canadian Forces (CF) and civilian health care providers who work consistently with each other in a collaborative manner to provide the services that were previously provided in isolation i.e., in a stovepipe fashion. The CDU Team is focused on meeting the in-garrison health needs of its rostered CF Members and Units, ensuring seamless Continuity of Care over time. The CDU civilian staff consists of Physicians, Nurse Practitioners (NPs), and administrative support staff. The CF staff includes MOs, Primary Care Nurses (PCNs), Nurse Practitioners (NPs), Physician Assistants (PAs), and Medical Technicians (Med Techs).

2. The CF Member has easy access to all health services on and off their Base, with the CDU administrative support staff providing reception, registration and appointment-booking functions.

### B-303. ROSTERING

1. **Introduction**. Rostering in the civilian health care environment involves individual members of the public registering with a physician or physician group for the purposes of obtaining non-emergency medical care exclusively through that physician or physician group. The College of Family Physicians of Canada has identified the following benefits associated with rostering:

a. Improved continuity of care over the patient’s lifetime;

b. Reduced costs and the elimination of duplication and overlap;

c. Timelier and more appropriate care;

d. More efficient and appropriate use of the medical care system;

e. Better preventive care and health promotion;

f. Improved patient mobility through the medical care system;

g. Decreases in patient frustration and anxiety;

h. Better patient outcomes; and

i. Improved patient participation in their care.

2. **Applying Rostering Principles to the Canadian Forces**

a. The CF Medical Clinic Roster is a list detailing the Base's CF Regular Force and CF Reserve Force units and the specific CDU to which each unit is assigned. All CF Regular Force, entitled CF Reserve Force members and other entitled personnel will be registered with a CDU through rostering. All members of a particular ship, squadron or regiment may be assigned i.e., rostered to a specific CDU.

b. Rostering an entire CF unit to a specific CDU facilitates a seamless transition when deploying the Unit or portion of the Unit. The CF Health Services (CFHS) staff who normally deploy with the Unit should be layered into its supporting CDU when in-garrison. This process greatly enhances Continuity of Care while maintaining unit affiliation for the CFHS staff.

c. The CDU's rostered population can vary by Base function and local circumstances but would normally be between 1500 and 3000 persons. Bases with up to 3000 CF members may elect to have only one CDU. During the implementation of the CF Medical Clinic Model, the CM and Base Surgeon will have input into the roster size and the methodology by which units or the CF Member are rostered. However, subsequent to this, the approach to rostering cannot change significantly otherwise the CF Member's continuity of care could be adversely affected.

d. The number of CF Medical Clinical staff at any particular site is determined by the number of CF members supported at that site and is influenced by the nature and intensity of operations and training activities supported. CF Health Services Group Headquarters (CF H Svcs Gp HQ) sets the clinical staffing requirements. How these clinical personnel are most effectively distributed among CDUs is the purview of the CF Medical Clinic leadership team.

e. The CF Member may not be satisfied with their primary health care provider. These members may select another primary health care provider within the same CDU. Where necessary, the CF Member may submit a memorandum to the CM requesting a change to another CDU and briefly outlining their reasons for the request. Requests for reassignment of CDU may be submitted for any of the following criteria:

(1) Gender preference of primary clinician;

(2) Language preference;

(3) Occupational/environmental medicine requirement, such as aviation medicine;

(4) Complexity of care; and

(5) Other.

f. Requests for reassignment of CDU should be supported.

**B-304. LEADERSHIP OF THE CARE DELIVERY UNIT**

1. The MO, appointed by the Base Surgeon in collaboration with the CM, will normally be the CDU Leader for all administrative, supervisory, occupational health and professional technical (Prof Tech) matters. By placing a MO in the role of "Team Leader", support to the CF Member's chain-of-command will be enhanced. The CDU Team Leader will report to the Primary Care Services Manager for administrative and management matters and to the Base Surgeon for Prof Tech matters.

2. Ideally, the MO selected to be the Team Leader will have one to two years of experience as an MO, including direct experience with an operational unit. When this MO is away, the responsibility for leading the CDU will be assigned to the second MO in the CDU.

3. When both of the MOs are away from the CDU, the CDU Primary Care Nurse (PCN) will normally act as the senior administrative and management authority for the CDU, while the civilian Medical Doctor (MD) will assume the responsibilities of the Senior Medical Authority (SMA).

4. The CDU PA has the overall supervisory role of the Med Techs in their CDU. The PA or the Sergeant/Master Corporal Med Tech may be called upon to take on additional administrative responsibilities when their CDU PCN is away.

**B-305. CARE DELIVERY UNIT STAFF**

1. The CDU Team works collaboratively with each other and with their patient to ensure that patient care is timely, appropriate and coordinated in support of the patient's well-being. In-house Physiotherapists, Pharmacists, MH practitioners and other health care providers who provide care either in collaboration with the CDU Team or through direct intervention, support the CDU Team.

2. The delivery of primary health care to the CF Member is one part of the dual responsibility of the CFHS in terms of in-garrison health care. The second aspect is support to local CF commanders in terms of helping units/formations achieve their missions. Delivering support to units integral to or lodged on the Base is an important priority of everyone who works at the CF Medical Clinic, although the primary responsibility for this support rests with the CF providers. To this end, the CF will ensure that there are sufficient numbers of CF clinical personnel with the appropriate occupational health and other qualifications to support CF operational missions.

3. For the CDU with a rostered population of 1500, the staffing would typically include the following[1]:

a. Two General Duty Medical Officers (GDMOs);[2]

b. One civilian MD;

c. One PCN;[3]

d. One PA;

e. One NP; and

f. Three Med Techs[4]

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[1] The proposed staffing of the CDU is based upon the assumption that, over the course of the next 3-4 years, there will be a significant improvement in the numbers of CF clinical personnel.

[2] The CFHS is established for 100 Captain GDMOs. It is anticipated that there will be a total of approximately 40-45 CDUs established across the CF. Thus, there will be approximately two Captain GDMOs assigned to each CDU. Where appropriate, these positions will be identified as requiring occupational training qualifications.

[3] The PCN has both an administrative and clinical role.

[4] The number of Med Techs in a CDU may vary depending upon their local availability. Three Med Techs are proposed, so that one of these may be at the rank of MCpl, allowing for an appropriate supervisory structure between the PA and the Corporal/Private (Cpl/Pte) Med Techs.

4. For the purposes of workload planning, MOs and PAs are assumed to be available for direct patient care 50% of the time and are thus the equivalent of 0.5 Full Time Equivalent (FTE) of a Civilian MD. NPs typically spend more time with patients than civilian MDs, and so they are also considered the equivalent of 0.5 FTE of a Civilian MD. Using this method, and again recognizing that the staffing mix will vary somewhat from CDU to CDU and from CF Medical Clinic to CF Medical Clinic, there should normally be a total of 3.0 FTE Civilian MD-equivalent clinical staff per 1500 rostered patients.

5. Backfill for vacation and sick time is necessary for some positions within the CDU in order to maintain timely access to care for patients and support to CF operations. Normally when backfill is provided, there is no other on-site staff member who would be able to assume duties additional to their own. The positions requiring backfill are identified in the generic template for each type of CF Medical Clinic.

6. Some rostered populations may have particularly high health care demands in comparison to others. This factor will need to be taken into account when assigning health care staff to the CDU.

7. Notwithstanding the typical staffing mix described above, the specific staffing mix at the CF Medical Clinic will be a reflection of the following factors.

a. **Availability of Local Civilian Health Care Professionals**. In some locations it may not be possible to hire civilian MDs, while in other locations it may not be possible to hire NPs. In these cases, the leadership of the CF Medical Clinic may choose to fill a Civilian MD position with a two NPs or fill a single NP position with a 0.5 FTE Civilian MD.

b. **Unique CF Occupational and Operational Requirements**. By way of example, for the purpose of achieving a greater flight surgeon capability, some Air Force Wings may choose to have their supporting CF Medical Clinic staffed with a higher ratio of Physicians, and therefore fewer PAs and NPs.

c. **The Evolving Canadian Practice Patterns in Primary Health Care**. As primary health care continues to evolve in the Canadian civilian health care environment as well as in the CF, a particular staffing ratio or mix may be demonstrated to be particularly effective and efficient. In keeping with its commitment to evidence-based management and evidence-based health care, the CF will consider all new evidence as it becomes available.

**Note:** Regardless of the particular mix of clinical professionals, the total clinical composition per 1500 rostered personnel remains the 3.0 FTE Civilian MD described above, unless otherwise approved by the Primary Care Renewal Initiative Steering Committee or CF H Svcs Gp HQ Deputy Chief of Staff Health Services Delivery.

8. **The Role of the General Duty Medical Officer**. The GDMO provides comprehensive primary care services to members of the supported population encompassing health promotion, prevention of disease and injury and curative, rehabilitation and support services as well as being an occupational health expert. The GDMO leading a CDU assumes both an administrative and clinical role. The CDU Leader, along with their CDU PA, ensures that their CDU supports training needs of its Med Techs while ensuring a balance between education and training and the patient's rights and privacy.

9. **The Role of the Civilian Medical Doctor**

a. The clinical role of the CDU Civilian MD is essentially the same as the CDU GDMO, with the exception that MOs are required to be significantly more involved with the activities of operational and training units on the Base. In this context, the principal unique role of the

Civilian MD is to provide continuity of primary care services to their CDU's rostered population.

b. The CDU Civilian MD will provide consultative and collaborative support to the NPs and PAs. The CDU Civilian MD will also be expected to engage in the clinical training of the Med Techs assigned to their CDU.

c. During the absence of both MOs from their CDU and to the degree permitted by the terms of their employment contract, the Civilian MD may act as the SMA for their CDU.

10. **The Role of the Nurse Practitioner**

a. The PCN, NP, and PA all have a significant role in delivering health care within the CDU setting. In this context, their roles are quite similar. Where their roles will differ is a function of the following factors:

(1) Their different scopes of practice; and

(2) The needs of their CDU at any given time.

b. In terms of the fluid day-to-day operation of the CDU, what is critical is not so much who is doing what, but a focus on the principal objective of the CF Medical Clinic - ensuring that the patient receives the right care from the right provider at the right time and supporting day-to-day work of the CDU to ensure that this care is delivered.

c. The NP functions as a member of their CDU in the provision of comprehensive primary health care services to their CDU's rostered population, encompassing health promotion, prevention of diseases and injuries and curative, rehabilitation and support services. Within their Scope of Practice, the NP performs a comprehensive health assessment and synthesizes data from multiple sources to make a diagnosis of a disease or disorder.

d. The NP initiates and manages the care of patients with a disease or disorder within their scope of practice and/or monitors the ongoing therapy of patients with chronic stable illnesses by providing effective pharmacological, complementary or counselling interventions.

e. The NP practices as a member of an interdisciplinary team and consults with members of other health professions as appropriate in order to ensure the health care needs of their patients are met.

f. The CFHS has identified the College of Nurses of Ontario Standards of Practice as the Provisional CF Scope of Practice for CF and Public Service NPs hired in CF Medical Clinics, CF-wide.

g. Responsibility for the Nurse Practitioner Scope of Practice, practice guidelines and other professional issues for NPs employed by the CF rest with the National Nursing Practice Leader. At the CF Medical Clinic level, a CF Nursing Officer will be appointed as the NP Practice Leader. In locations where there is no CF NP, a civilian NP will be appointed as the clinic representative to the National NP Practice Leader.

11. **The Role of the Physician Assistant**

a. The PA functions as a member of their CDU in the provision of comprehensive primary health care services to their CDU's rostered population. Activities encompass treatment /prevention of diseases and injuries and curative and support services in accordance with the Physician Assistant Scope of Practice.

b. The CDU PA works in collaboration with their CDU MOs, Civilian MD, NP and PCN to ensure the most appropriate and timely care for the CF Member.

c. The CDU PA will divide their time equally between the provision of patient care within their CDU and those administrative duties incumbent in their role. Included in the administrative responsibility are the supervisory and teaching functions for their CDU Med Techs. The patient care component will be focused on attending to Sick Parade, Walk-in and Urgent Care presentations.

d. The CDU PA replaces the Clinic Warrant Officer during absences and provides leadership and mentoring to the Med Techs assigned to their CDU, ensuring optimization of the learning opportunities and skills development.

12. **The Role of the Primary Care Nurse**

a. The PCN serving in the CDU will have a challenging Nursing experience that combines components of patient care and management.

b. In accordance with the Canadian Forces Nursing Concept Paper 2020, the role of CDU PCN is deemed an appropriate role for the Captain General Duty Nursing Officer (GDNO). However, since this position requires continuity, any GDNO posted into this position would need to be at a Reduced Readiness state. The CDU PCN is both an administrative and a clinical resource to their CDU Leader.

c. The CDU PCN requires an in-depth knowledge of current professional Nursing theory, with an emphasis on primary care, practice and techniques. The CDU PCN must have the ability to establish and maintain effective working relationships; demonstrate advanced clinical problem solving and communication skills, as well as management and leadership skills; effectively use the Nursing process to provide highly skilled and specialized direct/indirect patient care; and to plan, conduct and coordinate in-service training programs.

d. **Clinical Role of the Primary Care Nurse**

(1) The CDU PCN, within their scope of practice and under the supervision of the MO, treats patients with acute or chronic illnesses or injury on an episodic, outpatient basis. Treatment includes screening, triage, patient education, pain management, care planning, discharge planning and other interventions to restore, maintain or promote their patient's health.

(2) The CDU PCN promotes wellness and illness prevention while assisting in the management of acute and chronic diseases so the CF Member can attain their best possible health outcomes. Primary care Nursing services are provided to the CF Member who seeks care and assistance with self-management and/or family-supported health activities and may involve community-based agencies. The CDU PCN may assist with examinations, procedures, minor surgeries, dressing changes, administration of medications, injections, and immunizations. Additionally they may start intravenous therapy, perform phlebotomy, ECGs, and inhalation treatments as required.

e. **Administrative Role of the Primary Care Nurse**. In collaboration with their CDU Leader, the CDU PCN coordinates the daily functioning of their CDU's operations through supervision of their CDU administrative support and Health Records staff. The CDU PCN acts as a role model/mentor for staff within their area of responsibility and guide/coach staff in the accomplishment of their tasks. The CDU PCN will contribute to the performance management process for their CDU's Med Techs and administrative support staff.

13. **The Role and Rotation of the Medical Technician**

a. The Med Tech has significant clinical responsibilities while on deployed CF operations. For this reason, their employment while in-garrison must serve to ensure that they have the opportunities to train to their full scope of practice, particularly in the areas of assessment and treatment, so that they will be prepared for their role on deployed operations. Additionally, the Med Tech possesses skills and knowledge that are key to the success of the day-to-day operations of the CDU.

b. The Med Tech is employed in-garrison in support of two distinct objectives:

(1) They are integral to the effective and efficient functioning of the CDU Team; and

(2) They must have exposure to clinical training opportunities consistent with their role on deployed CF operations such as Pharmacy, Health Records and Physiotherapy.

c. The CF Medical Clinic with multiple CDUs will normally be staffed as follows:

(1) The first CDU will be staffed with one Sgt Med Tech and two Cpl Med Techs; and

(2) The remaining CDUs will each be staffed with one MCpl Med Tech and two Cpl Med Techs.

d. The Sgt/MCpl Med Tech rotation into the CDU will normally be for a minimum of one year. The core Med Tech positions in the CDU will normally be staffed with the same individual for a minimum duration of six consecutive months.

e. The Med Tech will be primarily responsible for screening, assisting with triage, patient preparation and, under supervision, the provision of treatment, in accordance with their scope of practice and under the appropriate level of supervision.

f. While the responsibility for teaching and training the Med Tech in clinical practice rests principally with the MO and the PA, the civilian MD and the NP also have a responsibility to contribute to the extent described in their respective Terms of Reference.

g. In addition to the CDU clinical setting, the Med Tech must also have opportunities for acquiring skills and knowledge in other areas, including Health Records, Pharmacy, and Physiotherapy. The CF Medical Clinic Operations and Training element will coordinate the timing and rotation of the Med Tech through these areas based on guidelines provided by CF H Svcs Gp HQ. The rotation to and through these areas will normally be not less that six months and not more than one year.

h. Med Tech availability for in-garrison employment and the opportunities for Med Tech training in the CDU will vary from Base to Base. For this reason, the CM, the Base Surgeon and the Clinic Warrant Officer will each have significant input into the manner in which they can most effectively achieve the employment and training objectives for the Med Tech at their Clinic.

14. **The Role of the Administrative Support Staff**

a. Each CDU normally has 2.0 FTE administrative/clerical staff to support the CDU operation. The key functions of this position include CDU reception, patient registration for unscheduled patient presentations (i.e., Sick Parade, Urgent Care, appointment scheduling, chart preparation and closure and management of referrals to Specialists and other external resources.)

b. The customer service component of the administrative support role is critical in terms of the effect this front-end process has on how the CF Member perceives the efficiency, effectiveness and caring elements of their total experience at the CF Medical Clinic. For this reason, the individuals placed in the administrative/clerical support role should be carefully selected and appropriately trained and supervised.

## B-306. CARE DELIVERY UNIT MEETINGS

1. Three types of regular meetings are required to ensure optimal CDU functioning.

a. **Team Meetings**. CDU team meetings should be held at least once every two weeks. These meetings are the CDU staff business meetings.

b. **Case Conferences**. Case conferences typically involve a group of professionals from diverse disciplines meeting to develop a shared understanding and care management plan for the CF member with particularly complex health care needs. Case conferences ensure that problems are properly identified, care is not duplicated and errors in communication are minimized. Case conferences also serve as a vehicle for education and an opportunity for health care providers to get to know each other thereby strengthening the team approach to health care delivery. Case conferences require that:

(1) Those involved must be able to synchronize their schedules to allow such a meeting to take a place;

(2) There is mutual respect and trust among the various professionals and a shared understanding of what each participant can bring to the care plan; and

(3) Case conferences that typically require one to two hours, should normally be held once per month for complex cases or more frequently as determined by the subject's primary clinician.

c. **Interdisciplinary Meetings**. Weekly interdisciplinary meetings of the CDU clinical staff are typically held to achieve the following objectives:

(1) Brief, informal exchanges of information and ideas about the CF member whose health care requirements are relatively straightforward;

(2) Development of general strategies to optimize the CF member's care and support to CF operations; and

(3) Preparations for specific upcoming tasks (e.g. Departure Assistance Group, Arrival Assistance Group).

2. As a matter of routine, one interdisciplinary meeting per month should be designated as the Case Conference Meeting.

1. As stated in the CF Surgeon General's Consensus Document on Collaborative Practice there are no shortcuts to successful Collaborative Practice. In particular, it is recognized that

there will be a significant up front investment of time and resources required to lay the foundation upon which successful Collaborative Practice can be built. Weekly interdisciplinary meetings will be one of the key means to establishing this foundation.

2. When Collaborative Practice is functioning optimally in the CDU, interdisciplinary meetings will often be brief, informal and targeted towards solving specific problems quickly and effectively.

## B-307. THE COMMUNITY HEALTH NURSE

1. The CF Model of Care introduces a role for the Community Health Nurse (CHN) that is different from the historical CHN role. In this role, the CHN is more involved with secondary prevention activities, such as blood pressure screening, well-women's clinics and immunizations and is less involved with primary prevention activities, such as health promotion and awareness training. The CHN will contribute significantly through patient education in the areas of Modification of Lifestyle, Exercise and Fitness, Nutrition and Weight Control and Stress Management. In those situations where their patient's condition requires significant one-on-one enhanced patient education, the patient will be scheduled for an appointment with a physician or NP for patient-specific education related to new or chronic disease management, such as diabetes, oncology, and communicable disease.

2. In understanding the role of the CHN it must be noted that all clinical professions in the CF Medical Clinic contribute to varying degrees to health promotion through a wide variety of activities. Additionally, the Strengthening the Forces Program has employees of the Canadian Forces Personnel Support Agency delivering health promotion programs to the CF Member under the local Prof Tech direction of the Base Surgeon and with national-level oversight from CF H Svcs Gp HQ Forces Health Protection staff.

3. The CHN has a direct reporting relationship to the Primary Care Services Manager, and is a member of the interdisciplinary team, providing direct patient care to the CF Member rostered to a CDU.

4. There will be 1.0 civilian CHN per CF Medical Clinic. Dependent upon the legitimate requirements of the CF Medical Clinic the CHN role may be augmented with a Nursing Officer, with the appropriate qualifications, who is assigned a Reduced Readiness state. The decision to add a Nursing Officer in support of the CHN will be made by CF H Svcs Gp HQ Deputy Chief of Staff Health Services Delivery with input from the CF Medical Clinic executive leadership and the CFHS formation-level and National Nursing Practice Leaders.

## B-308. THE CASE MANAGEMENT SERVICE

1. The CF Case Management Program provides Case Management services to the CF Regular Force and the entitled Reserve Force Member assigned Medical Employment Limitations. The Case Manager is responsible for establishing an ongoing relationship with the affected CF Member and helping them to navigate effectively through the CF and civilian health care systems to access related benefits with the view to achieve optimal health and well being.

2. The focus of Case Management services is on the CF Member in greatest need, that is, the CF Member with higher levels of illness and/or disability. The function of the Case Manager is to assist the CF Member to return to work and to educate them with respect to their illness/disability and the services and benefits for which they are eligible. When the CF Member cannot return to work because of their health condition, the Case Manager will facilitate an appropriate transfer of health care to either the civilian health care sector or to Veterans Affairs Canada.

3. Admission to the CF Case Management Program is determined by priority criteria as follows:

a. The CF Member awaiting release;

b. The CF Member on the Service Personnel Holding List;

c. The CF Member referred by an attending physician, including the CF Member on the Return to Work Program;

d. The CF Member assigned a Permanent Medical Category; and

e. The CF Member referred for a third extension of a Temporary Medical Category.

4. The Case Manager partners with the CF Member, the attending health care team and the applicable CF chains-of-command to help the CF Member return to duty and achieve/sustain optimal health. The Case Manager's relationship with the CDU PCN and other clinicians is important. Depending on the complexity the CF Member's health care, the CDU PCN will be responsible for coordinating health care, including elective civilian hospitalizations, in collaboration with the CF Member's assigned Case Manager.

5. The Case Manager reports to the PRIMARY CARE SERVICES MANAGER. The Case Manager has direct access to the Base Surgeon and other physicians, for the purpose of liaison with the CF Member's chain-of-command.

**B-309. THE URGENT CARE SERVICE**

1. Urgent Care is defined as physician intervention within 30 minutes for presentations that that could potentially progress to a serious problem requiring emergency intervention.

2. The CFHS accepts the following premises.

a. That the critically ill or injured CF Member may arrive at, or be brought to, the CF Medical Clinic with little or no advance warning.

b. That if this were to happen during normal service delivery hours, the appropriate resources would be available to Physicians, Nurses, PAs etc., so that Advanced Cardiac Life Support and Advanced Trauma Life Support protocols could be initiated, if needed.

c. That the critically injured or ill CF Member would be transferred to an appropriately resourced civilian health care facility at the earliest clinically-appropriate time, with the senior medical care provider on the scene having the final decision on where the patient should be transferred and when and how this would occur.

3. Situations that are not emergent but beyond the routine patient presentation will be managed by the clinician's of the CF Member's rostered CDU. These circumstances may require the use of the Treatment Room, for the management and/or observation of the CF Member.

4. There are a number of approaches the CF Medical Clinic may adopt to ensure that it is ready to respond to true medical emergencies. Examples of possible approaches are provided below.

a. **Duty Care Delivery Unit**. The CF Medical Clinic may assign, on a rotational basis, one of its CDUs to be available to respond to medical emergencies.

b. **Emergency Response Team**. The CF Medical Clinic may assign specific individuals from its CDUs to be part of an on-call emergency response team for the management of medical emergencies. A team might be comprised of a physician, nurse, PA and two Med Techs all of whom would carry on with their normal duties in their respective CDU but would be available by pager should a medical emergency arise.

c. **Operations and Training Element**. Depending upon the frequency of medical emergency occurrence and various staffing factors, the CM, Base Surgeon and Clinic Warrant Officer may choose to preferentially expose Med Techs to medical emergency situations under the guidance of a MO as part of their training for deployed operations. Assigning a MO and select Med Techs to the Operations and Training element and having the coverage of Urgent Care and Late Sick Parade assigned to this element.

**B-310. OBSERVATIONAL CARE**

1. There is no in-patient or overnight care provided by the CF Medical Clinic. Where local circumstances dictate, exemption may be granted to the CF Medical Clinic, when a request to do so has been approved by CF H Svcs Gp HQ Deputy Chief of Staff Health Services Delivery.

2. The downsizing of CF medical treatment facilities created the challenge of where to house the CF Member living in single quarters and requiring observation overnight or for a few days. Although the volume of these observational requirements is low, a requirement does exist. The need for Observational Care is generated primarily by the nature of the CF environment and the current civilian health care situation that encourages early discharge and Home Care vice a longer admission period in hospitals.

3. A significant number of CF members are single and living in quarters away from their families and friends. Another large portion of the CF population is transient i.e., away from their home Base attending occupation courses. During the summer months, this number increases as Cadets and Reserve Force personnel participate in their annual training. The capacity to hold patients in the CF Medical Clinic is non-existent or inappropriate for the required care. The transient CF Member has no support network other than their fellow course/training participants.

4. The primary reasons for requiring Observational Care fall into four main categories:

a. Surgical (i.e., day surgery, post-operative and dental);

b. Medical (i.e., pneumonia, cellulitis, hydration, palliative, poison ivy, infection control, monitor V.S., neuro, migraine, low back pain, I.V antibiotics, DVT, imposed bed rest, allergic reaction, gastro-enteritis, respiratory problems);

c. Psychological (i.e., adaptation, panic attacks, etc.); and

d. Social (i.e., waiting for Home Care services, barracks inappropriate for care, etc.).

5. The criteria for an Observation Care facility are few. The facility should be quiet and comfortable. Access to an individual who can provide care at a certain level that would not extend beyond sitting and personal care would be required. There would also need to be access to transportation and food.

6. Site considerations for the provision of observational care include:

a. Barracks Room;

b. Transient Quarters;

c. Permanent Married Quarter (PMQ); and

d. Motel/Hotel.

7. The patient should expect to receive the same level of care they would receive from a Home Care Worker/Personal Care Attendant attending to them in their home. The health care providers are expected in emergencies only to perform Cardio Pulmonary Resuscitation, if required, and call the physician or 911 as the situation warrants.

8. The provision of Observational Care is the responsibility of the CF Member's rostered CDU, through interventions by their PCN. The CDU PCN is responsible for arranging appropriate staffing for the observation of the CF Member. Specific CF care providers would be determined based upon availability and nursing care skills required. If the patient's health care requires skilled nursing interventions, a Nursing Officer may be assigned.

9. The authority for determining if Observational Care is appropriate in a given clinical situation is the attending Physician, who will also determine the level of care required. Staffing options for Observational Care include:

a. Nursing Officer/Med Tech from patient's rostered CDU;

b. Nursing Officer/Med Tech from the CF Medical Clinic Operations and Training element;

c. Contracted personnel; and

d. Personnel from patient's unit on a buddy-aid basis.

10. In addition, requirements for the CF Member's Observational Care may include but not be limited to the organization and provision of meals, housekeeping, laundry and transportation. These services may be provided through locally contracted arrangements, the CF Medical Clinic staff, volunteers, family or other available resources.

11. Dependent upon local demand for Observational Care, a more permanent solution may need to be considered. The allocation of one or two one-level PMQs (one for isolating patients with flu, gastro-enteritis, respiratory problems, etc.) in the CF Medical Clinic area is one option. This location would be accessible for civilian care; close to the CF Medical Centre and handy to most units should the Unit CO or their representative wish to visit the patient. In this scenario, the Observational Care facility would likely need to undergo some renovations to modify it to meet the needs of expected patients. This may include shower and bath rails, wider doors to permit a wheelchair, non-skid surfacing and perhaps countertops and appliances that permit universal access for those with physical limitations due to casts etc.

## B-311. IN-PATIENT AND SURGICAL SERVICES

1. There is no in-patient or overnight care provided by the CF Medical Clinic. Where local circumstances dictate, exemption may be granted to the CF Medical Clinic, when a request to do so has been approved by CF H Svcs Gp HQ Deputy Chief of Staff Health Services Delivery.

2. Where the need for surgical and in-patient services are justified, the CM and Base Surgeon have a responsibility to ensure that the services meet Canadian standards, and that staff have sufficient workload to maintain their competence in providing the services.

3. The departmental structure, staffing level, equipment, and number of beds will be based on the clinical necessity and the business case supporting the requirement. Typically, there will be only one Operating Room, a Recovery Room, and a small number of in-patient beds. A CF or civilian Nurse will typically be appointed to lead the in-patient and Surgical Service. The Service

will be staffed with the clinical specialists in surgery and anaesthesia, as well as other sub-specialists who have surgical privileges, Operating Room nurses and technicians, and a small number of Nurses and Med Techs serve the In-patient area.

## B-312. HOSPITALIZATION

1. The CF Member, the CF Medical Clinic and the CDU are responsible for ensuring the timeliness and accuracy of the communication of information concerning the CF Member's admission to a civilian hospital.

2. The CF Member who has been discharged from a civilian hospital or clinic will report to their rostered CDU for Follow-up Care and/or return to duty clearance, as required.

3. The assessment for and arrangement of Home Care services is the responsibility of the discharging civilian hospital in consultation with the PCN of the CF Member’s rostered CDU.

## B-313. HOME CARE AND PALLIATIVE CARE

1. In accordance with CF Spectrum of Care document, Home Care services may include Physician, Nursing, Physiotherapy, Occupational, Speech Therapy, Social Worker, Nutritionist and Home Maker (subject to needs assessment). Home Care will encompass acute and chronic Home Care and Palliative Care i.e., end-of-life Home Care services and be provided to the CF Regular Force Member, the entitled CF Reserve Force Member and the entitled Foreign Military Service Member.

2. Home Care refers to the provision of health care, community and social support programs to entitled personnel to enable individuals to receive care at home and/or live as independently as possible. It includes an array of services that enables patients, incapacitated in whole or in part, to live at home, often with the effect of preventing, delaying, or substituting for long-term or acute care alternatives. Based on the patient’s assessed needs, Home Care services could include Case Management, Nursing and other professional health care services, personal support and home making services. These services could be provided in a Base Barracks, PMQ, civilian house, apartment, or even in a hotel.

3. **Short-term Acute Home Care**. Short-term Acute Home Care is the provision of health and home support services provided to the CF Member experiencing an acute episode of illness or injury. The goal is to avoid admission to or reduce the length of stay in an acute care facility. The majority of CF members requiring Home Care fall into this category. Home Care involves both health and home support. The CDU PCN normally coordinates provision of this type of Home Care.

4. **Chronic (long-term) Home Care**. Chronic (long-term) Home Care is the provision of health and home support services provided to the CF Member requiring support for more than three months. It serves the CF Member with health and/or functional deficits in the home setting, both maintaining their ability to live independently and in many cases, preventing health and functional breakdowns, and eventual institutionalization. A very small number of CF members fall into this category. The Case Manager normally coordinates provision of this type of Home Care.

**5.** **Palliative Care**. Contracting out is recommended for Palliative Care. With clearly defined deliverables incorporated into the Statements of Work, including the use of a standard patient assessment tool, this option provides a standard for all Home Care services that currently does not exist. Service levels are enhanced, providing the necessary scope and depth of expertise required. It eliminates the need for the CF Medical Clinic staff to require on-going training in various skill sets that they may not frequently use (i.e., Palliative Care). Over capacity is avoided with the CF Medical Clinic staff acting as coordinators for Home Care only with the CF Medical Clinic remaining as their primary workplace.

## CHAPTER B-4

# DIAGNOSTICS AND THERAPEUTIC SERVICES

### B-401. OVERVIEW AND ORGANIZATIONAL STRUCTURE

1. The Diagnostic and Therapeutic Services Manager (DTSM) reports directly to the Clinic Manager (CM). Diagnostic and Therapeutic services include the Pharmacy, Laboratory, Physiotherapy, Diagnostic Imaging and Preventive Medicine, and all Specialist services, as well as the Central Sterilization Room and the Infection Control Nurse.

### B-402. DIAGNOSTIC IMAGING SERVICE

1. Access to quality Diagnostic Imaging (DI) services is an important part of primary health care for the CF Member. DI services may be provided on or off site. Regardless of CF Medical Clinic type, access to the services of Radiologists is standard. The CF Medical Clinic without on-site Radiologist support has DI services provided by contract with local providers.

2. The DI Team Leader has a matrix reporting relationship: to the DTSM for day-to-day operational and administrative activities and to the Base Surgeon for professional technical (Prof Tech) issues. The scope of responsibility for the DI team leader includes:

a. Accountability for the delivery of effective DI services;

b. Responsibility for the operation of the DI Service and the provision and coordination of Laboratory (Lab) services for the CF Member.

c. Responsibility to ensure the DI provided meet the Prof Tech and departmental standards of quality and efficiency; and

d. Supporting an organizational culture that fosters excellence and multidisciplinary teamwork, ensuring standards of DI Service operation meet and/or exceed accreditation expectations and other performance indicators, and coaching/mentoring other DI staff.

### B-403. LABORATORY SERVICE

1. Access to quality Laboratory (Lab) services is an important part of primary health care for the CF Member. Lab services may be provided on or off-site and include but are not limited to the provision of services related to haematology, coagulation, serology, chemistry/urinalysis, and microbiology. In situations where the CF Member must go off-site for Lab services the Care Delivery Unit (CDU) Primary Care Nurse (PCN) is responsible to ensure that the CF Member is adequately informed and prepared in accordance with the off-site Lab requirements.

2. The Lab Team Leader, reporting to the DTSM on a day-to-day basis and to the Base Surgeon for Prof Tech issues:

a. Is accountable for the delivery of effective Lab services;

b. Is responsible for the operation of the CF Medical Clinic laboratory and the provision and coordination of Lab services for the CF Member;

c. Promotes the CF Health Services (CFHS) vision and values, and guides their Lab staff towards sharing and contributing to these objectives; and

d. Supports an organizational culture that fosters excellence and multidisciplinary teamwork, ensuring standards of Lab operation meet and/or exceed accreditation expectations and other performance indicators, and coaching/mentoring other Lab staff.

## B-404. PHARMACY SERVICE

1. The focus of the CF Medical Clinic Pharmacy Service is the development of a standardized, interdisciplinary, patient-centered approach to the provision of Pharmacy services. Underlying themes include Continuity of Care, focusing on high quality customer service and fostering a collaborative approach within the CF Medical Clinic and with off-site resources.

2. The CFHS supports the Romanow Report[1] assertion that "pharmacists can play an increasingly important role as part of the primary health care team, working with patients to ensure that they are using medications appropriately and providing information to both physicians and patients about the effectiveness and appropriateness of certain drugs for certain conditions. This expanded role would allow pharmacists to consult with physicians and patients, monitor patients' use of drugs and provide better information and communication on prescription drugs."

3. The CF Medical Clinic Pharmacy Service is comprehensive, involving assessment; prevention; triage and care in collaboration with other health care providers. The CF Member receiving extended treatment requires ongoing support beyond a dispensing event including compliance with medication regimens, monitoring to identify changes in health status, which in turn, may require adjustments in their therapy. Also, these services are often required for the CF Member requiring more complex health care management.

4. CF primary care Pharmacy services are defined as the services provided by pharmacists that enhance the level of care provided to the CF Member (i.e., patient) and improve patient outcomes and system efficiencies. These services may or may not be initiated as a direct result of a prescription order. The focus should be on providing services that improve patient health outcomes.

5. The goals of the Pharmacist delivering primary care Pharmacy services in the CF should be targeted toward improving medication use, promoting health, preventing illness and assisting with managing disease.

6. Direct access to the CF Medical Clinic Pharmacist for drug therapy consultations and to obtain non-prescription medicines for minor ailments is common practice. The CF Medical Clinic Pharmacist should routinely be included as an active member of the CDU Team at interdisciplinary team meetings, especially those involving case conferences.

7. The CF Medical Clinic Pharmacist may be involved in collaboration with the on going care of the CF Member requiring:

a. Management and reporting of adverse drug reaction independently;

b. Management of allergic rhinitis with prescription products;

c. Management of anticoagulation therapy;

d. Management of diabetes;

e. Management of dyslipidemia;

f. Management of hypertension;

[1] Romanow Report on the Future of Health Care in Canada.

g. Smoking cessation programs with Zyban;

h. Symptom management of various medical conditions with over the counter and/or non-pharmacologic methods; and

i. Weight loss programs, in conjunction with Dieticians and/or Physicians.

8. The CF Medical Clinic Pharmacist, as a member of the interdisciplinary CDU Team, provides direct patient care and is integral to the effective management of the care provided to the CF Member. As part of the CDU Team, the Pharmacist will participate in the care of the CF Member and will be included in case conferences and interdisciplinary team meetings, where they will have the opportunity to provide advice to various health care professionals on appropriate pharmacotherapy and current best practice with respect to management of a certain disease state in a formal and structured environment.

9. The CF Medical Clinic Pharmacist has the responsibility to supervise all aspects of medical supply in accordance with National policies within their unit, including its detachments providing medical supply support. Medical supplies include pharmaceutical and non-pharmaceuticals. The Pharmacist is responsible for monitoring compliance at their unit, including its detachments, with policies relating to the use of pharmaceuticals such as Restricted Act Pharmaceutical.

## B-405. PHYSIOTHERAPY SERVICE

1. Physiotherapists are regulated primary care health care providers having specialized skills in the musculoskeletal assessment and rehabilitation of physical disability and impairments. Early access to Physiotherapy services leads to early interventions that lead to improved patient outcomes, significantly reduce the amount of lost time from work and lessen the overall impact on health care resources.

2. The CFHS supports that Physiotherapists in the CF Medical Clinic be allowed to work within their full scope of practice. This includes permitting the CF Member to access Physiotherapy services without a referral from a MO or civilian MD. Physiotherapy services at the CF Medical Clinic encompass consultation, assessment and treatment.

3. Direct access to the Physiotherapist through Sick Parade does not require that the Physician be consulted or briefed for sign-off on every CF Member seen by the Physiotherapist. As a regulated professional, the Physiotherapist is independently accountable for his/her actions. Alternatively, the CF Member may contact the Physiotherapy Service directly and schedule an appointment without the need of a referral from the Physician.

4. The CF Medical Clinic Physiotherapist should routinely be included as an active member of the CDU Team at interdisciplinary team meetings, especially those involving case conferences.

5. **Orthotics**

a. The CF Model of Care supports that Physiotherapists take an active role with the prescription, implementation and follow-up of the use of Assistive Devices, including Orthoses, and Orthopaedic supplies as this activity is within their scope of practice.

b. The Physiotherapist in the CF Medical Clinic has the clinical skills and knowledge to use an evidenced-based practice approach. The Physiotherapist understands that Assistive Devices and Orthoses should only be prescribed if impairments or decreased functional abilities have been clearly identified, measured, and quantified so that the baseline measure justifies the prescription of the device or orthosis. The Physiotherapist also

understands that the efficacy and effectiveness of the prescribed device or orthosis should be re-evaluated using the same indicative measures. The CF Medical Clinic Physiotherapy Service is an ideal resource to be utilized for most aspects of prescribing Orthoses, Prosthetic Devices and Assistive Devices.

c. The decision as to whether or not an orthosis should be prescribed, and the prescription of an appropriate orthosis should be the result of a team-based approach to care. While the Physician, Physiotherapist or Specialist may prescribe an orthosis, it is generally the Physiotherapist who will oversee the rest of rehabilitation, so it is essential that the Physiotherapist be involved in the prescription process, the exception to this being post-surgical bracing.

**B-406. PREVENTIVE MEDICINE SERVICE**

1. The Preventive Medicine (PMed) staff has a unique and highly specialized role that requires them to have quick and regular access to a senior MO. For this reason, the Base Surgeon is responsive to the Prof Tech needs of their supporting PMed Service whereas the DTSM oversees the administrative requirements of the PMed Service.

2. At Maritime Command Bases, the senior PMed Technician (Tech) typically works for the Fleet Support Medical Officer. At Bases with a Regular Force Field Ambulance, the senior PMed Tech often has field taskings and therefore normally reports to the Brigade Surgeon.

3. The role of the PMed Tech did not changed substantially as a result of the CF Primary Care Renewal Initiative. However, the role of the PMed Tech has increased substantially as a result of the Forces Health Protection initiative.

**B-407. SPECIALIST SERVICES**

1. The CFHS does not provide the full range of health services on Base and purchases services directly from civilian care providers. Either CF or civilian practitioners may provide Specialist services through local arrangements on or off-site. Specialist clinics occur at most CF Type III Medical Clinics and all CF Type IV and V Medical Clinics.

2. The CFHS Civilian-Military Cooperation (CIMIC) program assists the CF Medical Clinic to expedite referrals for their patients and to ensure that a full range of competent Specialists and other practitioners are available on a contracted basis.

**B-408. CENTRAL STERILIZATION SERVICE**

1. CFHS developed standards; based upon CSA standards, detail the precise instructions for safe and effective sterilization processes. CF Health Services Group Headquarters (CF H Svcs Gp HQ) Deputy Chief of Staff Health Services Delivery is responsible for the monitoring of these standards through a mentoring program. The CF Medical Clinic is assigned a Central Sterilization Process (CSP) Mentor, normally an Operating Room Technician, who is responsible to ensure all personnel working in the CSP in their designated area of responsibility are qualified yearly and that the prescribed CSP standards are followed.

2. The DTSM is responsible to ensure that all medical equipment is sterilized in accordance with CFHS standards. The Operations and Training Cell will assign, rotationally, CDU Medical Technicians (Med Techs) to the CSP when a central Treatment Room is operated in the CF Medical Clinic. It is the responsibility of the Operations and Training element to ensure that the CDU Med Techs are rotated through this assignment and that they have successfully completed the required training prior to being assigned to CSP duty. The DTSM will be provided with appropriate training and will have direct access to the supporting Infection Control Mentor as

required to ensure the standards identified by the CFHS Infection Control Program are maintained.

## B-409. INFECTION CONTROL SERVICE

1. The objective of the CFHS Infection Control Program (ICP) is to provide an interdisciplinary approach to the surveillance, prevention or reduction of the risks associated with the transmission of infectious agents among or between patients and health care personnel. The ICP Mentor scope of responsibility is to act as a consultant to or be responsible for the CFHS ICP in their designated area of responsibility.

2. The National Nursing Practice Leader, in consultation with the CF Surgeon General and the CF H Svcs Gp HQ Deputy Chief of Staff Forces Health Protection, determines the qualifications for the ICP Mentor. A civilian baccalaureate prepared Registered Nurse graduate of a recognized course in Infection Control should normally fill the ICP Mentor role.

3. ICP Mentor role will be filled on a regional/sector basis with 1.0 FTE ICP Mentor being assigned to CF Medical Clinics Esquimalt, Edmonton, Winnipeg, Petawawa, Ottawa, Valcartier and Halifax. Incumbents will report to their respective Base Surgeon.

## CHAPTER B-5

# MENTAL HEALTH

### B-501. OVERVIEW AND ORGANIZATIONAL STRUCTURE

1. Mental Health (MH) care in the Canadian Forces (CF) is provided in an interdisciplinary fashion. Disciplines involved in MH care provision include General Practitioners (GPs), Physician Assistants, Nurse Practitioners, Social Workers, MH Nurses, Psychologists, Addiction Specialists and Psychiatrists. Appropriately skilled Chaplains may also be involved. Regardless, MH care shall be available in a manner that facilitates access and reduces barriers, systemic and attitudinal.

2. A cornerstone of MH care delivery within the CF is the philosophy of Shared Care. For the purposes of the CF Medical Clinic, Shared Care is defined as a mechanism of Mental Health care in which primary medical care generalists and Mental Health care specialists collaborate in the provision of Mental Health care.

3. MH care is organized into two levels of service differentiated by the degree of service specialization and is defined as either being primary care or non-primary care in its delivery. Primary MH care is denoted as Psychosocial Care. Higher degrees of specialization (secondary, tertiary, quaternary) are called Mental Health Services and are accessed through referral from primary clinical services. Although a referral service, MH services will still provide care consistent with Shared Care through various collaborative and feedback mechanisms.

4. A basic principle of MH care is its use of regular interdisciplinary case review. MH care provided both within and outside of the CF Medical Clinic would be regularly reviewed. In this way, the CF Member can be assured that their MH care is of the highest quality, consistent with evidence-based best practices.

### B-502. THE PSYCHOSOCIAL SERVICE

1. The Psychosocial Service is the first level of MH clinical services and functions within the CF Medical Clinic as a common resource to the Care Delivery Unit (CDU). In addition to a Crisis Intervention Service, it provides a number of Social Work administrative services (i.e., screening, contingency cost moves, grants to members subject to forfeiture etc.); substance abuse/ dependency assessments and interventions; basic counselling services (i.e., educational, individual, couple or family counselling); and, in collaboration with the primary care GPs, MH maintenance and monitoring of services. Psychosocial services are brief and distinguished from Psychotherapy services in which therapy is guided by a fundamental theory of how the mind works.

2. The Psychosocial Service caters to two distinct populations. Entitled personnel will present to the Psychosocial Service with problems that they have identified as having some relationship to their mental well-being. In some cases these problems will be situational and may not impact on their broader health status. As CF members have indicated a preference to use services for which, when their health has not been negatively impacted, there is no Health Record. The interactions i.e., some marital problems, need for education about a specific issue etc. are recorded in the Psychosocial File. When the presenting problem has a negative impact upon the CF Member's health the Psychosocial Service interaction will be recorded in the subject CF Member's CF Medical Record. The CF Member will be informed of the health issue and the need for documentation.

3. The CF Medical Clinic Psychosocial Team functions as a shared resource to the CDU. The CDU Team and the Psychosocial Team may collaborate in the provision of MH care in

accordance with the principle of Shared Care. Access to these MH care providers may be through a patient presenting with a crisis, a patient directly seeking to access the Psychosocial Service or as accessed through the patient's CDU. The CDU health care provider may recommend to the patient that the Psychosocial Service be used and thus make an informal referral for service. Crisis intervention services exist as part of the Psychosocial Service to be staffed at the rate of 0.25 Full Time Equivalent (FTE).

## B-503. THE MENTAL HEALTH SERVICE

1. The MH Service comprises all non-primary level services involved in MH care. It is organized as a series of programs of various degrees of specialization i.e., Operational Trauma and Stress Support Centre program, Consultation Services, Addiction Treatment Services, etc. and is accessed through a common interdisciplinary intake process. Direct access crisis service is not a service provided by the MH Service as the Psychosocial Service provides it, although patients belonging to a particular MH Service program who develop a crisis are expected to have their needs met through the program from which they are receiving care. The CF Member can only access the MH Service through a referral from their CDU Medical Officer/civilian MD.

2. Wherever possible, it is desirable to have the MH Service physically sited close to the primary care services they support. This will depend upon the physical space and layout of the CF Medical Clinic. Some MH Services will also have geographic responsibilities i.e., some MH Services will provide program service to a number of CF Medical Clinics within a defined geographic catchments area.

## B-504. MENTAL HEALTH LEADERSHIP AND MANAGEMENT

1. Management and administrative support of MH care are provided through the CF Medical Clinic management structure. In settings where MH services are sufficiently large, a separate MH manager and administrative support structure may exist. The MH administrative support service is managed by the overlying CF Medical Clinic management structure. Professional technical (Prof Tech) leadership is provided in accordance with the provisions of the Mental Health Professional Technical Concept. When applied to the interdisciplinary MH care delivery systems this identifies a need for two overarching Prof Tech leaders. One Leader is responsible for the Prof Tech aspects of the Psychological Service care delivery and the other Leader is responsible for the Prof Tech aspects of the MH Service care delivery in the CF Medical Clinic where both services exist. The CF Medical Clinic will also have identified Practice Leaders for each of the MH disciplines existing therein. At the CF Medical Clinic in which a MH Service exists, the programs that comprise the Service may also have Program Leaders whose function is to provide Prof Tech oversight of the more specialized care provided by their program. In this way, a network of clinical leadership exists to support the care provided by MH care practitioners.

**Note**: Further detail and discussion concerning MH care delivery can be found in the Rx 2000 Mental Health Concept Paper.

## CHAPTER B-6

# SUPPORT SERVICES

### B-601. OVERVIEW AND ORGANIZATIONAL STRUCTURE

1. The Support Services Manger reports directly to the Clinic Manager (CM). Support services are those areas of the Canadian Forces (CF) Medical Clinic function that provide support to the Clinical Team. It encompasses Facility Management, Resource Management, Health Records Management, Safety and Security, Information Management/Information Technology, the Clinic Orderly Room function, and logistical requirements such as Supply, Contracting, and Transportation.

### B-602. FACILITY MANAGEMENT

1. The Support Services Manager is responsible to the CM for the effective, efficient and expedient delivery of all Facility i.e., building Management services for their CF Medical Clinic. The Support Services Manager will establish and maintain a close inter-departmental working relationship, through consultation and discussion with other managers, supervisors, and/or employees on matters relating to Facility Maintenance. The Support Services Manager will be expected to coordinate their CF Medical Clinic's Facility Management requirements with CF Health Services Headquarters (CF H Svcs Gp HQ) Deputy Chief of Staff Health Services Delivery and their supporting Base Construction Engineering Section.

2. The Facility Management responsibilities include:

   a. Coordinate the effective delivery of heating, ventilation and cooling (HVAC) services, electrical services, and structural repairs through designated Base or external providers by monitoring, investigating, evaluating, reporting and initiating corrective interventions on matters relating to the malfunctioning of HVAC and other related building maintenance functions;

   b. Deliver their Clinic's Workplace Hazardous Material Information System (WHIMS) program including records administration, maintenance of the program and identification of staff training requirements;

   c. Review, evaluate and assess all maintenance service activities to ensure compliance with established standards and regulations;

   d. Record and report deviations to the CM and initiate corrective action as necessary, in consultation with service providers and required reporting authorities;

   e. Provide advice and guidance to the CM on matters relating to facility layout, space allocation and/or configuration, equipment assignment and placement;

   f. Monitor and report on building security and environmental issues and recommend or initiate corrective action in keeping with established protocols;

   g. Organize, maintain and manage resources allocated to warranties, locksmiths, Fire Marshals, vending machines, laundry contract, driver (in liaison with the Chief Clerk) and House Keeping services;

   h. Review, process, and coordinate the acquisition of fixed assets requests, as approved by the established authorizing authority;

i. Ensure the provision of appropriate sanitation measures, medical and non-medical, in accordance with approved Environmental guidelines;

j. Coordinate Environmental services activities both interior and exterior (e.g., Spring and Autumn clean-up);

k. Manage Clinic parking;

l. Collect, record, review and report information for fire/building/safety inspections and any follow-up actions that may be required in keeping with established protocols; and,

m. Maintain consultation and liaison with Laundry services to ensure effective and timely service delivery.

**B-603. FINANCIAL MANAGEMENT**

1. The Support Services Manager is responsible to the CM for planning activities and for allocating and managing the resources assigned to their Clinic in order to ensure that objectives outlined in their Clinic's Business Plan are achieved effectively, efficiently and prudently. The Support Services Manager will conform to Assistant Deputy Minister (Finance and Corporate Services) (ADM (Fin CS) directives on Financial Controls, Expenditure Management, Management Information and Reporting and Procurement.

2. The Support Services Manager is responsible to:

a. Deliver programs giving due consideration to obtaining the best possible values for Public resources;

b. Make decisions in light of timely, relevant and reliable financial information, analysis and advice;

c. Ascertain that cost-effective controls are in place to safeguard assets and ensure probity;

d. Understand and report appropriately on their financial accountability; and

e. Ensure that the financial management systems and processes meet Department of National Defence and CF needs.

3. The Support Services Manager functions will include the following:

a. Develop an Annual Business Plan;

b. Establish an Accounts Payable;

c. Develop and maintain a Payroll System;

d. Establish a Management Decision-support System, including functions for financial analysis, variance reporting and corrective actions;

e. Develop a Financial Risk Assessment and Coverage Model;

f. Develop and maintain a Contract Management System relating to space, supplies, equipment and professional services; and

g. Develop financial policies and procedures, e.g., relating to Expense Reimbursement, Table of Authorities.

## B-604. HUMAN RESOURCES MANAGEMENT

1. **Overview**. The Support Services Manager has the responsibility to provide Human Resources Management services on behalf of all their Clinic's staff whether they are Regular Force members, Reserve Force members, or Public Service employees. They also manage all contractors.

2. **Canadian Forces Regular Force Clinical Personnel**. Although the principal reason for having clinical personnel in the CF is to support deployed CF operations, the reality is that CF clinical personnel spend well over 50% of their time working in an in-garrison setting. The CFHS must therefore strive to develop, through the CF Medical Clinic Model and related policies and programs, a professionally challenging and gratifying in-garrison employment environment for CF clinical personnel. In terms of achieving such an environment, CF clinical personnel should be given every reasonable opportunity to do the following:

a. Work to their full scope of practice;

b. Receive appropriate clinical professional training and development;

c. Work collaboratively in an environment characterized by mutual respect;

d. Apply their CF-unique skills and knowledge in the areas of operational medicine and occupational health; and

e. Assume specific management and leadership roles within the CF Medical Clinic.

3. **Canadian Forces Reserve Force Clinical Personnel**

a. The CF is committed to developing a more robust Health Services (HS) Reserve, responding to both the in-garrison and deployed needs of the CF Member. A group of interlinked initiatives have addressed the identified clinical skills deficiencies, have implemented a vertically integrated chain-of-command for CFHS personnel, and formally incorporated the CF occupation skill sets of the civilian licensed CFHS Reservist into a contemporary establishment structure.

b. The role of the Reserve element of the CFHS is to provide trained personnel to support, augment and sustain CFHS organizations for CF operations and training activities, while building and maintaining links between the CF and the local community.

c. The HS Reserve is positioned to successfully augment CF H Svcs Gp during operations. The HS Reserve is proactive and adaptable, capable of providing the requisite quality health care to the CF Environmental Commands and other stakeholders. The HS Reserve provides the CFHS with vital links to the broader Canadian civilian population and health care community.

d. In the context of CF in-garrison health care, the CFHS Reservist may be employed wherever opportunities exist and where employment contributes to both the goals of the CF Medical Clinic and the professional development of the CFHS Reservist.

4. **Civilian Employees**

a. Civilian health care providers make up an increasingly large proportion of clinical personnel in the CFHS. Without them, CFHS could not meet the needs of the CF Members for care, nor could the CFHS support the requirement for front line CF clinical personnel to participate in required maintenance of clinical skills programs, to attend courses and maintain effective relationships with the operational chains-of-command on

their Bases. It is therefore important that the CFHS strive to create a work environment in the CF Medical Clinic that supports the attraction and retention of quality Civilian clinical, administrative and managerial personnel.

b. All Human Resource – Civilian (HR-Civ) activities are centralized at CF H Svcs Gp HQ and staffed by the Human Resource and Business Management (HRBM) staff. The purpose of centralizing these activities is to ensure a consistent approach while maintaining the HR values of the organization and staffing an inclusive workforce representing the Canadian population.

c. Immediate on-site advice and support from the local Civilian HR Office will remain available to the CF Medical Clinic through its Support Services Manager, who will provide the HR-Civ coordination functions and act as the conduit to connect with the CF H Svcs Gp HQ HRBM staff on behalf of their Clinic.

d. Classification and staffing actions will be staffed to CF H Svcs Gp HQ HRBM staff. Civilian positions within the CF Medical Clinic will be staffed nationally with regional and local input. This minimizes duplication of effort and offers maximum flexibility at affordable Recruiting costs. The supporting Civilian HR Office Compensation Officer holds and maintains the Civilian employee's Personnel File. The CF Medical Clinic can however keep Leave and Training files on their Civilian personnel.

e. Civilian employee training will be centralized through the use of Individual Learning Plans and Competency Models for each group and level. It is the responsibility of managers to negotiate at review time what type of training is required by the employee to:

(1) Understand new initiatives;

(2) Career develop; and

(3) Train for competency gaps, such as the Health Records initiatives and Blue Cross information management and information technology systems.

f. Labour and staff relations issues are central issues dependent on the instrument of delegation. CF H Svcs Gp HQ provides assistance and coordinates with the local Civilian HR Officer to follow appropriate procedures. Some clinic managers are delegated Grievance Process Step 1 authority. Responses are coordinated and evaluated at CF H Svcs Gp HQ to ensure CF H Svcs Gp values are respected. Level 2 grievances and complaints are heard at CF H Svcs Gp, either by the Deputy Commander or the Chief of Staff.

5. **Contractors**. The Support Services Manager coordinates the requirements for hiring contractors to provide services to their Clinic. They are responsible for ensuring that contracting policies are adhered to and that the employer-employee relationship is not breached. The primary source of civilian clinical contractors is the Third Party Contract. Other local contracting means may be utilized in accordance with contracting guidelines.

**Note:** A separate Guide for Clinic Managers regarding the Third Party Contract has been produced and is available from CF H Svcs Gp HQ Deputy Chief of Staff Health Services Delivery.

## B-605. LOGISTIC SUPPORT TO THE CANADIAN FORCES MEDICAL CLINIC

1. The CM is responsible for planning activities and for allocating and managing the resources assigned to their Clinic in order to ensure that objectives outlined in their Clinic Business Plan are achieved effectively, efficiently and prudently. The CM will conform to ADM (Fin CS) directives on Financial Controls, Expenditure Management, Management Information

and Reporting, Procurement and Contracting services. The Support Services Manager will be directly responsible to develop, implement and maintain the effective, efficient and expedient delivery of logistic support to their Clinic. The Support Services Manager will coordinate General Supply, Transport and Contracting services for their Clinic.

2. The Support Services Manager functions will include the following:

a. Develop a Transportation Plan in concert with Base organizations and conforming to Base Directives;

b. Develop a General Supply process ensuring their Clinic's requirements are met in a timely and efficient manner while conforming to Base Directives;

c. Develop and maintain a Contract Management System relating to space, supplies, equipment and professional services; and

d. Establish a Management Decision-support System, including functions for financial analysis, variance reporting and corrective actions.

## B-606. HEALTH RECORDS

1. **Overview**. The Health Records function in the CF Medical Clinic will be centralized under the management of the Support Services Manager. There shall be strict access control to areas where Health Records are secured to ensure privacy and confidentiality is not breached. The Support Service Manager must consult with their CM and their Base Surgeon to limit access to Health Records to those who have a need to know. Specific guidelines and responsibilities related to Health Records include the following:

a. Within the CF Medical Clinic there is an integral Medical Records cell that provides the health care team with records that have been maintained in a secure manner, respecting the subject CF Member's privacy. Nonetheless, the CFHS recognizes the challenges of continuing to manage its services in the new Multidisciplinary Delivery approach with its current reliance on paper-based records. The CF Member's Health Record follows the CF Member on their postings in Canada, abroad and on deployed operations, adding to the challenges of maintaining a complete up-to-date Health Record. As part of the revamping of the CF health care information system the CFHS will be implementing, within the next five to eight years, an Electronic Health Record. It will not only support the direct delivery of patient care, but will enable the timely use of patient-specific information to support such things as epidemiological studies and management of CF health care resources.

b. The CFHS is responsible for the protection of personal health information and the fair handling of it at all times, throughout the CF, and in dealings with third party organizations. Appropriate care will be exercised in the collection, use, disclosure and protection of personal health information. However, the CF Member's right to privacy, and their personal health information become limited in some situations, as required by law.

c. The term Health Records refers to the storage and collection of all personal health information required to describe all aspects of health care provided to the CF Member throughout a military career or to other entitled personnel, regardless of physical mode or medium in which the information is stored.

d. The patient files of all CF Medical Clinic staff will be integrated and filed in accordance with Health Records policy in their Clinic's central Health Records department.

e. For training purposes and in accordance with the requirements of their QL3 OJSM, The Med Tech will normally be rotated through their CDU Health Records for a period of six months.

f. The Health Records clerks report to the Support Services Manager through the Health Records Practitioner/Team Leader.

2. **Health Information Custodian**. The term Health Information Custodian refers to all of the CF Medical Clinic staff involved in the handling of health information and is not intended to refer to a specific position or individual. This includes but is not limited to:

a. Reception of health data for inclusion in the health record;

b. Control of access to personal health information by employees, health care providers and patients;

c. Release of personal health information in accordance with established policy;

d. Protection of personal health information from unauthorized access, modification or destruction;

e. Storage and archiving of health records;

f. Collection, processing and maintaining personal health information data through appropriate coding where required;

g. Analysis and distribution of personal health information, as appropriate, to government authorities, funding agencies, and other organizations in accordance with established policy; and

h. Monitoring and auditing personal health information collected.

3. **Access to Personal Health Information**

a. Access to Personal Health Information will be:

(1) Granted on a need-to-know basis for the performance of specific functions related to the subject's employment or contract;

(2) Limited to those individuals and/or groups to whom CF H Svcs Gp personnel are providing direct patient care, consultation, referred clinical care/advice or administrative services/review;

(3) Provided through the use of a role and location-based Access Control Model i.e., users will be granted access information privileges based on roles assigned to the position(s) occupied by specific individuals, and their location. This will ensure the security and privacy of the Personal Health Information; and

(4) Violations or breaches, which may be identified in security audits, among other things, could result in administrative or disciplinary action being taken.

b. The CM will approve and control users assignment to positions that have access rights previously defined. CF H Svcs Gp HQ will manage users access and access control centrally.

c. In the CF Medical Clinic, Health Records must be professionally managed, with at least one qualified Medical Records Practitioner in any location where the CF is storing Health Records. The Health Records Practitioner of the parent CF Medical Clinic and the Formation-level coordinators are responsible to oversee the management of the Health Records at the CF Type I and Type II Medical Clinic.

d. Wherever possible and as per the CF Medical Clinic infrastructure template, Care Delivery Units (CDUs) should be located close to each other to allow for one central Health Records area, made up of individual segregated Health Records areas for each CDU.

4. **Definitions**

**Note:** The paper version of the CF Health Record is comprised of three distinct files, the Medical Record (CF 2034), the Psychosocial File and the Dental Record (CF 526).

a. **Medical Record (CF2034)**. The Medical Record is comprised of any information relating to the past, present or future physical health and mental health condition of an individual maintained for the purposes of providing health care and health-related services. This definition includes those records stored or maintained regardless of the physical mode or medium.

b. **Mental Health File**. The Mental Health File is a subset of the subject patient's Medical Record (CF2034). It contains all clinical recordings prepared by MH clinicians relating to the MH status of the patient and to information that impacts on the patient's MH and that requires the physician (general practitioner) involvement.

c. **Psychosocial Services File**. The Psychosocial Services file contains any information relating to the past or present psychosocial condition of an individual maintained by MH clinicians for the purposes of providing time-limited interventions that do not require physician (general practitioner) involvement. This definition includes those files stored or maintained regardless of the physical mode or medium.

5. **Storage of Clinical Documents in Offices**

a. The CF Health Record is designated Protected B.

b. The CF Health Record is to be returned to the Health Records element at day end and be requested again to their office the next business day.

c. The CF Health Record must be tracked and accessible at all times, by authorized personnel.

d. When the CF Health Record remains in the possession of a clinician beyond the normal hours of operation of the Health Records element:

(1) The security orders for Protected B information must be followed i.e., retention in a locked filing cabinet within a locked office where the CF Health Record is temporarily stored; and

(2) The Health Records Practitioner/Team Leader or the Support Services Manager must have a key to the locked filing cabinet.

6. **Chart Audits**

a. On a periodic basis, the CF Medical Clinic will conduct paper CF Health Record and Personal Health Information audits to ensure compliance with charting criteria. The CF H Svcs Gp HQ Health Information/Records Management (HI/RM) staff will conduct Staff Assistance Visit (SAV) evaluations at specific periods or as required to ensure that Canadian Council Health Services Accreditation (CCHSA) standards, concerning health information, are being attained.

b. National and local Professional Technical staff may conduct chart audits in the context of intra-discipline professional development initiatives and quality management programs.

c. The Provincial Medical College may request to review medical charts completed by a physician licensed in their province. Under some circumstances, this would entail College officials having access to the CF Member's chart(s). Such requests will normally be supported. However, as with any outside party request for access to personal information, the matter should be referred to the Base Surgeon.

7. **Regional/Sector Resources**. The CF Medical Clinic Support Services Manager and the Health Records Team/Practice Leader has the support of the Regional/Sector Health Record Coordinator and Health Records Technicians. Regional/Sector resources are staffed at four locations: Edmonton, Halifax, Ottawa and Valcartier to manage and supervise HI/RM services on a regional/sector basis. This will be accomplished through coordination and provision of advice and support to CF medical facilities in a given region/sector in accordance with established HI/RM professional practice and performance standards.

## B-607. THE CANADIAN FORCES MEDICAL CLINIC ORDERLY ROOM

1. The Support Services Manager oversees the support to their Clinic by the Clinic Orderly Room staff. The Clinic Orderly Room staff will provide the following services to their Clinic:

a. **Personnel Administration**. Clinic Personnel Administration support will be provided by the Clinic Orderly Room in conjunction with the Base Orderly Room.

b. **Finances**. The Clinic Orderly Room staff specifically the Finance and Blue Cross Clerks will manage their Clinic's Accounts Payable; and

c. **Mail**. The Clinic Orderly Room will be responsible for the receipt and dispatch of their Clinic's documentation.

## B-608. SAFETY

1. The Manager of Support Services is responsible for ensuring the Health Services Clinic has a Safety Officer appointed. It is the responsibility of the Safety Office to:

a. Ensure appropriate and adequate placement of Fire and Safety Order throughout the Clinic.

b. Ensure Fire Orders are up-to-date reflecting any national changes in policy as well as any local changes in the immediate environment

c. Ensure all Health Centre personnel have been oriented to the location of all Fire Orders and are familiar with the Fire Orders and Safety Policies and Regulations

d. Ensure WHMIS policies are up-to-date reflecting any national changes in policy as well as any local changes in the immediate environment.

## B-609. SECURITY

1. The Clinic Manager is responsible for all aspects of security of the clinic facilities, assets, resources and operations including physical security. The Medical Clinic will be responsible for the physical security of the clinic. Base Security Branch personnel are available to provide expert advice to the Clinic Manger with respect to physical security. It is the responsibility of the Support Services Manager to ensure there is a Security Officer appointed who has the responsibility to liaise with the Base Security Branch personnel to ensure adequate security safeguards with respect to personnel, information, material and other assets are provided.

2. The Support Services Manager through the Safety Officer is responsible for maintenance of alarm systems, control of building/office keys and reporting of security breaches. The Security Officer coordinates building lock-up and opening procedures, liaising with the Clinic Warrant Officer for establishment of the building lock-up duty roster.

## B-610. INFORMATION MANAGEMENT / INFORMATION TECHNOLOGY

1. This requirement was identified during the development of the position charters for the Primary Care Renewal Initiative (PCRI) pilot sites. Bases were not able to support the introduction of the computerized solutions that PCRI was requesting for either the network capabilities or manpower requirements.

2. In the longer term it is anticipated that the CF Type III Medical Clinic will receive almost all of their IT support from Base resources. As the Canadian Forces Health Information Systems (CFHIS) is implemented and the situation is reviewed on an ongoing basis, it is possible that the CF Type III Medical Clinic may require some dedicated IM/IT support.

3. Where IM/IT System Administration Coordinator support is eventually deemed necessary, the CF Type III Medical Clinic IM/IT Coordinator will be responsible for:

(1) The organization and operational efficacy of the CF Type III Medical Clinic's IT assets;

(2) Participation as required in the design and planning of infrastructure to support new applications and technologies;

(3) The provision of support to staff that utilizes these resources in the performance of their duties;

(4) Advice, support and instruction to users;

(5) E-mail account coordination;

(6) Installation of software, hardware; and

(7) Liaison with Base and National IT resources.

**Note:** CF Medial Clinics retain their current level of IM/IT support until CF H Svcs Gp HQ can demonstrate evidence to support a CF Medical Clinic IM/IT System Administration Coordinator requirement. This aspect of IM/IT support will be reviewed as CFHIS rolls-out.

## CHAPTER B-7

# OPERATIONS AND TRAINING

### B-701. OVERVIEW AND ORGANIZATIONAL STRUCTURE

1. The role of Operations and Training in the Canadian Forces (CF) Primary Health Care Model is to plan, coordinate and control the participation of CF clinical personnel in taskings and deployments external to the CF Medical Clinic proper. The Training Section will plan, coordinate and control the participation of their Clinic's personnel in training actions internal and external to their Clinic. The CF Medical Clinic Operations and Training element will provide information and advice on operations and training matters to their Clinic's leadership team.

2. It is anticipated that the CF Medical Clinic Operations and Training element will be led by a CFHS officer, usually a Lieutenant or Captain, although the position could be filled by a Major at the CF Type V Medical Clinic. A Training Non Commissioned Officer (NCO) will lead the Training Section. The Officer in Charge (OIC) of the Operations and Training element will report directly to their Clinic Manager (CM). However, for the CF Medical Clinic integral to the Regular Force Field Ambulance, the oversight of operations and training will be the responsibility of the Regular Force Field Ambulance Operations and Training Section.

3. The CF Medical Clinic Operations and Training element will maintain Clinic Personnel Current Information displays on operations and training activities. The Operations and Training element will coordinate and control personnel in support of Base and the operations of the supported operational-level Formation-based Command. This will include maintaining a briefing area, including maps and briefing materiel for use by their Clinic's leadership team. The Operations and Training element will be structured as follows:

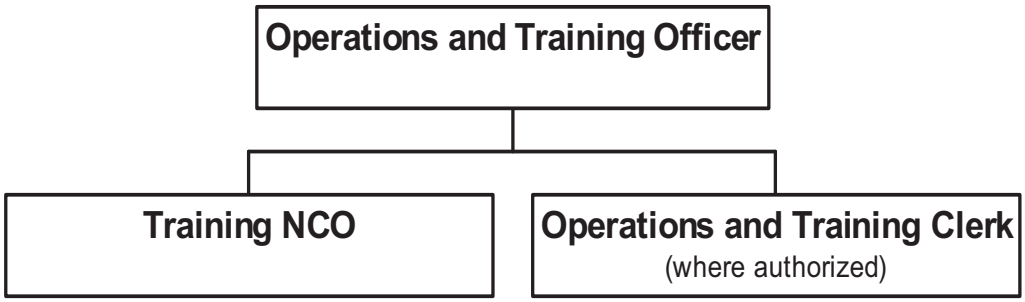


**Figure B-7-1, Outline Organization – CF Medical Clinic Operations and Training Element**

### B-702. ROLES AND RESPONSIBILITIES

1. The following responsibilities and tasks would normally fall under the purview of the CF Medical Clinic Operations and Training element:

a. **Operations Role**

(1) Coordinate taskings i.e.:

(a) Receive tasking from G3 Med Ops and higher formations;

(b) Seek nominations from Unit chain-of-command for taskings;

(c) Nominate Clinic personnel for taskings;

(d) Ensure selected personnel have all required equipment, qualifications and information for taskings;

(e) Brief personnel before deployment;

(f) Coordinate appointments with Clothing Stores, Base Transportation and other agencies as required; and

(g) Conduct Departure Assistance Group for deploying members.

(2) Maintain contact with Clinic personnel on deployed operations.

(3) Prepare and maintain Operations files on Clinic personnel on deployed operations.

(4) Post-Deployment i.e.:

(a) Brief members on return from deployment;

(b) Coordinate in-clearance to unit; and

(c) Ensure post-deployment follow-up is carried out.

(5) Coordinate departures and arrivals for Clinic personnel as required for Operational Training activities.

(6) Crash response, in partnership with other organizations

(7) Disaster response, in partnership with other organizations

(8) Support to Clinic Urgent Care Plan

(9) Support to Clinic Observational Care Plan

b. **Training Role**

(1) Coordinate Maintenance of Clinical Skills Program in partnership with Civil-Military Cooperation staffs.

(2) Coordinate Collective and Individual training i.e.:

(a) Continuing Professional Education;

(b) Civilian training programs;

(c) Orientation to the CF for civilian employees and contractors;

(d) Orientation to Base and Clinic for all incoming personnel;

(e) Individual Battle Standard Training;

(f) Driver training for issue of DND 404;

(c) Defensive Driver training; and

(d) First Aid and Cardio Pulmonary Resuscitation training.

(2) Coordinate job-specific training i.e.:

(a) Student On the Job Training;

(b) Medical Technician rotation;

(c) Emergency Care Simulator training; and

(d) Physical fitness training.

(3) Prepare and maintain Training files on Clinic personnel qualifications and training.

(4) Nominate personnel for courses i.e.:

(a) Liaise with Clinic chain-of-command to determine training requirements;

(b) Nominate Clinic personnel;

(c) Coordinate deployment and return of personnel on training courses; and

(d) Compile After Action reports.

## CHAPTER B-8

# BRINGING IT ALL TOGETHER

### B-801. ACCESSING CLINICAL SERVICES

1. The Canadian Forces (CF) recognizes that accessibility is one of the most important features of a successful primary health care system. The CF Health Services (CFHS) will strive to improve the degree to which the CF Member has access to care that they can trust and that is sensitive to their individual needs. The hours of operation for the CF Medical Clinic should strive to accommodate the needs of the CF Member and units on the Base. In the majority of cases, the hours of operation will be from 0730 – 1600 hrs.

2. The nature or intensity of activities at some CF installations may warrant operation of the CF Medical Clinic during extended hours i.e., at night and/or on weekends. In all cases, CF Health Services Group Headquarters (CF H Svcs Gp HQ) Deputy Chief of Staff Health Services Delivery will approve extended hours of operation after a review of the business case and operational needs analysis prepared by the Clinic Manager (CM).

3. Unique circumstances, usually involving the local availability of health care services and the nature of Base activities may require the CF Medical Clinic to operate on a 24/7 basis in terms of CFHS personnel being available on-call to provide care.

4. When the CF Medical Clinic is not open or by referral, the CF Regular Force Member and the entitled CF Reserve Force Member has a Blue Cross Card that entitles them to health care services through the civilian health care system to the same standard available to Canadians and consistent with the CF Spectrum of Care.

5. The CF Health Information Line (CFHIL) is a toll-free service available to the CF Member on a 24/7 basis. It provides needed health information to those who are unsure of whether to seek medical care, or where such medical care may be available closest to their current location. It is the responsibility of the CF Medical Clinic leadership team to publicize the existence of this service throughout their geographic area of responsibility.

### B-802. DIRECT ACCESS TO CF HEALTH CARE PROVIDERS

1. Direct access is defined as the ability of the CF Member and other eligible personnel to directly access a wide variety of health care professionals and allied professionals within the CF Medical Clinic without the requirement for a referral. However, for services provided outside of the CF Medical Clinic, the CF Member will be required to have a referral from a clinic staff member authorized to make such a referral.

### B-803. WAITING TIMES

1. Appointment waiting times are an easy-to-measure and important gauge of the accessibility of primary health care service being provided. Although comparable Civilian benchmarks vary, five to seven working days is an approximation of what many consider an acceptable wait period for non-urgent requests for an appointment with a clinician.

2. Waiting times are inextricably linked to three key factors.

   a. Length of appointment times;[1]

   b. Number of patients rostered to a care provider or Care Delivery Unit (CDU); and

   c. Methodology implemented to support Walk-in and Urgent Care presentations.

3. The issues of optimal waiting times, and the management of wait times and wait lists is a subject of great importance and concern to health care leaders in the civilian health care environment and the CF. The CFHS is beginning the process of determining and validating what constitutes a reasonable waiting time for access to each of the services listed in the CF Spectrum of Care document.

## B-804. PATIENT PROCESS FLOW

1. **Introduction**. The CF Model of Care represents a shift from the current walk-in access such as through Sick Parade, to an emphasis for the provision of most care through Scheduled Appointments. This is an intentional change in the way care is provided. By doing so, the CF Member will have the opportunity to develop a professional relationship with their primary care provider. This, over time, will enhance the management of patient-specific heath care concerns through Continuity of Care.

2. **Components of the Patient Process Flow**. There are four key components of the patient process flow. These are:

   a. Intake and Arrival;

   b. Assessment and Treatment;

   c. Disposition; and

   d. Follow-up Services

## B-805 INTAKE AND ARRIVAL

1. **General**. The CF Member can enter the CF Medical Clinic to access primary care through two streams as follows:

   a. Through walk-in opportunities such as Sick Parade/Late Sick Parade or Urgent Care; or

   b. By Scheduled Appointment.

2. **Reception**

   a. There are two main areas where Reception activities occur within the CF Medical Clinic. The first is the Central Reception. The Central Reception functions as an administrative section responsible for most of the CF Member's medical administrative needs. All CF Medical Clinics must have a centralized reception that operates at all times so that the CF Member will have a place to register and receive directions.

[1] The requirement to have an Occupational Health component to most appointments made by the CF Member with their clinicians necessarily requires a longer appointment time than one might typically find in a Civilian clinician's office.

b. Central Reception functions include:
   (1) Assignment of the new CF Member to a local clinician;

   (2) Clearing in/clearing out of the CF Member;

   (3) Reception functions and response to the CF Member's inquiries, provision of patient directions; and

   (4) Maintenance of the Clinic's Master Patient Index.

c. **Customer Service**. All aspects of Customer Service are of utmost importance in both the Reception areas. The CF Medical Clinic staff are expected to demonstrate exemplary Customer Service in interactions with the CF Member, their families and their visitors, whether in person or by phone, assessing, anticipating and fully meeting their needs and expectations. Staff will be empathetic, understanding and advocate on behalf of the patient at all times.

d. **Sick Parade**. Sick Parade is a pre-defined period when the CF Member may present, without an appointment, for an assessment of their acute health concern(s). The CF Member should only use Sick Parade if their symptoms or concerns are of less than 48 hours duration[2]. The CF Medical Clinic will provide access to care by scheduling fixed hours for Sick Parade, normally limited to early morning hours and by also providing for the capacity to manage walk-in unscheduled patients throughout the day.

e. **Walk-In**. Walk-in patients are those CF members who present to the CF Medical Clinic after the hours of Sick Parade, without an appointment, excluding Urgent Care presentations. The CF Member should be educated and encouraged to telephone the Clinic to schedule an appointment instead of dropping in, because they will receive better care through continuity of providers. The CF Member must be supported by their unit administration to attend Scheduled Appointments. The CF Member is best managed within their rostered CDU and can normally be accommodated through utilization of flexibility in patient scheduling practices. One approach to this is to have all CDU clinical staff be available for Sick Parade for the first one to three hours of the workday. After Sick Parade is completed, an appropriate number appointment slots, determined by clinical activity statistics, would be designated as Same-day and be kept open to accommodate walk-ins later in the day.

f. **Triage**

   (1) In the primary care context, triage is defined as the rapid, systematic assessment and collection of data related to the patient's chief complaint in accordance with the urgency of their presenting problem.

   (2) When the CF Member presents at the CF Medical Clinic with a medical concern, be it through Sick Parade, Walk-in or Urgent Care circumstances, the CF Member will be triaged by a qualified health care provider i.e., Nurse Practitioner, Physician Assistant, Primary Care Nurse or Sergeant Medical Technician (Med Tech), as soon as reasonably possible. Patient presentations to the CF Medical Clinic may range from Urgent Care situations to elective non-urgent appointments.

[2] Many CF members use Sick Parade for health concerns that have been present for well over 48 hours duration. Nevertheless, in an effort to optimize Continuity of Care, the definition of the parameters for Sick Parade for the purposes of the CF Medical Clinic Model is that it should only include patients with acute (< 48 hrs) health care concerns.

(3) The deployment status of the CF Member is to be considered when the level of urgency is assigned. In non-urgent care circumstances, the CF Member may be prioritized or moved up on a wait list for medical assessment or care relative to operational requirements but will not put in jeopardy another CF Member's care requirements.

(4) The civilian Emergency Standard for Triage is deemed to be an appropriate guideline that the CFHS can use to measure how well it is doing, particularly in the area of Sick Parade and Urgent Care. In accordance with the standards and terminology used in the majority of civilian Emergency Departments in Canada, patients are triaged into one of the following categories:

(a) **Resuscitative - Level 1 - Time to Clinician: Immediate**. Conditions that are a threat to life or limb or risk imminent deterioration requiring immediate aggressive interventions.

(b) **Emergent - Level II - Time to Clinician: Immediate**. Conditions that are a potential threat to life, limb or function, requiring rapid medical intervention or delegated acts.

(c) **Urgent - Level III - Time to Clinician: Less than 30 Minutes**. Conditions that could potentially progress to a serious problem requiring emergency intervention. May also be associated with significant discomfort to affecting ability to work or perform activities of daily living.

(d) **Less Urgent - Level IV - Time to Clinician: Less than 60 Minutes**. Conditions related to patient age, distress, potential for deterioration or complications would benefit from intervention or reassurance within one to two hours.

(e) **Non-Urgent – Level V - Time to Clinician: Less than 120 Minutes**. Conditions that may be acute but non urgent as well as conditions that may be part of a chronic problem with or without evidence of deterioration. The investigation of interventions for some of the illnesses or injuries could be delayed or referred for an appointment.

g. **Clinician Schedules**. The Clinician Profiles utilized for the scheduling of patient appointments in the CDU will reflect allowances for routine participation and commitment to the following:

(1) **All CDU Clinical Personnel**

(a) Intra-disciplinary meetings,

(b) Interdisciplinary i.e., Collaborative Practice meetings,

(c) CDU Team i.e., Business meetings,

(d) Case Conferences; and

(2) **CF Clinical Personnel**

(a) General Military Skills Training,

(b) Individual Battle Task Standards, training and evaluation,

(c) Physical Fitness, training and evaluation,

(d) Collective Training,

(e) General Duty Medical Officer (GDMO) Operational Medicine training at the rates of one half day per week for GDMOs posted to the Base and one day per week for the GDMO posted to the Regular Force Field Ambulance, and

(f) Maintenance of Clinical Skills Program training.

**Note:** The Clinician Profile for the GDMO will allow for the MO to be responsive to affiliated unit operations and training.

## B-806. ASSESSMENT AND TREATMENT

### 1. General

a. The CF Member presenting for care will be assessed by a member of their rostered CDU Primary Care Team, whenever possible.

b. The CFHS is responsible for ensuring that CFHS personnel are ready for their operational roles. It is entirely appropriate, if the patient consents, to repeat some examinations for educational and/or training purposes. By this means the Med Tech and other CF clinical trainees may optimize their training while in the CF Medical Clinic CDU. This is analogous to what happens in teaching hospitals throughout Canada with Medical, Nursing and Physiotherapy students. The direct supervision and professional oversight of the hands-on part of the training of CF clinical trainees will be managed within the CFHS in a manner similar to that used for clinical trainees in the civilian environment.

### 2. Periodic Health Assessments

a. The CDU administrative support staff will proactively schedule Periodic Health Assessments (PHAs), based on occupation requirements. PHA appointments can either be completed in one appointment or two, in accordance with occupational appropriateness as in the case of Divers, Drivers and Air Crew. Under these circumstances, the CF Member would come to the CF Medical Clinic to have the blood drawn several days in advance of the booked appointments for Parts I and II.

b. For PHAs when results are not required at the time of the assessment, it is possible for the CF Member to make only one trip to the CF Medical Clinic. Part 1 of the medical would be scheduled in coordination with Part II at any time throughout the day. This provides the CF Member with the convenience of requiring only one visit to the Clinic instead of two. In this approach the attending Physician completes the PHA without having the results of the Lab work and the CF Member is informed that they will be contacted if the Lab results are abnormal.

c. The preparation and management of all PHA and Medical Board documentation is the responsibility of the CDU administrative support staff for collation and completion. The distribution and filing of the documents is the responsibility of the Health Records staff.

### 3. Documentation

a. The CF Member presenting to the CF Medical Clinic during Sick Parade, as a Walk-in or on an Urgent Care basis will go directly to their rostered CDU. Upon arrival of the CF Member, the CDU administrative support staff, who will register the visit in the CFHIS system, will greet them. The CF Member’s Medical File i.e., CF 2034 will be requested from Health Records and the CF 2016 contained therein will be date stamped.

b. The CF Member's CF 2034 will be presented to the attending clinician for all patient encounters. It is the responsibility of the administrative support staff to prepare all files in advance of the patient's arrival for all scheduled appointments.

c. **CF 2016**

(1) The CF 2016 will remain in use and will now be kept as a permanent part of the CF Member's CF 2034 while the CF Member is in-garrison. The CF 2016 is the document where the attending clinician records progress notes during booked office visits and during Sick Parade wherever possible.

(2) The CF 2016 is secured within the CF 2034. It is the location for the documentation of progress notes by any of the CDU health care providers.

(3) The CF 2016 will continue to be one of the Health Record documents that accompany the CF Member on deployed operations.

d. **CF 2138**. The CF 2138 (Emergency Report) is typically used when the CF Member's CF 2016 is not available. The CF 2138 will be utilized in the CF Medical Clinic CDU for the transient CF Member i.e., the CF Member not posted to the supported Base. Health Records staff will file the CF 2138 in the subject CF Member's CF 2034 on the same day that the visit occurs thereby ensuring that it will be available for the attending clinician at the time of any follow-up appointments.

e. **Documentation of Telephone Advice**. All health care advice provided to the CF Member over the telephone will be documented in the subject CF Member's CF 2016 or on a CF 2138 if the CF 2016 is not available. The record of communication is a legal document and is retained in the subject CF Member's CF 2034.

f. **The Active Treatment Record**

(1) The Active Treatment Record (ATR) is a chronological record of assessment and treatment received during a time limited specific episode of care i.e., Case Management, Physiotherapy, Base Alcohol Coordinator etc. It becomes part of the subject CF Member's CF 2034 at the need of each treatment cycle. After discharge from a specific treatment/service, each re-entry to a service for either the same or a new condition requires the creation of a new ATR.

(2) The ATR provides the following:

(a) An aid to diagnosis, treatment planning and practice management;

(b) A record of the initial examinations and findings;

(c) A record of diseases or other abnormalities that occur after the initial assessment; and

(d) A chronological record of treatment received by the subject CF Member the specific episode of health care.

(3) The ATR may only be retained within the treating department when all of the following conditions are met:

(a) The subject CF Member is receiving a series of sequential, on-going interventions for the same condition;

(b) For a fixed period of time with a end of treatment cycle clearly identified; and

(c) The subject CF Member's CDU has been provided with a copy of the treatment plan.

(4) The ATR is to be stored securely in a centrally located locked area and filed in alphanumeric order. The appropriate departmental manager will have a key to the locked area.

g. **Informed Consent**

(1) An informed signed consent is required for the following:

(a) All procedures requiring local anaesthesia;

(b) Biopsies, incision/excision;

(c) Conscious sedation;

(d) Cryosurgery or electro surgical procedures, exception for cryosurgery carried out using liquid nitrogen and cotton swab;

(e) Injections, steroids;

(f) Procedures related to the spinal column such as lumbar puncture, epidurals, etc.; and

(g) Any other procedure/treatment plan that the care provider feels consent is required.

## B-807. DISPOSITION AFTER ASSESSMENT

1. **General**. The disposition of the CF Member after an assessment may be to:

a. Follow-up back with the clinician as required;

b. Follow-up with the clinician in a specified time period;

c. Modifications to duties and excused duty; or

d. Referral to a specialist service either internal or external to the CDU

2. **Documentation**

a. **The CF 2018, Medical Employment Limitations**

(1) When the assessment determines that modifications to duties are recommended, a CF 2018 Medical Disposition form is completed. The original is provided to the subject CF Member and the copy is filed in the subject CF Member's CF 2034.

(2) A CF 2018 is completed for all members attending the Health Services Clinic. It may identify a restriction to duty or excused duty or simply to constitute proof that the subject CF Member visited the Clinic.

(3) The CF Member requiring further diagnostic testing will have the requisitions for such tests prepared by their CDU administrative support staff. The CDU administrative support staff is not responsible to provide patient-specific education but when presenting the CF Member with the requisitions are responsible to

confirm that the patient received and understood any instructions provided. The CDU administrative support staff will also schedule any follow-up appointments as directed by the clinician, prior to the patient leaving the Clinic.

3. **Delegation of Base Surgeon Authority**

a. The operational-level Formation Surgeon in consultation with the Base Surgeon will determine who has the authority to sign off permanent medical category and other documents during periods when the Base Surgeon is absent.

b. Ideally, there will be a Medical Officer (MO) present at the Base at all times. However, under some circumstances a requirement may arise to have a civilian MD assume the capacity of Acting Base Surgeon. Where a civilian MD is acting in this capacity, the CM, the supported Base Commander and the operational-level Formation Surgeon must all be aware of the extent and limits of authority of the civilian MD while in this role and the specific period of time being covered. During the absence of both MOs from the CDU and to the degree permitted by the legal terms of their employment contract, the civilian MD may act as the Senior Medical Authority for their CDU.

4. **Chart Closure and Post Visit Entries**. When the attending clinician has finished with the CF Member's Health Record, the administrative support staff will initiate the Standard Operating Procedure for Chart Closure. Data collection and entry constitutes the main purpose behind this activity. Accurate statistics are essential. Types of data collected through this process include: Appointment Type, Appointment Status, Resource Code, Visit Description and Patient's Disposition. Reports are generated and provided to the appropriate manager to assist in the communication of relevant statistics to key stakeholders.

## B-808. FOLLOW-UP SERVICES

1. Utilizing information received from the CDU health care providers and/or reports generated from the Post-visit entry data by the CDU administrative support staff, the CDU Primary Care Nurse (PCN) will be responsible to initiate or delegate follow-up action to patients.

2. The CDU PCN will make follow-up telephone contact with patients who would benefit from personal contact based upon the length of the illness, complexity of care or those who have established a pattern of missed or cancelled appointments.

3. The purpose of the contact may include:

a. Confirmation of patient understanding and compliance with their treatment plan;

b. Ensure patient outcomes and treatment goals are being achieved;

c. Identify any unmet needs that may be resolved on behalf of the patient; and

d. Identify patient level of satisfaction with contracted services such as Home Care and Observational Care.

## B-809. SUPPORT TO THE TRANSIENT CANADIAN FORCES MEMBER

1. The transient CF Member, who presents to the CF Medical Clinic seeking care, will have their visit registered by the CF Medical Clinic Central Receptionist and a CF 2138 Emergency Report generated.

2. The Central Receptionist will contact the PCN(s) of the CDU(s) to ascertain the CDU most able to accommodate the assessment and treatment of the presenting transient CF Member.

3. The CF 2138 will serve as the permanent record of the assessment and treatment. Upon completion of the treatment cycle, the CF 2138 is to be mailed by Health Records to the subject CF Member's home Base and rostered CDU Health Records section.

4. For the CF Member on Temporary Duty (TD) at a the Base, away from their home unit, their Health Record will be managed as follows:

a. **TD Between Three and Six Months**. A temporary CF 2016 should be established when the CF Member first presents to the CF Medical Clinic.

b. **TD Greater Than Six Months**. The CF Member's CF 2034 should automatically accompany any CF Member who is being relocated to another Base for period in excess of six months.

CHAPER B-9

# MAKING IT WORK

## B-901. COLLABORATIVE PRACTICE

1. The goal of Collaborative Practice is to successfully integrate the skills and knowledge of health care providers from different disciplines to optimize patient care, and to support Canadian Forces (CF) operations.

2. The CF Surgeon General, the CF National Practice Leaders and the Director General Health Services Executive Committee believe that successfully integrating the skill sets of various health care providers will lead to improved care, more efficient care and enhanced support to CF operations. While the top priorities must always be optimizing patient care and support to CF operations, the CF Health Services (CFHS) recognizes that an additional priority of establishing successful collaborative practices must be the creation of a work environment that is professionally challenging and gratifying for all clinicians.

3. The CF Surgeon General and the CF National Practice Leaders are responsible for the issuance of specific National guidance on the subject of Collaborative Practice. The purpose of the CF Surgeon General's Working Group on Collaborative Practice is to convey the vision for the way ahead for the CFHS on this issue, and to identify the principles, which should guide this initiative. The consensus document produced by the Working Group is attached as Annex A.

4. Utilizing a lesson-learned, lesson-shared approach, CFHS personnel will be given the authority and the tools to develop Collaborative Practice solutions that work best for their particular Base and their particular group of health care professionals, provided such solutions are consistent with the principles of the CF Model of Care and the CF Surgeon General's professional technical (Prof Tech) guidelines.

## B-902. COMMITTEE STRUCTURE

1. **General**. The CFHS actively promotes a system-wide Continuous Quality Improvement (CQI) Program for all aspects of the CF health care system. The CFHS health care committee structure incorporates administrative roles and CQI/Accreditation functions required of the CF Medical Clinic.

2. **Accreditation Process**. The Accreditation Process requires the CF Medical Clinic to assess, evaluate and address the functions of the Clinic. The Clinic will be required to establish and operate Accreditation Committees. The Clinic functions to be assessed include governing and managing i.e., Leadership and Partnership, managing the physical environment and equipment i.e., Environment, managing people i.e., Human Resources, obtaining, managing and securing data and information i.e., Information Management and all aspects of delivering care in the Clinic. The Operational Trauma and Stress Support Centres will use the specialized Mental Health standards to assess their services.

3. **Accreditation Committees**. Accreditation committees are not required to exist as separate entities. The Clinic Manager (CM) and Base Surgeon will need to establish the committees required to address their Clinic's administrative, clinical and quality issues. They may choose to have committees deal with both administrative or clinical and quality issues. The leadership team of the CF Type III Medical Clinic not a detachment of a CF Type IV Medical Clinic may choose to combine several of the functions, such as Environment, Human Resources and Information Management into one support team to address clinical and quality issues. The

CF Medical Clinic with detachments will need to include members from each of their detachments on their committees

4. **Canadian Forces Medical Clinic Committees**. The CF Medical Clinic's committees are grouped into three broad functional categories:

a. Management;

b. Professional Technical; and

c. Quality.

5. **Management**. Management meetings facilitate the day-to-day business operation of the CF Medical Clinic and should be held weekly. Management meetings should be comprised of:

a. The Executive Committee Meeting (i.e., a meeting of the Clinic's senior oversight/decision makers). The Executive Committee meets to deal with Clinic level management issues. It should be composed of Department Heads and other senior Clinic personnel as appropriate. The CM should chair it. It reports and relates upward to the CFHS chain-of-command and to the supported operational chains-of-command. Internally it oversees:

(1) Department meetings, and

(2) Care Delivery Unit meetings.

6. **Professional Technical**. The Prof Tech committees assist the Base Surgeon in the execution of the Base Surgeon's responsibilities with regard to the clinical activities of their Clinic. The Prof Tech committees should meet no more frequently than monthly but not less frequently than quarterly.

a. The Clinical Advisory Committee (CAC) is the oversight/decision making body for clinical issues. It is composed of the local Practice Leaders and is chaired by the Base Surgeon. It reports upward to the Clinic's Executive Committee and relates upward to the operational formation-level and national-level elements of the Prof Technical Network. Internally it oversees:

(1) Intra-disciplinary committees/meetings;

(2) The Medical Records Audit Committee;

(3) The Pharmacy and Therapeutics Committee; and

(4) Case conferences, while not having a reporting relationship to the CAC, these meetings belong within the professional technical domain.

7. **Quality Management Framework**. The CF Medical Clinic's quality management framework exists to allow for CQI at all levels within the Clinic. The Quality Management committees listed below should meet monthly.

a. **Quality Council**. The Quality Council is the oversight/decision making body for CQI activities. It should be composed of the same individuals who are members of the Executive Committee plus the CQI Coordinator(s) and the Chairs of the QI teams if not already present due to other appointments. It reports upward to the Executive Committee and relates upward to the CF Health Service Group Headquarters CQI staff.

b. **Quality Improvement Teams**. QI teams are cross-functional teams established in accordance with the CF Health Care Standards developed in conjunction with the Canadian Council on Health Services Accreditation (CCHSA). They include the Leadership and Partnerships Team, the Health Care Team, the Mental Health Team, for clinics with an Operational Trauma and Stress Support Centre, and the Human Resources, Environment and Information Management Support teams.

c. **Utilization Management**. This is the systematic review of the patterns of resource utilization in support of health care delivery. This function should be assigned to an individual rather than a standing committee.

d. **Risk Management**. The same individual who performs the CQI Coordinator function should perform the Risk Management function.

e. **Quality Circles**. These are small ad hoc teams that can be convened at any level to address a specific issue or QI opportunity. They generally deal with discrete process issues that do not require additional resources to resolve.

f. **Mechanism(s) for Client/Stakeholder Input**. CCHSA and CF Health Care Standards require client and stakeholder input into CQI and certain executive planning activities. The CF Medical Clinic may opt to include clients or community partners directly on their Client/Stakeholder Team, or focus groups may be established to provide broader based input. For the Accreditation Survey, three focus groups are convened - Community Partners, Clients and Staff.

8. All CF Medical Clinic committees ultimately report to their Clinic's Executive Committee through their respective oversight committee.

9. The CF Type I Medical Clinic and the CF Type II Medical Clinic will need a basic Executive Committee. All other CF Medical Clinic committee activities should be achieved through partnership with their designated superior or parent clinic.

10. For the CF Type III Medical Clinic and the CF Type IV Medical Clinic, the committee functions outlined above remain. However, there is no need to devote committees to separately perform each function. Executive and Quality Council agendas could be combined or rotated. For CQI activities, accreditation teams will still need to be established but they can be smaller and the Support services teams can be combined. The CAC agenda should include the credentialing, Prof Tech and Medical Records auditing functions without the need to establish separate committees.

11. For the CF Type V Medical Clinic, the committee framework outlined above should be incorporated. The Executive Committee should be meeting weekly and the Quality Council monthly i.e., the reporting period for most of the data that this committee considers. For efficiency, it is recommended that one Executive Committee meeting monthly be used for the Quality Council meeting. Also for the CF Type V Medical Clinic, the need for separate credentialing, Medical Record auditing and Prof Tech committees will ultimately depend on the extent to which these functions are performed at CF H Svcs Gp HQ. They may end up as agenda items for the CAC.

## B-903. HEALTH SERVICES CIVILIAN-MILITARY COOPERATION

1. CF health care reform has led to a significant effort to increase partnering relationships with provincial health care organizations, and initiatives to more closely align CFHS training and qualification standards with those of the civilian health care sector. In support of these objectives, the CF has put into place the CFHS Civilian-Military Cooperation (CIMIC) Program. This Program is responsible for the development of standards and the purchase of services that will facilitate

the placement of CF clinicians into civilian hospitals for clinical skills maintenance related activities. They will also assist in finding Specialists, if required.

## B-904. INTRA-DISCIPLINARY MEETINGS

1. The purpose of intra-disciplinary meetings is to provide a forum for practitioners of the same discipline to share information and ideas in order to maximize their effectiveness as individual health care professionals and as part of the larger team. It is the expectation that these intra-disciplinary meetings should normally occur every one to two weeks, chaired by the Practice Leader or the Base Surgeon and have the following characteristics:

   a. Have a formal structure in terms of regularity, attendance requirements, agenda, and record of discussion; and also

   b. Allow for informal and highly interactive discussions among participants.

2. Depending upon the number of health care providers in the specific discipline at the Base/Wing level, and the manner in which care is provided within a geographical area, it may be necessary for some intra-disciplinary meetings to be conducted on a regional basis. The National Practice Leader will determine this requirement. There will normally be a national level intradisciplinary meeting on an annual basis, subject to any budgetary restraints. Whenever possible thee national level intradisciplinary meetings will be held in conjunction with other national meeting such as Op Med.

## B-905. DEALING WITH COMPLAINTS

1. In keeping with the CFHS vision as a caring and compassionate partner in health with individuals and the community, the CFHS is committed to addressing the concerns and complaints of the CF Member it serves. Complaints may be issues of either of a clinical or administrative nature, or both.

2. Complainants are encouraged to address their concerns directly with their health care provider. Every complaint is viewed as an opportunity to improve the health services provided by the CF.

3. Staff receiving a complaint or concern are to document the concern and notify their immediate manager, who refers the complaint to the appropriate person/group for investigation in accordance with the CF Surgeon General Prof Tech guidelines on such matters and other relevant CF and CFHS policies.

## PART C – TYPES OF CANADIAN FORCES CLINICS

## CHAPTER C-1

# INTRODUCTION

### C-101. GENERAL

1. High quality health care is assessed on the total appropriateness and suitability of care as perceived by patients and health care professionals, including compliance with clinical guidelines and best practices. The Canadian Forces Health Services (CFHS) must provide quality patient-centered care, based on clinical best practices, for the CF Member. This care must meet the CF Member's unique needs, anytime, anywhere.

2. Included in quality health care are such elements as waiting times, spectrum of care, standardization, easy of use/simplicity, and accessibility. Standardization is the best way to address regional inconsistencies. With a highly mobile population, standardization will make it easier for the CF Member to access and utilize their health care system. These quality health criteria will be achieved through a health services infrastructure and delivery system that responds to the health needs of the CF Member as well as to the needs of the CF to maximize readiness for CF operations.

3. The CFHS is responsible for ensuring a caring, responsive and coordinated process by which all health services provided to the CF Member are integrated. The Continuity of Care process involves the CF Member and an interdisciplinary health care team, supported by the CF Member's chain-of-command and by a continuous, comprehensive Health Record. Continuity of Care includes continuity of provider where practicable, a seamless efficient transition of the CF Member from one care provider to another, and from in-garrison to deployed operations. The CF Medical Clinic Model provides for good Continuity of Care by rostering the CF Member to a Care Delivery Unit (CDU) and by having a CF/civilian care provider mix with the civilian component providing in-garrison longer period stability and the CF component providing the in-garrison to deployed operations transition. Excellence in Health Record keeping will enhance all aspects of Continuity of Care.

3. Support to the CF operational chains-of-command is of utmost importance as this is the underlying principle of a military medical force. As a general rule within the CF context, the increase in the availability of the military workforce for deployed operations is a significant variable to the enhancement of operational capabilities. Inherent in support to the chains-of-command is the fostering of an environment that values stakeholder input, promotes the health and well-being of the CF Member, and responds to the operational needs of the CF.

4. There must be greater involvement of CF clinical personnel in Base operations and training activities There is a critical requirement for sufficient numbers of personnel with the appropriate occupational health and occupational medicine qualifications to meet operational support requirements. There is an absolute need for core clinical staff to allow occupational health and occupational medicine tasks to be carried out without degrading the health care services provided at the CF Medical Clinic.

### C-102. TYPES OF CANADIAN FORCES MEDICAL CLINIC

1. The primary approach to improving the delivery of in-garrison health services through the CF Model of Care will be single point of service. The single point of service concept:

   a. Supports a patient focused model;

b. Permits coordinated health care rather than fragmented service delivery;

c. Facilitates standardized delivery of health services; and

d. Improves Continuity of Care.

2. An important step identified to create a more standardized approach to the provision of in-garrison health care was the need to categorize i.e., type the CF Medical Clinic. Categorizing/typing aids in determining service standards, staffing levels, equipment requirements, and resource needs. A working group was convened in Ottawa in January 2001 to develop criteria for categorizing the CF medical clinics and to assign a category to each of the CF medical clinics.

3. It was originally determined that the CF Medical Clinic could be categorized as small, medium, or large. However, even within this categorization there could be significant differences. Therefore, the CF Medical Clinic will be type classified as one of five types. Subsequent chapters in this Part will detail the capabilities of each of the five types of CF Medical Clinic.

## C-103. THE POSITION CHARTER

1. **General**. The Position Charter is an on-going record of the allocation of staff positions to a specific CF medical clinic. The number of positions may not be altered without authority from CF Health Services Group Headquarters (CF H Svcs Gp HQ) Deputy Chief of Staff Health Services Delivery. Modification of the CF Medical Clinic Position Charter can be requested via submission of a Personnel Request and Justification document. Clinic Managers (CMs) are responsible to review their Clinic's Position Charter on a quarterly basis and submit the results of their review to CF H Svcs Gp HQ Organization and Establishment (O and E) staff. The substantive components of the Position Charter are outlined below.

2. **Position Number**. The Position Number is an alphanumeric designator used for staff identification. Personnel will be identified as name of clinic and position number for clarity i.e., Kingston 9A. Baseline staffing will use numeric designators. An alphanumeric designator will identify personnel added to the organization. The date the new position was authorized and the Personnel Request and Justification file number will be detailed in the Remarks column.

3. **Position Title**. Only position titles authorized by CF H Svcs Gp HQ O and E staff will be used in this column.

4. **Classification**. CF H Svcs Gp HQ O and E staff for military positions and NDHQ ADM (HR-Civ) for civilian positions will generate job classifications.

5. **Peoplesoft Position Number**. CF H Svcs Gp HQ O and E staff will generate this numeric designator.

6. **Backfill**. The last name of person filling-in for the incumbent will suffice. The full details of the backfill position will be detailed in the Adjunct Positions section. Reason for absence and expected date of return of the incumbent will be identified in the Remarks column. The Adjunct Position line number will be identified in the Remarks column.

7. **Adjunct Positions**. All temporary positions will be detailed in the Adjunct Position section i.e., the details of backfill personnel or temporary personnel hired for surge tasks will be provided in this section. Only permanent positions will be detailed in the sections above the Adjunct Positions section. The Backfill and Remarks columns will be used to guide readers to the Adjunct Position section for the complete details on personnel hired on a temporary basis.

## C-104. MATRIX OVERVIEW OF CLINIC TYPES

| | TYPE I | TYPE II | TYPE III | TYPE IV | TYPE V |
|---|---|---|---|---|---|
| **POPULATION SUPPORTED** | **< 500** | **< 1000** | **< 1000** | **> 1000** | **> 5000** |
| | | | | | |
| **Command Structure** | | | | | |
| | | | | | |
| Administrative Officer | | | X | | |
| Formation Surgeon | | | | | X |
| Base Surgeon | | | X | X | X |
| Clinic Manager | | | | X | X |
| Clinic Warrant Officer | | | X | X | X |
| Clinical Services Manager | | | | X | |
| Diagnostic & Therapeutic Services Manager | | | | X | X |
| Health Services Coordinator | X | | | | |
| Mental Health Manager | | | | X* | X |
| Primary Care Services Manager | | | | X | X |
| CQI/Risk Management Coordinator | X* | | X* | X | X |
| Secretary (Wing Surgeon/Clinic Manager) | | | X | X | X |
| Senior Administrative Authority | | X | | X* | |
| Senior Medical Authority | | X | | | |
| Support Services Manager | | | | X | X |
| | | | | | |
| **Primary Care** | | | | | |
| | | | | | |
| Administrative Support | | | | X | X |
| Community Health Nurse | | | X | X | X |
| Case Manager | | | X* | X | X |
| Centralized Reception | X* | X* | X | X | X |
| | | | | | |
| **Care Delivery Unit** | | | | | |
| | | | | | |
| Administrative Support Clerk | | | X | X | X |
| Civilian Physician | | X* | X | X | X |
| Medical Officer | | | | X | X |
| Medical Technicians | | X | X | X | X |
| Nurse Practitioner | | | X | X | X |
| Physician Assistant | | X | X | X | X |
| Primary Care Nurse | | | X | X | X |
| | | | | | |
| **Diagnostic & Therapeutic Services** | | | | | |
| | | | | | |
| Mental Health Team Leader | | | X* | X* | |
| Preventive Medicine | X* | X* | X* | X | X |
| Specialist Services Coordinator | | | | X | X |
| Infection Control Officer | X* | X* | X* | X* | X |
| Laboratory | | | X* | X | X |
| Diagnostic Imaging | | | X* | X | X |
| Pharmacy | | | X | X | X |
| Physiotherapy | | | X* | X | X |
| | | | | | |
| **MENTAL HEALTH** | | | | | |
| | | | | | |
| Psychosocial Services | | | X* | X | X |

| | TYPE I | TYPE II | TYPE III | TYPE IV | TYPE V |
|---|---|---|---|---|---|
| Psychology | | | | X* | X |
| Psychiatry | | | | X* | X |
| | | | | | |
| **SUPPORT SERVICES** | | | | | |
| | | | | | |
| Blue Cross Clerk | X* | X* | X* | X | X |
| Chief Clerk (military) | | | X | X | X |
| Finance Clerk | X* | X* | X | X | X |
| Health Records Clerks | | | X | X | X |
| Health Records Practitioner (Team Lead) | | | X* | X | X |
| Health Records Med Tech | X | X | X | X | X |
| IM/IT System Administration | | | | X | X |
| Transcriptionist | | | | X | X |
| | | | | | |
| **OPERATIONS AND TRAINING** | | | X | X | X |

***** In accordance with individual Clinic Position Charter

**Figure C-1-1, Matrix Overview of the Types of Canadian Forces Medical Clinic**

## C-105. OUTLINE FUNCTIONAL ORGANIZATION – CANADIAN FORCES MEDICAL CLINIC MODEL

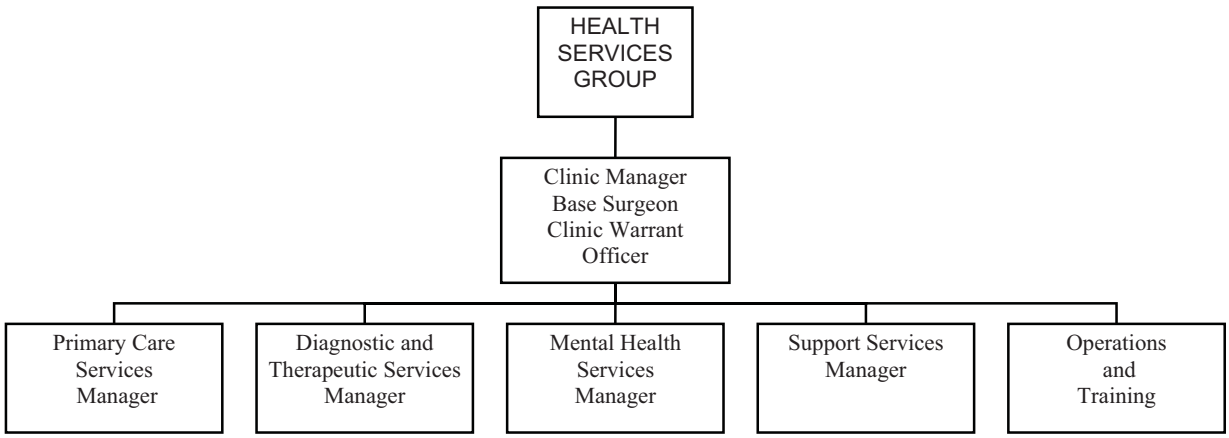


**Figure C-1-2, Outline Functional Organization of the Canadian Forces Medical Clinic Model**

## CHAPTER C-2

# THE CANADIAN FORCES TYPE I MEDICAL CLINIC

### C-201. INTRODUCTION

1. The Canadian Forces (CF) Type I Medical Clinic is organized as a health care administration detachment of a CF Type III, IV or V Medical Clinic. The CF Type I Medical Clinic does not provide direct patient care. The primary function of the CF Type I Medical Clinic is to coordinate access to external health services for the CF Member and other entitled personnel. Qualified administrative support personnel support clinical services personnel in order to streamline medical administrative processes. Clinic management staffs control partnerships and contracting with civilian health care providers and/or facilities. Systems will be in place to track patients and to keep their families and units informed. Patient care should not be perceived as disjointed and lacking continuity.

2. Organized as a health care administration detachment of a CF Type III, IV, or V Medical Clinic, the Senior Administrative Authority (SAA) is a Health Services Coordinator, a Physician Assistant (PA) or a Medical Technician (Med Tech). The parent CF medical clinic will provide Continuous Quality Improvement/Risk Management (COI/RM), Preventive Medicine (PMed) and Health Records services. The CF Type I Medical Clinic staff will ensure that the CF Member has access to Primary Care services, Urgent Care services or Specialists services. The parent CF medical clinic will provide Case Management services. Infection Control services will be provided by a supporting Infection Control Service element.

3. The coordination of access to external health services may encompass the following services:

a. Immunization clinics and individualized health promotion programs;

b. Specialist services;

c. Diagnostic Imaging services;

d. Laboratory services;

e. Pharmacy services with counselling;

f. Physiotherapy services;

g. Mental Health services;

h. Ophthalmology/Ears Nose and Throat services; and

i. Regional/sector Biomedical Technician services.

4. The CF Type I Medical Clinic will provide a well-structured patient-centered in-garrison Health Services Support (HSS) capability that is responsive to the needs of the CF Member and the supported formation commanders and unit commanding officers. It will provide routine health care and meet the unique requirements of the CF. Civilian health care providers employed in the Clinic will be oriented to military medicine and work in tandem with their CF colleagues to foster occupational medicine requirements.

5. The CF Type I Medical Clinic, as a dedicated in-garrison system, will respond to workload increases during peak training periods by adjusting staffing levels. It will facilitate access to care when needed for operational or career related requirements. The CF Member will be enrolled to a team of multi-disciplinary health care providers that will significantly improve Continuity of Care for the CF Member. This will extend to all areas in the Continuum of Care from prevention and primary health care, through coordination and follow-up of secondary and tertiary care, to rehabilitative and palliative care.

6. The CF Type I Medical Clinic will ensure that there are sufficient numbers of personnel with the appropriate occupational health and occupational medicine qualifications to support CF operations. There will be greater involvement of Clinic staff in Base operation and training activities. Optimization of CF and civilian health care providers to allow the CF health care provider opportunities to provide optimal support to CF operations and maximize the utilization of their CF occupational medicine skills.

## C-202. CHARACTERISTICS

1. The CF Type I Medical Clinic supports a population of less than 500 CF members and other entitled personnel. It does not deploy on operations and is not responsible for HSS to deployed operations.

## C-203. IDENTIFICATION

1. The CF Type I Medical Clinics are: CF Medical Clinic Calgary, CF Medical Clinic Chilliwack and CF Medical Clinic Sault Ste-Marie.

## C-204. LEADERSHIP

1. **Overview of Leadership of the Canadian Forces Type I Medical Clinic**. The Senior Administrative Authority (SAA) of the CF Type 1 Medical Clinic is a General Duty Medical Officer (GDMO), a Physician Assistant, a Medical Technician or a Public Service member. The SAA reports to the SAA of the parent CF medical clinic.

**Note:** The SAA of the CF Type I Medical Clinic is supported at the rate of 1.0 Full Time Equivalent (FTE) Administrative Support Clerk for the combined purposes of Receptionist, Financial Clerk and Blue Cross Clerk.

2. **Liaising with Operational Units**. Liaising with supported operational units encompasses the following:

a. Provision of a single point of contact in the Clinic for inquiries about a patient's disposition;

b. Tracking of Sick Leave and Medical Categories; and

c. Acting as the planning agency within the Clinic for patient repatriation from civilian hospitals or from deployed CF operations.

The SAA of the CF Type I Medical Clinic is responsible for ensuring the above-mentioned activities are carried out.

## C-205. INTERMEDIATE MANAGEMENT STRUCTURE

1. The CF Type I Medical Clinic does not have an intermediate management structure.

## C-206. GENERIC STAFFING TEMPLATE

| | Recommended FTE | Replacement FTE | Total Required FTE |
|---|---|---|---|
| **Command Structure** | | | |
| GDMO or PA or Med Tech or Public Service Member | 1.0 | | 1.0 |
| Med Tech | 1.0 | | 1.0 |
| **Support Services** | | | |
| Receptionist/ Blue Cross Clerk/Finance Clerk (Civ) | 1.0 | | 1.0 |

**Figure C-2-1, Generic Staffing Template of the Canadian Forces Type I Medical Clinic**

## C-207. PRIMARY CARE SERVICES

1. **General**. Limited primary care services are provided on site, where qualified personnel are available to provide such care in accordance with their Scope of Practice. If there is no one available to provide primary care, the CF Member will receive his or her care nearby at a supporting CF medical clinic or an appropriate civilian health care facility.

2. **Urgent Care**. Urgent Care would normally be provided by the nearest appropriate civilian health care facility.

3. **Documentation Associated with Assessment, Treatment and Disposition**. Documentation, of all patient interactions, is both a legal and professional responsibility. In the longer term, the CF Health Information System (CFHIS) and Electronic Health record (EHR) will obviate much of the requirement for paper files for in-garrison care. The descriptions provided in Chapter B-9 are therefore intended only to provide guidance on the use of the current paper documents until the CFHIS has been fully implemented

4. **Centralized Reception**

a. Reception functions as an administrative element in the CF Medical Clinic and is responsible for most of the CF Member's medical administrative needs. The CF Type I Medical Clinic must have centralized reception that operates at all times so that the CF Member has a place to register and receive directions.

b. Examples of what occurs at the centralized reception include:

(1) Assignment of the new CF Member to a clinician;

(2) Clearing in/clearing out of the CF Member;

(3) Reception functions and response to the CF Member's, provision of patient directions; and

(4) Maintenance of the Clinic's Master Patient Index.

## C-208. DIAGNOSTIC AND THERAPEUTIC SERVICES

1. Local civilian providers/health care facilities and the parent CF Medical Clinic may be utilized when the Clinic is not open or by referral when the following services are not provided on site:

a. Diagnostic Imaging;

b. Laboratory;

c. Pharmacy;

d. Physiotherapy;

e. Preventive Medicine; and

f. Specialist.

## C-209. MENTAL HEALTH SERVICES

1. Types I Clinics will not normally have a full-time MH presence unless specific local conditions or circumstances require this.

2. **Geographical Support**. The major MH facilities at Halifax, Valcartier, Ottawa, Edmonton and Esquimalt will be assigned support responsibility for a defined geographical area. These are defined as 'First Tier' support facilities. This applies to prof tech advice and the provision of MH services beyond the local capability of CF elements within that area. Certain other locations within each area will be designated as 'Second Tier' facilities providing support to designated local elements to the extent of their capability while having access to the applicable First Tier facility for similar support as required. In effect, this is a 'delegation' of the First Tier responsibility. Depending on local circumstances and the capabilities of the respective facilities, the support provided could involve the referral of patients to the supporting facility; the provision of visiting clinicians or the provision of prof tech advice and assistance

## C-210. SUPPORT SERVICES

1. **General**. The CF Type I Medical Clinic does not have an Administrative Officer or Support Services Manager.

2. **Health Records**. The Type I Medical Clinic is responsible for the Health Information/Records Management for its catchments population of entitled personnel.

3. **Chief Clerk**. There is no CF Chief Clerk at the CF Type I Medical Clinic.

4. **Finance, Blue Cross and Reception Functions**. The finance, Blue Cross and reception functions at the CF Type I Medical Clinic are combined in a 1.0 Full Time Equivalent Civilian position.

## C-211. OPERATIONS AND TRAINING

1. The CF Type I Medical Clinic does not have an Operations and Training element.

## CHAPTER C-3

# THE CANADIAN FORCES TYPE II MEDICAL CLINIC

### C-301. INTRODUCTION

1. The Canadian Forces (CF) Type II Medical Clinic is organized as a health care administration detachment of a CF Type III, IV or V Medical Clinic. The CF Type II Medical Clinic provides limited primary and urgent care services. Other services are provided by their parent CF Medical Clinic or referred out to the civilian health care system. Qualified administrative support personnel support clinical services personnel in order to streamline medical administrative processes. Clinic management staffs control partnerships and contracting with civilian health care providers and/or facilities. However, the responsibility for coordinating patient care aspects is left to the Primary Health Care Team. Systems will be in place to track patients and to keep their families and units informed. Patient care should not be perceived as disjointed and lacking continuity.

2. Organized as a health care administration section of a CF Type III, IV, or V Medical Clinic, the Senior Administrative Authority (SAA) is a Health Services Coordinator, a Physician Assistant (PA) or a Medical Technician (Med Tech). The parent CF Medical Clinic will provide Continuous Quality Improvement/Risk Management (COI/RM), Preventive Medicine (PMed) and Health Records services. The CF Type II Medical Clinic clinical staff will ensure that the CF Member has access to Primary Care services, Urgent Care services or Specialists services. The parent CF Medical Clinic will provide Case Management services. Infection Control services will be provided by a supporting Infection Control Service element.

3. The coordination of access to external health services may encompass the following services:

a. Immunization clinics and individualized health promotion programs;

b. Specialist services;

c. Diagnostic Imaging services;

d. Laboratory services;

e. Pharmacy services with counselling;

f. Physiotherapy services;

g. Preventive Medicine services;

h. Regional/sector Biomedical Technician services

4. The CF Type II Medical Clinic will provide a well-structured patient-centered in-garrison Health Services Support (HSS) capability that is responsive to the needs of the CF Member and the supported formation commanders and unit commanding officers. It will provide routine health care and meet the unique requirements of the CF. Civilian health care providers employed in the Clinic will be oriented to military medicine and work in tandem with their CF colleagues to foster occupational medicine requirements.

5. The CF Type II Medical Clinic, as a dedicated in-garrison Health Care System, will respond to workload increases during peak training periods by adjusting staffing levels. It will facilitate access to care when needed for operational or career related requirements. The CF Member will be enrolled to a team of multi-disciplinary health care providers that will significantly improve Continuity of Care for the CF Member. The CF Medical Officer (MO) leader of the Primary Health Care Team will act as the Senior Medical Authority for all of the primary health care needs of the CF Member. This will extend to all areas in the Continuum of Care from prevention and primary health care, through coordination and follow-up of secondary and tertiary care, to rehabilitative and palliative care.

6. The CF Type II Medical Clinic will ensure that there are sufficient numbers of personnel with the appropriate occupational health and occupational medicine qualifications to support CF operations. There will be greater involvement of Clinic staff in Base operations and training activities. There will be optimization of CF and civilian health care providers to allow the CF health care provider opportunities to provide optimal support to CF operations and maximize the utilization of their CF occupational medicine skills. A high level of standardization will be achieved primarily through utilization of the Care Delivery Unit (CDU) Model.

## C-302. CHARACTERISTICS

1. The CF Type II Medical Clinic supports a population of less than 1,000 CF members and other entitled personnel. It is responsible for the provision of in-garrison HSS to CF Regular Force members, entitled CF Reserve Force members and other entitled personnel and for ensuring that appropriate continuing professional education and training opportunities are provided to CFHS personnel.

2. The CF Type II Medical Clinic does not deploy and is not responsible for HSS to deployed operations. However, the CF Type II Medical Clinic does have a role, through the Operations and Training Cell of it's parent CF medical clinic, in ensuring that CFHS personnel are prepared and fit for participation on deployed operations.

## C-303. IDENTIFICATION

1. The CF Type II Medical Clinics are: CF Medical Clinic Casteau, CF Medical Clinic Dundurn, CF Medical Clinic Gander, CF Medical Clinic Geilenkirchen, CF Medical Clinic Goose Bay, CF Medical Clinic London, CF Medical Clinic Meaford, CF Medical Clinic Moncton, CF Medical Clinic Moose Jaw, CF Medical Clinic St. John's, CF Medical Clinic Suffield, CF Medical Clinic Vancouver and CF Medical Clinic Yellowknife.

## C-304. LEADERSHIP

1. The CF Type II Medical Clinic Senior Administrative Authority is either a MO, a Public Service Medical Doctor (MD), a PA or a Med Tech. The senior clinician is the facility's Senior Medical Authority. The SMA is responsible for ensuring that appropriate standards of practice are maintained and that approved processes are followed for all clinical programs provided by their clinic. The Base Surgeon of the parent CF medical clinic provides professional technical oversight.

2. **Liaising with Operational Units**. Liaising with operational units encompasses the following:

   a. Provision of a single point of contact in the Clinic for inquiries about a patient's disposition;

   b. Tracking of Sick Leave and medical categories; and

   c. Acting as the planning agency within the Clinic for patient repatriation from civilian hospitals or from deployed CF operations.

3. The CL is responsible for ensuring the above-mentioned activities are carried out. The civilian MD and other health care professionals in the Primary Health Care Team each have an obligation to liaise directly with their patients units where appropriate. The CL's responsibility is to ensure such liaison is carried out.

## C-305. INTERMEDIATE MANAGEMENT STRUCTURE

1. The CF Type II Medical Clinic does not have an intermediate management structure.

## C-306. GENERIC STAFFING TEMPLATE

| | Recommended FTE | Replacement FTE | Total Required FTE |
|---|---|---|---|
| **Command Structure** | | | |
| GDMO or Public Service MD or PA or Med Tech | 1.0 | | 1.0 |
| **Care Delivery Unit** | | | |
| Civilian MD | 0.5 | | 0.5 |
| Medical Technician | 3.0 | | 3.0 |
| **Support Services** | | | |
| Receptionist/Finance Clerk/Blue Cross Clerk | 1.0 | | 1.0 |

**Figure C-3-1, Generic Staffing Template of the Canadian Forces Type II Medical Clinic**

## C-307. PRIMARY CARE SERVICES

1. **General**. The CF Type II Medical Clinic provides limited Primary Care, Urgent Care or Specialist services on site. The CF Member is referred out via the National Provider Network.

2. **The Care Delivery Unit**. The CF Type II Medical Clinic has one CDU. The Senior Medical Authority advises the civilian MD on occupational medicine issues. The civilian MD reports to the Senior Administrative for administrative matters and to the Senior Medical Authority for concerns of a professional technical nature.

3. **Care Delivery Unit Staffing**. For the CF Type II Medical Clinic with a rostered population of less than 1,000 the CDU staffing would typically include the following[1]:

a. 0.5 Full Time Equivalent Civilian MD;

b. Three Medical Technicians (Med Techs)[2]; and

c. +/- Physician Assistant

[1] The proposed staffing of the CDU is based upon the assumption that, over the course of the next 3-4 years, there will be a significant improvement in the numbers of CF clinical personnel.
[2] The number of Med Techs in a CDU may vary depending upon their local availability.

4. **Civilian Medical Doctor**. The CDU civilian MD position is a half-time position. However, the incumbent attends the CF Type II Medical Clinic CDU on a daily basis. The civilian MD must possess a license to practice Family Medicine in the province in which the clinic is located and be in good standing with the provincial licensing and other professional regulatory organizations.

5. **Physician Assistant**. There may be a PA assigned to the CF Type II Clinic CDU in addition to the civilian MD.

6. **Medical Technicians**. Minimum three Med Techs will be staffed to the CF Type II Medical Clinic CDU.

7. **CDU Meetings**. CDU meetings are required to ensure optimal functioning of the CDU.

8. **Centralized Reception**

a. Reception functions as an administrative element in the CF Medical Clinic and is responsible for most of the CF Member's medical administrative needs. The CF Type I Medical Clinic must have centralized reception that operates at all times so that the CF Member has a place to register and receive directions.

b. Examples of what occurs at the centralized reception include:

(1) Assignment of the new CF Member to a clinician;

(2) Clearing in/clearing out of the CF Member;

(3) Reception functions and response to the CF Member's, provision of patient directions; and

(4) Maintenance of the Clinic's Master Patient Index.

## C-308. DIAGNOSTIC AND THERAPEUTIC SERVICES

1. Access to quality Diagnostic Imaging, Laboratory, Pharmacy and Physiotherapy services is an important part of primary health care for the CF Member. Typically these services will not be provided on-site at the CF Type II Medical Clinic. These services will be provided by referral to the parent CF Medical Clinic or to appropriate civilian health care facilities. Services provided by a supporting CF Medical Clinic include:

a. Infection Control services;

b. Biomedical Technician services;

c. Occupational Health services; and

d. Preventive Medicine services.

## C-309. MENTAL HEALTH SERVICES

1. Types II Clinics will not normally have a full-time MH presence unless specific local conditions or circumstances require this.

2. **Geographical Support**. The major MH facilities at Halifax, Valcartier, Ottawa, Edmonton and Esquimalt will be assigned support responsibility for a defined geographical area. These are defined as

'First Tier' support facilities. This applies to prof tech advice and the provision of MH services beyond the local capability of CF elements within that area. Certain other locations within each area will be designated as 'Second Tier' facilities providing support to designated local elements to the extent of their capability while having access to the applicable First Tier facility for similar support as required. In effect, this is a 'delegation' of the First Tier responsibility. Depending on local circumstances and the capabilities of the respective facilities, the support provided could involve the referral of patients to the supporting facility; the provision of visiting clinicians or the provision of prof tech advice and assistance

## C-310. SUPPORT SERVICES

1. **General**. The CF Type II Medical Clinic does not have an Administrative Officer or Support Services Manager.

2. **Health Records**. The CF Type II Medical Clinic is responsible for the Health Information/ Records Management for its catchments population of entitled personnel. The Health Records Practitioner of the supporting CF Medical Clinic supports the CF Type II Medical Clinic. The supporting Health Records Practitioner oversees the management of the Health Records and responds to Access to Information (ATI) requests.

3. **Chief Clerk**. There is no CF Chief Clerk at the CF Type II Medical Clinic.

4. **Finance, Blue Cross and Reception Functions**. The finance, Blue Cross and reception functions at the CF Type II Medical Clinic are combined in a 1.0 Full Time Equivalent Civilian position.

## C-311. OPERATIONS AND TRAINING

1. The CF Type II Medical Clinic does not have and Operations and Training element.

## CHAPTER C-4

# THE CANADIAN FORCES TYPE III MEDICAL CLINIC

### C-401. INTRODUCTION

1. The Canadian Forces (CF) Type III Medical Clinic is either a stand-alone CF Medical Clinic or a detachment of a CF Type IV or V Medical Clinic. It provides comprehensive primary care services and a number of diagnostic and therapeutic services on-site. Qualified administrative support personnel support clinical services personnel in order to streamline medical administrative processes. Clinic management staffs control partnerships and contracting with civilian health care providers and/or facilities. However, the responsibility for coordinating patient care aspects is left to the Primary Health Care Team. Systems will be in place to track patients and to keep their families and units informed. Patient care should not be perceived as disjointed and lacking continuity.

2. The CF Type III Medical Clinic leadership team will consist of the Clinic Manager, Base Surgeon and Clinic Warrant Officer. The Clinic could have management responsibility for detached capabilities including medical staff assigned to Recruiting Centres. The Clinic will have integral Continuous Quality Improvement/Risk Management (CQI/RM) and Preventive Medicine services if not provided, part time, by the supporting CF Medical Clinic. It will have an Operations and Training element and will be able to provide special environmental clinical support.

3. The CF Type III Medical Clinic Primary Health Care Team will provide comprehensive primary care services on-site including on-call clinician. Urgent Care services will be provided during normal working hours. It will have integral Case Management services if not provided by the supporting CF Medical Clinic

4. The CF Type III Medical Clinic Diagnostic and Therapeutics Team may provide the following services on-site; all other requirements will be referred out:

a. Immunization clinics and individualized health promotion programs;

b. Specialist services;

c. Diagnostic Imaging services;

d. Laboratory services;

e. Pharmacy services with counselling;

f. Physiotherapy services;

g. Preventive Medicine services;

h. Mental Health services;

i. Ophthalmology/Ears Nose and Throat services; and

j. Regional/sector Biomedical Technician services

5. The CF Type III Medical Clinic will provide a well-structured patient-centered in-garrison Health Services Support (HSS) capability that is responsive to the needs of the CF Member and the supported formation commanders and unit commanding officers. It will provide routine health care and meet the unique requirements of the CF. Civilian health care providers employed in the Clinic will be oriented to military medicine and work in tandem with their CF colleagues to foster occupational medicine requirements.

6. The CF Type III Medical Clinic, as a dedicated in-garrison health care system, will respond to workload increases during peak training periods by adjusting staffing levels. It will facilitate access to care when needed for operational or career related requirements. The CF Member will be enrolled to a team of multi-disciplinary health care providers that will significantly improve Continuity of Care for the CF Member. The CF Medical Officer (MO) Leaders of the Primary Health Care Team will act as the Senior Medical Authority for all of the primary health care needs of the CF Member. This will extend to all areas in the Continuum of Care from prevention and Primary Health Care, through coordination and follow-up of secondary and tertiary care, to rehabilitative and palliative care.

7. The CF Type III Medical Clinic will ensure that there are sufficient numbers of personnel with the appropriate occupational health and occupational medicine qualifications to support CF operations. There will be greater involvement of Clinic staff in Base operation and training activities. There will be optimization of CF and civilian health care providers to allow the CF health care provider opportunities to provide optimal support to CF operations and maximize the utilization of their CF occupational medicine skills. A high level of standardization will be achieved primarily through utilization of the Care Delivery Unit (CDU) Model.

## C-402. CHARACTERISTICS

1. The CF Type III Medical Clinic supports a population of less than 1000 CF members and other entitled personnel. It is organized as either a CF unit or as a detachment of a CF Type IV or V Medical Clinic. It is responsible for the provision of in-garrison HSS to CF Regular Force members, entitled CF Reserve Force members and other entitled personnel and for ensuring that appropriate continuing professional education and training opportunities are provided to CFHS personnel.

2. The CF Type III Medical Clinic does not deploy and is not responsible for HSS to deployed operations. However, the CF Type III Medical Clinic does have a role, through its own or it's parent CF Medical Clinic's Operations and Training element, in ensuring that CFHS personnel are prepared and fit for participation on deployed operations.

## C-403. IDENTIFICATION

1. The CF Type III Medical Clinics are: CF Medical Clinic Comox, CF Medical Clinic Longue-Pointe, CF Medical Clinic North Bay, CF Medical Clinic Shearwater, CF Medical Clinic Toronto and CF Medical Clinic Wainwright.

## C-404. LEADERSHIP

1. Senior administrative and clinical authorities in the CF Type III Medical Clinic are vested in the Base Surgeon. The Base Surgeon functions as both the Senior Administrative Authority and Senior Medical Authority of the Clinic. The Base Surgeon reports through the CFHS chain-of-command to the Commander Canadian Forces Health Services Group and ensures the in-garrison HSS provided by their Clinic and, if applicable, all of its detachments meet the needs of commanders and commanding officers in their designated area of responsibility.

2. The Base Surgeon, as CL of their Clinic, is responsible for ensuring that the appropriate clinical standards of practice are maintained and that approved processes are followed for all of the clinical programs carried out within their Clinic and, if applicable, all of its detachments.

3. An Administrative Officer (AO) and a Clinic Warrant Officer support the Base Surgeon. Secretarial support at the rate of 1.0 Full Time Equivalent (FTE) is provided in support of the Base Surgeon and the Clinic AO functions.

4. **Liaising with Operational Units**. Liaising with operational units encompasses the following:

   a. Provision of a single point of contact in the CF Type III Medical Clinic CDU for inquiries about a patient's disposition;

   b. Tracking of Sick Leave and medical categories; and

   c. Acting as the planning agency within the CF Type III Medical Clinic CDU for patient repatriation from civilian hospitals or from deployed CF operations.

**Notes:**

1. At the Base, the Base Surgeon, supported by the PCN and the Physician Assistant (PA), has the responsibility to ensure the above-mentioned activities are carried out. However, the civilian MD and other professional health care providers forming part of the CF Type III Medical Clinic CDU each have an obligation to liaise directly with their patients' units where appropriate. It is the Base Surgeon's responsibility to ensure such liaison is carried out.

2. At the Air Force Wing, the CF Type III Medical Clinic CDU Leader, supported by the CDU PCN and the PA, has the responsibility to ensure the above-mentioned activities are carried out. However, the civilian MD and other professional health care providers forming part of the CF Type III Medical Clinic CDU each have an obligation to liaise directly with their patients' units where appropriate. It is the CDU Leader's responsibility to ensure such liaison is carried out.

## C-405. INTERMEDIATE MANAGEMENT STRUCTURE

1. The intermediate management structure of the CF Type III Medical Clinic is as follows:

   a. **Primary Care Services Manager**. There is no Primary Care Services Manager at the CF Type III Medical Clinic;

   b. **Support Services Manager**. The CF Type III Medical Clinic AO performs the duties of Support Services Manager;

   c. **Diagnostic and Therapeutic Services Manager**. There is no Diagnostic and Therapeutics Services Manager (DTSM) at the CF Type III Medical Clinic;

   d. **Mental Health Manager**. There will be a civilian Mental Health (MH) Manager at each clinic that has an Operational Trauma Stress Support Centre or as otherwise determined by CF H Svcs Gp HQ. MH services with no MH Manager position designated will have a MH Team Leader who will report to the DTSM; and

   e. **Continuous Quality Improvement/Risk Management Coordinator**. The CF Type III Medical Clinic has a part-time CQI/RM Coordinator position.

## C-406. GENERIC STAFFING TEMPLATE

| | Recommended FTE | Replacement FTE | Total Required FTE |
|---|---|---|---|
| **Command Structure** | | | |
| | | | |
| Base Surgeon | 1.0 | | 1.0 |
| Administrative Officer/Support Services Manager | 1.0 | | 1.0 |
| Clinic Warrant Officer | 1.0 | | 1.0 |
| Secretary (Base Surgeon/AO) | 1.0 | | 1.0 |
| CQI/Risk Management Coordinator | 0.5 | | 0.5 |
| Infection Control (where applicable) | | | |
| | | | |
| **Preventive Medicine** (As per National Practice Leader) | | | |
| Senior Preventive Medicine Technician | | | |
| Preventive Medicine Technicians | | | |
| | | | |
| **Primary Care/Diagnostic and Therapeutics** | | | |
| | | | |
| Case Manager (if not supported by another Clinic) | | | |
| Case Manager Clerk (if not supported by another Clinic) | | | |
| Community Health Nurse | 1.0 | | 1.0 |
| | | | |
| **Care Delivery Unit** | | | |
| | | | |
| Civilian MD | 1.0 | 0.15 | 1.15 |
| Nurse Practitioner (or 0.5 Civilian MD) | 1.0 | 0.15 | 1.15 |
| Physician Assistant | | | |
| Primary Care Nurse | 1.0 | | 1.0 |
| Administrative Support Clerk | 2.0 | | 2.0 |
| Medical Technicians | 3.0 | | 3.0 |
| | | | |
| **Laboratory** (Status Quo) | | | |
| | | | |
| Senior Laboratory Technician (CF) / Team Leader | | | |
| Laboratory Technologist (CF or Civ) | | | |
| Laboratory Technician | | | |
| | | | |
| **Mental Health** (From MH SRB) | | | |
| | | | |
| Addictions Counsellor (Civ) | | | |
| Administrative Support | | | |
| Mental Health Nurse | | | |
| Psychiatrist (Civ) | | | |
| Psychologist (Civ) | | | |
| Social Work (CF or Civ) | | | |
| | | | |
| **Pharmacy** (As Per National Practice Leader) | | | |

| | Recommended FTE | Replacement FTE | Total Required FTE |
|---|---|---|---|
| | | | |
| Senior Pharmacist (CF or Civ) | | | |
| Pharmacist (Civ) | | .15 | |
| Medical Technician | | | |
| | | | |
| **Physiotherapy** (As Per National Practice Leader and established Public Service positions) | | | |
| | | | |
| Senior Physiotherapist (CF) | | | |
| Physiotherapists | | | |
| Physiotherapist Assistant | | | |
| Administrative Support | | | |
| Medical Technician | | | |
| | | | |
| **Diagnostic Imaging** (As per National Practice Leader) | | | |
| | | | |
| Senior Radiology Representative (CF) | | | |
| Technologist | | | |
| Ultrasound Technician (CF) | | | |
| Administrative Support | | | |
| | | | |
| **Support Services** | | | |
| | | | |
| Health Records Practitioner (if not supported by another Clinic) | 1.0 | 0.15 | 1.15 |
| Health Records Clerks/Technicians | 1.0 | | 1.0 |
| Medical Technician | 1.0 | | 1.0 |
| Chief Clerk (CF) | 1.0 | | 1.0 |
| Finance Clerk/Blue Cross Clerk (Civ) | 1.0 | | 1.0 |
| Reception Clerk (Civ) | | | |
| IM/IT System Administration Coordinator (if established) | | | |
| | | | |
| **Operations and Training** | | | |
| Operations and Training Officer | 1.0 | | 1.0 |
| Training NCM | 1.0 | | 1.0 |

**Figure C-4-1, Generic Staffing Template of the Canadian Forces Type III Medical Clinic**

## C-407. PRIMARY CARE SERVICES

1. **The Community Health Nurse**. There is 1.0 FTE civilian Community Health Nurse (CHN) assigned to the CHN role.

2. **Case Management**. Case Management services are provided on site by a supporting CF medical clinic.

3. **Centralized Reception**

a. Reception functions as an administrative section in the CF Medical Clinic and is responsible for most of the CF Member's medical administrative needs. The CF Type I Medical Clinic must have centralized reception functions that operate at all times so that the CF Member has a place to register and receive directions.

b. Examples of what occurs at the centralized reception include:

(1) Assignment of the new CF Member to a clinician;

(2) Clearing in/clearing out of the CF Member;

(3) Reception functions and response to the CF Member's, provision of patient directions; and

(4) Maintenance of the Clinic's Master Patient Index.

4. **The Care Delivery Unit**

a. **Leadership of the Care Delivery Unit**. Except for the CF Type III Medical Clinic on an Air Force Wing, there are no Medical Officer (MO) positions in the CDU and the Base Surgeon acts as advisor to the civilian MDs on occupational medicine issues.

b. **Care Delivery Unit Staffing**. CDU team members work collaboratively with each other and with the patient to ensure that health care is timely, appropriate and coordinated in support of the patient's recovery to complete wellness. The CF Type III Medical Clinic CDU with a rostered population of less than 1000, the staffing would normally include the following[1]:

(1) One Civilian MD;

(2) One Nurse Practitioner (NP);

(3) One Primary Care Nurse (PCN)[2];

(4) Three Med Techs[3]; and

(5) Two Administrative Support Clerks.

c. **Civilian Medical Doctor**. The CDU 1.0 FTE Civilian MD position is required five days a week. The incumbent must possess a license to practice Family Medicine in the province in which the clinic is located and be in good standing with the provincial licensing and other professional regulatory organizations.

d. **Nurse Practitioner**. The CDU 1.0 FTE NP producing at 0.5 FTE Civilian MD may be either CF or Civilian. In provinces where NPs are not licensed, 0.5 FTE Civilian MD will fill the position. Backfill is required (0.15 FTE) to ensure timely access to care.

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[1] The proposed staffing of the CDU is based upon the assumption that, over the course of the next 3-4 years, there will be a significant improvement in the numbers of CF clinical personnel.
[2] The PCN has both an administrative and clinical role.
[3] The number of Med Techs in the CDU may vary depending upon their local availability.

e. **Physician Assistant**. The Clinic Warrant Officer will function as CF Type III Clinic CDU PA for 50% of their time.

f. **Primary Care Nurse**. A Captain Nurse on Reduced Readiness status fills this position at the rate of 1.0 FTE. However, if no qualified CF Nurse is available, a civilian Nurse can fill the position. The incumbent, in collaboration with the CDU Primary Health Care Team, is responsible for the efficient and effective patient flow, follow-ups and all administrative activities within their CDU. Backfill is required from resources within the CDU as directed by the Base Surgeon to ensure ongoing coordination of CDU activities.

g. **Medical Technicians**. There is a minimum Med Tech requirement of 3.0 FTE at the CF Type III Medical Clinic CDU.

h. **Administrative/Clerical Support Clerk**. There is a 2.0 FTE Administrative/Clerical Support Clerk requirement at the CF Type III Medical Clinic.

5. **In-Patient Care**. There is no In-patient Service at the CF Type III Medical Clinic.

## C-408. DIAGNOSTIC AND THERAPEUTIC SERVICES

1. **General**. Physiotherapy, Pharmacy, Laboratory and Diagnostic Imaging services are included in this sub specialty at the CF Type III Medical Clinic. Some of these services, such as Pharmacy and Physiotherapy, provide counselling to the CF Member about their condition and maintain clinical documentation to ensure that the services provided are consistent with the needs of the CF Member.

2. **Scope of Diagnostic and Therapeutic Services**. The CF Type III Medical Clinic typically provides the following on site Diagnostic and Therapeutic services:

a. Diagnostic Imaging services;

b. Laboratory services;

c. Ophthalmology/Ears Nose and Throat services;

d. Pharmacy services inclusive of counselling;

e. Physiotherapy services;

f. Preventive Medicine services; and

g. Select Specialist services. Other requirements are referred out.

## C-409. MENTAL HEALTH SERVICES

1. In general, Type III bases/wings will have a dedicated MH services presence on the staff of the clinic

2. **Geographical Support**. The major MH facilities at Halifax, Valcartier, Ottawa, Edmonton and Esquimalt will be assigned support responsibility for a defined geographical area. These are defined as ‘First Tier’ support facilities. This applies to prof tech advice and the provision of MH services beyond the local capability of CF elements within that area. Certain other locations within each area will be designated as ‘Second Tier’ facilities providing support to designated local elements to the extent of their

capability while having access to the applicable First Tier facility for similar support as required. In effect, this is a 'delegation' of the First Tier responsibility. Depending on local circumstances and the capabilities of the respective facilities, the support provided could involve the referral of patients to the supporting facility; the provision of visiting clinicians or the provision of prof tech advice and assistance.

## C-410. SUPPORT SERVICES

### 1. The Administrative Officer – Support Services Manager

a. The CF Type III Medical Clinic AO is also the Clinic's Support Services Manager. The CF Type III Medical Clinic Support Services Manager is responsible for the Patient Administration Centre, material management, the Clinic's infrastructure, general administration, finance, and information management and information technology (IM/IT).

b. The CF Type III Medical Clinic AO/Support Services Manager is an intermediate management position that may be filled by CFHS personnel.

c. The CF Type III Medical Clinic Support Services Manager's scope of services includes:

(1) Patient Administration Centre/Reception services;

(2) Clinic Financial Management services;

(3) Human Resources Management in conjunction with CF Health Services Group Headquarters Senior Staff Officer Personnel Management and staff;

(4) IM/IT coordination with supporting Base IM/IT staff;

(5) Clinic Occupational Health Program, in conjunction, if applicable, with a supporting CF medical clinic;

(6) Clinic General Safety Program in conjunction with the supporting Base; and

(7) Clinic Orderly Room services.

### 2. Reception Services

a. The CF Type III Medical Clinic Central Reception should be an administrative element responsible for patient administrative needs.

b. The Central Reception should operate at all times so the CF Member has a place to register and receive directions.

c. The CF Medical Clinic Central Reception activities should include:

(1) Assignment of the new CF Member to a clinician;

(2) Clearing in/Clearing out of the CF Member;

(3) Reception functions and response to inquiries, provision of directions; and

(4) Maintenance of the Clinic's Master Patient Index.

d. There is a 1.0 FTE (Civ) for the CF Type III Medical Clinic's Central Receptionist role.

3. **Chief Clerk**. There is a 1.0 FTE Resource Management Clerk (RMS) for the CF Type III Medical Clinic's Chief Clerk role.

4. **Finance and Blue Cross Clerk**. There is a 1.0 FTE (Civ) for the CF Type III Medical Clinic's combined Finance Clerk and Blue Cross Clerk role. The Chief Clerk backfills.

5. **Health Records**

a. The Health Records Technicians report to the AO/Support Services Manager through the Health Records Team Leader. For training purposes and in accordance with the requirements of their QL3 OJSM, Med Techs will normally be rotated through the CF Type III Medical Clinic's Health Records Service for a period of six months. Wherever possible, CDUs should be located close to each other to allow for one centralized Health Records area, made up of individual segregated Health Records areas for each CDU.

b. There is a minimum of 1.0 FTE per CF Type III Medical Clinic assigned to the Health Records Practitioner role if a supporting CF medical clinic does not provide this support. The Health Records Practitioner oversees Health Records Technicians, reviews charts, codes and responds to Access to Information requests.

c. There is 1.0 FTE per CF Type III Medical Clinic assigned to the Health Records Technician role.

d. Medical transcription service is not provided at the CF Type III Medical Clinic.

6. **Information Management/Information Technology System Administration Coordinator**

a. This requirement was identified during the development of the position charters for the Primary Care Renewal Initiative (PCRI) pilot sites. Bases were not able to support the introduction of the computerized solutions that PCRI was requesting for either the network capabilities or manpower requirements.

b. In the longer term it is anticipated that the CF Type III Medical Clinic will receive almost all of their IT support from Base resources. As the Canadian Forces Health Information Systems (CFHIS) is implemented and the situation is reviewed on an ongoing basis, it is possible that the CF Type III Medical Clinic may require some dedicated IM/IT support.

c. Where IM/IT System Administration Coordinator support is eventually deemed necessary, the CF Type III Medical Clinic IM/IT Coordinator will be responsible for:

(1) The organization and operational efficacy of the CF Type III Medical Clinic's IT assets;

(2) Participation as required in the design and planning of infrastructure to support new applications and technologies;

(3) The provision of support to staff that utilizes these resources in the performance of their duties;

(4) Advice, support and instruction to users;

(5) E-mail account co-ordination;

(6) Installation of software, hardware; and

(7) Liaison with Base and National IT resources.

**Note:** CF medial clinics retain their current level of IM/IT support until CF H Svcs Gp HQ can demonstrate evidence to support a CF Medical Clinic IM/IT System Administration Coordinator requirement. This aspect of IM/IT support will be reviewed as CFHIS rolls-out.

7. **Chief Clerk**. There is 1.0 FTE CF Resource Management Clerk for the CF Type III Medical Clinic Chief Clerk role.

**C-411. OPERATIONS AND TRAINING**

1. The CF Type III Medical Clinic has an Operations and Training element.

## CHAPTER C-5

# THE CANADIAN FORCES TYPE IV MEDICAL CLINIC

### C-501. INTRODUCTION

1. The Canadian Forces (CF) Type IV Medical Clinic is a stand-alone CF medical clinic. It provides comprehensive Primary Care Services and a number of diagnostic and therapeutic services on-site. It may offer a range of Mental Health (MH) services. Qualified administrative personnel support clinical services personnel in order to streamline medical administrative processes. Clinic management staffs control partnerships and contracting with civilian health care providers and/or facilities. However, the responsibility for coordinating patient care aspects is left to the Primary Health Care Team. Systems will be in place to track patients and to keep their families and units informed. Patient care should not be perceived as disjointed and lacking continuity.

2. The CF Type IV Medical Clinic leadership team will consist of the Clinic Manager, Base Surgeon and Clinic Warrant Officer. The Clinic will have management responsibility for detached capabilities including medical staff assigned to Recruiting Centres. The Clinic will have integral Continuous Quality Improvement/Risk Management (CQI/RM) and an Operations and Training element. It will be able to provide special environmental clinical support.

3. The CF Type IV Medical Clinic will have at least one Care Delivery Unit (CDU). The Primary Health Care Team will provide comprehensive Primary Care Services on-site including on-call clinician. Urgent Care services will be provided during normal working hours.

4. The CF Type IV Medical Clinic Diagnostic and Therapeutics Team may provide the following services on-site; all other requirements will be referred out:

a. Immunization clinics and individualized health promotion programs;

b. Specialist Services;

c. Diagnostic Imaging Services;

d. Laboratory Services;

e. Pharmacy Services with counselling;

f. Physiotherapy Services;

g. Preventive Medicine Services

h. Mental Health Services;

i. Ophthalmology/Ears Nose and Throat Services; and

j. Regional/sector Biomedical Technician Services

5. The CF Type IV Medical Clinic will provide a well-structured patient-centered in-garrison Health Services Support (HSS) capability that is responsive to the needs of the CF Member and the supported

formation commanders and unit commanding officers. It will provide routine health care and meet the unique requirements of the CF. Civilian health care providers employed in the Clinic will be oriented to military medicine and work in tandem with their CF colleagues to foster occupational medicine requirements.

6. The CF Type IV Medical Clinic, as a dedicated in-garrison system, will respond to workload increases during peak training periods by adjusting staffing levels. It will facilitate access to care when needed for operational or career related requirements. The CF Member will be enrolled to a team of multi-disciplinary health care providers that will significantly improve Continuity of Care for the CF Member. The CF Medical Office (MO) Leader of the Primary Health Care Team will act as the Senior Medical Authority for all of the primary health care needs of the CF Member. This will extend to all areas in the Continuum of Care from prevention and Primary Health Care, through coordination and follow-up of secondary and tertiary care, to rehabilitative and palliative care.

7. The CF Type IV Medical Clinic will ensure that there are sufficient numbers of personnel with the appropriate occupational health and occupational medicine qualifications to support CF operations. There will be greater involvement of Clinic staff in Base operation and training activities. There will be optimization of CF and civilian health care providers to allow the CF health care provider opportunities to provide optimal support to CF operations and maximize the utilization of their CF occupational medicine skills. A high level of standardization will be achieved primarily through utilization of the Care Delivery Unit (CDU) Model.

## C-502. CHARACTERISTICS

1. The CF Type IV Medical Clinic supports a population of more than 1000 CF members and other entitled personnel. It is organized as a CF unit that is responsible for the provision of in-garrison HSS to CF Regular Force members, entitled Reserve Force members and other entitled personnel. It is also responsible for ensuring that appropriate continuing professional education and training opportunities are provided to CFHS personnel.

2. The CF Type IV Medical Clinic does not deploy and is not responsible for HSS to deployed operations. However, the CF Type IV Medical Clinic does have a role, through its Operations and Training Cell, in ensuring that CFHS personnel are prepared and fit for participation on deployed operations.

## C-503. IDENTIFICATION

1. The CF Type IV Medical Clinics are: CF Medical Clinic Bagotville, CF Medical Clinic Borden, CF Medical Clinic Cold Lake, CF Medical Clinic Edmonton, CF Medical Clinic Gagetown, CF Medical Clinic Greenwood, CF Medical Clinic Kingston, CF Medical Clinic Petawawa, CF Medical Clinic Shilo, CF Medical Clinic St. Jean, CF Medical Clinic Trenton, CF Medical Clinic Valcartier and CF Medical Clinic Winnipeg.

## C-504. LEADERSHIP

1. **General**

   a. At the CF Type IV Medical Clinic the administrative responsibility for in-garrison HSS is assigned to the Clinic Manager (CM). The CM reports through the CFHS chain-of-command to the Commander CF Health Services Group (Comd CF H Svcs Gp).

   b. The requirement for an effective, synergistic relationship between the CFHS chain-of-command and the Professional Technical (Prof-Tech) Network at each level within the CFHS is critical. The

working relationship between the CM and the Base Surgeon at the CF Type IV Medical Clinic should reflect an equal partnership with shared responsibilities and authorities. Although clear Terms of Reference and opportunities to participate in leadership training exercises together can support the establishment of an effective relationship, they cannot replace the essential ingredients of:

(1) A shared professional commitment to doing what is best for their patient; and

(2) Effective leadership and mentoring from their respective CFHS formation-level superiors.

c. To emphasize the requirement for the CF Type IV Medical Clinic's CM and the Base Surgeon to function effectively as a team; the CF Type IV Medical Clinic Organizational Chart should reflect the CM and the Base Surgeon occupying the same box at the top of the Organization Chart.

2. **The Clinic Manager - Senior Health Services Clinic Administrative Authority**

a. The CM of the CF Type IV Clinic reports through the CFHS Formation-level Commanding Officer to the Comd CF H Svcs Gp but ensures that the health services provided by their Clinic and its detachments support the operational needs of the supported formation commanders and unit commanding officers.

b. Once implemented, the centralized control and decentralized application will provide health care personnel with clearly defined responsibilities and the necessary authority to make timely decisions regarding the delivery of health care within their area of responsibility.

c. The CM of the CF Type IV Medical Clinic is responsible for the overall delivery of in-garrison health service programs in their designated geographical area of responsibility and as stipulated by the CF Spectrum of Care document. The CM is responsible for their Clinic's, including its detachments, efficient and effective day-to-day operation and for maintaining health service delivery accreditation standards. The CM has the responsibility for providing leadership and expertise in the overall planning, coordination, implementation and evaluation of all programs and services provided to CF members in their designated geographical area of responsibility. The CF is also responsible for the operation of the Base/Formation Clinic and for its fiscal management.

d. Using a collaborative team building approach, the CM maintains a work environment that encourages best practices, quality improvement, and innovative management with a patient focus.

e. The CM takes a leadership role in embodying the Comd CF H Svcs Gp vision, mission and values and encourages the same from all staff.

f. When the CM is absent, the Base Surgeon should normally assume the CM duties.

3. **The Base Surgeon - Senior Medical Authority**

a. As the Clinical Leader and the senior Prof Tech authority at the CF Type IV Medical Clinic, the Base Surgeon is responsible for ensuring that the appropriate clinical standards of practice are maintained and that approved processes are followed for all of the clinical programs carried out within their Clinic.

b. The Base Surgeon reports to the CFHS chain-of-command and to the supported operational chains-of-command via their CM. For the Prof Tech issues, the Base Surgeon reports to their CFHS Formation-level Senior Medical Officer.

c. When the CM is away, the Base Surgeon should normally assume the CM duties.

4. **Base Surgeon - Direct Supervisory Responsibilities**. The Base Surgeon at the CF Type IV Medical Clinic will have the following within their chain-of-command:

a. Clinical Practice Leaders in their Clinic; and

b. Medical Officers.

## C-505. INTERMEDIATE MANAGEMENT STRUCTURE

1. **Introduction**. With the exception of the Support Services Manager function, civilians will normally fill the intermediate management positions at the CF Type IV Medical Clinic. This enhances continuity in the CF Type IV Medical Clinic setting and respects the underlying principal of having CF health services personnel is their availability for deployment on operations on short notice.

2. **Intermediate Management Structure**. The intermediate management structure for the CF Type IV Medical Clinic is:

a. **Primary Care Services Manager (PCSM)** – this is a Public Service position;

b. **Diagnostic and Therapeutics Services Manager (DTSM) -** this is a Public Service position;

c. **Clinical Services Manager**. At small Type IV clinics, the Clinical Services Manager position is a position combining the functions of the PRIMARY CARE SERVICES MANAGER and the DTSM.

d. **Support Services Manager** – this is a CF Health Care Administrator (HCA) position.

e. **Mental Health Services Manager**. There will be a civilian Mental Health (MH) Manager at each CF medical clinic that has an Operational Trauma and Stress Support Center or as determined by the CF Mental Health Initiative. MH, with no MH Manager position, will have a MH Team Leader reporting to the DTSM.

f. **Continuous Quality Improvement/Management Coordinator**. The CF Type IV Medical Clinic will have one full-time coordinator (CF or civilian), who will also be responsible for CQI/RM at the CF Type IV Medical Clinic's detachment sites.

## C-506. GENERIC STAFFING TEMPLATE

| | Recommended FTE | Replacement FTE | Total Required FTE |
|---|---|---|---|
| **Command Structure** | | | |
| | | | |
| Clinic Manager | 1.0 | | 1.0 |
| Base Surgeon | 1.0 | | 1.0 |
| Clinic Warrant Officer | 1.0 | | 1.0 |
| Secretary (Base Surgeon /Clinic Manager) | 1.0 | | 1.0 |
| CQI/Risk Management Coordinator | 1.0 | | 1.0 |
| Primary Care Services Manager | 1.0 | | 1.0 |

| | Recommended FTE | Replacement FTE | Total Required FTE |
|---|---|---|---|
| Diagnostic and Therapeutic Services Manager | 1.0 | | 1.0 |
| Support Services Manager | 1.0 | | 1.0 |
| Mental Health Manager (As determined by Mental Health Initiative) | 1.0 | | 1.0 |
| Infection Control Officer (As applicable) | | | |
| | | | |
| **Primary Care** | | | |
| Administrative Support | 1.0 | | 1.0 |
| Community Health Nurse | 1.0 | | 1.0 |
| Case Manager | | | |
| Case Manager Clerk | | | |
| | | | |
| **Care Delivery Unit** | | | |
| | | | |
| Medical Officer | 2.0 | | 2.0 |
| Civilian MD | 1.0 | 0.15 | 1.15 |
| Nurse Practitioner | 1.0 | 0.15 | 1.15 |
| Physician Assistant | 1.0 | | 1.0 |
| Primary Care Nurse | 1.0 | | 1.0 |
| Administrative Support Clerk | 2.0 | | 2.0 |
| Medical Technicians | 3.0 | | 3.0 |
| | | | |
| **Diagnostic and Therapeutic Services** | | | |
| Preventive Medicine (As per Practice Leader Document) | | | |
| Senior Preventive Med Technician | | | |
| Preventive Med Technicians | | | |
| Specialist Services Co-coordinator (only if conducting many specialist clinics) | 1.0 | | 1.0 |
| | | | |
| **Laboratory** (Status Quo) | | | |
| | | | |
| Senior Lab Technician (CF) | | | |
| Lab Technologist (CF or Civ) | | | |
| Lab Technician | | | |
| | | | |
| **Mental Health** (From MH SRB) | | | |
| | | | |
| Addictions Counsellor (Civ) | | | |
| Administrative Support | | | |
| Mental Health Nurse | | | |
| Psychiatrist (Civ) | | | |
| Psychologist (Civ) | | | |
| Social Work (CF or Civ) | | | |
| Chaplain | | | |

| | Recommended FTE | Replacement FTE | Total Required FTE |
|---|---|---|---|
| | | | |
| **Pharmacy** (As per National Practice Leader) | | | |
| | | | |
| Senior Pharmacist (CF/Civ) | | 0.15 | |
| Pharmacist (Civ) | | 0.15 | |
| Pharmacy Technician (Civ) | | | |
| Medical Technician | 1.0 | | 1.0 |
| | | | |
| Physiotherapy (As National Practice Leader and current established Public Service positions) | | | |
| Senior Physiotherapist (CF/Civ) | | | |
| Physiotherapists | | | |
| Physiotherapist Assistant | | | |
| Medical Technician | | | |
| Administrative Support | | | |
| | | | |
| **Diagnostic Imaging** (As per National Practice Leader) | | | |
| | | | |
| Senior Radiology Tech (CF/Civ) | | | |
| Technologist | | | |
| Ultrasound Tech (CF) | | | |
| Administrative Support | | | |
| | | | |
| **Support Services** | | | |
| Health Records Practitioner (Team Leader) | 1.0 | 0.15 | 1.15 |
| Health Records Clerks | 2.0 | | 2.0 |
| Transcriptionist (Status Quo) | | 0.15 | |
| Chief Clerk (CF) | 1.0 | | 1.0 |
| Finance Clerk (CF or Civ) | 1.0 | | 1.0 |
| Blue Cross Clerk (Civ) | 1.0 | | 1.0 |
| Reception Clerk | 1.0 | | 1.0 |
| IM/IT System Administration Coordinator (if established) | 1.0 | | 1.0 |
| **Operations and Training** | | | |
| Operations and Training Officer | 1.0 | | 1.0 |
| Training NCM | 1.0 | | 1.0 |

**Figure C-5-1, Generic Staffing Template of the Canadian Forces Type IV Medical Clinic**

## C-507. PRIMARY CARE SERVICES

1. **Introduction**. The Primary Care Services Manager is responsible for overseeing the activities of centralized Reception, CDUs, Case Manager(s) and the Community Health Nurse(s). The range of

services that fall under the purview of the PRIMARY CARE SERVICES MANAGER include:

a. Appointment scheduling, internal and external;

b. Case Management services;

c. Centralized Reception;

d. Comprehensive care planning;

e. Comprehensive Primary Care services provided on-site, including on-call clinician;

f. Consideration, when applicable, of care to transient population;

g. Coordination of access to external health services;

h. Immunization clinic and individualized health promotion programs;

i. Dependants on Base and detachment clinics and Recruiting Centres;

j. Minimum of one Care Delivery Unit; and

k. Urgent Care services.

2. **Community Health Nurse**. There is 1.0 Full Time Equivalent (FTE) assigned to the role of Community Health Nurse (CHN)

3. **Case Management**. The Case Management team reports to the Primary Care Services Manager. Case Manager staffing at CF Medical Clinics is based upon clinic size and the provision of Operational Trauma and Stress Support Centre on site. Clerical administrative support is based on 1.0 FTE per two Case Managers.

4. **The Care Delivery Unit**

a. **Leadership of the Care Delivery Unit**. A MO will normally lead the CDU for all administrative, supervisory and Prof Tech matters. By placing an MO in the role of Team Leader, support to the chain-of-command will be enhanced. The MO Team Leader will report to the Primary Care Services Manager for administrative and management matters and to the Base Surgeon for Prof Tech matters. When the MO Team Leader is away, the CDU's second MO would normally assume the Team Leader's duties. If a second MO is not available for this purpose, the Primary Care Services Manager has two options:

(1) The Primary Care Services Manager act as a direct supervisor the CDU staff; or

(2) The Primary Care Services Manager can assign someone from within the CDU to be the overall supervisor for the CDU, for example the CDU PCN as the Administrative Authority and the civilian Medical Doctor (MD) as the Clinical Authority.

b. **Liaising With Operational Units**. The MO CDU Leader, supported by their CDU Primary Care Nurse (PCN) and their CDU Physician Assistant (PA), has the responsibility to ensure their CDU liaison activities are carried out. The civilian MD and others in the CDU have the obligation to liaise directly with the CF Member's unit where appropriate. It is the MO Team Leader's

responsibility to ensure such liaison is carried out.

c. **Care Delivery Unit Staffing**

(1) **Introduction**. The CDU team members work collaboratively with each other and with the CF Member to ensure that care is timely, appropriate and coordinated in support of the CF Member's recovery to complete wellness. The CDU team is supported by in-house Physiotherapists, Pharmacists and MH professionals, who provide care either in collaboration with the team or through direct intervention. For a CDU with a rostered population of 1500, the staffing would typically include the following[1]:

(a) Two General Duty Medical Officers (GDMOs)[2];

(b) One Civilian MD;

(c) One Nurse Practitioner (NP);

(d) One Primary Care Nurse (PCN)[3];

(e) Physician Assistant (PA);

(f) Three Medical Technicians (Med Techs)[4]; and

(g) Two Administrative Support Clerks.

(2) **Medical Officer**. There are 2.0 FTE MO per CDU, producing at 0.5 FTE Civilian MD each. One MO will be designated as the CDU Leader. In operational flying wings sufficient Flight Surgeon capability must be provided. Backfill will be required.

(3) **Civilian Medical Doctor**. There is 1.0 FTE Civilian MD required to attend the CDU five days a week throughout the year. The incumbent must possess a license to practice Family Medicine in the province in which the clinic is located and be in good standing with the provincial licensing and other professional regulatory organizations.

(4) **Nurse Practitioner**. There is 1.0 FTE NP per CDU producing at 0.5 FTE Civilian MD capacities. The NP may be either CF or Civilian. In provinces where NPs are not licensed, 0.5 FTE Civilian MD will fill the position. Backfill is required at the rate of 0.15 FTE to ensure timely access to care.

(5) **Physician Assistant**. There is 1.0 FTE PA per CDU producing at 0.5 FTE Civilian MD. In addition to providing patient care the CDU PA will coordinate the work of the CDU's Med Techs.

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[1] The proposed staffing of the CDU is based upon the assumption that, over the course of the next 3-4 years, there will be a significant improvement in the numbers of uniformed clinical personnel.
[2] The CFHS is established for 100 Captain GDMOs. It is anticipated that there will be a total of approximately 40-50 CDUs established across the CF (this number if approximate because CDU roster size will vary slightly from Base to Base). Thus, there will be approximately two Captain GDMOs assigned to each CDU.
[3] The Primary Care Nurse has both an administrative and clinical role.
[4] The number of Med Techs in a CDU may vary depending upon their local availability.

(6) **Primary Care Nurse**. There is 1.0 FTE PCN per CDU. A Captain Nurse on Reduced Readiness status fills this position. If no qualified CF Nurse is available, a civilian Nurse may fill the position. The incumbent is responsible for the efficient and effective patient flow, follow-ups and all administrative activities within their CDU. Backfill is required to ensure ongoing coordination of CDU activities. Replacement should be provided from resources available to the Primary Care Services Manager.

(7) **Medical Technicians**. There is a minimum requirement of 3.0 FTE Med Tech per CDU.

(8) **Administrative Support Clerk**. There is a requirement of 2.0 FTE Administrative Support Clerk per CDU.

d. **Augmented Care Delivery Units**. The CF Type IV Medical Clinic on training bases i.e., Kingston, Borden, Gagetown, and St-Jean will require additional CDU staff for those periods when there are additional transient CF members on Base. Incremental staffing at the following rates may be required per CDU

(1) **Civilian MD**. An additional 1.0 FTE Civilian MD; and

(2) **Nurse Practitioner**. An additional 1.0 FTE NP producing at 0.5 FTE Civilian MD. The NP may be either CF or civilian.

e. **In-Patient Care**. No In-patient services are provided at the CF Type IV Medical Clinic.

f. **Documentation Associated with Assessment, Treatment and Disposition**. Documentation, of all patient interactions is both a legal and professional responsibility. In the longer term, the CF Health Information System (CFHIS) and Electronic Health record (EHR) will obviate much of the requirement for paper files for in-garrison care. The descriptions provided in Chapter B-6 are therefore intended only to provide guidance on the use of the current paper documents until the CFHIS has been fully implemented.

## C-508. DIAGNOSTIC AND THERAPEUTIC SERVICES

1. The DTSM has responsibility for a broad range of services. The scope of on-site services within the administrative purview of DTSM include:

a. Diagnostic Imaging services;

b. Laboratory services;

c Mental Health services, where there is no MH Manager;

d. Ophthalmology/Ears Nose and Throat services;

e. Pharmacy services, including on-site counselling;

f. Physiotherapy services;

g. Preventive Medicine services; and

h. Specialist services.

2. **Diagnostic Imaging Service**. The CF Type IV Medical Clinic typically provides Diagnostic Imaging (DI) services on site. There may be exceptions to this general rule as a function of the availability of local resources, business case analysis and the nature and tempo of Base operations. The DI staff schedule appointments for on and off site DI services.

3. **Laboratory Service**. The CF Type IV Medical Clinic typically provides Laboratory (Lab) services on site. The Lab staff does the appointment scheduling for on and off site Laboratory services.

4. **Preventive Medicine Service**. The Preventive Medicine (PMed) Service has a unique and highly specialized role that requires quick and regular access to a Senior Medical Officer. For this reason, the Base Surgeon at the CF Type IV Medical Clinic is responsive to the needs of their Clinic PMed staff and the DTSM oversees their administrative requirements. At Maritime Command bases, the PMed staff typically functions under the professional technical oversight of the Fleet Support Medical Officer. At Land Forces bases with a Regular Force Field Ambulance, the PMed staff typically functions under the professional technical oversight of the Brigade Surgeon.

5. **Specialist Services**. Specialist services are typically found at the CF Type IV Medical Clinic. Specialists who may be either CF or civilian provide either on or off site Specialist services. The CDU administrative support staff schedules the referrals to Specialist services. The process is started when the administrative staff receives a completed Requisition for Consultation form from a health care provider of their CDU.

## C-509. MENTAL HEALTH SERVICES

1. In general, bases/wings at which there is a Type IV will have a dedicated MH services presence on the staff of the clinic

2. **Geographical Support**. The major MH facilities at Halifax, Valcartier, Ottawa, Edmonton and Esquimalt will be assigned support responsibility for a defined geographical area. These are defined as ‘First Tier’ support facilities. This applies to prof tech advice and the provision of MH services beyond the local capability of CF elements within that area. Certain other locations within each area will be designated as ‘Second Tier’ facilities providing support to designated local elements to the extent of their capability while having access to the applicable First Tier facility for similar support as required. In effect, this is a ‘delegation’ of the First Tier responsibility. Depending on local circumstances and the capabilities of the respective facilities, the support provided could involve the referral of patients to the supporting facility; the provision of visiting clinicians or the provision of prof tech advice and assistance

## C-510. SUPPORT SERVICES

1. **Introduction**. The Support Services Manager, as one of the CF Type IV Medical Clinic intermediate managers, is responsible for a wide range of services. A senior and experienced CF health Care Administrator (HCA) will typically fill this position. The CF Type IV Medical Clinic Support Services Manager’s scope of responsibility will include:

a. Facility Management;

b. Financial services;

c. Health Records services;

d. Human Resources management services;

e. Information Management/Information Technology services;

f. Occupational Health programs;

g. Clinic Orderly Room services; and

h. Transportation.

2. **Health Records**

a. The CF Type IV Medical Clinic is responsible for the professional management of the CF Member's Health Record. The Health Records Practitioner will oversee the management of Health Records at their CF Type IV Medical Clinic's detachment sites. Additionally, The CF Type IV Medical Clinic is responsible for the Health Records management and administration for catchments population of other entitled persons and all CF 2034s retained on site. The Health Records clerks report to the Support Services Manager through the Health Records Practitioner.

b. For training purposes and in accordance with the requirements of their QL3 OJSM, Med Techs will normally be rotated through Health Records for a period of six months.

c. Wherever possible and as per the CF Type IV Medical Clinic infrastructure template, CDUs should be located close to each other to allow for one centralized Health Records area, made up of individual segregated Health Records areas for each CDU.

d. There will be one civilian Health Records Practitioner and 2.0 FTE Civilian Health Records Clerk/Technicians staffed at CF Type IV Medical Clinic.

e. The transcription function is inherent to Health Records management and the CF Type IV Medical Clinic possessing Transcription services shall maintain the capability.

3. **Information Management/Information Technology System Administration Coordinator**

a. This requirement was identified during the development of the position charters for the Primary Care Renewal Initiative (PCRI) pilot sites. Bases were not able to support the introduction of the computerized solutions that PCRI was requesting for either the network capabilities or manpower requirements.

b. In the longer term it is anticipated that the CF Type IV Medical Clinic will receive almost all of their IT support from Base resources. As the Canadian Forces Health Information Systems (CFHIS) is implemented and the situation is reviewed on an ongoing basis, it is possible that the CF Type IV Medical Clinic may require some dedicated IM/IT support.

c. Where IM/IT System Administration Coordinator support is eventually deemed necessary, the CF Type III Medical Clinic IM/IT Coordinator will be responsible for:

(1) The organization and operational efficacy of the CF Type IV Medical Clinic's IT assets;

(2) Participation as required in the design and planning of infrastructure to support new applications and technologies;

(3) The provision of support to staff that utilizes these resources in the performance of their duties;

(4) Advice, support and instruction to users;

(5) E-mail account co-ordination;

(6) Installation of software, hardware; and

(7) Liaison with Base and national IT resources.

**Note:** CF Medial Clinics retain their current level of IM/IT support until CF H Svcs Gp HQ can demonstrate evidence to support a CF Medical Clinic IM/IT System Administration Coordinator requirement. This aspect of IM/IT support will be reviewed as CFHIS rolls-out.

4. **Chief Clerk**. 1.0 FTE CF Resource Management Clerk is assigned to the CF Type IV Medical Clinic. Base personnel staff some positions in the CF Type IV Medical Clinic Orderly Room. The Chief Clerk will control the Personnel Administration functions of the Clinic Orderly Room.

5. **Finance Clerk**. There is 1.0 FTE CF or Civilian Finance Clerk position at the CF Type IV Medical Clinic. It is expected that the CF Type IV Medical Clinic's Finance and Blue Cross clerks will cover for each other's absences. The Finance Clerk will perform Med Finance and Personnel Administration duties.

6. **Blue Cross Clerk**. There is 1.0 FTE CF or Civilian Blue Cross Clerk position at the CF Type IV Medical Clinic. It is expected that the Finance and Blue Cross clerks will cover for each other's absences. The Blue Cross Clerk will perform Med Finance duties.

## C-511. OPERATIONS AND TRAINING

1. The CF Type IV Medical Clinic has an Operations and Training element. However, for those clinics integral to the Regular Force Field Ambulance, the oversight of operations and training will be the responsibility of the Regular Force Field Ambulance Operations and Training element.

## CHAPTER C-6

# THE CANADIAN FORCES TYPE V MEDICAL CLINIC

### C-601. INTRODUCTION

1. The Canadian Forces (CF) Type V Medical Clinic is the largest stand-alone CF Medical Clinic. Headed by a Lieutenant Colonel, it provides comprehensive primary care services and a number of diagnostic and therapeutic services on-site. It may offer a range of Mental Health (MH) services. It may also have day surgery capability and limited In-patient Care on-site. Qualified administrative personnel support clinical services personnel in order to streamline medical administrative processes. Clinic management staffs control partnerships and contracting with civilian health care providers and/or facilities. However, the responsibility for coordinating patient care aspects is left to the Primary Health Care Team. Systems will be in place to track patients and to keep their families and units informed. Patient care should not be perceived as disjointed and lacking continuity.

2. The CF Type V Medical Clinic leadership team will consist of the Clinic Manager, Formation Surgeon and Clinic Warrant Officer. The Clinic will have management responsibility for detached capabilities including medical staff assigned to Recruiting Centres. The Clinic will have integral Continuous Quality Improvement/Risk Management (CQI/RM) and Preventive Medicine services, an Operations and Training element. It will be able to provide special environmental clinical support.

3. The CF Type V Medical Clinic will have at least three Care Delivery Units (CDUs). Primary Health Care Teams will provide comprehensive primary care services on-site including on-call clinician. Urgent Care services will be provided during normal working hours. The Clinic will have integral Case Management services.

4. The CF Type V Medical Clinic Diagnostic and Therapeutics Team may provide the following services on-site; all other requirements will be referred out:

a. Immunization clinics and individualized health promotion programs;

b. Specialist services;

c. Diagnostic Imaging services;

d. Laboratory services;

e. Pharmacy services with counselling;

f. Physiotherapy services;

g. Preventive Medicine services;

h. Mental Health services;

i. Ophthalmology/Ears Nose and Throat services; and

j. Regional/sector Biomedical Technician services.

5. The CF Type V Medical Clinic will provide a well-structured patient-centered in-garrison Health Services Support (HSS) capability that is responsive to the needs of the CF Member and

the supported formation commanders and unit commanding officers. It will provide routine health care and meet the unique requirements of the CF. Civilian health care providers employed in the Clinic will be oriented to military medicine and work in tandem with their CF colleagues to foster occupational medicine requirements.

6. The CF Type V Medical Clinic, as a dedicated in-garrison system, will respond to workload increases during peak training periods by adjusting staffing levels. It will facilitate access to care when needed for operational or career related requirements. The CF Member will be enrolled to a team of multi-disciplinary health care providers that will significantly improve Continuity of Care for the CF Member. The CF Medical Officer (MO) Leader of the Primary Health Care Team will act as the Senior Medical Authority for all of the primary health care needs of the CF Member. This will extend to all areas in the Continuum of Care from prevention and primary health care, through coordination and follow-up of secondary and tertiary care, to rehabilitative and palliative care.

7. The CF Type V Medical Clinic will ensure that there are sufficient numbers of personnel with the appropriate occupational health and occupational medicine qualifications to support CF operations. There will be greater involvement of Clinic staff in Base operation and training activities. There will be optimization of CF and civilian health care providers to allow the CF health care provider opportunities to provide optimal support to CF operations and maximize the utilization of their CF occupational medicine skills. A high level of standardization will be achieved primarily through utilization of the Care Delivery Unit (CDU) Model.

## C-602. CHARACTERISTICS

1. The CF Type V Medical Clinic supports a population of more than 5000 CF members and other entitled personnel. It is organized as a CF unit that is responsible for the provision of in-garrison HSS to CF Regular Force members, entitled CF Reserve Force members and other entitled personnel. It is also responsible for ensuring that appropriate continuing professional education and training opportunities are provided to CFHS personnel.

2. The CF Type V Medical Clinic does not deploy and is not responsible for HSS to deployed operations. However, it does have a role, through its Operations and Training element, in ensuring that CFHS personnel are prepared and fit for participation on deployed operations.

## C-603. IDENTIFICATION OF THE CANADIAN FORCES TYPE V MEDICAL CLINICS

1. The CF Type V Medical Clinics are: CF Medical Clinic Esquimalt, CF Medical Clinic Halifax and CF Medical Clinic Ottawa

## C-604. LEADERSHIP

1. **The Clinic Manager of the Canadian Forces Type V Medical Clinic**

   a. Administrative authority and responsibility for the CF Type V Medical Clinic is vested in the Clinic Manager (CM). The CM reports through the CFHS chain-of-command to the Commander Canadian Forces Health Services Group (Comd CF H Svcs Gp) and ensures that the in-garrison HSS provided by their clinic and, if applicable, all its detachments meet the operational needs of the CF commanders and commanding officers in their designated geographical area of responsibility.

      **Note:** Once implemented, the centralized control and decentralized application will provide health care personnel with clearly defined responsibilities and the necessary authority to make timely decisions regarding the delivery of health care within their designated area of responsibility.

b. The CM is responsible for the overall delivery of in-garrison health service programs, as stipulated in the CF Spectrum of Care document, in their designated geographical area of responsibility. The CM is responsible for the efficient and effective day-to-day operation of their Clinic, including, if applicable, all its detachments. Responsibility is inclusive of financial management and maintaining health service accreditation standards. The CM is also responsible for providing leadership and expertise in the overall planning, coordination, implementation and evaluation of all aspects of in-garrison HSS provided in their designated area of responsibility to CF members, units and formations.

c. Using a collaborative team building approach, the CM maintains a work environment that encourages best practices, Quality Improvement and innovative management with a patient-centered focus. The CM also takes a leadership role in embodying the Comd CF H Svcs Gp vision, mission and values and encourages the same from all their staff.

2. **The Formation Surgeon**

a. The Formation Surgeon at the CF Type V Medical Clinic is the local Clinical Leader (CL). The Formation Surgeon is responsible for ensuring that the appropriate clinical standards of practice are maintained and that approved processes are followed for all of the clinical programs carried out within their Clinic. The Formation Surgeon reports to the CFHS chain-of-command through their CM and through the designated medical authority at their superior CFHS headquarters on professional technical matters.

b. Using a collaborative team building approach, the Formation Surgeon maintains a work environment that encourages best practices, Quality Improvement and innovative professional technical approach with a patient-centered focus. The Formation Surgeon also takes a leadership role in embodying the CFHS professional vision, mission and values and encourages the same from all their staff.

c. The Formation Surgeon at the CF Type V Medical Clinic will typically have their Clinic's Infection Control Nurse, the Clinic Warrant Officer and their Clinic's Practice Leaders within their chain-of-command.

## C-605. INTERMEDIATE MANAGEMENT STRUCTURE

1. The intermediate management structure of the CF Type V Medical Clinic is:

a. **Primary Care Services Manager**. At the CF Type V Medical Clinic where the CM and the CL are Lieutenant Colonels, a Major Nursing Officer would typically fill the Primary Care Services Manager position. The Primary Care Services Manager would be selected on the basis of possessing requisite training, a proven track record of excellent supervisory skills and a commitment that they would not be deployed on operations for two to three years;

b. **Diagnostic and Therapeutic Services Manager**. A Public Service member will fill the Diagnostic and Therapeutic Services Manager (DTSM) position;

c. **Mental Health Services Manager**. There will be a civilian Mental Health (MH) Manager at each clinic that has an Operational Trauma Stress Support Centre or as determined by the CF Mental Health Initiative. MH, with no MH Manager position, will have a MH Team Leader reporting to the DTSM;

d. **Support Services Manager**. A CF Health Care Administrator will fill the Support Services Manager position; and

e. **Continuous Quality Improvement/Risk Management Coordinator**. A full time CF or civilian Continuous Quality Improvement/Risk Management (CQI/RM) Coordinator position is allocated to the CF Type V Medical Clinic.

## C-606. GENERIC STAFFING TEMPLATE

| | Recommended FTE | Replacement FTE | Total Required FTE |
|---|---|---|---|
| **Command Structure** | | | |
| | | | |
| Clinic Manager | 1.0 | | 1.0 |
| Formation Surgeon | 1.0 | | 1.0 |
| Base Surgeon | 1.0 | | 1.0 |
| Clinic Warrant Officer | 1.0 | | 1.0 |
| Secretary (Clinic Manager/Base Surgeon) | 1.0 | | 1.0 |
| CQI/RM Coordinator | 1.0 | | 1.0 |
| Primary Care Services Manager | 1.0 | | 1.0 |
| Diagnostic and Therapeutic Services Manager | 1.0 | | 1.0 |
| Support Services Manager | 1.0 | | 1.0 |
| Mental Health Manager (As determined by Mental Health Initiative) | 1.0 | | 1.0 |
| Infection Control Officer (As applicable) | 1.0 | | 1.0 |
| | | | |
| **Primary Care Service** | | | |
| Community Health Nurse | 1.0 | | 1.0 |
| Administrative Support | 1.0 | | 1.0 |
| Case Manager | | | |
| Case Manager Clerk | | | |
| | | | |
| **Care Delivery Unit** | | | |
| | | | |
| Medical Officer | 2.0 | | 2.0 |
| Civilian Medical Doctor | 1.0 | 0.15 | 1.15 |
| Nurse Practitioner | 1.0 | 0.15 | 1.15 |
| Physician Assistant | 1.0 | | 1.0 |
| Primary Care Nurse | 1.0 | | 1.0 |
| Administrative Support Clerk | 2.0 | | 2.0 |
| Medical Technicians | 3.0 | | 3.0 |
| | | | |
| **Diagnostic and Therapeutic Service** | | | |
| | | | |
| Specialist Services Coordinator | 1.0 | 0.15 | 1.15 |
| | | | |
| Preventive Medicine (as per National Practice Leader) | | | |
| Preventive Medicine Senior Technician | | | |
| Preventive Medicine Technicians | | | |
| | | | |

| | Recommended FTE | Replacement FTE | Total Required FTE |
|---|---|---|---|
| **Diagnostic Imaging (As National Practice Leader)** | | | |
| | | | |
| Senior Radiologist Rep (CF) | | | |
| Technologist | | | |
| Ultrasound Technician (CF) | | | |
| Administrative Support | | | |
| | | | |
| **Laboratory** (Status Quo) | | | |
| | | | |
| Team Leader/Senior Laboratory Technician (CF) | | | |
| Laboratory Technologist (CF or Civ) | | | |
| Laboratory Technician (CF) | | | |
| | | | |
| **Pharmacy** (As per National Practice Leader) | | | |
| | | | |
| Senior Pharmacist (CF or Civ) | | | |
| Pharmacist (Civ) | | | |
| Medical Technician | | | |
| | | | |
| **Physiotherapy** (As per National Practice Leader and established Public Service Positions) | | | |
| | | | |
| Senior Physiotherapist (CF) | | | |
| Physiotherapists | | | |
| Physiotherapy Assistant | | | |
| Administrative Support | | | |
| | | | |
| **Mental Health Service** (As per National Practice Leader) | | | |
| | | | |
| Addictions Counsellor (Civ (PS)) | | | |
| Psychiatrist (CF or Civ (PS)) | | | |
| Psychologist (Civ (PS)) | | | |
| Social Work (CF or Civ (PS)) | | | |
| Chaplain (CF) | | | |
| Nurse (CF or Civ (PS)) | | | |
| Administrative Support (Civ (PS)) | | | |
| | | | |
| **Support Services** | | | |
| | | | |
| Chief Clerk (CF) | 1.0 | | 1.0 |
| Finance Clerk/Blue Cross Clerk (Civ) | 1.0 | | 1.0 |
| Reception Clerk (Civ) | 1.0 | 0.15 | 1.15 |
| Health Records Practitioner (if not supported by a designated superior CFHS Clinic) | 1.0 | 0.15 | 1.15 |
| Health Records Technician/Clerk | 1.0 | | 1.0 |
| Medical Technician | 1.0 | | 1.0 |
| IM/IT System Administration Coordinator (if | | | |

| | Recommended FTE | Replacement FTE | Total Required FTE |
|---|---|---|---|
| established) | | | |
| | | | |
| **Operations and Training** | | | |
| | | | |
| Operations and Training Officer (CF) | 1.0 | | 1.0 |
| Training NCM (CF) | 1.0 | | 1.0 |
| | | | |
| **In-Patient Service** | | | |
| | | | |
| Operating Room – As per Position Charter | | | |
| Ward – As per Position Charter | | | |
| Emergency Room – As per Position Charter | | | |

**Figure C-6-1, Generic Staffing Template of the Canadian Forces Type V Medical Clinic**

## C-607. PRIMARY CARE SERVICES

1. **Introduction**. The Primary Care Services Manager is responsible for overseeing the activities of the CDUs, the Case Management team and the Community Health Nurse. Services to which the Primary Care Services Manager attends include:

a. Appointment scheduling, internal and external;

b. Case management;

c. Comprehensive care planning;

d. Comprehensive primary care on-site, including on-call clinician;

e. Coordination of access to external health services;

f. Immunization clinic and individualized health promotion programs;

g. Limited in-patient care provided on-site;

h. Minimum of three Care Delivery Units; and

i. Urgent Care services provided during normal working hours.

2. **The Community Health Nurse**. There is 1.0 Full Time Equivalent (FTE) Civilian Community Health Nurse (CHN) assigned to the Primary Care Services Manager.

3. **Case Management**. The Case Manager team reports to the Primary Care Services Manager. The staffing of Case Managers at CF medical clinics is based upon clinic size and the provision of Operational Trauma and Stress Support Centre on site. Clerical administrative support is based on 1.0 FTE per two Case Managers.

4. **In-Patient Care**. Normally The CF Type V Medical Clinic will not have In-patient beds. However, where unique local circumstances demand, CF H Svcs Gp HQ Deputy Chief of Staff Health Services Delivery may authorize the provision of In-patient Care.

5. **The Care Delivery Unit**

a. **Leadership of the Care Delivery Unit**. A Medical Officer (MO) will normally lead the CDU for all administrative, supervisory and Prof Tech matters. Placing the MO in the role of "Team Leader" enhances support to the CF member's chain-of-command. The MO Team Leader will report to the Primary Care Services Manager for administrative and management matters and to the Formation Surgeon for Prof Tech matters. When the MO Team Leader is away, the CDU's second MO would normally assume the Team Leader's duties. If a second MO is not available for this purpose, the Primary Care Services Manager has two options:

(1) The Primary Care Services Manager **can** act as a direct supervisor the CDU staff; or

(2) The Primary Care Services Manager can assign someone from within the CDU to be the overall Team Leader for the CDU, for example the Primary Care Nurse (PCN) as the Administrative Authority and the civilian Medical Doctor (MD) as the Senior Medical Authority.

b. **Liaising With Operational Units**. The MO CDU Leader, supported by their CDU PCN and their CDU Physician Assistant (PA), has the responsibility to ensure their CDU liaison activities are carried out. The civilian MD and others in the CDU have the obligation to liaise directly with the CF Member's unit where appropriate. It is simply the MO Team Leader's responsibility to ensure such liaison is carried out.

c. **Care Delivery Unit Staffing**

(1) **Introduction**. The CDU team members work collaboratively with each other and with the CF Member to ensure that care is timely, appropriate and coordinated in support of the CF Member's recovery to complete wellness. The CDU team is supported by in-house Physiotherapists, Pharmacists and MH professionals, who provide care either in collaboration with the team or through direct intervention. For a CDU with a rostered population of 1500, the staffing would typically include the following[1]:

(a) Two General Duty Medical Officers (GDMOs)[2];

(b) One Civilian MD;

(c) One Nurse Practitioner (NP);

(d) One PCN[3];

(e) One PA;

(f) Three Medical Technicians (Med Techs)[4]; and

(g) Two Administrative Support Clerks.

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[1] The proposed staffing of the CDU is based upon the assumption that, over the course of the next 3-4 years, there will be a significant improvement in the numbers of uniformed clinical personnel.

[2] The CFHS is established for 100 Captain GDMOs. It is anticipated that there will be a total of approximately 40-50 CDUs established across the CF (this number if approximate because CDU roster size will vary slightly from Base to Base). Thus, there will be approximately two Captain GDMOs assigned to each CDU.

[3] The Primary Care Nurse has both an administrative and clinical role.

[4] The number of Med Techs in a CDU may vary depending upon their local availability.

(2) **Medical Officer**. There are 2.0 FTE MOs per CDU, producing at 0.5 FTE Civilian MD each. One MO will be designated as the CDU Leader. In operational flying wings sufficient Flight Surgeon capability must be provided. Backfill will be required.

(3) **Civilian Medical Doctor**. There is 1.0 FTE Civilian MD required to attend the CDU five days a week throughout the year. The incumbent must possess a license to practice Family Medicine in the province in which the clinic is located and be in good standing with the provincial licensing and other professional regulatory organizations.

(4) **Nurse Practitioner**. There is 1.0 FTE NP per CDU producing at 0.5 FTE Civilian MD capacities. The NP may be either CF or civilian. In provinces where NPs are not licensed, 0.5 FTE Civilian MD will fill the position. Backfill is required at the rate of 0.15 FTE to ensure timely access to care.

(5) **Physician Assistant**. There is 1.0 FTE per CDU producing at 0.5 FTE Civilian MD. In addition to providing patient care the CDU PA will coordinate the work of the CDU's Med Techs.

(6) **Primary Care Nurse**. There is 1.0 FTE PCN per CDU. A Captain Nurse on Low Readiness status fills this position. If no qualified CF Nurse is available, a civilian Nurse may fill the position. The incumbent is responsible for the efficient and effective patient flow, follow-ups and all administrative activities within their CDU. Backfill is required to ensure ongoing coordination of CDU activities. Replacement should be provided from resources available to the PRIMARY CARE SERVICES MANAGER.

(7) **Medical Technicians**. There is a minimum requirement of 3.0 FTE Med Tech per CDU.

(8) **Administrative Support Clerk**. There is a requirement of 2.0 FTE per CDU.

d. **Augmented Care Delivery Units**. The CF Type V Medical Clinic at CFB Esquimalt, a CF training Base, will require additional CDU staff for those periods when there are additional transient CF members on Base. Incremental staffing at the following rates may be required per CDU

(1) **Civilian MD**. An additional 1.0 FTE Civilian MD; and

(2) **Nurse Practitioner**. An additional 1.0 FTE NP producing at 0.5 FTE Civilian MD capacities. The NP may be either CF or civilian.

e. **Documentation Associated with Assessment, Treatment and Disposition**. Documentation, of all patient interactions is both a legal and professional responsibility. In the longer term, the CF Health Information System (CFHIS) and Electronic Health record (EHR) will obviate much of the requirement for paper files for in-garrison care. The descriptions provided in Chapter B-6 are therefore intended only to provide guidance on the use of the current paper documents until the CFHIS has been fully implemented.

## C-608. IN-PATIENT AND SURGICAL SERVICES

1. At Type V CF Medical Clinics where surgical and in-patient services are provided, the CM and Base Surgeon have a responsibility to ensure that the services meet Canadian standards, and that staff have sufficient workload to maintain their competence in providing the services.

3. The departmental structure, staffing level, equipment, and number of beds will be based on the clinical necessity and the business case supporting the requirement. Typically, there will be only one Operating Room, a Recovery Room, and a small number of In-patient beds. A CF or civilian Nurse will typically be appointed to lead the In-patient and Surgical Service. The Service will be staffed with the clinical specialists in surgery and anaesthesia, as well as other sub-specialists who have surgical privileges, Operating Room nurses and technicians, and a small number of Nurses and Med Techs serve the In-patient area.

## C-609. DIAGNOSTIC AND THERAPEUTIC SERVICES

1. The DTSM has responsibility for a broad range of services. The scope of on-site services within the administrative purview of DTSM include:

a. Diagnostic Imaging services;

b. Laboratory services;

c Mental Health services, where there is no MH Manager;

d. Ophthalmology/Ears Nose and Throat services;

e. Pharmacy services, including on-site counselling;

f. Physiotherapy services;

g. Preventive Medicine services; and

h. Specialist services.

2. **Diagnostic Imaging Service**. The CF Type V Medical Clinic typically provides Diagnostic Imaging (DI) services on site. There may be exceptions to this general rule as a function of the availability of local resources, business case analysis and the nature and tempo of Base operations. The DI staff schedule appointments for on and off site DI services.

3. **Laboratory Service**. The CF Type V Medical Clinic typically provides Laboratory (Lab) services on site. The Lab staff does the appointment scheduling for on and off site Laboratory services.

4. **Preventive Medicine Service**. The Preventive Medicine (PMed) Service has a unique and highly specialized role that requires quick and regular access to a Senior Medical Officer. For this reason, the Formation Surgeon at the CF Type V Medical Clinic is responsive to the needs of their Clinic's PMed staff and the DTSM oversees their administrative requirements. At Maritime Command bases, the PMed staff typically functions under the professional technical oversight of the Fleet Support Medical Officer.

5. **Specialist Services**. Specialist services are typically found at the CF Type V Medical Clinic. Specialists who may be either CF or civilian provide either on or off site Specialist services. The CDU administrative support staff schedules the referrals to Specialist services. The process is started when the administrative staff receives a completed Requisition for Consultation form from a health care provider of their CDU.

6. **Ambulatory Clinics**. When CF and civilian Specialist services are a routine, almost-daily occurrence on-site at the CF Type V Medical Clinic the Specialist services are considered to be the equivalent of an Ambulatory Care Service. The easiest way to differentiate between the two is best done by comparing the number of clinics, number of providers, scope of services and

catchments area. Staffing requirements in support of Ambulatory clinics needs to be determined on a site-by-site basis.

## C-610. MENTAL HEALTH SERVICES

1. Type V bases/wings will have a dedicated MH services presence on the staff of the clinic

2. **Geographical Support**. The major MH facilities at Halifax, Ottawa and Esquimalt will be assigned support responsibility for a defined geographical area. These are defined as 'First Tier' support facilities. This applies to prof tech advice and the provision of MH services beyond the local capability of CF elements within that area. Certain other locations within each area will be designated as 'Second Tier' facilities providing support to designated local elements to the extent of their capability while having access to the applicable First Tier facility for similar support as required. In effect, this is a 'delegation' of the First Tier responsibility. Depending on local circumstances and the capabilities of the respective facilities, the support provided could involve the referral of patients to the supporting facility; the provision of visiting clinicians or the provision of prof tech advice and assistance

## C-611. SUPPORT SERVICES

1. **Introduction**. The Support Services Manager, as one of the CF Type V Medical Clinic intermediate managers, is responsible for a wide range of services. A senior and experienced CF Health Care Administrator (HCA) will typically fill this position. The CF Type V Medical Clinic Support Services Manager's scope of responsibility will include:

a. Financial services;

b. Health Records services;

c. Human Resources management services;

d. Information Management/Information Technology services;

e. Occupational Health programs;

f. Clinic Orderly Room services ;and

g. Transportation.

2. **Health Records**

a. The CF Type V Medical Clinic is responsible for the professional management of the CF Member's Health Record. The Health Records Practitioner will oversee the management of Health Records at their CF Type V Medical Clinic's detachment sites. Additionally, The CF Type V Medical Clinic is responsible for the Health Records management and administration for catchments population of other entitled persons and all CF 2034s retained on site. The Health Records clerks report to the Support Services Manager through the Health Records Practitioner.

b. For training purposes and in accordance with the requirements of their QL3 OJSM, Med Techs will normally be rotated through Health Records for a period of six months

c. Wherever possible and as per the CF Type V Medical Clinic infrastructure template, CDUs should be located close to each other to allow for one centralized Health Records area, made up of individual segregated Health Records areas for each CDU.

d. There will be one civilian Health Records Practitioner and 2.0 FTE Civilian Health Records Clerk/Technicians staffed at CF Type V Medical Clinic.

e. The transcription function is inherent to Health Records management and the CF Type V Medical Clinic possessing Transcription services shall maintain the capability.

3. **Information Management/Information Technology System Administration Coordinator**

a. This requirement was identified during the development of the position charters for the Primary Care Renewal Initiative (PCRI) pilot sites. The Bases were not able to support the introduction of the computerized solutions that PCRI was requesting for either the network capabilities or manpower requirements.

b. In the longer term it is anticipated that the CF Type V Medical Clinic will receive almost all of their IT support from Base resources. As the Canadian Forces Health Information Systems (CFHIS) is implemented and the situation is reviewed on an ongoing basis, it is possible that the CF Type V Medical Clinic may require some dedicated IM/IT support.

c. Where IM/IT System Administration Coordinator support is eventually deemed necessary, the CF Type V Medical Clinic IM/IT Coordinator will be responsible for:

(1) The organization and operational efficacy of the CF Type V Medical Clinic's IT assets;

(2) Participation as required in the design and planning of infrastructure to support new applications and technologies;

(3) The provision of support to staff that utilizes these resources in the performance of their duties;

(4) Advice, support and instruction to users;

(5) E-mail account co-ordination;

(6) Installation of software, hardware; and

(7) Liaison with Base and national IT resources.

**Note:** CF medial clinics retain their current level of IM/IT support until CF H Svcs Gp HQ can demonstrate evidence to support a CF Medical Clinic IM/IT System Administration Coordinator requirement. This aspect of IM/IT support will be reviewed as CFHIS rolls-out.

4. **Chief Clerk**. 1.0 FTE CF Resource Management Clerk is assigned to the CF Type IV Medical Clinic. Base personnel staff some positions in the CF Type IV Medical Clinic Orderly Room. The Chief Clerk will control the Personnel Administration functions of the Clinic Orderly Room.

5. **Finance Clerk**. There is 1.0 FTE CF or Civilian Finance Clerk position at the CF Type IV Medical Clinic. It is expected that the CF Type IV Medical Clinic's Finance and Blue Cross clerks will cover for each other's absences. The Finance Clerk will perform Med Finance and Personnel Administration duties.

6. **Blue Cross Clerk**. There is 1.0 FTE CF or Civilian Blue Cross Clerk position at the CF Type IV Medical Clinic. It is expected that the Finance and Blue Cross clerks will cover for each other's absences. The Blue Cross Clerk will perform Medical Finance duties.

## C-612. OPERATIONS AND TRAINING

1. The CF Type V Medical Clinic has an Operations and Training element.

## PART D - MEASURING CANADIAN FORCES MEDICAL CLINIC PERFORMANCE

## CHAPTER D-1

# PERFORMANCE MEASUREMENT

### D-101. OVERVIEW

1. The Canadian Forces (CF) Medical Clinic leadership team, and indeed all Clinic staff, is accountable for ensuring that they provide high quality clinical care in accordance with established standards and that resources expended in providing this care are managed appropriately. The performance measurement program must include activities that support quality improvement, mitigate risk, foster patient safety and encourage the reporting of errors. To assess the degree to which the CF Medical Clinic is meeting clinical and managerial accountability, a performance measurement program is required.

### D-102. QUALITY IMPROVEMENT

1. The Canadian Council on Health Services Accreditation (CCHSA) Accreditation Program requires that the CF Health Services (CFHS) and its medical clinics have a formal Quality Improvement (QI) program. CCHSA defines QI as an organizational philosophy that seeks to meet clients' needs and exceed their expectations by using a structured process that selectively identifies and improves all aspects of service.[1] QI focuses on excellence but also recognizes the inherent risks involved in delivering health care.

2. By incorporating QI processes into the daily practice of health care, the Medical Clinic facilitates the evaluation and improvement of health care systems and processes. The emphasis is on using evidence to determine how the system is working and what improvements need to be made.

3. Continuous QI (CQI) is an interdisciplinary endeavour. Expertise from all areas is required to ensure that health care systems and processes, including patient care, are continually improved.

4. By ensuring each of the components of the QI Program is in place and documented the Medical Clinic will have established a framework for QI that addresses both excellence of care and risk management.

### D-103. RISK MANAGEMENT

1. **Overview**

   a. Risk refers to circumstances that may prevent or impede the attainment of objectives. It includes failure to recognize and seize upon opportunities. The objectives at risk can be strategic, operational, financial or compliance.

   b. Risk management (RM) is defined by Treasury Board as a systematic approach to setting the best course of action under uncertainty by identifying, assessing, understanding, acting on and communicating risk issues. Integrated RM furthers the objectives of RM through a continuous, proactive and systematic process to understand, manage and communicate from an organization-wide perspective. It is about making strategic decisions that contribute to the achievement of an organization's overall corporate

[1] CCHSA AIM Program, 2005

objectives.

c. The process consists of four steps:

(1) Risk Identification;

(2) Risk Assessment/Analysis;

(3) Risk Response; and

(4) Risk Evaluation.

d. Risk assessment entails determining the probability i.e., likelihood of the event and the impact of the event. Probability can be assessed on a relative scale (Low, Medium, High) or ordinal scale (0, 10%, 50%). Impact can be assessed on a relative scale, ordinal scale or actual dollar impact. The probability of the event times the impact of the event provides the Risk Status of the event.

e. Risk response can entail a number of alternative approaches such as:

(1) Recognizing the risk but not taking any action;

(2) Using an alternative approach thereby eliminating or reducing the situation which gives rise to the risk;

(3) Transferring the risk to another party such as by contracting the specific activity that would have generated the risk;

(4) Preparing a contingency plan in the event the risk occurs; and

(5) A combination of the above or other approaches.

f. Linkages between the QI and RM programs identify opportunities for organizational improvement, improved effectiveness and efficiency and minimizing adverse patient effects.

2. **Quality Improvement/Risk Management Coordinator**. The QI/RM Coordinator ensures, on behalf of the CF Medical Clinic leadership team, that a continuous QI/RM program is established and maintained in the Clinic or group of clinics. The QI/RM Coordinator provides the link between the Clinic leadership team and the quality committees/teams established to monitor the quality of services provided and identify and address opportunities for improvement. The QI/RM Coordinator is a facilitator. The QI/RM Coordinator mentors the Clinic leadership team and clinic staff in QI and RM processes and techniques. The QI/RM Coordinator facilitates the work of the committees, provides education, and ensures communication is maintained between and among teams. During the Accreditation Phase, the QI/RM Coordinator facilitates all the processes associated with Accreditation, including education sessions, the completion of the self-assessment and arranging the Survey Visit. The QI/RM Coordinator also develops and maintains linkages with the Canadian Forces Health Services Group Headquarters QI/RM staff and with the CCHSA. During the period of Accreditation, approximately 12 to 18 months, the QI/RM Coordinator will need to devote 90% of their time to the Accreditation process.

3. **Patient Safety**

a. In the last few years the issues of patient safety and health care error have become important topics in health policy and health care practice in several countries including

the United States, Australia and Great Britain.[2] Canada has also taken a leadership role with the creation of the Canadian Patient Safety Institute. Increasing patient safety by reducing health care error and adverse events is an essential aspect of the clinic Quality Improvement and Risk Management Program.

b. Patient safety is the prevention and mitigation of unsafe acts within the health care system. Strategies for improving patient safety include creating a culture that supports the identification and reporting of unsafe acts, effective measurement of patient injuries and other relevant outcome indicators, and tools for developing or adapting structures and processes to reduce reliance on individual vigilance.[3] Even with the best systems in place, things sometimes go wrong. Improving the safety of patients is about creating an environment that is open to disclosure and committed to change.

4. **Sentinel Events**. A sentinel event is a type of adverse event or occurrence. A sentinel event is defined by the CCHSA, as an unexpected incident, related to system or process deficiencies, which leads to significant consequences or major and enduring gloss of function for a recipient of health care services. Major and enduring loss of function refers to sensory, motor, physiological, or psychological impairment not present at the time services were sought or began. The impairment lasts for a minimum period of two weeks and is not related to an underlying condition. Sentinel events also include events that have or could have catastrophic impact on the organization's financial, human and physical resources. All adverse events, including sentinel events, are captured in the Occurrence Reporting process and promptly reported to CF H Svcs GP HQ through the HS Chain-of-command.

**D-104**. **OCCURRENCE REPORTING**

1. **Overview**. The incident reporting process has been revitalized so that it provides information that is more relevant and timely in support of the RM Program. A description of the Occurrence Reporting Program follows:

a. Occurrence reporting is used to discover faulty systems or processes that do not support clinicians in their roles or have the potential to led to adverse events. Events occur when safeguards are deficient, missing or fail; with unidentified or improperly understood risks; or when changes create unidentified risks or defeat the existing safeguards.

b. Occurrences are preventable events that may cause harm to people, the environment or the organization. An occurrence is an event, accident or circumstance that resulted in, or could have resulted in an unintended, undesired outcome. Reporting of such events is an integral part of QI and RM.

c. Occurrences involving patients or staff members require proper documentation. The CFHS Occurrence Report is designed to facilitate recording of an event or occurrence. The objective of the integrated Occurrence Reporting System is to communicate information to appropriate members of the CF Medical Clinic staff regarding unusual occurrences, which require investigation and/or resolution.

d. The person or persons most directly involved, or by those who observed or discovered the unusual occurrence will immediately report it. The occurrence will be reported on the CFHS Occurrence Report. The information is confidential. To minimize the risk of litigation or loss associated with an unusual occurrence, staff and management must expedite the communication of unusual occurrences to their immediate manager, who will complete the occurrence Management Action/Follow-Up Report.

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[2] Patient Safety and Healthcare Error in the Canadian Healthcare System; Baker, GR; Norton, P
[3] CCHSA AIM Progam, 2005

e. Two types of occurrences are described below:

(1) **Patient Care Occurrences**

(a) An unplanned incidence or occurrence in patient care includes an event that results in an injury to the patient, any other event that constitutes a risk to patient safety or may result in a claim against the Crown. Unusual events in patient care are documented on the Occurrence Report Form.

(b) Documentation of the event is to be made in the CF 2016 in a factual manner with no statement of blame or cause.

(2) **Visitor Incidents**. All incidents involving visitors are also to be recorded on the Occurrence Report Form by the employee who witnessed the incident or to whom it was reported. Visitors who have sustained any type of injury are to be strongly encouraged to obtain assessment and/or treatment.

2. **Occurrence Rating Scales**. A level of risk is assigned to all occurrences based on severity of outcome. Examples of ratings are;

a. **None**. Any reported incident where a patient was not directly involved. This includes dispensing-related and order-related events noted prior to any patient involvement;

b. **Low**. No harmful effect to the patient but potential risk identified. This pertains to falls in which no injury was sustained but there was potential for injury. In medication incidents, the therapeutic effect of the drug was not altered but the administration or omission of the drug was inappropriate: The patient sustained minimal effects and a minimal risk to the patient was identified. This includes abrasions, skin breakdown and tears, pain, minor burns, contusions and bruises. These may or may not require intervention, for example, sutures, X-rays, and physician examination. In medication incidents, the therapeutic blood level of the drug was altered by administration or omission but there is no resultant physical symptomatology;

c. **Moderate**. Moderate to harmful effects to the patient and high potential for risk was identified. This includes moderate lacerations, burns and pain. These conditions may require extended observation, or may or may not prolong length of stay. In the case of medication incidents, effects were likely to occur if there had been continued administration or omission of the drug; and

d. **High**. The patient had serious harmful effects that required immediate intervention to resolve or prevent further deterioration of the patient's condition such as operative or life support i.e., a sentinel event. These incidents may prolong length of stay, for example, fractures and unplanned surgical occurrences. In medication incidents, this includes any physical response such as anaphylactic shock and sudden increase or decrease in pulse, blood pressure or respirations. A drastic outcome includes a patient suffered permanent injury or death, such as death occurring during surgery or post-anaesthetic care, falls inducing injury, medication errors or significant adverse reactions, procedural or treatment error, etc.

3. **Procedure for Reporting Occurrences**

a. Clinic staff are expected to report occurrences or events (any happening that is not consistent with routine operation of the facility or routine care of the client and is likely or potentially likely to lead to adverse effects upon a client, personnel or the organization) in accordance with the established procedures for Occurrence Reporting.

b. The person involved in or discovering the event, reports it to their supervisor who notifies the clinic manager. The clinic manager is responsible for ensuring the required immediate and follow-up action is taken. The documentation is forwarded to the clinic Quality Improvement Coordinator who collates all occurrences in a quarterly report for the clinic manager. The quarterly reports are forwarded to the CFHS HQ Quality Improvement (QI) Manager for trending and distribution to the appropriate (office of primary interest) OPI at headquarters. Annually the CFHS HQ QI Manager collates all occurrence reports and develops a trend report for CFHS HQ and the clinics.

## D-105. PERFORMANCE INDICATORS

1. **Introduction.** Not everything that can be counted counts; and not everything that counts can be counted. This remark by Albert Einstein can be used to summarize a couple of basic points about quality indicators. They are not simply compilations of data that draws together anything that can be counted about health care outcomes. A careful sorting of data for relevance to quality is required. At the same time, not everything that is important for quality can be represented by objective indicators; qualitative judgements must play a role.

2. Historically, quality has been defined by how we well we measure up to current training, accreditation, and clinical practice standards. While these are important, the ultimate test of overall quality of care is the degree to which we have successful outcomes in the patients we treat. Our commitment to provide the highest quality patient care, requires that feedback loops from the outcomes of care, be provided back to the providers to allow us to assess, monitor, and improve the effect of our activities.

3. Quality indicators must be simple. Simplicity means that indicators must be few in number, so that clinicians can focus on a few key targets for improvement. It also means they must be readily understandable to clinicians, managers, and ultimately, the CF. They must be easy to collect - preferably, built into the process of clinical record keeping - so that the data required is reliably and consistently collected.

4. A performance indicator is defined as a measurement tool, screen or flag that is used as a guide to monitor, evaluate and improve the quality of patient care, clinical support services and organizational functions that affect patient outcomes.

5. **Clinical Indicators**. Outcome-based clinical indicators are not readily available in the literature, particularly as they apply to a military cohort. For this reason, the CF Surgeon General has established a Clinical Indicators Working Group. The goal of this Working Group is to develop relevant clinical indicators based on literature reviews, retrospective chart analysis, and prospective research studies. As indicators and the means to collect the indicators are developed, the CF Surgeon General will advise clinicians through the Professional Technical (Prof Tech) Network.

6. **Management Indicators**. A wide assortment of management indicators have been developed for use in the civilian health care sector, ranging from various financial indicators to patient satisfaction indicators to service utilization indicators. Indicators for Primary Care services are not readily available, but are under development by the Canadian Institutes for Health Information. A number of CFHS initiatives have been undertaken to assess and develop indicators that are useful to the CF. In particular, the evaluations done by the Canadian College of Health Service Executives and Hollander Analytical Services produced useful indicators that are discussed below.

7. The requirement for the collection and collation of system quality indicators offer an exciting framework for quality assessment and improvement. The interpretation and reporting by the Clinic Leadership Team assists leaders both at the Clinic and at the HQ levels, to think big, to

think of the whole system and continuum of care. They force us to be clear about the outcomes expected of care processes, and guide us to focus our quality improvement efforts on those components of care that offer the most potential for improvement. Ultimately, they will help us all provide better care to patients.

8. In association with the CFHS stated goal of becoming more aligned with the civilian health care sector, and the desire to achieve formal accreditations through the Canadian Council of health Services Accreditation (CCHSA), the CCHSE recommended that the CFHS follow the dimensions of quality as articulated by the CCHSA. This recommendation serves to focus the organization on quality as an overriding objective, consistent with the mission and values determined by the DGHS. The CFHS quality dimension and corresponding descriptors are:

a. Customer Perspective to Responsiveness and Client/Community Focus Dimensions

b. Internal Business Perspective to System Competency Dimension

c. Innovation and Learning Perspective to Work life Dimension

9. **Responsiveness Dimension**. The CFHS anticipates and responds to changes in the needs and expectations of the patient and/or community and to changes in the environment. Descriptors grouped under this responsiveness dimension include

a. **Availability**. Service(s) and resources e.g., financial, human, information, equipment are available to meet the needs of the patient and/or community.

b. **Accessibility**. The patient and/or community easily secure required or available services in the most appropriate setting.

d. **Timeliness**. Services are provided and/or activities are conducted to meet patient and/or community needs at the most beneficial or appropriate time.

e. **Continuity**. Coordinated services are provided across the continuum over time.

f. **Equity**. Decisions are made and services are delivered in a fair and just way.

10. **Examples of Indicators** within this dimension are:

a. Average Response Time; and

b. Average time to complete work orders.

11. **System Competency Dimension**. The CFHS consistently provides services in the best possible way, given the current and evolving state of knowledge. The organization achieves the desired benefit for patient and/or communities, with the most cost-effective use of resources. Descriptors reflective of this dimension are:

a. **Appropriateness**. Services meet the needs of the patient and/or community), achieve CFHS goals, are proven i.e., evidence-based to produce benefits, and are based on established standards.

b. **Competence**. An individual's knowledge, skill and attitudes are appropriate to the service provided.

c. **Effectiveness**. Services, interventions, or actions achieve optimal results.

d. **Safety**. Potential risks and/or unintended results are avoided or minimized.

e. **Legitimacy**. Services and/or activities conform to ethical principles, values, conventions, laws, and regulations.

f. **Efficiency**. Resources i.e., inputs are brought together to achieve optimal results i.e., outputs with minimal waste, re-work, and effort.

g. **System Alignment**. The mission, vision, goals, and objectives of the CFHS are clear, well integrated, coordinated and understood both internally and externally. These are reflected in organization plans, delegations of authority, and decision-making processes.

12. **Examples of System Competency Indicators** include:

a. Meeting budget targets;

b. Waiting lists;

c. Waiting times;

d. Missing results from the health record;

e. Turnaround time for tests and diagnosis;

f. Successful accreditation survey outcomes; and

g. Evidenced-based continuous improvement.

13. **Patient/Community Focus Dimension**. The CFHS strengthens its relationship with the patient and/or community. The organization does this by encouraging community participation and partnership in its activities. Descriptors identified for this dimension include:

a. **Communication**. All relevant information is exchanged with the patient, family and/or community in a manner that is ongoing, consistent, understandable and useful.

b. **Confidentiality**. Information to be kept private is safeguarded.

c. **Participation and Partnership**. The patient and/or community actively participate as a partner in decision-making, and in service planning, delivery, and evaluation.

d. **Respect and Caring**. Politeness, consideration, sensitivity and respect are incorporated into all interactions with the patient and/or community.

e. **Organization responsibility and Involvement in the Community**. The CFHS supports and strengthens the community and its development, and contributes to its overall health.

14. **Examples of Indicators** reflective of a Patient/Community focus include:

a. Patient satisfaction surveys;

b. Elapse time to schedule an appointment;

c. Elapse target times;

d. Satisfaction with the continuity and coordination of care; and

e. Trends in patient complaints.

15. **Work Life Dimension**. The CFHS provides a work atmosphere conducive to performance excellence, full participation, personal/professional and organizational growth, health, well-being, and satisfaction. Descriptors identified for this dimension are:

a. **Open Communication**. The CFHS fosters a climate of openness, free expression of ideas, and information gathering.

b. **Role Clarity**. Staffs have clearly defined job scope and objectives, and these align with team and the CFHS goals.

c. **Participation in Decision-Making**. Staff input is encouraged and used in decision-making.

d. **Learning Environment**. Staff creativity, innovation and initiative are encouraged. The necessary training and development, to attain the CFHS goals and personal/professional development objectives, is provided.

e. **Well-being**. The CFHS provides a safe, healthy, and supportive environment, recognizes staff contributions, and links staff feedback to improvement opportunities.

16. **Examples of Indicators** for the work life dimension include:

a. Employee satisfaction surveys;

b. Satisfaction of the Clinic staff with the services provided internally;

c. Opportunities for training and development;

d. Participation in decision-making; and

e. Participation in improving their work environment.

17. A report card showing how these indicators would be reported follows.

| Targeted Population | Targeted Performance Areas |
|---|---|
| **CLIENT**<br><br>Process indicator | **RESPONSIVENESS**<br><br>**Provides a measure of interrelated activities and steps undertaken to achieve these**<br><br>**Monitoring of referral patterns**<br>i.e., to/from ER departments, mental health, other providers etc.<br><br>**Monitoring of number of people not accommodated on a same day basis**, i.e., walk-ins as requested. i.e., turn-away(s)<br><br>**Number of clients assessed within 24 hours of referral**<br>**Number of clients referred** |
| Outcome indicator | Measures can either disease specific, general health patient performance or patient satisfaction |
| Disease specific | **Number of clients with decreased signs of depression**<br>**Number of clients being treated for depression** |
| General health | **Number of clients with improved independence post hip replacement**<br>**Number of clients undergoing procedure** |
| Client performance | **Number of clients taking meds as prescribed by doctor**<br>**Number of clients with prescription meds** |
| **CLIENT** | **CLIENT FOCUS**<br><br>**Monitoring of client satisfaction**<br><br>Using a carefully designed satisfaction questionnaire based on select client related indicators<br>Monitoring of occurrences/incidents/complaints over time and by type |
| **STAFF**<br><br>Nursing<br><br>Medical<br><br>Structure Indicator<br><br>Support Services<br><br>Finance<br><br>Human Resources | **SYSTEM COMPETENCY**<br><br>**Number of triage functions, indirect versus direct service contacts**<br><br>**Chart audits based on pre-selected criteria**<br><br>**Number of X-ray units per clinic or region**<br><br>Catchments population<br><br>See Technical Reports<br><br>**Be within + or – 2% of original budget in relation to input variables**<br><br>**Staff turnover under 5% per year** |
| **STAFF** | **WORK LIFE**<br><br>**Staff Injuries per month**<br>**Satisfaction rate measuring improved employee performance post-training** |

**Figure D-1-1, Sample Report Card for Clinic Manager Using Performance Indicators**

## D-106. THE RESULTS-BASED MANAGEMENT AND ACCOUNTABILITY FRAMEWORK

### 1. General

a. Development of a Results-based Management and Accountability Framework (RMAF) for the CFHS was completed as part of a broader evaluation project examining two CFHS initiatives: the Primary Care Renewal Initiative (PCRI) and the Case Management Program[4]. The RMAF has been prepared for the PCRI within in-garrison care and may be seen as a component RMAF under the umbrella RMAF, or Balanced Scorecard (BSC), for the Director General Health Services/Commander Canadian Forces Health Services Group (DGHS/Comd CF H Svcs Gp). Within DGHS/CF H Svcs Gp, there are two closely linked lines of business: in-garrison care and operations, each of which shares a common vision, mission, and values with the larger organization.[5] Health care services in the CF must be viewed within the context of the Department of National Defence corporate strategy to maintain a multi-purpose, combat-capable sea, land and air force that will protect Canadians, and their interests and values abroad. In-garrison care supports the corporate strategy through maximizing operational fitness among CF members, ensuring CF medical personnel are trained and competent for operational taskings, while at the same time meeting the health needs of the CF Member. Thus the management and delivery of in-garrison health care services must achieve an appropriate balance between the needs of the organization and the needs of the individual. The larger concern of Resource Management, and the internal processes perspective has been re-labelled as Continuum of Health Services. The Learning and Growth perspective remains the same.

b. Figure D-1-2 below presents a Strategy Map for the CF Medical Clinic Model of in-garrison health care. It should be noted that the strategic goal and the five strategic themes are applicable to the broader DGHS/CF H Svcs Gp interests while the specific strategic objectives for each of the four BSC perspectives apply primarily to the CF Medical Clinic Model of in-garrison health services delivery. If achieved, these objectives should contribute to the overall corporate goal. Some of these strategic objectives may also be applicable to health care delivery in operational settings.

[4] A separate RMAF for the Case Management Program has been completed.

[5] The DGHS FY 2002/2003 Business Plan emphasizes the overlap between in-garrison care and support to operations noting that activities and functions are not easily compartmentalized as might be suggested by our model and hence there is a certain degree of artificiality in the separation.

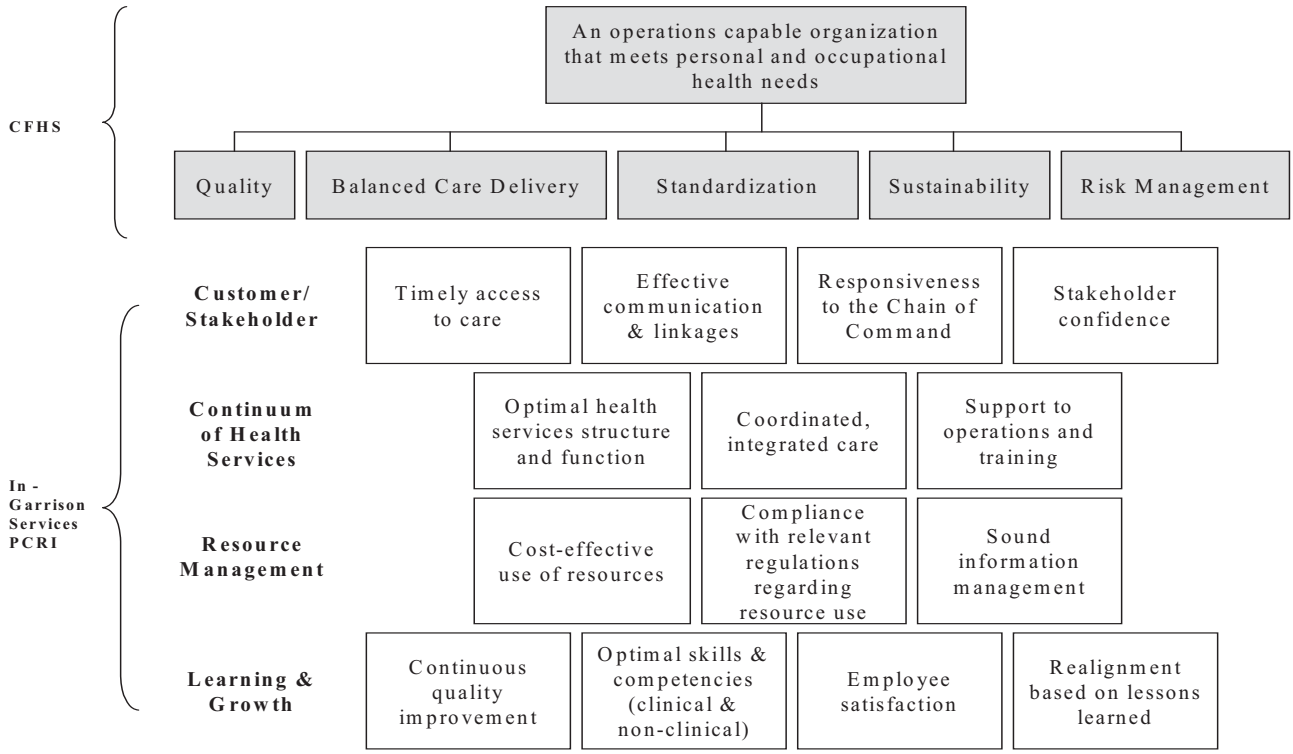


**Figure D-1-2, CF Clinic Model Strategy Map**

c. The Hollander Report points out that there is little scientific evidence regarding whether or not primary health care is an effective or efficient mode of health care delivery.

d. In fact there is relatively good evidence in peer-reviewed journals (including research done by CFHS) that collaboration between pharmacists and physicians does significantly improve clinical outcomes for some disease states as exemplified by the treatment of dyslipidemia. CDN Journal of Hospital Pharmacy: Vol 56: 1- Feb-2003

e. The CFHS is determined to succeed at all aspects of being an evidence-based organization including the associated commitment to measure the clinical results of the processes and model through which health care is delivered to members of the CF. Since the CFHS is only a small part of the greater Canadian health care spectrum, any significant changes to care delivery instituted within the CFHS that are not widely used in the broader Canadian system will have a to be supported by appropriate evidence . In fact, the CFHS will cease the opportunity to be one of the leaders in Canada in terms of delivering the evidence that primary care renewal, including the use of collaborative practice and clinical practice guidelines, will translate into improved clinical outcomes.

## D-107. PERFORMANCE INDICATORS FOR SUPPORT SERVICES

1. **Introduction**. The purpose of this section is to outline the requirements for Support services that will ensure a fully integrated CF Medical Clinic. The CCHSEC report provided recommendations for individual support services that strongly support clinical services and additionally provided specific recommendations concerning core minimum staffing requirements, core competencies and defined the performance standards for each support service.

2. Support services are intended to:

   a. Improve client services;

   b. Support the Clinic teams in health delivery as well as allowing its members to focus on the tasks that they are skilled to perform and interested;

   c. Introduce standardized functions across the CFHS; and

   d. Enhance performance measurements through improved competencies.

3. **Human Resource Services**

   a. **Mandate**. To develop, implement and maintain a personnel support system to meet the needs of the CFHS.

   b. **Functions**

      (1) Develop and maintain performance measurement system.

      (2) Develop and implement human resource policies.

      (3) Gather employee input via employee attitude surveys and support to bring about the changes.

      (4) Assume an employee advocacy role.

      (5) Liaise with the Human Resources groups at National Defence Headquarters (NDHQ) on behalf of the DGHS/Comd CF H Svcs Gp.

   c. **Performance Standards**

      (1) **For Clinic Managers**

         (a) Responsiveness:

            i. Response time to inquiries;

            ii. Timeliness for opening the Employee File; and

            iii. Information provided regarding salary level, working conditions and employee benefits.

         (b) Provision of accurate information to Payroll services.

         (c) Up-to-date Performance Appraisals on file.

         (d) Implementation of Best Practices and review of practices on a regular basis.

(e) Links with the NDHQ Human Resources groups for provision of services to CFHS human resources.

(f) Development of job descriptions for all positions in close collaboration with managers.

(2) **Employee Orientation**. Provision of a complete Employee Orientation Program.

(3) **Policies and Procedures**

(a) Development of Human Resources policies and procedures.

(b) Dissemination of policies and procedures to managers and staff.

(c) Policy acknowledgment process to ensure that the staffs are aware of most important policies.

(3) **Labour Relations**

(a) Maintain statistics on grievances and referrals to arbitration.

(b) Ensure training for managers on collective agreement language.

(4) **Client/Community Focus**. All actions lead to the efficient and effective use of personnel to support the delivery of care.

(5) **Work Life**

(a) Creative solutions are developed.

(b) Participation in decision-making.

4. **Finance Services**

a. **Mandate**. To develop, implement and maintain a financial control and decision support system to meet the needs of the CFHS.

b. **Functions**

(1) Develop an annual business plan.

(2) Establish an Accounts Payable.

(3) Develop and maintain payroll system.

(4) Establish a management decision-support system, including functions for financial analysis, variance reporting and corrective actions.

(5) Develop a financial risk assessment and coverage model.

(6) Develop and maintain a contract management system relating to space, supplies, equipment and professional services.

(7) Develop financial policies and procedures, e.g. relating to expense reimbursement, table of authorities.

c. **Performance Standards**

(1) **For Clinic Managers**

(a) Responsiveness.

(b) Variance analyses completed on time and correctly.

(c) Adherence to budget variance expectations.

(2) **System Competency**

(a) Managers use variance analyses to develop and implement or recommend action plans.

(b) Attainment of outcomes specified in the business plan.

(c) Unqualified signature to Letter of Attestation.

(3) **Client/Community Focus**. All actions lead to the efficient and effective use of resources to support the delivery of care.

(4) **Work Life**

(a) Creative solutions are developed.

(b) Participation in decision-making.

5. **Health Records Services**

a. **Mandate**. Health Records services ensure that health information and data contained in the Health Record is available, accessible, accurate, secure and comprehensive.

b. **Health Records Functions**. To achieve its mandate and ensure that essential key elements are present, implemented and maintained in the CF Medical Clinic, Health Records services must provide the following functions: Transportation of records - Chart retrieval - Chart tracking - Chart purging and maintenance - Reception and collection of records and loose notes - Filing of records - Filing of loose reports - Assembling of records - Qualitative and quantitative analysis - Coding - Abstracting - Release of Information - Utilization Review - Audit - Evaluation - Quality Assurance - Transcription services.

c. **Functions**. In accordance with the CF Medical Clinic's needs, the following functions will be performed either with dedicated or shared resources depending on the workload at the specific clinic setting. They are retrieval of records, transcription services as required as well as analysis, coding, abstracting and release of information.

d. **Performance Standards**

| Key Indicator | Performance Indicator | Desired Outcomes |
|---|---|---|
| **Responsiveness** | 1. Percentage of records found when requested<br>2 Turnaround time for filing of charts and filing of loose reports<br>3. Data submission to CIHI<br>4 Transcribed reports turnaround time<br>5. Response time for release of information (correspondence) requests<br>6. Transmission of documentation and data to Headquarters | 1. 100% records found<br>2. Within 24 hours of receipt<br>3. Within CIHI set time lines<br>4. Within 24 to 48 hours depending on report types<br>5. Within two weeks of receipt of request<br>6. Within one week of point of care (real time electronically) |
| **System Competency** | 1. Customer satisfaction survey<br>2. Accreditation survey outcome<br>3. Quality of data<br>4. Audit<br>5. Working tools and technology appropriateness and accuracy<br>6. Fluctuation and variation in paid hours and operating expenses<br>7. Chart completion<br>8. Corporate training and qualified staff | 1. Respond and act on all concerns<br>2. Meet all Health Records CCHSA Standards<br>3. As defined and accepted by CIHI standards<br>4. At least five audits nationally per year<br>5. Leading edge systems and technology<br>6. Meeting budget targets<br>7. Within 30 days<br>8. Core competencies met and orientation done within a week of hiring |
| **Client Focus** | 1. Communication of new policies and procedures to internal and external clients<br>2. Confidentiality safe guarded<br>3. Records signed out<br>4. Peer Reviews with external clients | 1. Monthly meetings, communiqués, focus groups, conference calls<br>2. Confidentiality pledge signed by all staff<br>3. Chart tracking available<br>4. Information exchanged and best practices implementation |
| **Quality of Work Life** | 1. Timeliness and quality of information sharing<br>2. Continued education<br>3. Daily tasks, job functions and schedules are clearly defined | 1. Regular visits to all health care centers, conference calls, communiqués<br>2. Professional affiliations<br>3. Job analysis and descriptions regularly updated. Two-week schedules are posted |

**Figure D-1-3, Performance Standards for Health Records Services**

6. **Quality Improvement Services**

a. **Mandate**. To create, coordinate and facilitate a management system that will enable all levels of the CFHS to monitor and improve the quality of care and service.

b. QI is the responsibility of all staff. Every leader/manager must be held accountable for the quality of their group's outcomes just as they are held accountable for their budget and staff performance. QI cannot assume responsibility for the quality of care or service or the organization. QI is responsible for providing sufficient information, supporting resources and staff for training and team facilitation to allow each leader and his group to meet their performance goals.

c. The development of a quality management system will allow the CFHS to:

(1) Translate their vision into clear, measurable outcomes;

(2) Provide tools for assessing, managing and improving health service to the CF;

(3) Develop and monitor over time measures of quality, customer service, and organizational alignment and efficient use of resources; and

(4) Have a consistent approach to improving quality for all areas.

d. **Functions**

(1) Enable the establishment of a QI Program including RM for the organization's health delivery and support services including standardization of the types of QI information gathered at the CFHS national, formation (sector) and clinic levels.

(2) Monitor the implementation of changes to improve quality and reduce risks at the CFHS formation (sector) level including cross-formation (sector) sharing of best practice.

(3) Recommend changes to improve quality at the Clinic level.

(4) Determine, design and coordinate the delivery of an intensive QI education program for the organization's staff on an on-going basis.

(5) Ensure delivery of the QI approved programs for all CFHS formation (sector) and Clinic staffs.

(6) Develop a corporate system to analyze and communicate on BSC performance measurements.

(7) Implement the analysis and feedback on BSC performance measurements needed for the formation (sector) -specific initiatives.

(8) Develop and support a patient relations/advocacy program.

(9) Determine the appropriate external performance assessments in which to participate, e.g., organizational accreditation activities.

(10) Participate in external performance assessments at the Clinic level, e.g., Accreditation activities.

(11) Participate in external performance assessments at formation (sector) level, e.g., Accreditation activities.

e. **Clinic Manager**

(1) Implement QI programs at the Clinic level.

(2) Implement and coordinate all accreditation activities at the Clinic level.

(3) Held accountable for the quality of their group's outcomes.

f. **Performance Standards**

(1) **Responsiveness**

(a) Meeting response time targets for requests from staff to the QI.

(b) On time reporting to established set time lines.

(2) **System Competency**

(a) Successful accreditation survey outcome.

(b) Improved customer (entitled personnel) satisfaction.

(c) Evidence of continuous improvement based on system-wide indicator data.

(d) Trends in customer complaints.

(e) Meeting budget targets.

(3) **Client Focus**

(a) Satisfaction of the Clinic staff with the support provided by the QI.

(b) Level of staff knowledge about QI philosophy and methods as demonstrated through surveys.

(4) **Quality of Work Life**. Satisfaction of the Clinic staff with learning opportunities, participation in decision-making, role clarity on improving their work environment

7. **Clinic Reception**

a. **Functions**

(1) **Telephone reception**. In an average Type IV Clinic, there would be approximately 100 to 150 incoming telephone calls each day. Most of these calls are from the CF Member who: wants to make an appointment, wants lab test results, wants prescriptions refilled, wants to speak to their physician or wants information. Other calls would be from outside physicians, hospitals, labs and x-ray facilities, business people such as computer vendors, insurance representatives, and family and friends of Clinic staff.

(2) **Basic Management Principles for Reception Staff**. Basic management principles would ensure that the Physician and staff work at a high level of

efficiency. These basic practice management principles include, but are not limited to:

(a) Maintain a friendly and professional attitude at all times, so the first impression that a patient or potential patient receives of the Clinic is positive.

(b) Meet regularly with physicians and other clinical staff to review problem areas.

(c) Constantly assess problem areas and make suggestions for improvement.

(d) Communicates with the Physician and other clinical staff by Activity Slips for non-urgent or emergency requests or information.

b. **Performance levels can be adjudicated by:**

(1) Conducting Patient Satisfaction surveys.

(2) Ease of patient flow through the system

(3) Assessing physician satisfaction with staff performance.

(4) Measuring staff job satisfaction.

(5) Performance standards can be achieved by

(a) Defining protocols to provide consistent guidelines for staff.

(b) Applying sound management principles to all positions.

(c) Annual performance reviews.

8. **Biomedical Engineering**

a. **Mandate**. To ensure CF health delivery personnel are provided, and have access to, safe, efficient and effective medical technology in every aspect of health care delivery, by promoting the safe and efficient use of medical technology and delivering medical technology management services in an efficient and timely fashion in accordance with applicable provincial and federal regulations and the CCHSA Accreditation Standards.

b. **Functions**. The following functions describe the nature of actions expected from the Biomedical Engineering services:

(1) Equipment Maintenance i.e., preventive maintenance.

(2) Equipment Repair, unscheduled or emergency maintenance.

(3) Contract Management i.e., contracted out services.

(4) Asset management i.e., Inventory Control.

(5) Equipment disposal i.e., recommendation goes to Material Management for salvage value recovery.

(6) Capital planning i.e., equipment renewal, development, prioritization, standardization, project management, implementation.

(7) Health device alert and recall management and follow-up.

(8) Regulation compliance monitoring.

(9) Incident investigation and reporting.

(10) Unsatisfactory condition report/complaint i.e., review and, as required, incident reporting as noted above.

(11) Quality Assurance.

(12) In-service and clinical operation training.

(13) Technology forecast, assessment and design.

c. **At the Clinic**

(1) No dedicated full-time staffing requirements are anticipated for the CF Type 1 and Type 2 Medical Clinic, however the CFHS formation (sector) BME will relate operational issues to the Clinic Manager

(2) CFHS formation (sector) Biomedical Engineering personnel and external contractors mandated by the CFHS Formation (Sector) are expected to deliver service by pre-scheduled visits.

d. **Performance Standards**

(1) **Responsiveness**

(a) Average Response time.

(b) Average time to complete work orders.

(2) **System Competency**

(a) Total BME Costs as a percentage of replacement value of the Medical Asset base and/or Clinical activity.

(b) Percentage compliance to the Preventive Maintenance Schedule.

(c) Number of work orders.

(d) Number of open/incomplete work orders.

(e) Ratio of contracted out services to overall costs.

(f) Efficiency of recoverable costs i.e., reported vs. worked hours.

(3) **Client focus**. Client Satisfaction surveys.

(4) **Work life**

(a) Employee Satisfaction surveys.

(b) Staff turnover.

## CHAPTER D-2

# MANAGEMENT INFORMATION SYSTEM GUIDLEINES

### D-201. GENERAL

1. The Canadian Institute of Health Information Guidelines for Management Information Systems in Canadian Health Care Facilities (CIHI MISG) are national standards that provide a design structure and methodology based on an integrated approach to managing financial and statistical data related to the operations of Canadian health service organizations. They were developed in recognition of the need to improve the effectiveness and efficiency of health service organizations in Canada through better information and performance measurement and to facilitate more meaningful comparative reporting. The MISG have been adopted by Canadian hospitals and represent the backbone of hospital management information systems and Federal/Provincial health care performance reporting.

### D-202. OVERVIEW OF PERFORMANCE MANAGEMENT

1. The Canadian Forces Health Services (CFHS) MISG management information/decision support system will support effective CFHS performance measurement.

a. The information from the CFHS MISG system will support management accountability for clinic performance, and will support action-oriented performance management on the part of clinic managers.

b. CFHS MISG reports will provide performance indicators to allow managers to monitor the following key areas of health services delivery: financial, staffing, productivity, utilization. Health outcomes are NOT part of MISG information.

c. An understanding of the details and causes of current performance will also be facilitated by the data in MISG management reports, but may also require additional investigation and knowledge on the part of CFHS managers. In other words, MISG data will not have all of the answers to all management questions at any given time.

d. CFHS MISG will support a continual state of evolution and improvement by providing a consistent, reliable set of performance measurements that will maintain its relevance over time, and that can also be used to compare similar functional centres at different locations.

### D-203. EVIDENCE-BASED CARE

1. Evidence-based care refers to clinical knowledge and practices applied by health care providers in order to make decisions about the care of patients. At this time, CFHS MISG management indicators and statistics will not incorporate evidence of compliance with clinical practice guidelines, and will not reflect associated health outcomes. The CF Surgeon General has established an interdisciplinary Working Group to measure and report on these attributes of CFHS performance. CFHS MISG management information will complement the Working Group's findings by providing an objective measure of resource utilization trends associated with clinical practices and health patterns. Implementation of formal workload measurement systems will provide measures of the relative workload of health care providers for collaborative /consultative activities such as team meetings, case conferences, etc.

## D-204. EVIDENCE-BASED MANAGEMENT

1. The CFHS MISG will provide a complete set of objective, consistent, reliable data required for the resource management quadrant of the CFHS Balanced Scorecard. The types of data and indicators that will be provided by CFHS MISG include:

a. Costs of operating the Clinic, as well the individual services within the Clinic e.g., Care Delivery Unit, Laboratory, Pharmacy, Case Management, etc.

b. Human Resource worked hours utilized to operate the Clinic and its individual services, as well as to fulfill other CFHS mandates e.g., Maintenance of Clinic Skills, military training, etc.

c. Staff workload units utilized to provide various types of health services to various types of clients.

d. Utilization of various types of Clinic health services and referred out services by various categories of clients.

e. Percent variances i.e., actual relative to plan and changes over time.

## CHAPTER D-3

# PERFORMANCE REVIEW

### D-301. STAFF ASSISTANCE VISITS

1. Staff Assistance Visits (SAVs) are one of the mechanisms used by Canadian Forces Health Services Headquarters (CF H Svcs Gp HQ) to ensure that the CF Member receives adequate health care by evaluating the quality, efficiency, appropriateness, and effectiveness of the care provided at the CF Medical Clinic. SAV team members offer guidance and direction when appropriate.

2. There are three types of SAV. The Laboratory and Diagnostic Imaging SAV where senior Clinical Advisors conduct regular visits to ensure compliance with the established regulatory standards. The Focus SAV is conducted to resolve a particular issue at a departmental level that requires assistance from CF H Svcs Gp HQ. Finally, the Full SAV that is conducted at the request of a Clinic Manager, operational-level Formation Surgeon, or higher authority.

### D-302. BASE SERVICES INDEX

1. Initiated in 2000 by the Vice Chief of Defence Staff, the CF Service Index Model is based on the Integrated Defence Management System. The Service Index Model recognizes that there are four elements or pillars to the mission of the CF Base. These pillars include realty assets, support operations, personnel and community. This project aimed at developing common standards to measure the services delivered at the Base and implement a process to monitor these standards. The standards focus on the needs and expectations of the users of the service rather that the providers of those services. The basis of these standards are three fold.

   a. To provide equitability of support services to the CF Member, their family and their units regardless of their CF location.

   b. To provide freedom of manoeuvre to the Base Commander that permits innovative approaches to service delivery.

   c. To allow improved decision-making through reliable, measurable and accurate information.

2. The development and implementation of two of these standards are the responsibility of the Canadian Forces Health Services (CFHS), Health and Ambulance services. The Ambulance standard has been developed and implemented. Quarterly reports have led to the refinement of the standard. Health services delivery will be measured using the Canadian Council on Health Services Accreditation (CCHSA) – Achieved Improve Measurement (AIM) standards.

### D-303. ACCREDITATION

1. The CF has been working under the Rx 2000 initiative with the CCHSA to develop and implement an accreditation program for the CFHS. The CF Accreditation Program will continue to monitor the Primary Care Renewal Initiative pilot sites, pursue Continuous Quality Improvement (CQI) initiatives and provide required support to the CF Medical Clinic in preparation for the commencement of the formal Accreditation Survey process, scheduled for September 2005. The proposed Accreditation Program is one aspect of a broader CQI initiative that is currently being developed by Rx 2000. It should be noted that the CCHSA AIM Program does not specify what indicators an organization should monitor. Rather, it indicates the areas where indicators should

be developed. The CF Medical Clinic Model Results-based Management Accountability Framework (RMAF) was reviewed and these areas were found to be highly consistent with the areas of performance specified in the CF Medical Clinic Model strategy map.

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# GLOSSARY AND ABBREVIATIONS

## GLOSSARY

**Access (to Health Care)**

The means or opportunity for a CF member to reach or use a health care program or service; the services are either required or available, provided in the most appropriate setting and at the right time, and based on the CF member's needs.

**Advocate**

A representation or supporter of clients or groups concerns and interest, or to represent and support. Being a patient advocate is the professional duty of all health professionals.

**Ambulatory Care**

A mode of delivering health care services, in locations/clinics/centres, staffed by multidisciplinary providers whose goals are to prevent disease while patients are well, and treats illness, in a setting consistent with the severity and acuity of the condition. The emphasis is primary and secondary care, and counselling to the patient and families with the intent to prevent hospitalisation.

**Assessment**

A process by which the characteristics and needs of patients, groups, populations, and communities or situations are evaluated or determined so that they can be addressed. The assessment is used to plan services or actions.

**Authority**

The right for making a decision and to require compliance by subordinates.
(A-AE-219-002/AG-001)

**Benchmarking**

The act of comparing results of one service's evaluations to the results of other services, interventions, programs, or organisations; and the act of examining one organisation's processes against the process of other organisations that are recognised as excellent, as a way of making

# GLOSSAIRE ET ABRÉVIATIONS

## GLOSSAIRE

**Accès (aux soins de santé)**

Moyen ou possibilité pour un membre des FC de profiter des programmes ou des services de soins de santé requis ou disponibles ou d'en faire usage au bon endroit, au bon moment, et en fonction de ses besoins particuliers.

**Défenseur**

Représentant ou personne sympathique aux préoccupations et aux intérêts des clients ou des groupes. Tous les professionnels de la santé ont le devoir de défendre leurs patients dans l'exercice de leur profession.

**Soins ambulatoires**

Mode de prestation de services par des dispensateurs multidisciplinaires de soins de santé, dans des établissements, des cliniques ou des centres ayant pour but de prévenir la maladie chez les patients en bonne santé et de traiter les autres en fonction de la gravité et du caractère aigü de leur état. Il s'agit principalement de soins primaires et secondaires, mais également de counseling du patient et des familles en vue de prévenir une hospitalisation.

**Évaluation**

Processus grâce auquel les caractéristiques et les besoins des patients, des groupes, des populations et des communautés ou des situations sont évalués ou établis afin qu'on puisse y donner suite. L'évaluation sert à planifier les services à offrir ou les mesures à prendre.

**Autorité**

Droit de prendre une décision et d'exiger que les subordonnés s'y conforment.
(A-AE-219-002/AG-001)

**Analyse comparative**

Action de comparer les résultats des évaluations d'un service à ceux d'autres services, interventions, programmes ou organismes, et établissement de comparaisons entre les processus d'une organisation et ceux d'autres organismes jugés excellents, de façon à apporter

improvements.

**Best practice evidence**

Approaches that have been shown to produce superior results, selected by a systematic process, and judged as exemplary, good or successful demonstrated. Also known as best practice guidelines and best practice.

## Care co-ordination/co-coordinator

The assumption of responsibility for the care of a patient throughout the continuum of care, ensuring timely access to necessary services and appropriate follow-up care. This includes referral, patient tracking, an uninterrupted treatment plan, health records transfer to assist health care providers to make decisions, provider continuity which increases the efficiency of the visit, patient compliance and quality of provider judgement and ongoing follow-up.

**Continuum of Care**

An integrated and seamless system of settings, services, service providers, and service levels to meet the needs of clients or defined populations. Elements of the continuum are: self-care, prevention and promotion, short-term care and service, rehabilitation, and support. Also continuum of services.

**Care Delivery Unit (CDU)**

A primary health care team, located at a CF clinic, that focuses through group practice on meeting the primary health needs of rostered CF-members and military units while in-garrison. The CDU is a multidisciplinary team of core civilian and non-core military clinicians, tasked with the provision of quality patient care, ensuring seamless continuity of care over-time. The civilian staff of a CDU consists of a Physician, a Nurse Practitioner, a Registered Nurse, and a social worker. The military staff that supports the CDU when available, are a Medical Officer and a Physician Assistant. Medical

des améliorations.

**Expérience clinique reliée aux pratiques exemplaires**

Approches ayant permis d'obtenir des résultats supérieurs. Sélectionnées selon un processus systématique, elles ont été jugées « exemplaires », « bonnes » ou « fructueuses ». On les appelle également lignes directrices sur les pratiques exemplaires et meilleures pratiques.

**Coordination/coordonnateur de soins**

Prise de responsabilité dans le traitement d'un patient, tout au long du continuum de soins, afin de lui assurer l'accès opportun aux services nécessaires et au suivi approprié. Cette définition englobe les éléments suivants : aiguillage, localisation du patient à l'intérieur du système de santé, plan de traitement ininterrompu, transfert du dossier médical pour aider les dispensateurs de soins de santé à prendre des décisions; continuité des services assurés par le dispensateur afin d'augmenter l'efficacité de la visite, respect du traitement par le patient, qualité de jugement du dispensateur de soins et suivi permanent.

**Continuum de soins**

Système intégré et continu de paramètres, de services, de dispensateurs de soins et de niveaux de services pour répondre aux besoins des clients ou de populations définies. Au nombre des éléments inclus dans le continuum, mentionnons l'autogestion de la santé, la prévention des maladies et la promotion de la santé, les soins et services de courte durée et de longue durée, la réadaptation et les services de soutien. On parle aussi de continuum de services.

**Unité de soins primaires (USP)**

Équipe de soins de santé primaires, en poste dans une clinique des FC, qui met l'accent sur les pratiques de groupes visant à satisfaire les besoins de soins de santé primaires des membres actifs des FC et des unités militaires en garnison. L'USP emploie une équipe multidisciplinaire de cliniciens cadres, militaires ou non militaires, chargés d'administrer des soins de qualité aux patients en vue d'assurer la continuité des soins de façon permanente. Le personnel civil de l'USP comprend un médecin, un infirmier ou une infirmière praticien(ne), un infirmier ou une infirmière autorisé

Assistants can be assigned to a CDU as support staff.

(e) et un travailleur ou une travailleuse social(e). Le personnel militaire de l'USP, le cas échéant, se compose d'un médecin militaire et d'un adjoint au médecin. Des adjoints médicaux peuvent être affectés à une USP en qualité de personnel de soutien.

**Decentralized booking**

**Service de rendez-vous decentralisé**

Appointments for all or most clinicians are booked through at each point of care reception office. This allows for better management of resources and wait lists.

**Centralized Health Records**

All medical files (CF 2034, mental health file and psychosocial file) of all CF members and other entitled personnel belonging to the base/wing are in the same physical location, i.e. Health Records Department

**Centralized Reception**

An administrative section in CF clinics that is primarily responsible for the administrative needs of patients. Responsibilities include reception services, updating patient identification cards or labels, central booking services, management of the internal scheduling system, data capture and assistance with patient travel.

**Client/patient**

**Client/patient**

The client refers to a person or persons with whom the health professional is engaged in a professional therapeutic relationship. In most cases the client is an individual. The client may also be a family, a group (as in psychotherapy) or a community (as in the public health field). In research, the client is a subject or participant, and in education, the client may include students.

Une ou des personnes avec qui le professionnel de la santé entretient une relation thérapeutique professionnelle. Dans la majorité des cas, il s'agit d'un individu, mais le client peut également être une famille, un groupe (par exemple en psychothérapie) ou une communauté (dans le domaine de la santé publique). Dans le domaine de la recherche, le client est un sujet ou un participant et dans le contexte de l'éducation, le nom de client peut aussi être attribué aux étudiants.

**Clinic Categorization**

A systematic approach to classifying all CF clinics IAW the type of services that is provided in-house, the size of the population served, and the extent of the support provided to satellite clinics, if any. There are five clinic types

**Catégorisation des cliniques**

Méthode systématique de classification de toutes les cliniques des FC, en fonction du type de services offerts à l'interne, de la taille de la population desservie et de l'étendue du soutien assuré dans les cliniques satellites, le cas échéant. Cinq catégories de cliniques ont été identifiées, elles vont du type I au type V.

**Clinical Pathways**

Interdisciplinary evidence-based tools developed and used by health care providers to define and coordinate optimal interventions, and their sequencing and timing**;** a cause and effect grid that identifies expected behaviours of the client and staff against a timeline; a clinical system that organises and sequences the care giving process at the client/family and caregiver level to achieve quality and cost outcomes. Clinical pathways can incorporate Disease Management Protocols.

**Cheminement Clinique**

Outils fondés sur des données interdisciplinaires probantes élaborées et utilisées par les dispensateurs de soins de santé pour définir et coordonner les interventions optimales, ainsi que leur déroulement et leur enchaînement; une grille cause-effet détermine les comportements attendus du patient et du personnel dans le cadre d'un échéancier précis; un système de gestion clinique organise et planifie le processus de prestation de soins au niveau des clients, des familles et des dispensateurs de services afin d'assurer les meilleurs soins au meilleur prix. Le terme « cheminement clinique » peut également intégrer les protocoles de gestion des soins thérapeutiques.

**Competence**

The ability of a professional to integrate the professional attributes required to perform in a given role, situation or practice setting. Professional attributes include, but are not limited to, knowledge, skill, judgement, attitudes, values and beliefs.

**Compétence**

Aptitude d'un professionnel à démontrer les qualités professionnelles requises pour jouer un rôle donné dans une situation ou un contexte d'exercice de sa profession. Les qualités professionnelles requises incluent, sans toutefois s'y limiter, les connaissances, les habiletés, le jugement, les attitudes, les valeurs et les croyances.

**Complaint**

The expression of a problem, an issue, or dissatisfaction with services that may be verbal or in writing.

**Plainte**

Expression verbale ou écrite d'un problème, d'une question ou d'une insatisfaction face à des services reçus.

**Consent**

The voluntary agreement or approval given by a patient who understands the information given about their conditions, the proposed service, the risk, benefits, potential outcome, options or alternatives, if any, and the consequences of accepting or refusing the proposed service. The consent process confirms the right of competent adults to give or withhold their agreement to services, and to have a substitute decision maker(s) involved when they are not competent to consent.

**Consentement**

Accord volontaire ou approbation par un client qui comprend l'information fournie au sujet de son état de santé, les services proposés, les risques, les avantages, les résultats éventuels, les options ou les choix qui s'offrent à lui, le cas échéant, ainsi que les conséquences de l'acceptation ou du refus des services proposés. Le consentement confirme le droit des adultes compétents à accepter ou à refuser des services et à ce qu'une autre personne puisse prendre la décision s'il est lui-même incapable de donner son consentement.

**Continuity of Care**

CFHS is responsible for ensuring a caring, responsive and coordinated process by which all health services provided to an individual are integrated. This process involves the CF member and an interdisciplinary health care team, supported by the member's chain-of-command and by a continuous, comprehensive health record. Continuity of care includes continuity of provider where practicable, and seamless and efficient transition of the member from one care provider to another where required.

**Continuité des soins**

**Contracting out**

Practice of employer having work performed by an outside contractor and not by regular employees in the unit.

**Impartition**

Pratique en vertu de laquelle un employeur fait exécuter un travail par un entrepreneur de l'extérieur plutôt que de le confier aux employés réguliers de l'unité.

**Core civilian staff**

A group of civilian clinicians or service support personnel that is stable in staffing and essential to the smooth and continuous functioning of a CF clinic. They represent permanent staffing in the provision the quality health care and support services, permitting military health care providers and support staff to meet their operational requirements without adversely affecting continuity of care and health programs for CF members.

**Personnel civil de base**

Groupe de cliniciens civils ou de membres des services de soutien, employés permanents essentiels à la bonne marche et au fonctionnement continu d'une clinique des FC. Ces personnes constituent un effectif permanent chargé d'offrir des soins de santé et des services de soutien de qualité, permettant aux dispensateurs de soins et au personnel de soutien militaire de satisfaire aux exigences opérationnelles sans compromettre la continuité des soins et les programmes de santé offerts aux membres des FC.

**Credential (verb)**

To assess and attest to an individuals knowledge, skills, competence, and their compliance with specific requirements.

**Titres de compétences**

Évaluation et attestation des connaissances, des habiletés, des compétences d'un individu, ainsi que de leur conformité avec des besoins spécifiques.

**Culture**

Culture refers to the learned values, beliefs, norms and ways of life of an individual that influence thinking, actions, and decisions.

**Culture**

Valeurs acquises, croyances, normes et style de vie qui influencent la façon de penser, les actes et les décisions d'un individu.

**Customer oriented approach**

A client-oriented business philosophy and attitude of management and the workforce towards customers. The organisation incorporates strategies that build commitment and a shared vision for quality service and customer satisfaction. The organisation's policies, processes and procedures integrate these strategies and reinforce a service culture among the staff, where day-to-day provision of services follows a customer orientation and strives for exceptional service, exceeding the clients' expectations and needs. Examples of how to achieve a customer service approach include: increasing professionalism on the frontline, improving customer relations; effective and proactive complaint handling; developing listening, vocal and written friendly communications skills; setting standards for quick response in customer service and to clients requests and concerns; stress management; telephone techniques; building a positive self-image; team building and problem-solving; and monitoring team performance and quality indicators. Also customer service.

**Approche axée sur la clientèle**

Philosophie de l'entreprise et attitude de la gestion et des travailleurs envers la clientèle. L'organisation incorpore des stratégies qui favorisent l'engagement et une vision partagée de la qualité du service et de la satisfaction du client. Les politiques, les processus et les procédures de l'organisation intègrent ces stratégies et renforcent au sein du personnel une mentalité axée sur le service dont la prestation quotidienne est orientée vers le client et préconise un service exceptionnel dépassant les attentes et les besoins de celui-ci. Voici quelques exemples de l'approche à adopter en matière de services à la clientèle : accroître le professionnalisme de première ligne, améliorer les relations avec les clients, traiter les plaintes efficacement et de façon proactive, développer des capacités d'écoute, des habiletés pour les communications « amicales » verbales et écrites, établir, au niveau des services à la clientèles, des normes permettant de donner suite rapidement aux demandes et aux préoccupations des clients, de gérer le stress et d'adopter des techniques de communication téléphonique, développer une image de soi positive, constituer une équipe et résoudre les problèmes, en plus de superviser le rendement de l'équipe et les indicateurs de la qualité. On parle aussi de **service à la clientèle**.

**Deliver (Health Care)**

To produce and supply health services to CF members at CF Health Service Centres or CF satellite sites.

**Prestation de soins de santé**

Organisation et prestation de services aux membres des FC dans des centres de services de santé ou dans des établissements satellites des FC.

**Disease State Management (DSM) Protocols**

A standard protocol that describes in sequence the recommended tests, treatments or procedures that are most appropriate for common medical situations. DSMs recommend actions that are sufficient and efficient, neither excessive nor deficient, based on best practice evidence. They allow for exceptions when justified by clinical circumstances. The protocols help ensure that patients receive the best quality medical care, in a standardised fashion and cost-effective way. DSMs can become part of Clinical pathways, to allow for a broadened multidisciplinary and holistic approach to care.

**Evaluation**

The assessment of the degree of success in meeting the goals and expected results (outcome) of the organisation, service, program population, or clients.

**Evidence-based practice**

The synthesization and application of scientific evidence to improve quality and effectiveness in clinical care.

**Health**

The state of complete physical, mental, social and spiritual wellbeing, not merely the absence of disease. Health is the extent to which individuals and populations are able to develop aspirations and satisfy needs, and to change and cope with the environment. Health is seen as a resource for everyday life, not the objective of living. It is seen as a positive concept emphasising social and personal resources, as well as physical capacities. (World Health Organisation (WHO))

**Protocoles de gestion des problèmes de santé (GPS)**

Protocoles standard décrivant dans l'ordre les tests recommandés, les traitements ou les procédures les plus appropriés dans le cas de problèmes de santé courants. Les protocoles GPS recommandent des mesures suffisantes et efficaces, ni excessives ni déficientes, fondées sur les pratiques exemplaires. Ils prévoient des exceptions lorsque les circonstances cliniques le justifient. Les protocoles aident à assurer que les patients reçoivent la meilleure qualité de soins médicaux, de façon uniforme et rentable. Les protocoles GPS peuvent devenir un élément des cheminements cliniques et permettre une approche multidisciplinaire et globale plus large des soins.

**Évaluation**

Évaluation du degré de succès obtenu au niveau de l'atteinte des objectifs et des résultats (conclusions) auxquels l'organisation, le service, la population inscrite aux programmes ou les clients sont en droit de s'attendre.

**Pratique fondée sur l'expérience clinique**

Action de synthétiser et d'appliquer l'expérience clinique scientifique à l'amélioration de la qualité et de l'efficacité des soins cliniques.

**Santé**

Bien-être intégral, au plan physique, mental, social et spirituel, et non seulement absence de maladie. La santé est la mesure dans laquelle les personnes ou les populations sont capables non seulement de satisfaire leurs aspirations et leur besoins, mais également de modifier leur environnement et de s'y adapter. La santé est considérée comme une ressource nécessaire à la vie quotidienne et non comme l'objectif de notre existence. Elle est perçue comme un concept positif privilégiant tout autant les ressources sociales et personnelles que les capacités physiques. [ Organisation mondiale de la santé (OMS)].

**Home Care**

As essential health and/or personnel support services, delivered at one's place of residence to a person/client, who without such services, would require placement in a costlier setting such as a hospital or a nursing home or would not be able to remain safely at home. (Canadian Home Care Association)

**Soins à domicile**

Services de soutien au personnel et services de santé essentiels offerts au domicile d'une personne/d'un client qui, sans ces services, devrait faire l'objet d'un placement en établissement beaucoup plus coûteux, par exemple dans un hôpital ou un foyer de soins infirmiers, ou serait incapable de demeurer à la maison en toute sécurité. (Asssociation canadienne de soins et services à domicile)

**Indicator**

Performance measurement tool, screen or flag that is used as a guide monitor, evaluate, and improve the quality of client service delivery, support services, leadership and partnership. Indicators relate to structure, processes and outcomes.

**Indicateur**

Outil, écran ou drapeau de mesure du rendement utilisé comme guide pour superviser, évaluer et améliorer la qualité de la prestation des services à la clientèle, des services de soutien, du leadership et du partenariat. Les indicateurs sont reliés à la structure, aux processus et aux résultats.

**Information Management**

Planning, organising and controlling data. It is an organisation-wide function that includes clinical, financial and administrative databases. The management of information applies to both computer-based and manual systems.

**Gestion de l'information**

Planification, organisation et contrôle des données. Cette fonction, qui vise l'ensemble de l'organisation, inclut le maintien de banques de données cliniques, financières et administratives. La gestion de l'information s'applique à la fois aux systèmes informatiques et manuels.

**In-garrison care**

In-garrison care consists of all the health care provided to CF members and other entitled persons in Canada. It is inclusive of pre and post deployment activities, field training and work on the ranges. In-garrison care is exclusive of operations and exercises, and when the ships are away from a Canadian port. Patients that are repatriated from operations and exercises are considered to be under in-garrison care

**Soins en garnison**

Tous les soins de santé dispensés aux membres des FC et aux autres personnes admissibles au Canada. Ils incluent les soins offerts avant et après les déploiements, l'entraînement en campagne et le travail aux champs de tir. Les soins offerts en garnison n'incluent pas ceux qui sont administrés au cours des opérations et des exercices et quand les navires ne sont pas dans un port canadien. Les patients rapatriés au terme d'opérations et d'exercices sont considérés comme recevant des soins en garnison.

**Input**

The material, equipment, information, people, money or environmental conditions needed to carry out the process**.**

**Intrant**

Matériel, équipement, information, personnes, argent ou conditions environnementales nécessaires à l'application du processus.

**Medical boards**

A specific and detailed military medical administrative process of health assessment of service members, to accurately identify employability. Part I and II are to be done together

**Commissions médicales**

Processus spécifique et détaillé de l'administration médicale militaire permettant d'évaluer l'état de santé des membres des FC afin d'établir avec précision leur employabilité. Les parties I et II de

in order to reduce the number of visits to the clinic by the patient.

l'évaluation doivent être effectuées en même temps de manière à réduire le nombre de visites du patient à la clinique.

**Medical Liaison**

The process of initiating and maintaining open communications with the patient's military unit and the other facilities where the patient is receiving health care services. It involves patient advocacy, proactive patient tracking throughout the civilian health care system, problem solving, and maintaining a database on the health status of military units. Understanding unique military requirements and operational issues is an essential element to this function.

**Liaison médicale**

Processus d'établissement et de maintien de communications ouvertes avec l'unité militaire du patient et les autres installations dont il reçoit des services de soins de santé. La liaison médicale relève du défenseur du patient, elle comporte une méthode proactive permettant de le retracer dans le système de soins de santé civil, la résolution des problèmes et le maintien d'une base de données sur la condition physique des membres des unités militaires. Le titulaire de cette fonction doit absolument comprendre les besoins uniques des militaires et les questions opérationnelles.

**Modified Care Delivery Unit**

Modified Care Delivery Units are CDU on training bases that require an increase incremental staff for those periods when there are additional transient CF members on Base.

**Multidisciplinary**

A variety of disciplines that participate in the assessment, planning, and/or implementation of client or group services with close interaction and integration among each other to achieve common goals. Also interdisciplinary.

**Groupe multidisciplinaire**

Variété de disciplines participant à l'évaluation, à la planification et/ou à la mise en œuvre des services offerts aux clients et aux groupes, exerçant une interaction étroite les uns avec les autres aux fins de l'atteinte d'objectifs communs. On l'appelle aussi groupe interdisciplinaire.

**Need**

Physical, mental, emotional, social, or spiritual requirement for well-being. Needs may or may not be perceived or expressed by the person in need. They must be distinguished from demands, which are expressed desires, not necessarily needs.

**Besoin**

Exigence d'ordre physiologique, mental, émotionnel, social ou spirituel essentielle au bien-être. Les besoins peuvent être perçus ou exprimés ou ne pas l'être par l'individu concerné. Ils doivent être différenciés des demandes qui sont l'expression de désirs, mais pas nécessairement de besoins.

**Observational Care**

Holding patients overnight for a health condition that normally would not warrant hospitalisation, but is necessitated primarily by the nature of the military transient environment and the high bed occupancy rate in the civilian hospitals. Also patient holding or residential care.

Hébergement de patients pour la nuit en raison d'un problème de santé qui ne justifierait normalement pas une hospitalisation, mais qui s'impose surtout à cause de la nature transitoire du contexte militaire et du taux d'occupation élevé des lits dans les hôpitaux civils. On parle aussi de garde de patients ou de soins en établissement.

**One stop shopping**

A customer service approach providing easy access, at times and in places that are convenient to the patient, ensuring that the right provider, is at the right place at the right time to meet the patient's individual needs.

**Point de service unique**

Approche facilitant l'accès aux services à la clientèle aux heures et aux endroits qui conviennent aux patients, qui sont ainsi assurés que
que le dispensateur de soins dont ils ont besoin sera au bon endroit, au bon moment, et pourra répondre aux besoins individuels de chacun.

**Output**

The product or service that is created by the process; that which is handed off to the customer.

**Extrants**

Produit ou service engendré par le processus et fourni au client.

**Patient rostering**

Process by which CF members are enrolled to a particular Care Delivery Unit and receive all primary health care through this team. Entire military units are to be rostered to a CDU, facilitating regular reporting to Commanders on the health status of their unit or Brigade, and the timely identification of adverse health trends.

**Inscription à la liste des patients**

Processus grâce auquel les membres des FC sont inscrits dans une unité de soins primaires et reçoivent tous leurs soins de santé par l'entremise de cette équipe. Tous les membres des unités militaires doivent être inscrits dans une USP, de manière à faciliter l'envoi régulier de rapports informant le commandant de l'état de santé des membres de son unité ou de sa brigade, et à permettre d'identifier à temps les tendances négatives en matière de santé.

**Performance Measurement**

The significance of operational performance measurement can best be appreciated by examining the importance of its role in evaluating the efficiency and effectiveness of various programs.

**Mesure de performance**

Pour mieux comprendre le sens de l'expression « mesure du performance opérationnel », il convient d'examiner l'importance de son rôle dans l'évaluation de l'efficacité et de l'efficience des divers programmes.

**Population Health**

A way of looking at health and services, and an approach to managing them, that focuses on the needs of a given group as a whole, and the factors that contribute and determine health status. A population health approach facilitates the integration of services across the continuum of care.

**Santé de la population**

Façon de considérer la santé et les services et approche de gestion mettant l'accent sur les besoins de l'ensemble d'un groupe donné, ainsi que sur les facteurs qui contribuent à déterminer l'état de santé. Une approche fondée sur la santé de la population facilite l'intégration des services tout au long du continuum de soins.

**Practice Leader**

Responsible for recommending professional standards and policies governing their particular profession as well as the definition and maintenance of professional competencies.

A practice leader can be at the clinic, regional/

**Chef de l'exercice de la profession**

Il doit recommander les normes et les politiques régissant sa profession de même que définir les compétences professionnelles et en assurer le maintien.

Un chef des services professionnels peut être en

sector, and national level. The National Practice Leader, previously known as MOC Advisor, can be the designated process owner for a particular set of activities that occur in primary health care within their scope of responsibility.

**Primary Health Care**

Primary health care serves as the CF member's initial and on-going access into the health care system and is delivered by a multi-disciplinary team of civilian and military health care professionals who have developed a sustained partnership with the member using a collaborative team approach. The CF primary health care team will:

- provide and coordinate access to a broad range of health services including, but not limited to health promotion, disease prevention, health maintenance, counselling, patient education, vaccination, diagnosis and treatment of acute and chronic illnesses;
- facilitate referral to secondary and tertiary health care services while maintaining a variety of speciality and institutional, consultative and referral relationships for specific care needs.

**Primary prevention**

Primary prevention is general awareness and sensitisation of a population to particular risk behaviour. Health maintenance through ongoing education is a major component of primary care. Primary Care clinics and education programs provide information, foster better understanding and compliance with treatment, teach new skills in self-management and encourage positive changes in lifestyle in a setting that supports the practice of new skills and behaviours.

poste dans une clinique, au niveau de la région ou du secteur et à l'échelle nationale. Le chef national de l'exercice de la profession, autrefois appelé conseiller GPM, peut-être le responsable du processus désigné pour une série d'activités particulières reliées aux soins de santé primaires relevant de son secteur de responsabilité.

**Soins de santé primaires**

Les soins de santé primaires assurent au membre des FC un accès initial et permanent au système de soins de santé. Ils sont offerts par une équipe multidisciplinaire de professionnels de la santé civils et militaires qui, grâce à une approche d'équipe, ont développé un partenariat prolongé avec le membre. L'équipe de soins de santé primaires des FC assurera les services suivants :

- offrir et coordonner l'accès à une vaste gamme de services de santé incluant, sans toutefois s'y limiter, la promotion de la santé, la prévention des maladies, la préservation de la santé, le counseling, l'éducation du patient, la vaccination, le diagnostic et le traitement des affections aiguës et chroniques;
- faciliter le processus de consultation vers des services de soins de santé secondaires et tertiaires tout en continuant à offrir une variété de soins spécialisés, en entretenant des relations à caractère institutionnel et consultatif, de même qu'en formulant des recommandations pour répondre à certains besoins spécifiques en matière de traitement.

**Prévention primaire**

Prise de conscience et sensibilisation générales de la population face à un comportement à risque particulier. La préservation de la santé, grâce à l'éducation permanente, est un élément important des soins primaires. Les cliniques de soins primaires et les programmes d'éducation fournissent de l'information, favorisent une meilleure compréhension et un plus grand respect du traitement, enseignent de nouvelles habiletés en matière d'autogestion de la santé et encouragent les changements positifs de style de vie dans un contexte favorisant l'adoption de nouvelles compétences et de comportements différents.

**Procedure**

Written set of instructions that describes the approved and recommended steps for a particular act or sequence of acts.

**Process**

A sequence of steps, tasks or activities that converts inputs to an output. A work process adds value to the inputs by changing them or using them to produce something new.

A work process is made up of steps, tasks or activities and has a beginning and an end. Using inputs, it produces either a tangible product or an intangible service as its output. The process adds value to the inputs.

At its simplest: Input → Process → Output

**Process mapping**

A graphic representation of a process showing the sequence of tasks, using a modified version of standard flowcharting symbols. The activity of creating a detailed flowchart of a work process showing its inputs, tasks, and activities in sequence.

**Process Owner**

For each set of activities, functions or processes occurring in CF clinics, there is a person responsible for that activity at the national level. This person ensures that processes and related procedures are evidenced-based, patient focused, cost effective, and are being implemented in a relatively standardised fashion throughout CF clinics. This person has the authority to initiate change, revision or deletion of the process. The process owner may or may not be a National Practice Leader.

**Professional Accountability**

Being responsible for one's actions and decisions, and accepting the consequences. Health professionals demonstrate accountability through their decision-making process, competency and integrity. It is reflected through their actions and

**Procédure**

Série d'instructions écrites décrivant les étapes approuvées et recommandées à suivre pour poser un acte ou une série d'actes particuliers.

**Processus**

Série de mesures, de tâches ou d'activités de conversion des intrants en extrants. Un processus de travail ajoute de la valeur aux intrants en les modifiant ou en les utilisant pour en produire de nouveaux.

Le processus de travail comporte des mesures, des tâches ou des activités; il a un commencement et une fin. À l'aide d'intrants, il produit des extrants, sous forme de produit tangible ou de service intangible. Le processus ajoute de la valeur aux intrants.

Plus simplement : Intrants → Processus → Extrants

**Description des processus**

Représentation graphique d'un processus illustrant une série de tâches, à l'aide d'une version modifiée de symboles d'organigrammes. L'activité consiste à créer un graphique détaillé d'un processus de travail illustrant ses intrants, ses tâches et ses activités dans l'ordre.

**Responsable du processus**

Chaque série d'activités, de fonctions ou de processus en vigueur dans les cliniques des FC relève d'une personne responsable de cette activité à l'échelle nationale. Cette personne s'assure que les processus et les procédures connexes sont fondés sur des résultats cliniques, axés sur le patient, rentables et appliqués d'une façon relativement uniforme dans toutes les cliniques des FC. Cette personne est autorisée à modifier, revoir ou annuler le processus. La responsabilité d'un processus peut relever ou non d'un chef national de l'exercice de la profession.

**Imputabilité professionnelle**

Assumer la responsabilité de ses actes et de ses décisions et en accepter les conséquences. Les professionnels de la santé font preuve d'imputabilité par leur façon de prendre des décisions, leur compétence et leur intégrité,

through accurate documentation.

lesquelles se reflètent dans tous leurs actes et dans l'exactitude des documents qu'ils établissent.

**Professional Technical Network (Prof Tech Net)**

A lateral and vertical communication network for each health profession within the CF. It is established as a means to improve through efficient communication, the quality of care, standards of practice, practice guidelines, and working environments. It also serves to advance professional issues and promote team building. The Prof Tech Net will facilitate the consistent application of policies, and improve the ability to monitor their application and obtain timely feedback from the field on the appropriateness of a policy or of other changes. Each occupation has a National Practice Leader as leader of their respective network.

**Réseau professionnel et technique (RPT)**

Réseau de communications latérales et verticales à l'intention de chaque professionnel de la santé des FC. Il permet, grâce à une communication efficace, d'améliorer la qualité des soins, les normes d'exercice de la profession et les directives connexes ainsi que le milieu de travail. Il contribue aussi à l'avancement des questions professionnelles et favorise la constitution de l'équipe. Le RPT facilite l'application cohérente des politiques et améliore l'aptitude à en superviser l'application de même qu'à obtenir en temps voulu une rétroaction des personnes concernées quant au bien-fondé d'une politique ou à d'autres changements. Chaque profession relève d'un chef national de l'exercice de la profession qui gère son propre réseau.

**Provide (Health Care)**

To make available health care services or to make adequate arrangements that enable CF members to access the health services, either internally or externally to CF Health Service Centres.

**Prestation (de soins de santé)**

Rendre les services de soins de santé accessibles ou prendre des dispositions adéquates permettant aux membres des FC d'accéder aux services de santé internes ou externes offerts dans les centres de services de santé des FC

**Providers (Health care)**

Individuals who provide health care services, working in collaboration with others on a team. The provided services are based on an integrated service plan

**Dispensateurs (de soins de santé)**

Individus qui fournissent des services de santé et qui travaillent en collaboration avec les autres membres d'une équipe. Les services sont offerts en fonction d'un plan de services intégrés.

**Quality**

The degree of excellence; the extent to which an organisation meets clients' needs and exceeds their expectations.

**Qualité**

Degré d'excellence ou mesure dans laquelle un organisme répond aux besoins des clients et dépasse leurs attentes.

**Quality Improvement**

Organisational philosophy that seeks to meet client needs and exceed their expectations by using a structured process that selectively identifies and improves all aspects of services.

**Amélioration de la qualité**

Philosophie de l'organisation visant à répondre aux besoins des clients et à dépasser leurs attentes en recourant à un processus structuré qui identifie et améliore de façon sélective tous les aspects des services offerts.

**Readiness**

Readiness is the level of preparedness for personnel and materiel to respond to the tasks described in a scenario or to an operation being

**Capacité opérationnelle**

Niveau de préparation exigé du personnel et du matériel pour exécuter les tâches décrites dans un scénario ou en vue d'une opération éventuelle. Le

considered. The 1994 Defence White Paper provides overall direction and guidance to the recommended CF readiness levels. The technical, material, manning and training level of the unit shall determine the overall readiness for individual units of the CF. The time assigned to a unit to reach the readiness level is the time required to be fully manned and equipped at organisational strength including unit training and logistics stocks required for the operational mission assigned. (Strategic Capability Planning for the Canadian Forces June 2000)

Livre blanc de 1994 formule des directives et des conseils quant aux niveaux de capacité opérationnelle recommandés pour les FC. Le degré de préparation technique, le matériel, la dotation et l'entraînement d'une unité déterminent la capacité opérationnelle globale de chaque unité des FC. Le temps alloué à une unité pour atteindre le niveau de capacité opérationnelle requis correspond au temps qu'il lui faut pour compléter ses effectifs et obtenir l'équipment qui lui est nécessaire, ce qui inclut l'entraînement de ses membres et les stocks logistiques exigés par la mission opérationnelle qui lui est assignée. (Planification de la capacité stratégique des Forces canadiennes, juin 2000)

**Referral**

A direction from another provider or organisation to provide services for a client, to obtain additional services from another organisation or provider.

**Aiguillage**

Directive émanant d'un dispensateur de soins ou d'un organisme de services à la clientèle en vue d'obtenir des services supplémentaires d'une autre organisation ou d'un autre dispensateur de soins.

**Responsibility, Accountability and Authority**

Having a responsibility involves having the authority and the obligation to act, including the authority to direct or authorise others to act. It also means being accountable for how these responsibilities have been carried out in light of agreed expectations. In a public sector organisation such as the CF or DND, each individual is obliged to *account* fully and promptly to those who, in the hierarchy, conferred the responsibilities, for the way they have been carried out and for how the relevant authorities have been used.

**Responsabilité, imputabilité et autorité**

Avoir une responsabilité signifie avoir l'autorité et l'obligation d'agir, notamment être autorisé à diriger ou à en autoriser d'autres à agir. Cette définition signifie également être imputable quant à la façon dont ces responsabilités ont été assumées en tenant compte des attentes exprimées. Dans un organisme du secteur public tel que le MDN ou les FC, chaque personne doit *rendre compte* intégralement dans les meilleurs délais à ceux qui, dans la voie hiérarchique, lui ont confié des responsabilités, de la façon dont ces responsabilités ont été assumées et dont les autorisations pertinentes ont été employées.

**Risk**

Chance or possibility of danger, loss or injury. For health services organisations, this can relate to the health and wellbeing of clients, staff, and the public; property; reputation; environment; organisational functioning; financial stability; and other things of value.

**Risque**

Risque ou possibilité de danger, de perte ou de blessure. Dans le cas des organismes des services de santé, les risques peuvent être reliés à la santé et au bien-être des clients, du personnel et du public, aux biens, à la réputation, au milieu, au fonctionnement de l'organisation, à la stabilité financière ainsi qu'à d'autres éléments de valeur.

**Roster plan**

A list detailing a Base's regular and reserve force units and the specific Care Delivery Unit (CDU) they are rostered to. The plan outlines any special occupational health or language service requirements a CDU must provide to appropriately

**Plan d'inscription des patients**

Liste des unités de la Force régulière et de la Réserve d'une base et Unité de soins primaires (USP) spécifique où sont inscrits les membres de ces éléments. Le plan fait état de différents besoins spéciaux en rapport avec l'hygiène du travail ou les

meet specific unit needs.

services linguistiques qu'une USP doit offrir pour répondre adéquatement aux besoins spécifiques d'une unité.

**Satellite Clinic**

A CF clinic that provides limited health care services, and reports to a larger or **superior** CF clinic for technical guidance and support. A satellite clinic can be a Type I, II, or III clinic, IAW the CF Clinic Categorisation.

**Clinique satellite**

Clinique des FC offrant des services de soins de santé limités et relevant d'une clinique plus grosse ou **de niveau supérieur** des FC en ce qui a trait aux conseils et au soutien technique. La clinique satellite peut être de type I, II ou III, conformément à la catégorisation des cliniques des FC.

**Scope of practice**

The limits within which a care provider practices determined by the required level and type of knowledge, level of critical thinking and ability to apply judgement in a given situation.

**Champ d'activités**

Limites dans le cadre desquelles les méthodes utilisées par un dispensateur de soins sont déterminées par le niveau et le type requis de connaissances, de pensée critique et d'aptitude à appliquer son jugement à une situation donnée.

**Secondary prevention**

Secondary prevention is screening to identify those who may be at risk.

**Prévention secondaire**

Sélection des patients qui pourraient être à risque.

**Sick Parade (Immediate Care)**

A pre-defined period of time during which CF-members and other eligible personnel may present, without an appointment for assessment of health concerns over not greater than 48 hours duration.

**Revue des malades (Soins immédiats)**

Période préétablie au cours de laquelle les militaires des FC et les autres membres du personnel admissibles peuvent se présenter sans rendez-vous à la salle d'examen médical pour faire évaluer des problèmes de santé datant de moins de 48 heures.

**Spectrum of Care (CF)**

A formal document that defines and describes the health care benefits and services, medical and dental, that is available for CF members and other eligible persons. These services are provided at no cost to the CF member. CF family members are not covered by the CF Spectrum of Care but rather by the provincial health system of the province where they reside.

**Gamme de soins (FC)**

Document officiel définissant et décrivant les avantages des soins de santé ainsi que les services médicaux et dentaires offerts aux membres des FC et aux autres personnes admissibles. Ces services sont fournis gratuitement aux militaires. Les membres de leurs familles n'ont pas accès à la gamme des soins offerts par les FC, mais ils sont plutôt admissibles au système de soins médicaux de la province où ils habitent.

**Standard**

Desired and achievable level of performance against which actual performance can be compared.

**Norme**

Niveau de rendement désiré et réalisable en fonction duquel le rendement réel peut être comparé.

**Standards of Practice**

The standards of practice set out the expectations

**Normes d'exercice de la profession**

Elles précisent les attentes reliées à la conduite et

for conduct and practice. The three major components are professional standards, practice expectations, and legislation and regulations.

à la pratique dont les trois principales sont les normes professionnelles, les attentes concernant l'exercice de la profession, lois et règlements.

**Superior Clinic**

A CF clinic that provides a wide range of health care services and has the appropriate resources and expertise to provide technical support to the smaller CF satellite clinics that reports to it. It could be a Type VI, V or VI clinic, IAW the CF Clinic Categorisation.

**Clinique de niveau supérieur**

Clinique des FC offrant une vaste gamme de services de soins de santé et possédant les ressources et l'expertise pertinentes pour assurer le soutien technique des cliniques satellites plus petites des FC qui relèvent d'elle. Il peut s'agir d'une clinique de type VI, V ou VI, conformément à la catégorisation des cliniques des FC.

**Tertiary care**

Is specialised and highly technical care accessed for the diagnosis and treatment of complicated or unusual health problems. Clients who require tertiary care present with an extensive and often complicated pathological condition.

Tertiary settings are usually regional hospitals or provincial health science centres that house sophisticated diagnostic equipment and perform complex therapeutic procedures that require advanced expertise by medical and nursing specialists.

**Soins tertiaires**

Soins spécialisés et hautement techniques auxquels les militaires ont accès pour obtenir un diagnostic ou le traitement de problèmes de santé compliqués ou inhabituels. Les clients qui ont besoin de soins tertiaires souffrent d'une affection grave et souvent compliquée.

Les établissements de soins tertiaires sont généralement des hôpitaux régionaux ou des centres provinciaux de soins de santé qui disposent d'un équipement de diagnostic sophistiqué et qui emploient des procédures thérapeutiques complexes exigeant une expertise poussée de la part des spécialistes du domaine médical et infirmier.

**Tertiary prevention**

Tertiary prevention is rehabilitation or treatment of a disease or injury.

**Prévention tertiaire**

Réadaptation ou traitement d'une maladie ou d'une blessure.

**Triage**

The rapid, systematic assessment and collection of data related to the patient's chief complaint in accordance with the urgency of his/her presenting problem within the following categories: resuscitative, emergent, urgent, less urgent and non-urgent.

**Triage**

Évaluation rapide et systématique ainsi que collecte de données reliées à la principale plainte du patient, en fonction de l'urgence de son problème dans les domaines suivants : manœuvres de réanimation, problèmes très urgents, urgents, moins urgents et non urgents.

**Utilization management**

Examination and evaluation of the appropriateness of the use of an organisation's or a service's resources. Also known as utilization review.

**Gestion de l'utilisation des ressources**

Examen et évaluation de l'utilisation pertinente des ressources d'un organisme ou d'un service. On parle aussi d'examen de l'utilisation.

**Wellness**

The state of being well, contented, healthy. Includes the physical, emotional, mental, social, and

**Mieux-être**

État de bien-être intégral, de satisfaction, de santé, touchant les dimensions physiques, émotionnelles,

spiritual dimensions. Also known as well-being.

mentales, sociales et spirituelles, également appelé bien-être.

## APPENDIX 3 TO ANNEX A1

## CANADIAN FORCES DENTAL SERVICES CLINIC MODEL

# CFDS Clinic Model

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|---|---|
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## Background

1. This Instruction similarly sorts dental clinics into five groups, corresponding to the Rx2000 model. An overview of the five clinic types is attached at Annex A. The 'Clinical Care' requirements for CFDS clinics are detailed at Annex B and are based on patient population. The 'Command' requirements for CFDS clinics generally consist of a Dental Officer Detachment Commander and Dental Technician Dental Clinic Coordinator of appropriate rank; larger clinics also warrant a Senior Dental Hygienist, an Assistant Clinic Coordinator and/or a Support Services Manager.

2. When calculating the number of clinical providers required for a given population, the Dent Det Comd (DDC) and Snr Hygst are expected to contribute to direct patient care. Their clinical load may be reduced depending on the scope of the command task. As a minimum, two days per week of clinical treatment will be required to maintain the clinical skills required of the senior clinician in the detachment. It is expected, however, that DDCs employed in Type 1 to Type 4 clinics will significantly exceed this.

3. Clinic Coordinators and Assistant Clinic Coordinators will be expected to dedicate some time to assist with clinic administration, beyond that which constitutes leadership or management functions. Additional civilian support services will be available to perform the remaining workload.

## Policy

### A. Type I Dental Clinic – 'Satellite Clinic'

4. **Description**: Type I Dental Clinics service a population of less than 1000 patients, and are a satellite of a Type IV or Type V clinic. The CF Type I Dental Clinics are: Shearwater (Det Halifax), RMC (Det Kingston), Dockyard (Det Esquimalt), Citadelle (Det Valcartier), M12 Annex (Det Petawawa), and Dwyer Hill (Det Ottawa).

5. **Command**: Capt Det Comd, Sgt Clinic Coord. The Dent Det Comd is expected to assume a full clinical load of 600 patients. Command function tasks are expected to be completed in one half-day/week. The Clinic Coord can provide 0.6 FTE performing support services tasks.

6. **Support Services**: Service support consists solely of a receptionist who is also responsible for financial administration. The clinic coordinator and chairside dental technicians/assistants are available to perform those service support functions beyond the capability of the receptionist.

## B. Type II Dental Clinic – 'Small Detachment'

7. **Description**: Type II Dental Clinics service a population of less than 1000 patients, as a standalone dental clinic. The CF Type II Dental Clinics are: North Bay, Toronto, London, Gander, Geilenkirchen, Casteau – SHAPE, Goose Bay, St John's, and Moose Jaw.

8. **Command**: Capt Det Comd, Sgt Clinic Coord. The Dent Det Comd is expected to assume a full clinical load of 600 patients. Command function tasks are expected to be completed in one half-day/week. The Clinic Coord can provide 0.6 FTE performing support services tasks.

9. **Support Services**: Service support consists solely of a receptionist who is also responsible for financial administration. The clinic coordinator and chairside dental technicians/assistants are available to perform those service support functions beyond the capability of the receptionist.

## C. Type III Dental Clinic – 'Medium Size Detachment'

10. **Description**: Type III Dental Clinics service a population of less than 2000 patients, as a standalone dental clinic. The CF Type III Dental Clinics are: Comox, Bagotville, Cold Lake, Greenwood, Longue-Pointe, Shilo, Wainwright, Winnipeg, and St-Jean.

11. **Command**: Maj Det Comd, Capt Det 2 i/c, Sgt Clinic Coord, MCpl Asst Clinic Coord, Sgt Snr Hygst. The Det Comd is expected to provide 0.8 FTE as a clinical care provider. The Det 2i/c is expected to assume a full clinical load of 600 patients. The Clinic Coord is available 0.4 FTE to perform support services tasks. The Asst Clinic Coord is available 0.4 FTE to perform support services tasks and 0.4 FTE to provide clinical care delivery as a chairside assistant. The Snr Hygst is expected to assume a full load of 800 patients.

12. **Support Services**: Support Services staffing requirements are 1.0 FTE reception staff and 1.6 FTE support staff. The Command Staff is available to provide 0.8 FTE support services functions; a CR4 is required to complete the remaining support services tasks.

## D. Type IV Dental Clinic – 'Large Detachment'

13. **Description**: Type IV Dental Clinics service a population of more than 2000 patients, as a standalone dental clinic. Type IV Dental Clinics may support a satellite Type I clinic and/or support unmanned 'temporary duty' clinics in multiple locations. The CF Type IV Dental Clinics are: Kingston, Trenton, Borden, and Gagetown.

14. **Command**: Maj AGD Det Comd, Capt Det 2i/c, WO Clinic Coordinator, MCpl Asst Clinic Coordinator, and Sgt Snr Hygienist. The Det Comd is expected to provide 0.6 FTE as a clinical care provider. The Det 2i/c is expected to assume a full clinical load of 600 patients The Snr Hygst is expected to assume a full clinical load of 800 patients. The Asst Clinic Coord is available 0.4 FTE to perform support services tasks and 0.2 FTE to provide clinical care delivery as a chairside assistant. There is a total of 0.4 FTE available to perform support services tasks.

15. **Support Services**: Support Services staffing requirements are 2.0 FTE reception staff and 2.4 FTE administrative staff. The Command Staff is available to provide 0.4 FTE support services functions; 2 CR4s are required to complete the remaining support services tasks.

## E. Type V Dental Clinic – 'Regional Specialty Centre'

16. **Description**: Type V Dental Clinics service a population of more than 4000 local patients, plus a catchment area. They are regional specialty centres, and offer a full spectrum of dental specialty care with multiple dental specialists on staff. Patient referrals from other clinics are accepted. Type V Dental Clinics may support a satellite Type I clinic and/or support unmanned 'temporary duty' clinics in multiple locations. The CF Type V Dental Clinics are: Valcartier, Ottawa, Esquimalt, Petawawa, Halifax, and Edmonton.

17. **Command**: LCol Det Comd, Maj 51A Det 2i/c, MWO Clinic Coordinator, WO Assistant Clinic Coordinator, Sgt Support Services Manager and WO Senior Dental Hygienist.

18. The Det Comd and Det 2i/c are each expected to provide 0.6 FTE (3 days/week) as a clinical care provider. The Snr Hygst is expected to assume a partial clinical load of 600 patients. The Clinic Coord is occupied full time with command and management tasks. The Asst Clinic Coord is available 0.4 FTE to perform support services tasks. The Support Services Manager is available 0.6 FTE to perform support services tasks. There is a total of 1.0 FTE available to perform support services tasks.

19. **Support Services**: Support Services staffing requirements are 3.0 FTE reception staff and 4.0 FTE administrative staff. The Command Staff is available to provide 1 FTE support services functions; this leaves a requirement for 3.0 FTE additional staff. An AS2 and 2 CR4s are required to complete the remaining support services tasks.

# References

A. CMP SID #02/08 CFDS RESTORE 17 Jul 08

# 1.0 Annexes

A. Annex A - Matrix Overview of Dental Clinic Types
B. Annex B - Establishment Ratios for CFDS Clinics

# CFDO 1-2 - Annex A

2009-07-08

## Matrix Overview of Dental Clinic Types

| Command | | | | | |
|---|---|---|---|---|---|
| **Population Support** | **Type I <1000** | **Type II <1000** | **Type III <2000** | **Type IV >2000** | **Type V >4000** |
| Detachment Commander | Capt (.1) | Capt (.1) | Maj (.2) | Maj AGD (.4) | LCol (.4) |
| Detachment 2 i/c | | | Capt (.1) | Capt (.1) | Maj (.4) |
| Clinic Coordinator | Sgt (.4) | Sgt (.4) | Sgt (.6) | WO (1) | MWO (1) |
| Asst Clinic Coord | | | MCpl (.2) | MCpl (.4) | WO (.6) |
| Senior Hygienist | | | Sgt (.1) | Sgt (.1) | WO (.2) |
| Support Services Manager | | | | | Sgt (.4) |
| Total Command Staff (FTE) | .5 | .5 | 1.2 | 1.8 | 3.0 |

| Support Services | | | | | |
|---|---|---|---|---|---|
| **Population Support** | **Type I <1000** | **Type II <1000** | **Type III <2000** | **Type IV >2000** | **Type V >4000** |
| Fin Mgmt/Blue Cross | .1 | .2 | .4 | .6 | 1 |
| Administrative Clerical | .1 | .1 | .2 | .3 | .6 |
| Health Records Clerical | .1 | .1 | .2 | .3 | .4 |
| IM/IT System Administration | .1 | .1 | .2 | .2 | .4 |
| Supply | .2 | .2 | .3 | .5 | .8 |
| Dental Care Program Clerical | .1 | .1 | .3 | .5 | .8 |
| **TOTAL (less reception)** | .7 | .8 | 1.6 | 2.4 | 4.0 |
| AS2 / CR4 requirement (note 1) | 0.1 | 0.2 | 0.8 | 2.0 | 3.0 |
| Reception | 1 | 1 | 1 | 2 | 3 |
| Total Dental Clinic (FTE) | 1.7 | 1.8 | 2.6 | 4.5 | 7.0 |

| Clinical Care Delivery | | | | | |
|---|---|---|---|---|---|
| **Population Support** | **Type I <1000** | **Type II <1000** | **Type III <2000** | **Type IV >2000** | **Type V >4000** |
| DO/DE (note 2) | X | X | X | X | X |
| Dent Tech/Asst | X | X | X | X | X |
| Hygienist (note 2) | X | X | X | X | X |
| Nurse (note 3) | | | 0.2 | 0.2 | 1 |
| OMFS | | | | | 1 |
| Periodontist | | | | | 1 |
| Prosthodontist | | | | | 1 |
| AGD | | | | 1 | 1 |

**Notes**: Numbers in brackets refer to full time equivalents (FTE) required to complete this function.

1. This takes into account the FTE that the command staff can spend performing Support Services functions other than reception, and represents the amount of additional staff required.
2. Requirement for Dental Officer/Dentists and Hygienists will be reduced by clinical contribution of Dent Det Comd and Snr Hygst.
3. Nurse required only if intravenous sedations being performed by an OMFS, Periodontist or AGD.

# CFDO 1-2 - Annex B

2009-07-08

## Establishment Ratios for CFDS Clinics

1. The following tables amalgamate the OSEER ratios for dentists and dental assistants, the hygienist ratio developed at Ref A, and the Support Services requirements developed in CFDO 1-3. Patient loads have been amended for clinical personnel in command positions to reflect the time required to perform these duties.
2. 'DCP' refers to the patient load to whom the dental officers can provide annual examinations and required treatment. Clinical Specialist officers are providing treatment based on referrals from general dentists, hence are not assigned a DCP patient load. AGD specialists do perform annual exams, but also devote treatment time to referred patients and are assigned a lower DCP patient load.

| **Clinic Manning Ratios** | | |
|---|---|---|
| **Clinic Personnel** | **DCP (patients)** | **Reqr DA support (MCpl, Cpl, C-Por HS-PHS6)** |
| Capt DO | 600 | 1.6 |
| DE2 or Calian dentist | 800 | 2.0 |
| Maj 51A | 600 | 1.6 |
| Maj DDC 51A | 480 | 1.6 |
| Maj AGD | 300 | 1.6 |
| Maj AGD DDC | 200 | 1.0 |
| LCol DDC | 200 | .6 |
| OMFS | 0 | MCpl plus 1 |
| Perio | 0 | 1.6 |
| Prosth | 0 | 1.6 |
| Hyg Sgt/Civ | 800 | |
| Hyg WO | 600 | |
| Hyg MWO | 400 | |

| CFDS Clinic Establishment Requirements | |
|---|---|
| **Rank/MOC** | **Criteria** |
| LCol 51A/B | 1 in every Type V Dental Clinic as Dent Det Comd |
| Maj 51A | 1 as Dent Det Comd in Type III Dental clinics |
| | 1 as Deputy Det Comd in each Type V Dental Clinic |
| Maj 51B - AGD | 1 as Det Comd in Type IV Dental Clinics |
| | 1 in each Type V Dental Clinic (Regional Specialty Care Centre) |
| Maj 51B - OMFS | 1 in each Type V Dental Clinic (Regional Specialty Care Centre) |
| Maj 51B - Perio | 1 in each Type V Dental Clinic (Regional Specialty Care Centre) |
| Maj 51B - Prostho | 1 in each Type V Dental Clinic (Regional Specialty Care Centre) |
| Capt 51A | 1 as Det Comd in each Type I and Type II Dental Clinic |
| | At least one in every clinic (patient load of 600 pers) |
| MWO 738 | 1 in each Type V Clinic as Clinic Coordinator |
| MWO 738 (Hygst) | 1 at Dent Det Ottawa with secondary duty as CFDS Senior Hygst /Sub-occupation advisor |
| WO 738 | 1 at each Type IV clinic as Clinic Coordinator |
| | 1 at each Type V clinic as Asst Clinic Coordinator |
| WO 738 (Hygst) | 1 in each Type V Clinic as Senior Hygst |
| Sgt 738 | 1 in each Type V clinic as Support Services Manager |
| | 1 in each Type I, II and III clinic as Clinic Coordinator |
| Sgt 738 (Hygst) | 1 in each Type III and Type IV clinic as Snr Hygst |
| | 1 in selected Type II clinics with minimal patient load as Clinic Coordinator and clinical provider |
| MCpl 738 | 1 in each Type III and Type IV clinic as Asst Clinic Coord |
| | 1 for each Maj 51B OMFS |
| | As required for chairside duties in Type V clinics |
| Cpl 738 | As reqr – see provider ratio table above |
| C-P 738 | As reqr – see provider ratio table above |
| DE2 (Civ dentist) | As reqr (patient load of 800 pers) |
| HS-PHS 6 (Dental Assistant) | As reqr – see provider ratio table above |
| EG-05 (Hygienist) | As reqr (patient load of 800 pers) |
| CR3 (Reception) | 1 in each dent clinic under 2000 patients |

| CFDS Clinic Establishment Requirements | |
|---|---|
| **Rank/MOC** | **Criteria** |
| | 2 in each dent clinic with 2000 – 4000 patients |
| | 3 in each dent clinic with over 4000 patients |
| CR4 | 2 in each Type V Dental Clinic (Regional Specialty Care Centre) |
| | 2 in each Type IV Dental Clinic |
| | 1 in each Type III Dental Clinic |
| AS2 | 1 in each Type V Dental Clinic (Regional Specialty Care Centre) |
| NU (Nurse) | 1 in each Type V Dental Clinic (Regional Specialty Care Centre) |
| | 0.2 in each clinic with AGD Maj Det Comd (all Type IV and selected Type III clinics) |

Date modified: 2016-05-31

## APPENDIX 4 TO ANNEX A1

## SPECTRUM OF CARE: MEDICAL AND DENTAL BENEFITS AND SERVICES

## Spectrum of Care: Medical and Dental Benefits and Services

The Canadian Forces (CF) Spectrum of Care document was first published on 21 December 1998 to describe the health benefits and services available and publicly funded for CF members and other eligible persons. It is published by the Surgeon General under the authority of Chief Military Personnel (CMP) and is updated regularly.

The CF Spectrum of Care document provides direction to CF health care providers, Base/Wing Surgeons, Dental Detachment Commanders, CF chain of command and CF members. It authorizes the use of public funds to ensure that CF members have access to a standard of health services that is comparable overall to that received by Canadians under provincial health care plans. Inclusions and exclusions apply everywhere in Canada and abroad, regardless of what health services are covered by provincial or allied health plans. The Spectrum of Care's primary focus is not on equity with the provinces, but rather on operational benefit: i.e having the right person available for operations with the right level of health fitness.

The Spectrum of Care Committee must represent CF operational needs and is chaired by Assistant CMP with representation from all three Environments. Its recommendations must be endorsed by CMP, presented at least annually or as required to Armed Forces Council (AFC) and Program Management Board (PMB), and may result in Memoranda to Cabinet if necessary to ensure that resources are allocated to support Spectrum of Care decisions.

Decisions to include or exclude a health service are based upon the following five principles:

- the treatment, service, or item adheres to the scientific principle of evidence based medicine; this principle would eliminate any new medical procedures or remedies that have not been adequately investigated and scientifically found to provide a significant health benefit (e.g. homeopathic remedies);
- the treatment, service, or item is necessary for the purpose of maintaining health and mental well-being or preventing disease; it permits the diagnosis or treatment of an injury, illness or disability;
- the treatment, service, or item is not for purely experimental, research or cosmetic purposes;
- the treatment, service, or item is funded by at least one province or federal agency; this principle is in keeping with Public Service Health Care Plan (PSHCP) criteria; and
- the benefit sustains or restores a serving member to an operationally effective and deployable status.

Requests for amendments, additions, or deletions of health services must be addressed through the CF Health Services chain of command to Director Medical Policy or Director Dental Services as applicable.

The Spectrum of Care document consists of guidelines that are regularly updated in response to changes in technologies and in provincial health care plans. It does not constitute a list of rights, and the final decision as to whether or not a service is provided, approved, and/or funded for a specific CF member is made by the applicable senior medical or dental authority.

J-R Bernier
Brigadier-General
Surgeon General
Commander CF Health Services Group

(Reviewed May 2013)

**General Information**

The Constitution Act places responsibility upon the Federal Government for providing medical care to members of the Canadian Forces (CF). This is because the Canada Health Act and the provincial health insurance acts exclude members of the CF from the list of "insured persons" for the purpose of provincial health care coverage. Therefore, the CF provides its members with comprehensive health care comparable to that guaranteed to all Canadian citizens under the Canada Health Act.

The Canada Health Act of 1 April 1984, which applies to all Canadians, states that: "....the primary objective of Canadian health care policy is to protect and restore the physical and mental well-being of the residents of Canada and to facilitate reasonable access to health services without financial or other barriers." the Act further states that insured person means: "....a resident of the province other than a member of the Canadian Forces."

On behalf of the Department of National Defence (DND) and CF, Commanders are responsible to ensure that the health services requirements of CF members and eligible persons are met. The Commander CF Health Services Group (H Svcs Gp) will develop and maintain an organizational structure to assist CF health care personnel and enable Commanders, within the chain of Command, to fulfill their responsibilities for the provision of health care to entitled members.

**Definitions**

**NPN:** National Provider Network. A national network of civilian medical care providers (individuals or facilities) contracted to assist in the delivery of in-garrison medical care to eligible persons when CF Health Services (CF H Svcs) resources are not available.

**HCC:** Health Care Coordinator. The HCC is the Senior Medical Authority on each CF Base/Wing, who is responsible for the management of in-garrison medical services provided to the military population in their designated area of responsibility.

**Certified Civilian Health Practitioner:** A civilian who is registered, licensed or certified to provide health services within the province in which care is provided; and

**Certified Military Health Practitioner:** A military health care provider, who is registered, licensed or certified to provide health services within a province of Canada.

**CPA:** Contracted Plan Administrator. The CPA is the civilian agency that has been contracted to administer the NPN. The CPA assists the HCC in ensuring health services are available to all eligible persons.

**Medical/Dental Local Authority:** A Medical or Dental senior health professional on each Base/Wing, who has the authority to approve health services provided by the CF.

**Clinical Specialist:** Physician, surgeon or dentist, who has specialized training in medicine or dentistry exceeding the level of training acquired by a general practitioner or dentist.

**Attending Physician:** A military or civilian physician, who usually sees the patient.

**Related Links**

Canadian Armed Forces Drug Benefit List

**Section menu**

**Medical and Dental Benefits and Services**



## Medical Coverage, Eligibility, Management and Access to Health Care

### Coverage

Within the limits provided in this document, CF members and other eligible persons will be:

1. provided comprehensive coverage, whether serving in Canada or abroad, including:
    a. hospitalization and physician services;
    b. supplemental health benefits including drugs and health practitioner's benefits;
    c. occupational health services; and
    d. dental services.
2. excluded from any deductible fees or co-payments for care and services provided by or authorized by the CF;
3. provided emergency health services from the nearest appropriate military or civilian treatment facility; and

4. responsible for all costs related to health care services not authorized, or for services from sources other than those designated and authorized by the senior Health Services authority. In addition, payment will not be made for treatments or therapies if they are deemed to be:
    a. controversial;
    b. not scientifically founded or proven;
    c. not medically beneficial; or
    d. provided solely for cosmetic purposes.

Limitation: Health Services Outside Canada. Eligible persons residing in Canada will not be entitled to routine health services outside Canada.

Note: Consideration will be given for cost recovery for the fees that result from missed appointments.

**Eligibility**

All Regular Force (Reg F) personnel are covered by the Spectrum of Care (SoC) from the time of enrolment to the effective date of release from the CF. Reserve Force (Res F) personnel are covered only during specified periods of eligibility based on their duty status and the relatedness of their illness or injury to military service (QR&O 34.07).

From time-to-time, other persons may be authorized for specific services or for specified periods of time. Some examples are: visiting military forces, foreign military exchange personnel and their dependants, CF recruit applicants and civilian food handlers.

**Management**

The SoC committee determines the services to which members are entitled. Entitlement to services is based upon the following five guiding principles:

1. the benefit adheres to the scientific principle of evidence based medicine. This principle would eliminate any new medical procedures or remedies that have not been thoroughly and scientifically investigated (e.g. homeopathic remedies);
2. the benefit is necessary for the purpose of maintaining health and mental well-being, preventing disease, diagnosing or treating an injury, illness or disability;
3. the benefit is not for purely experimental, research or cosmetic purposes;
4. the benefit is funded by a single province or federal agency. This principle is in keeping with Public Service Health Care Plan (PSHCP) criteria; and
5. the benefit sustains or restores a serving member to an operationally effective and deployable member of the CF.

The spectrum of care consists of six parts:

1. Comprehensive Medical Care;
2. Supplemental Health Care;

3. Occupational Health Care;
4. Preventive Medicine;
5. Health Promotion; and
6. Comprehensive Dental Care.

**Accessing Health Care**

Access to Health Care will, by necessity, be slightly different from base to base and dependent on: the base role, the size of the military population, the base location, the type and size of facilities available and the number and type of military and civilian Health Care personnel available. The local HCC and Dental Detachment Commander will be responsible to clearly publish any changes to the procedures and routines for accessing both regular and emergency health care.

Access to private medical clinic could be appropriate if there is either a clinical or operational requirement and the process is described in the Enhanced Access Health Care Services.

## Comprehensive Dental Care Services

The Canadian Forces (CF) (through the Canadian Forces Dental Services) provides comprehensive dental care, as defined in Queen's Regulations and Orders (QR&O) 35.01, to entitled personnel. Levels of dental care range from urgent dental care to operational dental fitness care and oral health dental care. Dental Care is delivered by a complement of general practitioners and specialists in a managed setting utilizing priorities for care, selection criteria and evidence-based guidelines.

### Levels of Dental Care

Urgent Dental Care. Includes restricted dental treatment and is the care provided to relieve acute pain; treat acute oral conditions; treat trauma to oral and associated facial structures, including broken teeth and fillings; and/or repair broken dentures and other oral appliances.

Operational Dental Fitness Care. This is the non-urgent dental care required to establish a state of operational dental fitness. It includes dental care that, in the opinion of the treating dentist, cannot be deferred for 12 months or more without increasing the likelihood of a dental urgency. The care required to establish a state of operational dental fitness is defined in A-MD-007-089/JD-000, Canadian Forces Dental Care Program (CFDCP). All CF members entitled to comprehensive dental care shall be provided with ‘Operational Dental Fitness Care’.

Oral Health Care. This is the dental care required to establish oral health, and includes all dental care beyond that required to establish a state of operational dental fitness. This includes preventive dental care and rehabilitative dental care to re-establish oral health, and is in keeping with the standard and scope of oral health care available to most Canadians. CF members entitled to comprehensive dental care are eligible for Oral Health Care depending upon the availability of resources.

Throughout the continuum of levels of dental care a wide range of dental services are available to entitled personnel. Eligible dental services mean services listed hereafter, when rendered by a dental officer/dentist or dental specialist, or rendered by a dental hygienist/dental assistant, (or rendered by a licensed denturologist/ denturist) under the direct supervision /prescription of a dental officer/dentist or dental specialist.

Eligible dental services include:

- Diagnostic Services
- Preventive Services
- Periodontal Services
- Restorative Services - Minor
- Restorative Services - Major
- Prosthodontic Services - Minor
- Prosthodontic Services - Major
- Orthodontic Services - Minor
- Orthodontic Services - Major

- Endodontic Services
- Surgical Services
- Adjunctive General Services

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**Diagnostic Services**

1. oral examination;
2. oro-facial examination;
3. intra and extra-oral radiographs;
4. advanced diagnostic imaging;
5. biopsy of oral tissue;
6. tests and laboratory assessments; and
7. diagnosis and treatment planning.

**Preventive Services**

1. oral hygiene instructions;
2. dental cleaning;
3. fluoride treatment;
4. caries control;
5. pit & fissure sealants;
6. diet & nutritional counseling;
7. group instruction;
8. sports mouth guards; and
9. other preventive services.

**Periodontal Services**

1. non-surgical services;
2. scaling & root planing;
3. surgical services;
4. post-surgical treatment;
5. occlusal equilibration;
6. occlusal appliances; and
7. other periodontic services.

**Restorative Services - Minor**

1. amalgam, resin, glass ionomer restorations;
2. pin reinforcements for these restorations;
3. temporary restorations; and
4. polishing of restorations.

**Restorative Services - Major**

1. crowns & inlays;
2. labial veneers;
3. retentive pins, posts and cores; and
4. other restorative services.

**Prosthodontic Services - Minor**

1. removable dentures (complete and partial);
2. repairs;
3. adjustments; and
4. relining & rebasing

**Prosthodontic Services - Major**

1. fixed dentures (bridges);
2. repairs of fixed appliances;
3. implant supported prostheses;
4. oro-facial and cranial prosthetic rehabilitation; and
5. other prosthetic services.

**Orthodontic Services - Minor**

1. minor tooth movement to correct crowding/spacing in a quadrant/sextant/arch;
2. positioning abutment teeth prior to prosthodontic treatment; and
3. treatment that can normally be completed within 12 months.

**Orthodontic Services - Major**

1. treatment to correct a functional disability related to malocclusion.

**Endodontic Services**

1. pulp capping;
2. pulpotomy & pulpectomy;
3. non-surgical root canal therapy;
4. retreatment;
5. surgical root canal therapy; and
6. other endodontic services.

**Surgical Services**

1. removal of cyst, tumors, and neoplasms;
2. treatment of oral and maxillofacial fractures;
3. surgical correction of maxillofacial deformities;
4. extractions;
5. surgical extractions;

6. surgical / capsular or muscular intervention in TMD therapy;
7. soft and hard tissue pre-prosthetic surgery;
8. placement of osseointegrated implants; and
9. other surgical services.

**Adjunctive General Services**

1. emergency services not otherwise specified;
2. management of TMD;
3. sedation;
4. consultation;
5. forensic dental service; and
6. other adjunctive services.

## Comprehensive Medical Care Services

Services will include:

- Physician Services
- Hospital Services
- Ambulance Services
- Addiction Counseling and Treatment
- Social Work Services
- Out-Patient Diagnostic Services
- Rehabilitation Care
- Home Care
- Assistive Devices and Adaptive Equipment
- Long Term Care Facilities
- Health Practitioner Benefits
- Bariatric Surgery
- Corneal Cross-Linking (CXL)

### Physician Services

Physician services to include:

1. diagnosis and treatment of any illness or injury, to the full extent required;
2. counseling with regard to health promotion and preventive medicine;
3. surgery, to include bariatric surgery as described below;
4. administration of anesthesia;
5. obstetrical care, including pre- and post-natal care; and
6. administration of immunizations.

### Hospital Services

This benefit provides reimbursement for reasonable and customary charges for hospital confinement in a general or specialized hospital, as required, including:

1. coverage for any service provided by a duly registered hospital in Canada including out-patient facilities and diagnostic fees normally charged to the provincial authority; and
2. semi-private hospital accommodation whenever available and compatible with the clinical condition. This applies to all CF members irrespective of rank.

### Ambulance Services

Emergency ground and air ambulance services, as the clinical situation and availability dictate. With prior approval, patient transfer by ground or air ambulance is included. Inappropriate ambulance use may result in cost recovery action.

### Addiction Counseling and Treatment

Out-patient and residential addiction counseling and treatment programs when prescribed by an attending physician including:

1. assessment by a physician and/or a specialized counselor, as authorized by the HCC, at the request of the patient or of the military supervisor, to determine the presence of addiction/substance abuse concerns and to determine the required treatment, as well as any supportive counseling and/or detoxification that may be required prior to treatment. This may also involve family members and co-workers/supervisors;
2. formal in-patient treatment programs involving individual, group and family therapy/education sessions;
3. early intervention groups for counseling, for those not requiring the in-patient program;
4. follow-up sessions for a minimum of one year after treatment, on a weekly basis, with the referring physician and/or addiction counselor. Such sessions to be in a group setting with individual counseling, as necessary; and
5. care delivered to family members must be in accordance with the instruction 5100-07 Member Focus Family Care.

**Social Work Services**

1. assessment interviews including screening for isolated or unaccompanied postings, compassionate request assessments, intake assessments, psychosocial assessments;
2. counseling interviews including individual, marital, family or group therapy/counseling;
3. written reports on all assessment and counseling interviews;
4. stress management;
5. suicide prevention;
6. critical incident stress management programs;
7. life skills program;
8. family support services; and
9. care delivered to family members must be in accordance with the instruction 5100-07 Member Focus Family Care.

**Out-Patient Diagnostic Services**

Laboratory, Diagnostic Imaging and other diagnostic procedures when prescribed by an authorized health practitioner.

**Rehabilitation Care**

Care in rehabilitation centers or other rehabilitation programs, for members requiring extensive or specialized rehabilitation resulting from illness or injury.

**Home Care**

Home care services are eligible when the attending physician certifies they are required and the needs cannot be met on an out-patient basis. Appropriate home care services will be provided for eligible service members in their private residence, or in quarters, whether at their home base or elsewhere in Canada. Home care services may include:

1. physician services;
2. nursing services (including case management and mental health);
3. physiotherapy services;
4. occupational therapist;
5. speech pathologist;
6. social worker;
7. nutritionist;
8. respiratory therapist;
9. psychologist;
10. home support services: to include light housekeeping, personal care, meals on wheels, meal preparation, and respite care;
11. medical equipment and supplies. and
12. assistive device and adaptive equipment that would expedite return home after hospital/rehab center stay.

**Assistive Devices and Adaptive Equipment**

Items required for meeting in a timely manner the medical needs for functional independence of entitled CF members. The Base Surgeon is given authority to prescribe immediate ADAE requirements and their installation to a maximum of $15 000 per item. This does not include permanent home modification which would be covered under CBI 211.

**Long Term Care Facilities**

1. Nursing Home. Nursing home services when an eligible person requires 24-hour medical supervision, as well as nursing and personal care; and
2. Chronic Care. Care in chronic care facilities for eligible persons who have long-term illnesses or disabilities which cannot be treated at home.

**Health Practitioner Benefits**

Out-Patient services of the following practitioners when prescribed by the attending physician, within the limits as follows:

1. physiotherapist (20 appointments);
2. speech language pathologist (10 appointments);
3. psychologist (10 appointments);
4. chiropractor (10 appointments);
5. osteopath (10 appointments);
6. dietary counselor (5 appointments);

7. acupuncture, when in conjunction with pain management or when used as an adjunct to treatment of substance dependence (10 appointments); and
8. podiatrist or chiropodist (5 appointments).

Note: Physicians can authorize attendance as indicated, per condition, after which physician follow up of each case is required to ensure that care is progressing and to determine whether further care is required. Patient care, rather than monetary limits per se, will be the determining factor.

**Bariatric Surgery**

Bariatric surgery is an effective procedure for the treatment of a bona fide medical condition: morbid obesity. This surgery is recognized as a legitimate surgery and included as an entitled service within the majority of provincial health care plans.

Bariatric surgery is included in the SoC as an entitled service for CAF members who meet strict medical criteria: BMI > 35 and the presence of recognized comorbid medical conditions (**such as** glucose metabolism abnormality, type 2 diabetes, hypertension, dyslipidemia, **demonstrated** cardiovascular disease, or obstructive sleep apnea) **and** documented failure of the usual non-surgical weight loss treatments such as lifestyle modifications under the direction of the patient's primary care provider and/or a dietician. Final assessment of suitability for this surgery is at the discretion of the Senior Staff Officer Primary care within the Directorate of Medical Policy.

**Corneal Cross-Linking (CXL)**

Canadian Armed Forces members are eligible to receive corneal cross-linking (CXL) as a treatment for keratoconus, subject to approval by the Senior Staff Officer Primary Care (SSO Primary Care) within the Directorate of Medical Policy (D Med Pol). The process for seeking SSO Primary Care approval is as follows:

1. **Patient Evaluation** – The member must have a diagnosis of keratoconus from an ophthalmologist who also considers the member a candidate for CXL. Before proceeding to request SSO Primary Care approval for the CXL procedure on one or both eyes (through the Base or Wing Surgeon, B/W Surg), the member's primary care clinician must obtain a surgical opinion from an ophthalmologist who performs CXL procedures;
2. **Sending for SSO Primary Care Approval** – SSO Primary Care approval is sought in accordance with the procedures detailed in CFHS Instruction 5000-03, Requesting Items or Services as Canadian Armed Forces Spectrum of Care Exceptions;
3. **SSO Primary Care Approval** – The SSO Primary Care will then assess whether CFHS will pay for the CXL procedure, using the following criteria. The decision will be documented in the Canadian Forces Health Information System (CFHIS) and communicated to the B/W Surg IAW CFHS Instruction 5000-03:
    a. ensuring that the CXL procedure has not been carried out on the same eye in the past. CFHS will only pay once per lifetime per eye;
    b. assessing the consultant ophthalmologist(s)' reports carried out as part of the patient's evaluation;

c. determining that the diagnosis of keratoconus has been established; and
d. verifying that, if the CXL procedure proposed is to be done in conjunction with a refractive laser eye surgery procedure, the member will be paying for the latter procedure, which is outside of the Spectrum of Care;

4. **Payment for CXL Procedure** – If the SSO Primary Care approves the CXL procedure for the member, the following payment guidelines are to be adhered to. All fees will be paid to the CXL service provider through the CFHS third-party payment processor (currently Blue Cross), **not by direct reimbursement to the CAF member**. Any proposed exceptions to these guidelines must be pre-approved by the SSO Primary Care:

    a. Total fees, including the ophthalmologist's consulting fee and the technical/procedure fee, should not normally be greater than $1,500 per eye, and
    b. Fees paid above will cover:
        i. pre- and post-procedure ophthalmologist assessments,
        ii. pre- and post-procedure corneal pachymetry,
        iii. corneal de-epithelization,
        iv. all isotonic riboflavin drops,
        v. any other drops required,
        vi. the technician's time, and
        vii. the use of the UV-A light or any other energy source required for the procedure; and

5. **Payment for Follow-Up** – Patient follow-up visits on subsequent days are billed by the ophthalmologist separately through the CFHS third-party payment processor in accordance with the usual fee schedule for ophthalmologist services.

## Excluded Medical and Dental Services

### Medical Services Excluded from Entitlement

Unless specifically required by the CF, eligible persons will not be entitled to coverage for the following items:

1. most services provided for purely cosmetic purposes or dictated by other than a medical requirement. Some of the excluded services are:
    a. removal of wrinkles;
    b. excision or dermabrasion of tattoos and scars, except as a result of injury or surgery;
    c. capillary graft to correct hereditary alopecia (hair loss);
    d. electrolysis, except for pathological hirsutism or folliculitis;
    e. correction of a congenital deformity, except if it causes significant physical symptoms;
    f. excision of excess adipose tissue;
    g. any type of laser eye therapy: orthokeratology, radial keratotomy, or photo refractive keratotomy; and
    h. breast implants (except after a mastectomy).
2. reversal of tubal ligation or vasectomy;
3. massage therapy (except for still serving VAC pensioned members who were already medically assessed and found eligible for the treatment in 2013 according to the direction given in CFHS Instruction 5010-13 "Delivery of Pension-Related Health Benefits"); and
4. homeopathic and unproven herbal remedies.

### Dental Services Excluded from Entitlement

Unless specifically required by the CF, eligible personnel will not be entitled to coverage for the following items:

1. dental examinations required by a third party;
2. any service provided for purely cosmetic purposes, unless required to restore that caused by accident or service-related traumatic injury; and
3. treatments or therapies viewed by medical/dental authorities as controversial or not scientifically validated.

**Health Promotion Activities**

Health Promotion activities including, but not limited to:

1. addictions awareness and prevention, including alcohol, other drugs, gambling and tobacco;
2. injury prevention and promotion of active living;
3. nutritional wellness, including healthy eating, performance nutrition and weight management;
4. social wellness, including stress management, anger management, family violence awareness and prevention, healthy relationships, and mental fitness and suicide awareness; and
5. promotion of healthy lifestyles.

## Limitations to Medical and Dental Care

### Medical Care Limitations

Limitations on the type, level and frequency of services will be applied by the Senior Medical Authority based on selection criteria and guidelines developed by the Surgeon General. These limitations are designed to ensure that a comprehensive range of appropriate medical services are provided to eligible persons based on professionally assessed need.

### Dental Care Limitations

Limitations on the type, level and frequency of services are applied by the senior dental authority based on selection criteria and guidelines developed by the Director Dental Services on behalf of the Director General Health Services. These limitations are designed to ensure that a comprehensive range of appropriate dental services are provided to entitled personnel based on professionally assessed need. For entitled CF members, major restorative, prosthodontic, orthodontics and surgical services are usually limited to members with:

- three or more years of completed service; and
- sufficient time remaining in their current terms of service to complete the procedures and the required follow-up.

Major orthodontic services are limited to the treatment of a functional disability related to malocclusion.

## Occupational Dental Examinations

All statutory or regulatory mandated occupational dental examinations are covered. These include, but are not limited to:

1. dental condition on enrolment examination;
2. periodic dental examinations;
3. overseas dental examinations;
4. isolation dental examinations;
5. aircrew dental examinations;
6. diving dental examinations;
7. submariner dental examinations; and
8. pre-deployment dental examinations.

**Occupational Health Examinations**

All statutory or regulatory mandated occupational health examinations will be covered.

1. These will include, but are not limited to:
    a. recruit medical examinations;
    b. periodic medical examinations;
    c. overseas medical examinations;
    d. isolation medical examinations;
    e. aircrew medical examinations;
    f. diving medical examinations;
    g. submariner medical examinations;
    h. food handlers medical examinations;
    i. release medical examinations;
    j. pre-deployment medical examinations;
    k. post-deployment medical examinations;
    l. pre-incarceration medical examinations; and
    m. medical category reviews;
2. Periodic audiogram screening in conjunction with PHA;
3. Screening for pulmonary function, at the direction of the local medical authority;
4. Other such diagnostic, diagnostic imaging, or laboratory procedures as may be mandated by the local medical authority;
5. Radiological survey of personnel exposed to dysbaric environment;
6. Examination of personnel exposed to hazardous environments, including but not limited to:
    a. Lead exposure;
    b. Isocyanate Exposure;
    c. Polychlorinated Biphenyls;
    d. Otto Fuel;
    e. Radioactive Material; and
    f. Radioactive Luminous Compounds.
7. Immunization programs; and
8. Occupational vision care including:
    a. contact lenses for the correction of vision, and repairs to them, when required for operational duties and when authorized by the HCC;
    b. safety eyeglasses that are necessary for the correction of vision, and repairs to them, when authorized by the local medical authority;
    c. respirator eyeglasses that are necessary for the correction of vision, and repairs to them, when required for operational duties and when authorized by the local medical authority; and
    d. sunglasses that are necessary for the correction of vision, and repairs to them, when required for operational duties and when authorized by the local medical authority.

**Preventive Medicine Services**

All services required to ensure the acceptable working conditions for Canadian Forces members including, but not limited to:

1. Hygiene and sanitation
    a. sanitary inspections;
    b. water quality and systems inspections and testing; and
    c. food services and facilities inspections.
2. Communicable diseases
    a. epidemiological investigations;
    b. Sexually Transmitted Infection (STI) investigations; and
    c. Tuberculosis (TB) contacts tracking/follow-up.
3. Integrated pest management
    a. in-garrison pest control;
    b. pest control inspections of ships, aircraft and vehicles; and
    c. fumigations.
4. Occupational health inspections including
    a. sound and noise inspections/surveys;
    b. air quality inspections/surveys;
    c. illumination surveys;
    d. thermal stress surveys;
    e. storage facility inspections; and
    f. ergonomic surveys.

## Supplemental Health Care

In addition to the comprehensive coverage, supplemental health care benefits will include:

1. CF Drug Benefits
2. Vision Care Benefits
3. Miscellaneous Expense Benefits

### 1. CF Drug Benefits

- Medications Included on the Drug Benefit List
- Medications not included on the Drug Benefit List
- Restrictions to the Medications on the Drug Benefit List
- Updating of the Drug Benefit List
- Accessing Medications
- The Role of the CF Drug Exception Centre

### Medications Included on the Drug Benefit List

The CF provides a wide variety of both prescription and non-prescription drugs to its members. These medications are defined in the Drug Benefit List. The medications on this list must generally be proven to provide a therapeutic effect. Other products, such as selected medical devices or supplies may also be included as Drug Benefits if there is evidence available to support their therapeutic value.

Drugs benefits will include, but not be limited to:

- drugs which normally require a prescription;
- drugs which may not legally require a prescription, but which are only available at an accredited pharmacy, and have known therapeutic value;
- replacement therapeutic nutrients provided that there is no other nutritional alternative to support the life of the member;
- injectable drugs, including allergy serum and vaccines;
- compounded prescriptions;
- vitamins and minerals listed in the CF Drug Benefit List which are prescribed for the treatment of a chronic disease when the use of such products are proven to have therapeutic value; and
- drug delivery devices, such as those used to deliver asthma medications, which are integral to the product.

### Medications Not Included on the Drug Benefit List

Products which do not have a proven therapeutic value will not be included in the Drug Benefit List. Products which fall outside the CF SoC will also not be reimbursed. As well, not all medications in a given therapeutic category will necessarily be included. If several different drug entities are available with similar mechanisms of action and similar therapeutic effects, a smaller

selection of these medications is included. This will ensure rationalization of re-supply during deployment.

The following items are not considered to be benefits, and will not be funded:

- personal hygiene products (e.g. non-therapeutic soaps and shampoos, contact lens solutions, pumice stones, toothpaste and mouthwashes);
- agents of debatable therapeutic value (e.g. multivitamin preparations for general consumption, drugs for weight loss, herbal products, and homeopathic preparations); and
- drugs for purely cosmetic effects (e.g. drugs for male pattern baldness).

**Restrictions to the Medications on the Drug Benefit List**

Certain medications are only approved for use in specific conditions, generally because their therapeutic potential may be limited or their side effects are more significant: these medications require Special Authorization to confirm that criteria for use have been met, and to thereby ensure optimal drug therapy. As well, other medications which are not routinely provided may be considered for use when the CF Drug Benefit alternatives are not well tolerated or are ineffective. The use of these medications must be consistent with an evidence-based approach, and must be approved through the CF Drug Exception Centre (toll-free number 1-877-469-1003).

**Updating of the Drug Benefit List**

The Drug Benefit List is constantly being updated to reflect published literature and/or therapeutic guidelines. Such evidence is reviewed extensively by the Federal Pharmacy and Therapeutics (P&T) Committee, which includes independent physicians and pharmacists across Canada and representatives from various federal agencies. Based on such a review, this Committee makes recommendations as to whether medications should be added/removed from benefit lists. The CF P&T Committee then assesses this information, considering operational demands, and makes a decision regarding the status of the medications on the Drug Benefit List.

**Accessing Medications**

Prescriptions for medications should be filled at the local base pharmacy. If the base does not have a pharmacy, or if medication is required after-hours or in an emergency, the prescription may be filled at a community pharmacy. However, if a prescription is presented to a community pharmacy, a valid Blue Cross card will be required to process the prescription (if the community pharmacy will not honour the Blue Cross card, the prescription should be transferred to another pharmacy).

If the medication prescribed is an unrestricted benefit, the medication will be dispensed without complications. If the medication prescribed requires Special Authorization, the base pharmacist will attempt to determine if the criteria for use have been satisfied (if such a prescription is presented to a community pharmacy, the community pharmacist will contact the Blue Cross adjudication centre to determine if criteria for use have been met). If the Special Authorization

criteria are not met, or if the drug prescribed is not on the Drug Benefit List, the CF Drug Exception Centre will contact the prescriber and/or pharmacist to discuss alternative treatment options or obtain further information to support the use of the non-benefit item.

CF personnel whose workplace is located more than 50 km from a CF pharmacy may have the option of enrolling in the OTC Benefit Card Program. This program allows eligible personnel to access certain non-prescription medications directly from a civilian pharmacy. To obtain more information regarding enrolment in this program, members may contact the OTC Card Program Administrator at (toll-free) 1-866-886-1304 or CSN 849-5886.

**The Role of the CF Drug Exception Centre**

The CF Drug Exception Centre is responsible for adjudicating requests for medication which are either not included as benefits or which do not satisfy the criteria for Special Authorization use. This Centre collects relevant information and reviews each case on an individual basis to determine the most appropriate drug therapy available. This Centre also liaises with Blue Cross and base pharmacies to ensure that Special Authorization criteria and medication access will be consistent for CF members across Canada. Prescribers who anticipate concerns regarding approval of prescriptions may discuss other drug options with their base pharmacist, or alternately may contact the Drug Exception Centre directly at 1-877-469-1003 (toll-free).

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**2. Vision Care Benefits**



Eye Examinations are performed in accordance with CF Periodic Health Assessment requirement or as per occupational health standards and whenever clinically necessary. Eye Examinations are to be conducted by an ophthalmologist, optometrist or ophthalmic technician working under the authority of the Senior Medical Authority.

Entitled Personnel: All members of the Reg F and those entitled Res F members (in accordance with QR&O 34.07) are entitled to optical services as outlined in the CFHS Policy and Guidance: Optical Supply and Services: Entitlement to Frames and Lenses, Policy # 4020-05

Entitlement to Glasses: Two approved frames (in accordance with Standing Offer Agreement) with the proper prescription (single vision, regular bifocals, trifocals and/or progressive lenses in clear lenses) will be supplied as the initial issue to all entitled personnel to ensure and maintain operational and occupational efficiency. Frames and lenses are expected to last for a period of

two years and will comply with CF dress standards. After the initial issue of two pairs of glasses, the entitlement for replacement is one new pair every two years.

Entitlement to Specialty Glasses: Specialized corrective glasses, such as sunglasses, safety glasses, ballistic eye wear and respirator glasses, will be in accordance with established scales of issue or other entitlement documents.

Entitlement to Contact Lenses: Contact lenses that are necessary for therapeutic purposes, as prescribed by a consultant ophthalmologist/optometrist or for other medical requirement, are funded with prior approval of Canadian Forces Health Services Center (CF H Svcs C) Senior Medical Authority. Contact lenses for Refractive Requirement or trade requirements are funded in accordance with current Policy and Guidance: Optical Supply and Services: Entitlement to Contact lenses, Policy # 4020-03.

Buying Up Option: CF members, who wish to upgrade their glasses from those provided by the Standing Offer Agreement (SOA) or Local Purchase Order (LPO), will pay any differences in cost between the price quoted in the SOA or LPO and that of the upgrade as long as the upgrades are not part of the Non-authorized Optical Frames and Lenses found in the CFHS Policy and Guidance: Optical Supply and Services: Entitlement to Contact lenses, Policy # 4020-03.

Optical Providers: CF H Svcs Group/D H Svcs Del is responsible for initiating the SOA request with input obtained from CF H Svcs Cs. Public Works and Government Services Canada prepares the document that includes a description of requirements for the provision of optical frames and lenses for a specific site. Entitled personnel will obtain all frames and lenses through providers named in the local SOA. If a member decides to obtain frames and/or lenses from a provider not named in the SOA, DND will not reimburse any of the costs.

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**3. Miscellaneous Expense Benefits**

The item or service must be medically necessary for the treatment of disease or injury, and must be prescribed by a physician unless otherwise specified. Repairs or replacement of medical equipment will not be made at DND expense when it has been determined that the equipment has been misused. Eligible expenses are the reasonable and customary charges for the following items:

- Hearing Aids
- Orthopaedic Footwear (Military Pattern)
- Orthopaedic Footwear (Civilian Pattern)
- Orthotics
- Trusses, Canes, Crutches, Splints, Casts, Cervical Collars and Off The Shelf Braces
- Custom Made Braces
- Elasticized Support Stockings
- Bandages and Surgical Dressings
- Orthopaedic Brassieres

- Wigs
- Ostomy Supplies, Catheters and Drainage Bags
- Prosthesis and Implants
- Oxygen
- Needles, Syringes, and Chemical Diagnostics Aids
- Insulin Pumps and Associated Equipment
- Blood Glucose Monitors
- Durable Equipment
- Infertility
- Third Party Medical Services
- Laser Treatment of Dermatologic Conditions

Hearing Aids, limited to $2,000 every 48-month period for each ear,

Orthopaedic Footwear (Military Pattern), including modification when authorized by the HCC, once every twelve months, expenses: for other than initial entitlement, the member will pay the price of the equivalent military footwear (unless the footwear is normally issued on a no cost replacement basis).

Orthopaedic Footwear (Civilian Pattern), including athletic footwear, may be modified at public expense when prescribed and approved in accordance with the regulations for military pattern orthopaedic footwear. Individuals may have a maximum of two pairs of shoes, one pair of athletic shoes and one pair of boots, modified per year. Eligible persons must however, purchase the footwear at their own expense. DND shall only pay for modifications.

Orthotics, limited to two pairs every twenty four months.

Trusses, Canes, Crutches, Splints, Casts, Cervical Collars and Off The Shelf Braces when prescribed by an authorized practitioner (see Dental Section for dental braces).

Custom Made Braces when prescribed by a medical specialist.

Elasticized Support Stockings. Stockings manufactured to individual patient specifications and elasticized apparel for burn victims.

Bandages and Surgical Dressings required for the treatment of an open wound or ulcer.

Orthopaedic Brassieres, limited to $100 every twelve months.

Wigs, when the patient is suffering from significant hair loss as the result of a disease or illness, limited to the maximum of $2000/lifetime.

Ostomy Supplies, Catheters and Drainage Bags when indicated and prescribed by the attending physician.

Prosthesis and Implants: (see Dental Section for dental implants),

1. breast prostheses following mastectomy, and replacement, but not within 24 months of the last purchase for the same side;
2. temporary artificial limbs; and
3. permanent artificial limbs and replacement thereof, but not within:
    a. 60 months from the last purchase of the same limb in the case of a member over 21 years of age, unless medically proven that growth or shrinkage of the surrounding tissue requires replacement of the existing prosthesis at an earlier date; or
    b. 12 months from the last purchase of the same limb in the case of a member 21 years of age or less.

Oxygen and its delivery devices.

Needles, Syringes, and Chemical Diagnostics Aids for the treatment of diabetes.

Insulin pumps and associated equipment, when prescribed by a specialist.

Blood Glucose Monitors when prescribed by a specialist.

Durable Equipment, manufactured specifically for medical use, which is required for therapeutic use in the patient's private residence and is recommended by the HCC, may be rented or purchased. Eligible durable equipment includes, but is not limited to, items such as wheelchairs, walkers, hospital beds, apnea monitors and alarm systems for anuretic patients. Reimbursement will be limited to the cost of non-motorized equipment unless medically proven that the patient requires motorized equipment.

Note: Any type of aid to daily living which is not a recognized form of medical treatment or any equipment that is not specifically designed for medical use is not an eligible benefit. Also refer to section on Assistive Device and Adaptive Equipment.

Infertility

1. Investigation: Eligible persons are entitled to investigation of infertility; and
2. Procedure: Eligible persons are entitled to the following procedures for infertility:
    a. artificial insemination: for a diagnosed medical condition only;
    b. in-vitro fertilization (IVF) funding will be provided only:
        i. if the infertility is the result of bilateral Fallopian tube obstruction;
        ii. for a maximum of three cycles; and
        iii. to serving members, not to civilian dependants, spouses or partners of serving members;
    c. medication as an adjunct to IVF when the bilateral tube obstruction criteria is met; and
    d. intra-cytoplasmic sperm injection (ICSI) will be provided:

        i. for male factor infertility;
        ii. for a maximum of three cycles; and

iii. to serving members, not to civilian dependants, spouses or partners of serving members;

3. Experimental or controversial new procedures not covered by provincial health care plans will not usually be funded by CF H Svcs. When in doubt, the HCC should contact D Med Pol - SSO Primary Care for advice.

Note: Investigation and procedures for infertility are not funded when the infertility is the result of voluntary sterilization.

Third Party Medical Services. Medical appraisals, certifications or testimonies required by a member or Third party including:

1. proof of death;
2. a medical-legal examination of a member injured on duty, or related litigation arising from events occurring while on duty;
3. an examination required under a provincial mental patient's protection act;
4. an examination required under a provincial public curatorship act; or
5. an examination required under the Quebec Pension Plan or Canada Pension Plan

This would also include services which would be easily available to the majority of Canadians from their family physician for a nominal fee such as CF physician-completion of forms, e.g. visa applications, adoption medical fitness assessment, insurance medicals, driver medicals and sport diving medicals. No fees for the physician's time will be charged to the CF member for the provision of these services. However, where there are additional external costs associated with the provision of these services, such as charges for the use of outside-the-Clinic diagnostics, these costs will be the responsibility of the CF member seeking the service. The CF physician will nevertheless assist with ordering the required tests. In situations where the demand for CF medical services is high, third party medical services would be accorded a lower priority than:

- The provision of medical care directly to patients; and
- The provision of medical support to CF training and/or operations

Civil aviation medical examinations are not a benefit except when they are done by CF flight surgeons for a CF pilot and as part of a CF-required assessment of the pilot's fitness to fly CF aircraft. Psychological assessments required as part of custody disputes or any other examination, appraisal, testimony, or certification required by a member or a third party involved in any criminal litigation that arises from events occurring during off-duty periods, or for any litigation instigated privately by a member are not an eligible benefits.

Laser Treatment of Dermatologic conditions. The following treatments are included:

1. laser treatment of tattoos resulting from sexual abuse, prisoner of war experience and traumatic tattoos (imbedded particulate);
2. laser treatment for scars which interfere with function or with operational military equipment;

3. laser treatment for to add significant and unsightly vascular and pigmented facial lesion of the face and neck (upon recommendation of a dermatologist);
4. laser treatment for Rosacea (upon recommendation of a dermatologist), and
5. laser treatment for acne scarring: (upon recommendation of a dermatologist and mental health provider).

## Canadian Armed Forces Drug Benefit List

### What is the Canadian Armed Forces Drug Benefit List

The Canadian Armed Forces Drug Benefit List describes those medications that have been determined appropriate for public funding and subsequent provision to Canadian Armed Forces personnel. The processes followed for listing decisions on the Drug Benefit List are consistent with the vision and mission of the Canadian Forces Health Services, the Canadian Armed Forces Spectrum of Care, decisions of the Canadian Forces Pharmacy and Therapeutics Committee (CFPTC) and apply the principles of Evidence Based Medicine. There are two types of benefit medications on the Canadian Armed Forces Drug Benefit List: Regular Benefit, and Special Authorization.

### Instructions

To search, enter the series of characters on which you wish to search in any or all of the text fields above. For example, the brand name search string **tylenol** will return search results including any record which starts with, ends with or contains the word "tylenol". Searches are not case sensitive and search text must **not** be placed in quotes. You can also use the "%" wildcard inside a string of characters to refine your search. For example **a%n** will find both **a**cetami**n**ophen and **a**moxicilli**n**.

Also, please note that the "Match **any** of the above search criteria" search still limits the search results by the "Benefit Type" selected.

If you use the **any** option, all records matching any of the free-text criteria listed will be included in the search results.

If you use the **all** option, only records which match each one of the free-text criteria entered will be included in the search results.

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### Search the Canadian Armed Forces Drug Benefit List

Enter search parameters below then click on "Search"

Generic:

Brand:

Drug Identification Number (DIN):

Anatomical Therapeutical Chemical (ATC):

1. Use drop down menu to search by medication class:

2. Type in ATC critera:

Strength (number):

Benefit Type: Any

Search Options

Optional Search Criteria: -- Match Options --

Customize search options: -- Customize search options --

Sort

Sort by: Generic

Also sort by: Brand Name

Search Reset

**Special Authorization/Exception Drug Payment Criteria**

Search the Special Authorization/Exception Drug Payment Criteria

**Disclaimer**

The Canadian Armed Forces has made every effort to ensure the accuracy of information at the time of publication. However, the Canadian Armed Forces makes no warranties of any kind regarding this information, including but not limited to any warranty of accuracy, completeness, timeliness, reliability or fitness for a particular purpose and such warranties are expressly disclaimed.

The information published on this site is updated quarterly. Therefore, the information published on this site does not necessarily reflect the new changes. The most recent information on the Canadian Armed Forces Drug Benefit List and/or clarifications and details concerning the information published on this site may be obtained by calling the Canadian Forces Drug Exception Centre (CFDEC) at 1-877-469-1003.

**More information**

If you cannot find the information you are looking for in this database or if you have additional questions, you may contact the Canadian Forces Drug Exception Centre at 1-877-469-1003.

Date modified:
2014-07-16

# APPENDIX 5 TO ANNEX A1

# DAOD 1002-0, ADMINISTRATION OF THE PRIVACY ACT

# DAOD 1002-0, Administration of the Privacy Act

## Table of Contents



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## 1. Introduction

**Date of Issue:** 2004-10-01

**Date of Last Modification:** 2015-09-30

**Application:** This DAOD is a directive that applies to employees of the Department of National Defence (DND employees) and an order that applies to officers and non-commissioned members of the Canadian Armed Forces (CAF members).

**Supersession:** NDHQ Instruction ADM(Per) 7/83, *Privacy Act – DND Implementation*

**Approval Authority:** Corporate Secretary (Corp Sec)

**Enquiries:** Director Access to Information and Privacy (DAIP)

## 2. Policy Direction

**Context**

**2.1** Among the rights that the Canadian public most value are those with respect to their privacy and the sanctity of their personal information, i.e. information about an identifiable individual that is recorded in any form. The purpose of the *Privacy Act* is to extend the present laws of Canada that protect the privacy of individuals with respect to personal information about themselves held by a government institution and that provide individuals with a right of access to that information.

**Note –** The terms “personal information” and “government institution” are defined in section 3 of the *Privacy Act*.

**2.2** The Supreme Court of Canada has characterized the *Privacy Act* as "quasi-constitutional" law because of the role privacy plays in the preservation of a free and democratic society. Privacy protection in this sense means limiting government interventions into the private lives of Canadians to lawful and necessary purposes. This protection is an essential element in maintaining public trust.

**2.3** Heads of government institutions are responsible for the effective, well-coordinated, and proactive administration of the *Privacy Act* and *Privacy Regulations* within their institutions.

### Policy Statement

**2.4** The DND and the CAF are committed to protecting the privacy of individuals with respect to their personal information that is under DND and CAF control. The personal information that the DND and the CAF create, collect and control must be maintained at a high standard. Within the DND and the CAF there will be a clear and consistent respect for both the letter and the spirit of the *Privacy Act* and *Privacy Regulations*.

### Requirements

**2.5** In order to implement this policy, the DND and the CAF must:

a. facilitate compliance with the *Privacy Act* and *Privacy Regulations* in order to enhance their effective application;
b. apply consistent practices and procedures in the administration of the *Privacy Act* and *Privacy Regulations* when responding to all requests filed for access to records of personal information; and
c. ensure effective protection and management of personal information by identifying, assessing, monitoring and mitigating privacy risks in programs and activities involving the creation, collection, retention, use, disclosure and disposal of personal information.

## 3. Consequences

### Consequences of Non-Compliance

**3.1** Non-compliance with this DAOD may have consequences for both the DND and the CAF as institutions, and for DND employees and CAF members as individuals. Suspected non-compliance may be investigated. The nature and severity of the consequences resulting from actual non-compliance will be commensurate with the circumstances of the non-compliance. Consequences of non-compliance may include one or more of the following:

a. the ordering of the completion of appropriate learning, training or professional development;
b. the entering of observations in individual performance evaluations;
c. increased reporting and performance monitoring;
d. the withdrawal of any authority provided under this DAOD to a DND employee or CAF member;
e. the reporting of suspected offences to responsible law enforcement agencies;
f. the liability of Her Majesty in right of Canada;
g. the application of specific consequences as set out in applicable laws, codes of conduct, and DND and CAF policies and instructions; and
h. other administration administrative or disciplinary action, or both.

**Note –** In respect of the compliance of DND employees, see the Treasury Board (TB) *Framework for the Management of Compliance* for additional information.

# 4. Authorities

### Authority Table

**4.1** The following table identifies the authorities associated with this DAOD:

| The … | has or have the authority to … |
|---|---|
| Minister of National Defence | ▪ designate, by order, one or more officers or employees to exercise or perform any of the powers, duties or functions as the head of a government institution under the *Privacy Act* that are specified in the order. |
| Deputy Minister, Corp Sec and DAIP | ▪ exercise all powers, duties and functions as designated by the Minister under the *Privacy Act*; and<br>▪ issue direction to the DND and the CAF on all matters related to the *Privacy Act* as specified by the President of the TB, the designated Minister responsible for preparing policy instruments concerning the operation of the *Privacy Act* and *Privacy Regulations*. |

# 5. References

### Acts, Regulations, Central Agency Policies and Policy DAOD

- *Privacy Act*
- *Privacy Regulations*
- *Framework for the Management of Compliance*, Treasury Board
- *Policy on Privacy Protection*, Treasury Board

### Other References

- DAOD 1002-1, *Requests under the Privacy Act for Personal Information*
- DAOD 1002-2, *Informal Requests for Personal Information*
- DAOD 1002-3, *Management of Personal Information*

## APPENDIX 5 TO ANNEX A1

## DAOD 1002-1 REQUESTS UNDER THE PRIVACY ACT FOR PERSONAL INFORMATION

# Requests under the *Privacy Act* for Personal Information Identification

**Date of Issue** 2004-10-01

**Application** This is a directive that applies to employees of the Department of National Defence ("DND employees") and an order that applies to officers and non-commissioned members of the Canadian Forces ("CF members").

**Supersession** NDHQ Instruction ADM(Per) 7/83, *Privacy Act – DND Implementation*

**Approval Authority** This DAOD is issued under the authority of the Assistant Deputy Minister (Finance and Corporate Services) (ADM(Fin CS)).

**Enquiries** Director Access to Information and Privacy (DAIP)

**Document Contents** This document contains the following topics:

# Overview

**Terminology**

The following table provides information on terminology used in this DAOD:

| In this DAOD … | has/have the same meaning as in … |
|---|---|
| • administrative purpose;<br>• government institution;<br>• personal information;<br>• personal information bank; and<br>• Privacy Commissioner | section 3 of the *Privacy Act*. |
| • disclosure of personal information | chapter 3 of the Treasury Board of Canada Secretariat policy entitled *Use and Disclosure of Personal Information*. |
| • record | section 3 of the Access to Information Act. |

**Access to Personal Information**

Under the *Privacy Act*, every individual who is a Canadian citizen or a permanent resident within the meaning of the *Immigration and Refugee Protection Act*, or is present in Canada, has a right to, and must upon request, be given access to:

- their personal information contained in a personal information bank (PIB); and
- any other personal information about them under the control of a government institution if they are able to provide sufficiently specific information on the location of the information as to render it reasonably retrievable by the government institution.

**Formal Requests for Personal Information**

Formal requests for personal information are made under the *Privacy Act* and must:

- be made in writing and signed;
- identify the PIB number or provide sufficient information on the location of the personal information to render it reasonably retrievable; and
- be submitted in person, by mail or facsimile at (613) 995-5777 to the DAIP:
  Director Access to Information and Privacy
  National Defence Headquarters
  101 Colonel By Drive
  Ottawa, Ontario
  K1A 0K2

Formal requests may not be sent by email.

**Informal Requests for Personal Information**

For information concerning informal requests for personal information, see DAOD 1002-2, *Informal Requests for Personal Information*.

# Operating Principles

**Time Limit**

Requesters are entitled to expeditious processing of their requests for personal information. Section 14 of the *Privacy Act* provides a 30-calendar day time limit in which to respond. Responding to formal requests within the time limit provided under the *Privacy Act* is essential to ensure the success of the DND and the CF policy of transparency and to promote its relationship with the Canadian public.

**Extension of Time Limit**

Under section 15 of the *Privacy Act*, the 30-calendar day time limit may be extended in certain circumstances.

The DAIP must ensure that the requester is notified of the reason for an extension prior to the expiration of the original 30-calendar day time limit.

**Disclosure Refusal**

If access to personal information is refused, the DAIP must advise the requester, in writing, of the:

- specific provision of the *Privacy Act* upon which the refusal was based; and
- right to complain to the Privacy Commissioner about the refusal.

**Forms of Access**

Under subsection 17(1) of the *Privacy Act* and subject to the *Privacy Regulations*, if an individual is to be given access to personal information, the DND must:

- permit the individual to examine the information; or
- provide the individual with a copy of the information.

**Language of Access**

Under subsection 17(2) of the *Privacy Act*, the following action is taken if access to personal information is requested by an individual in one of the official languages:

| If the personal information … | then … |
|---|---|
| already exists under the control of the DND in the language requested, | access must be given in the requested language. |
| does not exist in the requested language, | the DAIP must have it translated or interpreted for the individual if the DAIP considers a translation or an interpretation to be necessary to enable the individual to understand the information. |

*Continued on next page*

## Operating Principles, continued

**Exemptions**

Under specific provisions of the *Privacy Act*, personal information may be exempt from disclosure.

The exemptions are provided to:

- protect the interests of third parties such as individuals or organizations who could be adversely affected by the disclosure of the personal information to the requester; and
- establish a delicate balance between the rights of the requester and other interests to be protected under certain circumstances.

If an exemption is applied, the requester is informed of the reason and the applicable provision of the *Privacy Act*.

# Complaints and Investigations

**Role of the Privacy Commissioner**

The Privacy Commissioner provides an independent review of the government's compliance with the *Privacy Act*.

The Privacy Commissioner:

- receives, investigates and responds to complaints made under the Act;
- provides an annual report to Parliament on these activities; and
- applies or appears before the Federal Court in judicial review proceedings.

**Complaints**

Under subsection 29(1) of the *Privacy Act*, the Privacy Commissioner must receive and investigate complaints made by individuals concerning administration of the Act by government institutions.

The complaints that the Privacy Commissioner must investigate are set out in paragraphs 29(1)(*a*) to (*h*) of the Act. They must be made in writing, unless otherwise authorized by the Privacy Commissioner.

**Investigation by the Privacy Commissioner**

Investigations of complaints by the Privacy Commissioner are conducted in private. Upon completion of the investigation, the Privacy Commissioner usually reports the results of the investigation to the complainant and to the DAIP.

**Application to Federal Court**

Under section 41 of the *Privacy Act*, if an individual has been refused access to personal information requested under subsection 12(1), and a complaint has been made to the Privacy Commissioner and investigated, and the results reported, the individual may apply to Federal Court for a review of the matter.

# Responsibilities

**Responsibility Table**

The following table identifies the responsibilities regarding requests under the *Privacy Act* for personal information:

| The … | is/are responsible for … |
|---|---|
| DAIP | • establishing policies and procedures to permit individuals efficient access to personal information to which they are entitled;<br>• receiving, controlling and responding to formal requests for personal information;<br>• verifying the requester's right of access;<br>• ensuring the request can be understood by an experienced DND employee or CF member before sending it to the appropriate Office of Primary Interest (OPI) responsible for the physical custody and management of the personal information requested;<br>• applying exemptions if necessary;<br>• consulting OPIs on the exemptions to apply, if necessary;<br>• approving or refusing disclosure of personal information under the *Privacy Act*;<br>• deciding, on a case-by-case basis, if personal information is to be translated or interpreted;<br>• advising individuals if their personal information has been released inadvertently;<br>• creating and amending PIBs within the DND, with Treasury Board's approval;<br>• ensuring that the necessary regulations, guidelines and publications are available within the DND and the CF; and<br>• providing guidance to OPIs on questions concerning formal access to personal information. |
| OPIs | • complying with *Privacy Act* taskings from the DAIP for personal information and forwarding the requested records as quickly as possible within the timeframes set by the DAIP;<br>• informing the DAIP of the anticipated response date if not able to provide the requested information within the time frame;<br>• seeking immediate advice from the DAIP if in doubt regarding any aspect of the *Privacy Act*; and<br>• recommending exemptions, if applicable. |
| DND employees and CF members requesting personal information | • determining whether to submit a request for personal information under the *Privacy Act* or an informal request; and<br>• submitting a written and signed request to the DAIP that identifies, where possible, the PIB that contains the information or provides sufficiently specific information on the location of the personal information. |

# References

**Source References**

- *Privacy Act* and *Privacy Regulations*
- *Policy on the Management of Government Information*, Treasury Board of Canada Secretariat
- *Privacy and Data Protection*, Treasury Board of Canada Secretariat
- *Use and Disclosure of Personal Information*, Treasury Board of Canada Secretariat
- *Info Source – Sources of Federal Employee Information*, Treasury Board of Canada Secretariat
- *Access to Information and Privacy Designation Order*, May 29, 2002
- DAOD 1002-0, *Personal Information*

**Related References**

- *Access to Information Act*
- *Immigration and Refugee Protection Act*
- DAOD 1001-0, *Access to Information*
- DAOD 1001-1, *Formal Requests for Access to Departmental Information*
- DAOD 1001-2, *Informal Requests for Access to Departmental Information*
- DAOD 1002-2, *Informal Requests for Personal Information*
- DAOD 1002-3, *Management of Personal Information*
- *Defence Subject Classification and Disposition System*

## APPENDIX 5 TO ANNEX A1

## DAOD 1002-2, INFORMAL REQUESTS FOR PERSONAL INFORMATION

# Informal Requests for Personal Information

## Identification

**Date of Issue** 1999-04-09

**Date of Modification** 2004-10-01

**Application** This is a directive that applies to employees of the Department of National Defence ("DND employees") and an order that applies to officers and non-commissioned members of the Canadian Forces ("CF members").

**Approval Authority** This DAOD is issued under the authority of the Assistant Deputy Minister (Finance and Corporate Services) (ADM(Fin CS)).

**Enquiries** Director Access to Information and Privacy (DAIP)

**Document Contents** This document contains the following topics:

# Overview

**Terminology**

In this DAOD, the following terms have the same meaning as in section 3 of the *Privacy Act*:

- "personal information";
- "personal information bank"; and
- "Privacy Commissioner".

**Access to Personal Information**

DND employees and CF members, current and former, may have access to their personal information under the control of the DND or the CF by making:

- an informal request pursuant to this DAOD; or
- a formal request under the *Privacy Act*.

**Formal Requests for Personal Information**

For information concerning formal requests for personal information, see DAOD 1002-1, *Requests under the Privacy Act for Personal Information*.

The granting of informal access does not preclude an individual from submitting a formal request under the *Privacy Act*.

# Operating Principles

**Submission of an Informal Request**

Informal requests normally permit a more expeditious access to specific personal information.

Individuals making informal requests for their personal information must:

- request, orally or in writing, their personal information directly from the office of primary interest (OPI) responsible for the physical custody and management of their personal information; and
- indicate the personal information bank (PIB) number from the *Table of PIBs* block, or provide a clear description of the requested information that corresponds to a PIB in the table.

If the request is for information that is not described in the *Table of PIBs* block, a formal request must be submitted to the DAIP.

Only formal requests can form the basis of a complaint to the Privacy Commissioner.

**Access upon Retirement, Release or Transfer**

Personal information gathered and maintained for personnel administration purposes during the employment of DND employees or the service of CF members must, upon request, be made available to them upon their retirement, release or transfer.

**Storage**

Personal information that may be exempt under the provisions of the *Privacy Act* must be easily movable (i.e., within a temporary docket or a sealed envelope clearly marked "To be opened only by …") from those files for which informal access is normally granted.

If not required by the *National Archives Act*, the OPIs should not maintain duplicate copies of records.

# Processing Informal Requests

**Processing Informal Requests**

Informal access must:

- occur at a time and location convenient to both the OPI and the requester; and
- normally be given within 30 calendar days of the date of the request.

The following table outlines the actions performed by an OPI after receiving an informal request for personal information:

| Step | Action by OPI | |
|---|---|---|
| 1 | Inform the requester of the difference between:<br>informal access; and<br>formal access under the *Privacy Act*. | |
| 2 | **If you …** | **then …** |
| | hold the requested information, | tell the requester. |
| | do not hold the requested information, | send the request to the appropriate OPI (if known) or direct the requester to the DAIP. |
| 3 | **If the information requested is …** | **then …** |
| | contained in a PIB designated for informal access (See Table of PIBs block), | remove all personal information pertaining to other individuals and all other information that must be severed (see the information in the Severances map).<br>Note – When in doubt about how to apply severances, consult the DAIP for advice. |
| 4 | not contained in a PIB designated for informal access, | tell the requester to send a formal request under the *Privacy Act* to the DAIP. |
| | Inform the requester of any severances applied and their justifications (using the sections of the *Privacy Act* as guidance). | |
| 5 | • Provide the requester access to the requested information and, if practicable, provide access to a photocopier; or<br>• Send the requester a copy of the requested information if viewing the information at DND or CF facilities would reasonably cause the requester undue inconvenience. | |

**Personal Information Released Inadvertently**

If personal information about another individual is released inadvertently with requested information to a requester, the OPI must:

- advise the requester to return the personal information immediately to the OPI and not to retain any copies; and
- provide the DAIP with details of the inadvertent release.

# Personal Information Banks Designated for Informal Access

**Overview**

The PIBs provide a summary of personal information held by the DND and the CF. The *Privacy Act* requires that PIBs include all personal information that is organized or intended to be retrieved by:

- the individual's name;
- an identifying number or symbol; or
- other particular assigned only to that individual.

PIBs must also include personal information that has been, is being used or is available for use for an administrative purpose.

Requesters may be granted informal access to their personal information contained in the departmental PIBs designated for informal access listed in the table below.

Requests for personal information not found in the PIBs designated for informal access must be processed through the DAIP, the departmental privacy coordinator, by means of a formal request for personal information. (See DAOD 1002-1, *Requests under the Privacy Act for Personal Information*.)

**Table of PIBs**

The following table shows an alphabetical list, updated yearly, of the PIBs designated for informal access and the PIB number for that type of information:

| PIB Name | PIB Number |
|---|---|
| Academic Records – Students of a Canadian Military College | DND PPE 844 |
| Administrative Review Case Files | DND PPE 814 |
| Alert Manning Personnel System (AMPS) | DND PPE 871 |
| Attendance and Leave | DND PSE 903 |
| Cadet Instructor Cadre Personal Information Bank | DND PPE 822 |
| Canadian Forces Casualty Database | DND PPE 817 |
| Canadian Forces Command and Staff College – Boards/Selection Processes | DND PPE 821 |
| Canadian Forces Drug Testing Program | DND PPE 890 |
| Canadian Forces Employment Equity Program | DND PPE 816 |
| Canadian Forces Member Personal Information File | DND PPE 818 |
| Canadian Human Rights Act – Discrimination – Civilian | DND PPU 036 |
| Canadian Human Rights Act – Discrimination – Military | DND PPU 035 |
| Chaplain Service | DND PPE 807 |

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# Personal Information Banks Designated for Informal Access, continued

**Table of PIBs,** continued

| PIB Name | PIB Number |
|---|---|
| Command and Staff Course – Student Files | DND PPE 843 |
| Complaints Against Military Police Members | DND PPU 070 |
| Conflict of Interest and Post-Employment Code – Military | DND PPE 864 |
| CSE Mentor Program | DND PPE 820 |
| Dental Records | DND PPE 811 |
| Department of National Defence and Veterans Affairs Canada Centre for the Support of Injured and Retired Members and their Families | DND PPE 824 |
| Dependant Education Allowances | DND PPE 876 |
| Designation of Additional Dependants, Remuneration Supplement Claims and Hospital/Medical Claims Outside of Canada | DND PPE 809 |
| Discipline | DND PSE 911 |
| DSSPM – Clothing Online | DND PPE 829 |
| Electronic Network Monitoring Logs | DND PSE 922 |
| Employee Assistance | DND PSE 916 |
| Employee Personnel Record | DND PSE 901 |
| Employment Equity Program | DND PSE 918 |
| Enrolment Bank– Applicants | DND PPU 025 |
| Financial Assistance – Canadian Forces Personnel Assistance Fund (CFPAF) | DND PPE 802 |
| Financial Counselling | DND PPE 803 |
| Financial Planning | DND PPE 804 |
| Grievances | DND PSE 910 |
| Harassment | DND PSE 919 |
| Harassment | DND PPE 875 |
| History, Heritage and Honours | DND PPE 823 |
| Human Resources Management Information System (HRMS) | DND PPE 805 |
| Human Resource Research and Evaluation Information Data Bank | DND PPE 815 |
| Identification and Access Control Cards | DND PPE 896 |
| Identification and Building Pass Cards | DND PSE 917 |

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# Personal Information Banks Designated for Informal Access, continued

**Table of PIBs,** continued

| PIB Name | PIB Number |
|---|---|
| Insurance – Service Income Security Insurance Plan (SISIP) | DND PPE 808 |
| Internal Disclosure of Information Concerning Wrongdoing in the Workplace | DND PSE 923 |
| La Relève Executive Feeder Group | DND PPE 861 |
| Medical Professional Standards Register | DND PPE 898 |
| Medical Records | DND PPE 810 |
| Merit Award Program | DND PPE 826 |
| Military Personnel – Grievance File | DND PPE 831 |
| Military Police Audit Reports Data Bank | DND PPU 071 |
| Military Police Credential Review Board Data Bank | DND PPE 833 |
| Military Postgraduate Student Records | DND PPE 878 |
| Minutes of Proceedings of Courts Martial | DND PPE 830 |
| National Defence Fingerprint File | DND PPE 801 |
| National Search and Rescue Secretariat | DND PPU 050 |
| Non Public Fund (NPF) Employee Personnel Records | DND PPE 865 |
| Occupational Safety and Health | DND PSE 907 |
| Officer Boards for Academic Enhancement and Specialist Training Plans | DND PPE 848 |
| Official Languages | DND PSE 906 |
| Parking | DND PSE 914 |
| Pay and Benefits | DND PSE 904 |
| Pay Records File | DND PPE 858 |
| Pension File | DND PPE 859 |
| Performance Evaluation Report File | DND PPE 838 |
| Performance Reviews and Employee Appraisals | DND PSE 912 |
| Personnel Files – Training | DND PPE 842 |
| Personnel Selection Officer Training Files | DND PPE 877 |
| Privacy | DND PPU 030 |
| Public Key Infrastructure (PKI) Service Request Forms | DND PPE 813 |

*Continued on next page*

# Personal Information Banks Designated for Informal Access,
continued

**Table of PIBs,**
continued

| PIB Name | PIB Number |
|---|---|
| Recognition Policy | DND PSE 920 |
| Request From and Disclosure to Investigative Bodies | DND PPE 854 |
| Sea, Army and Air Cadet Personnel Files | DND PPE 839 |
| Selection Board and Supplementary Selection Board Results | DND PPE 899 |
| Selection Boards for the In-Service Commissioning Plans | DND PPE 847 |
| Service Prison and Detention Barrack Records | DND PPE 863 |
| Social Work Services | DND PPE 812 |
| Squadron Personnel File – Officer Cadets | DND PPE 845 |
| Staffing | DND PSE 902 |
| Staffing Program | DND PPU 065 |
| Suggestion Award Program | DND PPE 825 |
| Training and Development | DND PSE 905 |
| Travel and Relocation | DND PSE 913 |
| Unit Military Personnel File | DND PPE 836 |
| Values and Ethics Code for the Public Service | DND PSE 915 |
| Vehicle, Ship, Boat and Aircraft Accidents | DND PSE 908 |
| Workplace Daycare | DND PSE 930 |

# Severances

**Severances Based on Exemptions**

When personal information is released informally, severances must be applied based on the exemptions under the *Privacy Act*, as set out in the *Exemption Table* block.

**Mandatory and Discretionary Exemptions**

There are two different types of exemptions governing the release of personal information as shown in the *Exemption Table* block.

| **Under the column labelled *Requirement to Withhold*, a designation of …** | **means the information …** |
|---|---|
| mandatory | shall not be released. |
| discretionary | may or may not be released.<br><br>Note – In many cases, the decision to release the information is based on the injury test. |

**Injury Test**

Severances based on an injury test provide for the denial of access to requested information if disclosure "could reasonably be expected to have a detrimental effect" to the interest specified in the exemption.

Three general factors shall be considered when evaluating potential injury, as explained in more detail in the document of the Treasury Board of Canada Secretariat entitled *Exemptions*. Those factors are the degree to which the injury is:

- specific;
- current; and
- probable.

**Example – Injury Test**

If the release of personal information pertaining to an ongoing investigation would likely result in the disappearance of evidence not yet collected, the reasoning of paragraph 22(1)(b) of the Privacy Act shall be used as guidance to refuse access to the information.

In the case of a formal request under the *Privacy Act*, paragraph 22(1)(*b*) would be legally invoked, not just used as guidance.

*Continued on next page*

## Severances, continued

**Exemption Table** The exemptions under the *Privacy Act* that are used to sever information for informal requests for personal information are set out in the following table:

| Exemption | Information relating to … | Requirement to Withhold | Action |
|---|---|---|---|
| 18(2) | exempt banks | Discretionary | Do not release without consulting the DAIP. |
| 19(1)<br>19(2) | personal information obtained in confidence (from another government, organization or institution) | Mandatory | Do not release unless the government, organization or institution that provided the information consents to its release or makes the information public. |
| 20 | federal-provincial affairs | Discretionary | Do not release if the release could reasonably be expected to be injurious to the conduct of federal-provincial affairs. |
| 21 | international affairs and defence | Discretionary | Apply the injury test. |
| 22(1)(*a*) | law enforcement and investigations | Discretionary | Apply the exemption, as necessary, in relation to the investigative bodies specified in section 5 of the *Privacy Regulations*. |
| 22(1)(*b*) | law enforcement and investigations | Discretionary | Apply the injury test. |
| 22(2) | policing services for provinces or municipalities | Mandatory | Do not release without consulting the DAIP. |
| 23 | security clearances | Discretionary | Do not release if the release could reasonably be expected to reveal the identity of who provided the information. |
| 24 | individuals sentenced for an offence | Discretionary | Apply the injury test. |
| 25 | safety of individuals | Discretionary | Do not release if the release could reasonably be expected to threaten the safety of individuals. |
| 26 | another individual | Mandatory/<br>Discretionary | Do not release information concerning other individuals without their consent. Otherwise, the information can only be released in accordance with subsection 8(2) of the *Privacy Act*. |
| 27 | solicitor-client privilege | Discretionary | Do not release without consulting the DAIP (who will consult legal services as required). |
| 28 | medical records | Discretionary | Apply the injury test for information relating to the physical/mental health of the requester. Refer to section 13 of the *Privacy Regulations*. |

# Responsibilities

**Responsibility Table**

The following table identifies the responsibilities regarding informal requests for personal information:

| The … | is/are responsible for … |
|---|---|
| DAIP | • establishing policies and procedures to permit individuals efficient informal access to personal information to which they are entitled;<br>• providing training pertaining to informal requests for personal information within the DND and the CF;<br>• advising individuals when their personal information has been released inadvertently;<br>• creating and amending PIBs within the DND and the CF, with Treasury Board approval;<br>• ensuring that the *Privacy Act*, regulations, DAODs, guidelines and publications pertaining to informal requests for personal information are available within the DND and the CF; and<br>• providing guidance to OPIs on questions concerning informal requests for personal information. |
| OPIs | • complying with the *Privacy Act* when granting individuals informal access to their personal information;<br>• providing informal access to personal information in accordance with this DAOD;<br>• refraining from annotating records to indicate that an individual was afforded informal access;<br>• maintaining statistics in order to measure workload and client service associated with informal access; and<br>• consulting the DAIP if there is any doubt about whether personal information may be accessed or disclosed. |

# References

**Source References**

- *Privacy Act* and *Privacy Regulations*
- *Exemptions*, Treasury Board of Canada Secretariat
- *Privacy and Data Protection*, Treasury Board of Canada Secretariat
- *Info Source – Sources of Federal Employee Information*, Treasury Board of Canada Secretariat
- DAOD 1002-0, *Personal information*

**Related References**

- DAOD 1001-0, *Access to Information*
- DAOD 1001-1, *Formal Requests for Access to Departmental Information*
- DAOD 1001-2, *Informal Requests for Access to Departmental Information*
- DAOD 1002-1, *Requests under the Privacy Act for Personal Information*
- DAOD 1002-3, *Management of Personal Information*
- CFAO 15-2, *Release – Regular Force*
- *Defence Subject Classification and Disposition System*
- MPPol & TP, *Information Management: Release of Information and disclosure*, Chapter 11

# APPENDIX 5 TO ANNEX A1

# DAOD 1002-3, MANAGEMENT OF PERSONAL INFORMATION

# Management of Personal Information

## Identification

**Date of Issue** 2004-10-01

**Application** This is a directive that applies to employees of the Department of National Defence ("DND employees") and an order that applies to officers and non-commissioned members of the Canadian Forces ("CF members").

**Approval Authority** This DAOD is issued under the authority of the Assistant Deputy Minister (Finance and Corporate Services) (ADM(Fin CS)).

**Enquiries** Director Access to Information and Privacy (DAIP)

**Document Contents** This document contains the following topics:

# Overview

**Terminology**

The following table provides information on terminology used in this DAOD:

| In this DAOD … | has/have the same meaning as in … |
|---|---|
| • administrative purpose;<br>• government institution;<br>• personal information;<br>• personal information bank; and<br>• Privacy Commissioner | section 3 of the *Privacy Act*. |
| • disclosure of personal information | chapter 3 of the Treasury Board of Canada Secretariat (TBS) policy entitled *Use and Disclosure of Personal Information*. |
| • record | section 3 of the *Access to Information Act*. |

**Scope**

This DAOD describes the requirements for the collection, use, disclosure, retention and disposal of personal information under sections 4 to 8 of the *Privacy Act*.

# Collection of Personal Information

**Authorized Operating Program or Activity**

The personal information of DND employees and CF members must not be collected unless it is related directly to an authorized operating program or activity. In addition, the DND and the CF must not collect any more personal information than is necessary to carry out the program or activity.

Personal information is collected by the DND and the CF for purposes such as:

- career management;
- security;
- discipline;
- administration; and
- medical and dental treatment.

Personal information that is collected must be maintained at National Defence Headquarters (NDHQ), an NDHQ-controlled formation, a unit or a records support unit.

**Personal Information to be Collected Directly**

Personal information which is intended to be used for an administrative purpose must be collected directly, if possible, by the DND or the CF from the individual concerned, unless:

- the individual authorizes otherwise; or
- the personal information may be disclosed to the DND or the CF under subsection 8(2) of the *Privacy Act*.

**Individual to Be Informed of Purpose**

When personal information is collected from an individual, the individual must be informed of the purpose for which the information is obtained. This provides the individual with knowledge of, and some control over, the collection of the information.

Normally, the purpose should be evident from the title of the record containing the personal information. If not, it must be indicated clearly on the record.

**Exceptions**

It is not necessary to collect personal information directly from an individual or to inform the individual of the purpose of the collection if this would:

- result in the collection of inaccurate information;
- defeat the purpose of the collection; or
- prejudice the use for which the information is collected.

# Use and Disclosure of Personal Information

**Authorized Use of Personal Information**

Personal information under the control of the DND or the CF must not, without the consent of the individual to whom it relates, be used for any purpose not mentioned in section 7 of the *Privacy Act*.

**Consistent Use of Personal Information**

Personal information may be used by the DND or the CF for a use consistent with the purpose for which it was collected. Consistent use of personal information is explained in detail in the TBS policy entitled *Use and Disclosure of Personal Information*.

**Disclosure of Personal Information**

Personal information under the control of the DND or the CF must not, without the consent of the individual to whom it relates, be disclosed except in accordance with section 8 of the *Privacy Act*.

**Disclosure to Federal Investigative Bodies**

A federal investigative body may request personal information under the control of a government institution.

Under paragraph 8(2)(e) of the *Privacy Act*, such a request must:

- be in written form;
- describe the information required; and
- describe the purpose for which it is required.

A copy of the request must be submitted to the Office of Primary Interest (OPI) for the personal information that is requested before disclosure of the information.

Such requests may only be authorized by the DAIP or the acting DAIP.

The DAIP must retain a copy of every request received and the personal information disclosed and must make those copies available to the Privacy Commissioner, as required. Requests are held for a minimum of two years.

Individuals may request access to their personal information held in banks related to federal investigative bodies. However, much of the information would normally be exempt under section 22 of the *Privacy Act*, for example, that in Military Police investigations.

For the purpose of paragraph 8(2)(e) of the *Privacy Act*, the federal investigative bodies relevant to the DND and the CF are:

- boards of inquiry;
- the Canadian Forces National Counter-Intelligence Unit; and
- the Military Police.

*Continued on next page*

## Use and Disclosure of Personal Information, continued

**Guidance on Use and Disclosure**

DND employees and CF members who require guidance on the use and disclosure of personal information should contact the DAIP.

**Correction, Notation and Notification**

Subsection 12(2) of the *Privacy Act* provides that an individual who is given access to personal information that has been used, is being used or is available for use for an administrative purpose, and who believes that the information is inaccurate or incomplete, may:

- request the correction of that information;
- require that a notation be attached to the information reflecting any correction requested, but not made; and
- require that any person or body, to whom such information has been disclosed for use for an administrative purpose within two years, be notified of the correction or notation.

If the information was disclosed to another government institution, the DND or the CF must ask that institution to make the correction or notation on any copy of the information under its control.

# Retention and Disposal of Personal Information

| | |
|---|---|
| **Retention Periods** | The required retention periods for most DND and CF related personal information bank (PIB) records are stated in records retention and disposal schedules approved by the National Archivist and set out in the Defence Subject Classification and Disposition System. |
| **Administrative Purpose** | In accordance with subsection 4(1) of the *Privacy Regulations* and the TBS policy entitled *Retention and Disposal of Personal Information*, personal information that has been used by the DND or the CF for an administrative purpose must be retained. |
| **Disposal of Personal Information** | The disposal of personal information is carried out in accordance with the principles outlined in the *Retention and Disposal of Personal Information* policy. |

# Personal Information Banks

**Context**

The *Privacy Act* requires that the DND and the CF establish PIBs and include in them all the personal information under their control.

With the approval of the TBS, new PIBs are established, and existing PIBs are modified, by the DAIP.

All PIBs designated for informal access and their corresponding numbers are listed in DAOD 1002-2, *Informal Requests for Personal Information*.

**Information to be Included in PIBs**

PIBs must include personal information that:

- has been used, is being used or is available for use for an administrative purpose; or
- is organized or intended to be retrieved by the name of an individual or by an identifying number, symbol or other particular assigned to an individual.

**Content of PIBs**

Each PIB contains the description of the personal information, authorized uses, consistent uses, and retention and disposal standards. The classes of personal information must be described in sufficient detail to facilitate the right of access under the *Privacy Act*.

***Info Source***

*Info Source* is a TBS publication that contains an index and a description of all PIBs as well as classes of personal information under the control of each federal institution. It is updated annually by individual departments such as the DND and is available electronically on the Access to Information and Privacy (ATIP) website on the Defence Information Network and also on the TBS web site.

# Responsibilities

**Responsibility Table**

The following table identifies the responsibilities associated with the management of personal information:

| The … | is/are responsible for … |
|---|---|
| DAIP | • ensuring that regulations, guidelines and publications pertaining to the management of personal information are available within the DND and the CF;<br>• creating and amending, with TBS approval, PIBs within the DND and the CF; and<br>• providing guidance to OPIs on questions concerning the management of personal information. |
| OPIs | • managing personal information in accordance with sections 4 to 8 of the *Privacy Act*; and<br>• seeking guidance from the DAIP as required in the management of personal information. |

# References

**Source References**

- *Privacy Act* and *Privacy Regulations*
- *Collection of Personal Information*, Treasury Board of Canada Secretariat
- *Corrections and Notations*, Treasury Board of Canada Secretariat
- *Privacy and Data Protection*, Treasury Board of Canada Secretariat
- *Retention and Disposal of Personal Information*, Treasury Board of Canada Secretariat
- *Use and Disclosure of Personal Information*, Treasury Board of Canada Secretariat
- *Info Source – Sources of Federal Employee Information*, Treasury Board of Canada Secretariat
- DAOD 1002-0, *Personal Information*
- ATIP website

**Related References**

- *Access to Information Act*
- DAOD 1001-0, *Access to Information*
- DAOD 1001-1, *Formal Requests for Access to Departmental Information*
- DAOD 1001-2, *Informal Requests for Access to Departmental Information*
- DAOD 1002-1, *Requests under the Privacy Act for Personal Information*
- DAOD 1002-2, *Informal Requests for Personal Information*
- CFAO 15-2, *Release – Regular Force*
- *Defence Subject Classification and Disposition System*
- MPPol & TP, *Information Management: Release of Information and disclosure*, Chapter 11

**APPENDIX 5 TO ANNEX A1**

**5020-20 DISCLOSURE OF PERSONAL INFORMATION**

# Disclosure of Personal Health Information

**Document Status:** Current
**Document Type:** **Instruction**
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**SME:** D H Svcs Del
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## Background

1. This document supersedes Med Dir 1/04 "Disclosure of Personal Health Information" which was originally issued and effective on 21 Apr 04. It was last amended (amendment #3) on 11 Feb 12. This version contains changes in paragraphs 41 and 64.

### Application

2. This Instruction applies to all Canadian Armed Forces (CAF) personnel, Department of National Defence (DND) Public Servants, contractors and sub-contractors who provide health services to CAF members.

## Direction

3. Consistent with the *Privacy Act* (hereafter referred to as "*the Act*") and with bylaws and guidelines of provincial medical licensing authorities, personal health information will not be disclosed without the consent of the individual to whom it relates. There are exceptions to the general rule of protection of personal information in accordance with the permitted disclosures that are outlined in subsection 8(2) of *the Act*. For more information on these exceptions please see the table in Reference D.

### Abbreviation Table

4. The table below explains the definitions used in this policy.

| Abbreviation | Title or Term in Full |
|---|---|
| BOI | Board of Inquiry |
| BPA | Bureau of Pensions Advocates |
| CAF | Canadian Armed Forces |
| CF H Svcs Gp HQ | Canadian Forces Health Services Group Headquarters |
| CFAO | Canadian Forces Administrative Orders |
| CFPM | Canadian Forces Provost Marshall |
| CO | Commanding Officer |
| DAIP | Director Access to Information and Privacy |
| D Med Pol | Director Medical Policy |
| DO | Dental Officer |
| DOB | Date of Birth |

| Abbreviation | Title or Term in Full |
|---|---|
| HCP | Health Care Provider |
| HI/RM | Health Information/Records Management |
| MEL | Medical Employment Limitation |
| Med Tech | Medical Technician |
| MO | Medical Officer |
| PA | Physician's Assistant |
| RCDC | Royal Canadian Dental Corps |
| SI | Summary Investigation |
| SISIP | Service Income Security Insurance Plan |
| SN | Service Number |
| VAC | Veterans Affairs Canada |

**Definitions**

5. Definitions are provided for the purpose of this policy.

6. Consent: Consent is an individual's implied or expressed permission to receive treatment or to use or disclose their personal health information. Three requirements must be met in order for a consent to be valid:

a. The consent must have been voluntary;
b. The patient must have had the capacity to consent; and
c. The patient must have been fully and properly informed.

7. Consent means an individual's implied or expressed permission to use or disclose their personal health information. Expressed consent will contain in writing:

a. Identification of individual providing permission as well as the individual to whom the information relates;
b. A description of the information concerned;
c. Instructions on the extent of the use of disclosure, including a valid duration (timeframe) for the consent;
d. Identification of name and address of recipient; and
e. Date and original signature of the individual providing permission.

8. Voluntary: Patients must always be free to consent to or refuse treatment or disclosure of information, free of any suggestion of duress or coercion or undue influence from a third party. Consent obtained under any suggestion of compulsion either by the actions or words of the clinician or others may be no consent at all and therefore may be successfully repudiated.

9. Capacity: Patients must be competent to consent. An individual, who is able to understand the nature and anticipated effect of proposed treatment and alternatives, including the consequences of no treatment, and implications of disclosure of information, is competent to give valid consent. It is well accepted that a person suffering from mental incapacity may still retain sufficient ability to give valid consent to medical treatment or disclosure of information.

10. Informed: Consent to treatment or disclosure of information must be an "informed" consent. The patient must receive information and adequate explanation about the nature of the proposed investigation or treatment, its anticipated effect and its expected benefits as well as the significant risks (material and special) involved, alternatives available and likely consequences of not having the treatment. The patient must also receive information and adequate explanation about the nature of the personal health information to be disclosed, by any method whatsoever, to any person, group, agency, institution or other body within or outside the CAF. The duration for which the disclosure of information is in effect and the extent of its use must also be discussed.

11. Disclosure: The release of personal health information, regardless of media, with or without consent of the individual to whom it relates, or as required by law to any person, group, agency, institution or other body within or outside the CAF.

12. Health Care Providers (HCPs) - Members of the CAF health care team, civilian employees and contractors who provide clinical services that address medical, dental and mental health issues. HCPs include physicians (general practitioners and specialists), physician's assistants (PA), nurse practitioners, registered nurses, mental health nurses, operating room nurses, critical care nurses, medical technicians/assistants, preventive medicine technician, pharmacists, physiotherapists, optometrists, certified ophthalmic technicians, diagnostic imaging technologists, laboratory technologists, nutritionists, psychiatrists, social workers, psychologists, addiction counsellors, dentists (general practitioners and specialists), dental hygienists, dental technicians, dental assistants, as well as other individuals licensed or certified by a provincial or federal authority to provide clinical care.

13. Mental Health Clinicians: Mental Health Clinicians are members of the CAF health care team, contractors and civilians who provide mental health clinical services, usually encompassing psychiatrists, mental health nurses, social workers, psychologists, addiction counsellors, and physicians (general practitioners).

14. Medical Personnel: Medical personnel means a medical HCP, case manager, health information custodian, medical admin clerk or other CF H Svcs Gp member or individual who is employed by, or under contract with, the CAF to provide medical services for the CAF.

15. Dental Personnel: Dental personnel means a dental HCP, dental clinic receptionist or other RCDC member or individual who is employed by, or under contract with, the CAF to provide dental services for the CAF.

Health Record - Reference E

Medical Record (CF2034) - Reference E

Mental Health File - Reference E

Physical Health File - Reference E

Psychosocial Services File - Reference E

Personal Health Information - Reference E

Health Information Custodian - Reference E

# Overview

### Protection of Personal Information

16. Consistent with *the Act* and with bylaws and guidelines of provincial medical and dental licensing authorities, personal health information will not be disclosed without the consent of the individual to whom it relates. There are exceptions to the general rule of protection of personal information in accordance with the permitted disclosures that are outlined in subsection 8(2) of *the Act*. For more information on these exceptions please see the table in Reference D. In accordance with *the Act*, any third party personal information will be reviewed and removed on the relevant copies prior to disclosure.

### Context

17. Honest communication between a patient/client and a health care provider is possible only when the patient/client is certain that personal health information will be maintained in confidence. Without this trust, medical and dental personnel are limited in their ability to assess the health of patients/clients and give to them the most appropriate care.

## Disclosure with the Patient's Consent

18. The following information may be disclosed with the patient's consent:

a. Communications between patients/clients and health services personnel are confidential and must be protected against improper disclosure.
b. Health services personnel are therefore under restriction not to volunteer information obtained from a patient/client in the course of providing them with professional health care services.
c. Health services personnel may disclose confidential information when authorized or directed by the patient/client to do so.

## Disclosure without Patient's Consent – General

19. There are circumstances when disclosure may take place without the patient's consent. In general terms, the direction below applies regarding the disclosure of personal health information. Physicians, dentists, senior physician's assistants on independent duty, case managers and mental health clinicians acting in the course of their duties will disclose by confidential report (without the client's authorization) to:

a. The appropriate health authority in any province of Canada, any information relating to a reportable disease such as tuberculosis of any member;
b. A Deputy Minister of Highways, or such other provincial authority as may appear appropriate, details of any person who on application for enrolment in, on active service in, or on release from the CAF was found by Service medical authorities to be suffering from or having suffered from a seizure disorder or any condition in which disease or therapy threatens the ability to operate a motor vehicle safely;
c. The Chief of the Air Staff (CAS), any medical condition that makes a patient unfit to fly an aircraft;
d. Any appropriate provincial or municipal health authority, any information pertaining to a sexually transmitted disease or infectious disease diagnosed in a member;
e. A provincial cancer treatment and research foundation, any information relating to a history or diagnosis of cancer of any member;
f. The appropriate federal and provincial authority on information relating to suspected child abuse by a member; and
g. The appropriate authority any information regarding a patient's significant risk of dangerous or violent behaviour.

**Disclosure without Consent to Specified Investigative Bodies**

20. Section 8 (2) (e) of *the Ac*t permits direct access disclosure, without consent, to specified investigative bodies. The written request from these bodies must specify the purpose of enforcing any law of Canada, or of a province or territory, on carrying out a lawful investigation, and describe the information to be disclosed.

21. These requests are actioned by the Director of Access to Information and Privacy (DAIP) at NDHQ. Units should contact DAIP for guidance.

22. Some of the specified investigative bodies listed are Boards of Inquiry, Military Police, Special Investigators (SIU), Royal Canadian Mounted Police (RCMP) and the *Canadian Human Rights* Commission (CHRC) investigators, under Section 35 of the *Canadian Human Rights Act*.

**Third Parties**

23. A CAF member's personal health information can only be shared with a third party otherwise not specified in this Instruction, such as a lawyer or an insurance company, with the consent of the CAF member.

**Shared Care**

24. A CAF member's personal health information may be provided to other health care professionals for the purpose of providing care. Where two or more CAF health care providers are jointly caring for the same member, a formal consent to share or provide the CAF member's health care information between or to other health care professionals is not required.

**Health Information Custodians**

25. Health Information Custodians will provide photocopies of personal health information on request of CAF members, or their authorized agents, in accordance with *the Act*. These circumstances are outlined in this Instruction.

**Disclosure to Commanding Officers**

26. In accordance with the *Privacy Act*, and subject to legislated exceptions, no specific diagnosis or course of treatment will normally be disclosed to, or discussed with the CO. In accordance with Reference G, medical personnel must provide COs with detailed MELs but "specific information such as diagnosis and detailed treatment should not be disclosed". Since there is generally no Command requirement to know the name of a specific consultant or treatment facility providing care to a CAF member, medical staff should therefore withhold the name if it would reveal the patient's diagnosis (for example the name of an in-patient addiction treatment facility).

27. Examples of personal information which CANNOT be disclosed:

a. Specific clinical findings relating to the disease / injury, specific clinical findings (such as signs and symptoms), diagnosis, course of treatment (e.g. names of drugs prescribed/details of surgery, details of emergency treatment, if any), results of tests;
b. Specific details regarding why an individual has been referred to a specialist;
c. The name of the specific institution or treatment facility/clinic or of a specific clinician/specialist if it would reveal the specific diagnosis;
d. Cause of injury where disclosure would unavoidably reveal the diagnosis; or
e. Course of medical care where the disclosure itself would unavoidably reveal a diagnosis even if the specific disease or condition is never mentioned.

**Disclosure Related to MELs**

28. To assist the CO in dealing effectively with a CAF member who may present with health problems (physical and/or mental health) or psychosocial conditions, the Health Care Provider (HCP), may present to the CO:

a. The CAF member’s medical employment limitations (MELs);
b. Anticipated absences from the workplace; and
c. Where possible, a prognosis (chance of recovery).

29. Any medical employment limitations that have been assigned to a CAF member because of a health problem or psychosocial condition, as well as the prognosis of that condition (where possible), will be fully described and explained to the CAF member’s CO by the member’s HCP. *Note: Actual copies of a CAF member's health record should not be provided without written consent.*

# Disclosure to an Individual

**Formal and Informal Requests**

30. There is an informal and a formal method by which a member, dependent or civilian may gain access to personal health information compiled on the individual as described in *the Act*.

**Formal Method**

31. The formal method for requesting access to personal health information is by applying under *the Act* to the Director of Access to Information and Privacy (DAIP).

**Informal Method**

32. Requests for informal access to personal health information are made directly to a supporting health services facility in accordance with Reference D. The request for access to personal health information will be written and will specify the information needed to satisfy the purpose of the request.

**Informal Method – Options**

33. Units will provide the use of a room or private area where, in the presence of an attendant, the member's medical record (physical health or mental health files) or dental record may be made available. To ensure that the member understands the content of the record, the attendant will be:

a. A medical officer or senior medical technician to assist the member in the review of the medical record;
b. A dental officer to assist the member in the review of the dental record. At units where there is no dental officer, such as at small stations and ships, the Medical Technician will make arrangements through the Commanding Officer 1 Dental Unit (CO 1 Dent U) for the member to view his file in the presence of a dental officer; or
c. In the case of mental health information, a mental health clinician, preferably one who has seen the member as a client
d. The health services unit will provide the member with copies from the member’s medical record (physical health or mental health files) or dental record as required by the member. In many cases, portions of a medical record or dental record may be copied to satisfy a request; accordingly, the exact requirement for information should be determined with the member.

34. Prior to the appointment, the attendant shall examine the record and determine if it contains:

a. Exempt material, e.g. police reports or extracts, and material involving National Security
b. Information concerning third parties (even if the name of the third party is not mentioned as it is possible that the name could be ascertained or inferred by the individual); or
c. Material written by a non-medical or non-dental person concerning the member’s health or behaviour and given to a medical or dental officer on a confidential basis.

**Exemption from Disclosure**

35. Units will not action requests for access to information that is contained in any mandated DND/CAF accident or hazardous occurrence investigation into the death or injury of a member of the Canadian Forces. Such requests for access will be forwarded to NDHQ or VAC authorities as follows:

a. CAF members’ requests will be directed to NDHQ Ottawa, Attention: DPCA 4; and
b. Former members of the Canadian Forces: requests will be directed to Records Manager, Documentation Center, Outside Documents Section, Veterans Affairs Canada, Ottawa, Ontario K1A 0P4.

**Disclosure to a Board of Inquiry (BOI)**

36. Pursuant to section 45(2) of the *National Defence Act*, a BOI is entitled to have access to any personal health information or any other record that the Board may formally request in writing.

**Disclosure to a Summary Investigation or Any Other Mandated DND/CAF Accident or Hazardous Occurrence Investigation**

37. An SI of an accident or occurrence resulting in death or injury to an individual pursuant to QR&O 21.46(2) or 21.46(3) and any other mandated DND/CAF accident or hazardous occurrence investigation may be ordered in lieu of a BOI where a death or injury occurs under circumstances

that do not warrant a detailed and formal BOI. An officer conducting such an SI or other investigation does not have the power of a BOI insofar as witnesses are concerned, but the circumstances of the investigation may cause health care authorities to be asked to provide personal health information to the investigating officer for inclusion in the report.

38. Specific personal information relevant to the investigation may be disclosed to a Summary Investigation and any other mandated DND/CAF accident or hazardous occurrence investigation without consent. A HCP who has not provided care to the member, if possible, will review the member's complete health record, and will thereafter provide the investigating officer (IO) with an explanatory written report, containing only personal information that is strictly relevant to the investigation. *Note: Actual copies of a CAF member's health record shall not be provided without written consent of the CAF member.*

39. For all other SIs, a HCP may only disclose to an SI Investigator:

a. The CAF member's medical employment limitations (MELs);
b. The level of care required; and
c. Where possible, a prognosis (chance of recovery).

40. Any medical employment limitations that have been assigned to a CAF member because of a health problem or psychosocial condition, as well as the prognosis of that condition (where possible), will be fully described and explained to the SI investigator by the member's HCP. *Note: Actual copies of a CAF member's health record shall not be provided without written consent of the CAF member. Where it is not possible to obtain consent, units are encouraged to contact DAIP for guidance or convene a BOI.*

**Military Police**

41. When medical or social work information is required in the course of an authorized investigation, a Military Police member must be in possession of either a completed and approved 8(2)(e) *Privacy Act* form or a search warrant. IAW the provisions of CAFAO 22-4, when such authorization is presented, a medical officer or social work officer, or in the case of units without a medical officer, the senior medical assistant, shall provide a verbal or written summary of the information relevant to the investigation, upon request by Military Police personnel. Any dispute with regard to the release of medical or social work information is to be referred through the chain of command to the Surgeon General and the CAFPM for resolution.

**Non-CF H Svcs Gp Departments within DND (Minister's Office, Ombudsman's Office, CAF Grievance Board) or Federal Government**

42. In some circumstances non- CF H Svcs Gp departments within DND or within the federal government have a requirement for personal health information in order to answer complaints made by CAF members about their health care. Some examples are:

a. Complaints to the Canadian Human Rights Commission;
b. Redresses of grievance; and,
c. Ministerial inquiries.

43. CF H Svcs Gp personnel will provide relevant information to allow these non- CF H Svcs Gp departments to respond to these complaints on receipt of formal/authorized request. This is considered to be either "purpose" or "consistent use" disclosure to non-health care providers for the purpose of their making career medical/administrative decisions, in accordance with sections 7 (a) and 8(2)(a) of *the Act* and the Treasury Board InfoSource definitions of "purpose" and "consistent use" for which CAF Medical Records and Dental Records are created and maintained.

**Director Military Careers Administration (DMCA), Area HQ or Equivalent Staff**

44. For the purpose of assisting a Regular or Reserve Force member to respond to an Administrative Review, the member's personal health information may be shared with Director

Military Careers Administration (DMCA), or the Area HQ or equivalent staff with the valid written consent of the member.

**Casualty Reporting**

45. International Statistical Classifications of Diseases (ICD) codes will not be included in casualty messages. (Note: This direction supersedes that provided in CFAO 24-1 which is currently being revised to comply with the *Privacy Act*.)

**Attorney General of Canada Representative**

46. A CAF member's Health Record (Physical Health File, Mental Health File, and/or Psychosocial Services File) or Dental Record will be disclosed to the legal representatives of the Attorney General of Canada who are assigned to provide legal advice to or represent the Crown when the CAF member:

a. Makes a complaint to the Canadian Human Rights Commission with respect to service in the CAF and their health is relevant to the complaint, pursuant to section 8(2)(a) of *the Act*;
b. Applies for or pursues redress of grievance with respect to service in the CAF and their health is relevant to the redress, pursuant to section 8(2)(a) of *the Act*;
c. Submits a claim against the Crown in right of Canada and/or its officers, agents, servants or employees, with respect to service in the CAF and their health is relevant to the claim, pursuant to section 8(2)(a) of *the Act*; or,
d. Files a lawsuit against the Crown in right of Canada and/or its officers, agents, servants or employees, with respect to service in the CAF and their health is relevant to the lawsuit, pursuant to section 8(2) (d) of *the Act*.

**Disclosure by Court Order**

47. Where personal health information is requested under court order, copies of the relevant items of personal health information will be prepared and provided under the provisions of Section 8 (2) of *the Act*.

# Disclosure for Purpose of Claim against Third Party to Lawyers

**For Purpose of Claim against Third Party**

48. Where a member, directly or through a lawyer, makes a request in writing for personal health information concerning injuries suffered by the member or for any other matter for the purpose of pursuing a private claim, etc, against a third party, the Health Information Custodian will forward the claim to AJAG for their review and approval.

49. Upon AJAG's approval the Health Information Custodian will prepare copies of the personal health information pertinent to the request and send the copies to the lawyer. The member's written consent to release information from the Health Record (Physical Health File, Mental Health File or Psychosocial Services File) or Dental Record will be placed in the Health Record as appropriate.

50. When specified in the request, the Health Information Custodian will refer the request to the physician or mental health clinician who will prepare a reply based on the records, giving such information as appears pertinent to the claim (e.g. in the case of an injury – the extent of the injuries, length of hospitalization, and degree of disability). The Health Information Custodian will forward the reply to AJAG.

**AJAG's Approval & Responsibility**

51. AJAG will review the claim received by the Health Information Custodian and obtain direction through JAG channels if the Crown interest appears to require it. Otherwise, the claim will be approved by AJAG and sent back to the Health Information Custodian to process the request.

52. The reply prepared by the physician, dentist or mental health clinician, with the request for personal health information, will be passed to the nearest Assistant Judge Advocate General (AJAG).

53. The AJAG will forward the reply to the member's lawyer(s) or obtain direction through JAG channels if the Crown interest appears to require it. A copy of the reply along with the member's written consent to release information from the Health Record (Physical Health File, Mental Health File or Psychosocial Services File) will be placed in the Health Record as appropriate.

# Disclosure to Judicial Proceeding

### Testimony before a Judicial Body, Court or Tribunal

54. When personal health information is requested during a judicial proceeding the information will be provided.

### Disclosure by Court Order

55. Where personal health information is requested by order of a judicial body, court or tribunal, the issue of disclosure may be referred through the normal chain of communication to NDHQ/Director General Health Services/CF H Svcs Gp authorities, specifically, to the Manager of Health Information/ Records Management and to either the Senior Counsel CAF Health Services Legal Advisory or to the nearest AJAG.

### Consultation of AJAG

56. Additionally, the nearest AJAG will be contacted and apprised of the situation. The AJAG will obtain direction through JAG channels if the Crown interest appears to require it. Copies of the personal health information requested will be prepared and sent upon AJAG’s approval.

# Disclosure to Agencies, Organizations or Individuals Assisting a Member in an Application for a Medical Pension

### Member Assistance in an Application for a Medical Pension

57. Members of the Canadian Forces who are applying for a medical pension may seek assistance from a veteran's organization or a legal advisor in the preparation of an application.

58. Consequently, a duly authorized representative of a veteran's organization such as The Royal Canadian Legion or the member's lawyer will require access to relevant personal health information in order to prepare a pension claim supported with appropriate clinical documentation from the patient records.

### Health Services Units’ Responsibility and Processing Requests

59. Health Services units will provide personal health information on members of the Canadian Forces to a representative of the VAC or BPA, a representative of a veteran’s organization or a lawyer assisting a member in the preparation and presentation of an application of a medical pension to VAC.

60. A photocopy of clinical documents will be provided on request to a representative of a serving member of the Regular Force who is applying to VAC to establish an eligibility to a disability pension for a condition not clearly attributable to the performance of duty. In order that the request is processed by the supporting medical unit, the following conditions must be met:

a. A formal written request to obtain access to personal health information is presented by either the member or the member’s duly appointed representative;
b. The request is accompanied by the member's original authorization and should be dated; and
c. The request be an original and contain the following elements:
    i. service number (SN), DOB, rank, name, initials and unit of the applicant;
    ii. The specific medical and/or dental condition(s) for which information is requested, and;
    iii. The full postal address to which the information is to be forwarded.

**Veterans Affairs Canada**

61. Disclosure of personal health information to VAC pursuant to a request by VAC following a CAF member's or former CAF member's application for a disability pension, is considered "consistent use" of that information in accordance with *the Act* and, as such, consent is not required.

# Disclosure to SISIP

**Completion of Insurability Forms**

62. Physicians (general practitioners) are responsible for signing evidence of insurability forms for service personnel. This service will be provided without fee.

**Disclosure Regarding a Claim under SISIP**

63. Upon reception of the member’s consent and the request completed by the physicians (general practitioners, case managers, senior physician’s assistants on independent duty, or personnel specifically appointed for this purpose by the CF H Svcs), copies of personal health information pertinent to the request will be sent to SISIP.

# Disclosure to Insurance Companies Other Than SISIP

**Requirements**

64. The following requirements will be met:

a. A formal written request to obtain access to personal health information is presented by either the member or the member’s duly appointed representative;
b. The request be an original and contain the following elements:
    i. Service number (SN), DOB, rank, name, initials and unit of the applicant;
    ii. The specific medical and/or dental condition(s) for which information is requested, and;
    iii. The full postal address to which the information is to be forwarded.
c. The request is accompanied by the member's original authorization and dated.
d. If the request does not conform to the above requirements, the request will be returned to the insurance company with an explanatory letter.

# Disclosure to Civilian Practitioners

**Requirements**

65. Personal health information from a member's Health Record (Physical Health File, Mental Health File, or Psychosocial Services File or Dental Record) may be provided to a registered health care provider of any province of Canada, as long as the following provisions are met:

a. The member is being provided care or treatment by the health care provider who is requesting the information; and

b. The health care provider has requested the information, or the member has requested in writing (or consented) that information be directed to the health care provider, or CF H Svcs medical or dental authorities are of the opinion that it is in the best interest of the member that the information should be provided.

**The CF2034 (other than the Mental Health File)**

66. Only a physician (general practitioner) or senior physician's assistant on independent duty will disclose information from the CF 2034. The disclosure of personal health information may take the form of a written confidential report or the provision of photocopies of relevant documents from the record. The original record itself will not be made available to the civilian health care provider.

**The Mental Health File**

67. Only a mental health clinician will disclose information from the mental health file. The disclosure of personal health information from the mental health file may take the form of a written confidential report or the provision of photocopies of relevant documents from the record. The original record itself will not be made available to the civilian health care provider.

**The Psychosocial Services File**

68. Only a mental health clinician will disclose information from the psychosocial services file. The disclosure of personal information from the psychosocial services file may take the form of a written confidential report or the provision of photocopies of relevant documents from the record. The original record itself will not be made available to the civilian health care provider.

**The CAF Dental Record**

69. Only a dentist will disclose information from the CAF Dental Record. The disclosure of personal information from the dental record may take the form of a written confidential report or the provision of photocopies of relevant documents from the record. The original record itself will not be made available to the civilian health care provider. Original radiographs may be lent to civilian dental care providers but must be returned to the CAF Dental Record once the treatment is completed.

# Disclosure to CAF/DND Physicians

**Medico-legal Action Against CAF/DND Physicians or Dentists**

70. CAF/DND physicians or dentists may require access to relevant personal health information in order to prepare their response to a patient complaint submitted to the Royal College of Physicians and Surgeons of Canada or any provincial college by a CAF member. Upon presentation of a formal notice, such as a subpoena, the Health Information Custodian will provide photocopies of the CAF member's Medical Record or Dental Record to the CAF/DND physician.

# Disclosure to Federal, Provincial or Municipal Authorities

**Federal, Provincial and Municipal Authorities**

71. CF H Svcs Gp personnel must comply with federal and, as a matter of CAF policy, provincial laws, and be prepared to disclose to the appropriate authorities, without the CAF member's consent, any information regarding:

a. A CAF member's significant risk of dangerous or violent behaviour;
b. Any suspected child abuse case;
c. Any medical condition that makes a CAF member unfit to fly an aircraft or drive a motor vehicle,
d. Any reportable disease; and
e. Any other similar information.

**For Public Interest**

72. Provincial statutes require, under specific circumstances, that health authorities disclose a member's personal health information when the disclosure of such information is in the public interest.

73. This Instruction cannot provide specific direction that will cover all existing statutes. It will, therefore, be the responsibility of all physicians (general practitioners), dentists, senior physician's assistants on independent duty, mental health clinicians and case managers to apprise themselves of the relevant statutes and to comply with the provisions of these statutes in respect to the disclosure of information.

**Guidelines to Mental Health Clinicians in the Case of Disclosure of Mental Health or Psychosocial Services Information in the Public Interest**

74. Mental health clinicians acting in the course of their duties will disclose by confidential report to third parties without the client's authorization only when:

a. The disclosure is required or allowed by law i.e. the requirement to report to the appropriate federal and provincial authority information relating to suspected child abuse by a member; or
b. The patient is at significant risk of engaging in dangerous or violent behaviour.

**Coroner's Investigation & Entitlement to Information**

75. In those instances where a member has died as a result of violence, negligence, misconduct, malpractice or any circumstances, obscure or other, as may require investigation, a provincial coroner will usually conduct an investigation into such a death. Provincial statutes provide an appointed Coroner with specific investigative powers that entitle the coroner to:

a. Inspect any place in which a deceased person was, or in which the coroner has reasonable grounds to believe a deceased person was, prior to death;
b. Inspect and extract information from any records or writing relating to the deceased or their circumstances and to reproduce copies from these records or writings as the coroner believes necessary; and
c. To seize anything, including records that the coroner has reasonable grounds to believe is material to the purposes of the investigation.

**Health Services Authorities' Compliance**

76. Health Services authorities will comply with the relevant statutes concerning coroner investigations and will provide any and all personal health information that the coroner believes pertinent to the investigation.

**Delegation of Coroner's Powers**

77. Coroners may authorize a legally qualified medical practitioner or a police officer to exercise all or any of the powers delegated to them under the provincial statutes. On such occasions when the coroner investigating a death delegates his powers, health services authorities will provide personal health information to the authority delegating such powers.

**Release of Information to Civilian Authorities**

78. Personal health information associated with the Health Record (Physical Health File, Mental Health File or Psychosocial Services File or Dental Record) as defined in *the Act* Section 3 will not be released by DND to civilian authorities except in accordance with the terms of section 8(2) of *the Act*.

**Release of Information to Civilian Police**

79. Personal health information requested by civilian police will be passed to the DND Privacy Coordinator for review and authorization. It will be accompanied by a recommendation by the physician (general practitioner), dentist, senior physician's assistant on independent duty or mental health clinician as to the sensitivity of the information and the degree of injury, if any, which may exist if the information is released.

**Requirement of Member's Written Permission**

80. If appropriate, DND may obtain written permission from the person to whom the personal health information refers to release the information and include this documentation in the submission to the DND Privacy Coordinator.

**Processing Emergency Requests**

81. Emergency requests for personal health information received from civilian police will be coordinated with the base/wing/station military police who will refer such requests immediately by telephone or message to the Director General Security and Director Police Operations. Any release of information by that office will only be done with the approval of the DND Privacy Coordinator.

**Disclosure to Professional Associations and to Workers Compensation Board – Guidelines**

82. An investigator from a Workers' Compensation Board is authorized, under provincial statute, to have access to personal health information in order to substantiate a claim for compensation. A physician (general practitioner) or senior physician's assistant on independent duty will provide personal health information contained in the Medical Record of a dependant or civilian that has been treated for injuries as a result of employment. There is no requirement to obtain the consent of the individual who is the subject of the investigation.

**Responding to Questionnaires – with Security Implication**

83. From time to time, questionnaires requesting information in regard to professional training or other qualifications are received by service members from various professional bodies and associations, e.g.: the Canadian Medical Association, the Registered Nurses' Association of the different provinces, the Pharmaceutical Association, etc. When the information requested appears to have a security implication or relate to personal health information, such questionnaires will be forwarded with pertinent local information to the Surgeon General through the relevant medical professional/technical chain of command for consideration and reply. Requests for information from dental professional bodies and associations that may have security implications or relate to personal health information will be forwarded to Director Dental Services through the chain of command for consideration and reply.

# Audit

**Types of Audits**

84. On a periodic basis, each CF H Svcs unit will conduct audits on the disclosure of personal health information to ensure compliance, use and protection of the confidentiality, security and integrity of data and information. Audits will be conducted to ensure personal health information may only be used for the purpose for which it was collected or received. On a periodic basis, CF H Svcs Gp HQ will conduct audits on disclosure of paper/electronic personal health information to ensure compliance and protection of the confidentiality, security and integrity of data and information.

**Audit Retention Period**

85. Audit reports will be retained by each facility for a period of ten (10) years and will be destroyed thereafter.

# Responsibility

### Responsibility Table

86. The following table outlines the primary responsibilities regarding the disclosure of personal health information.

| The... | is/are responsible for... |
|---|---|
| DGHS | • Approving orders and instructions for the disclosure of personal health information. |
| Surgeon General/D Dent Svcs | • Providing technical and professional direction for the disclosure of personal health information; and<br>• Representing the CF H Svcs Gp in resolving disputes regarding the disclosure of an individual's personal health information, as applicable (medical/dental). |
| SSO HSI | • Establishing policies and procedures regarding the protection, use, security and integrity of personal health information;<br>• Establishing policies and procedures regarding the disclosure of personal health information and,<br>• Providing management direction concerning the disclosure of personal health information. |
| CF H Svcs Gp Privacy Officer | • Advising SSO HSI regarding the privacy issues related to CF H Svcs personal health information; and<br>• Representing the CF H Svcs Gp in providing professional guidance regarding the disclosure of personal health information. |
| HI/RM Manager CF H Svcs HQ | • Advising SSO HSI regarding issues related to disclosure of personal health information. |
| Health Care Providers | • Protecting an individual's personal health information from unauthorized disclosure;<br>• Complying with a CO's request for information regarding a member's employment limitations, the level of care required, anticipated absences from the workplace and, where possible, a prognosis;<br>• Complying with a request from a BOI to provide an individual's relevant personal health information;<br>• Complying with a request from an SI to provide an individual's relevant personal health information, however, unless the SI pertains to an accident or occurrence resulting in injury or death to an individual, this is limited to that information that may be provided to a CO; and<br>• Complying with federal and provincial laws with respect to disclosure of confidential personal health information. |

# References:

A. *Privacy Act* and Regulations
B. DAOD 1002-0, Personal Information

C. DAOD Disclosure (in development)
D. DAOD 1002-2, Informal Access to Personal Information
E. CF H Svcs Gp Instruction 7000-34, General Overview: Health Information/Records Management
F. QR&O 21.47, Findings on Injury or Death
G. CANFORGEN 039/08, CMP 018/08 131851Z FEB 08 ? Disclosure of Med/Social Work Information to Commanding Officers
H. CFAO 22-04, Security and Military Police Services

Date Modified: 2014-10-30

# APPENDIX 5 TO ANNEX A1

# 5020-25 PERSONAL HEALTH INFORMATION - USE

# Personal Health Information – Use

| | |
|---|---|
| **Document Status:** | Current |
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## Background

### Authority and Application

1. This Instruction applies to all Canadian Armed Forces (CAF) personnel, Department of National Defence (DND) Public Servants, contractors and sub-contractors who provide health services and/or health services support to CAF members.

### Purpose

2. The purpose of this Instruction is to outline acceptable use of personal health information (PHI) that is under the control of CFHS and to provide the framework for acceptable use of PHI in accordance with the federal *Privacy Act (PA)*.

### Definitions

**Note:** *Definitions are provided for the purpose of this Instruction.*

3. Access - Opportunity to make use of an information system. [1] The opening and /or viewing of PHI.

4. Anonymized information – the information is irrevocably stripped of direct identifiers (e.g. name, service number), a code is not kept to allow future re-linkage, and risk of re-identification of individuals from remaining indirect identifiers (e.g. date of birth, place of residence) is low or very low. [2]

5. Canadian Forces Health Services – People and installations providing health services to CAF members and other entitled persons on behalf of the Department of National Defence.

6. Consistent Use - A use of information that has a reasonable and direct connection to the original purpose(s) for which the information was obtained or compiled. Consistent use of PHI is governed by section 7 of the *PA*.

7. Disclosure - The release [3] or transfer of PHI by any method to any person or organization external to CFHS. The disclosure of PHI by CFHS is governed by section 8 of the *PA*.

8. Need-to-know - The principle that only persons who have a requirement for PHI to perform their official duties shall access PHI.

9. Personal Health Information (PHI) - Personal information, as defined in section 3 of the *PA*, that relates to an individual's diagnosis, treatment or care. It includes any medical, dental, or psychosocial information that is collected when a health service is provided to an individual. It also includes information on the payment for a health care program or service, health services provider information and patient registration information. It does not include information on a CAF member's medical employment limitations (MELs), anticipated absences from the workplace or prognosis (chance of recovery) or general severity of an acute health condition (e.g. seriously injured or very seriously injured).

10. Practice Review - An assessment or evaluation of the professional performance or competence of a health care provider.

11. Quality Assurance - A process (often retrospective) which measures adherence to established standards and criteria; includes activities such as audits, inspections, evaluations; outcomes of QA activities often inform quality improvement initiatives. [4]

12. Quality Improvement - Better patient experiences and outcomes achieved through changing provider behaviour and organization through using systematic change method and strategies. [5]

13. Use -The exploitation of PHI or the application of PHI to a specific purpose. Use includes sharing or transfer of PHI by any method to any other person within CFHS, but does not include disclosure. Use of PHI is governed by section 7 of the *PA*.

**Abbreviations**

14. The table below explains the acronyms and abbreviations used in this Instruction.

| Acronyms / Abbreviations | Term in Full |
|---|---|
| CAF | Canadian Armed Forces |
| CFHS | Canadian Forces Health Services |
| CF H Svcs Gp | Canadian Forces Health Services Group |
| CoC | Chain of Command |
| Comd | Commander (CF H Svcs Gp) |
| D Dent Svcs | Director Dental Services |
| *PA* | *Privacy Act* |
| PHI | Personal Health Information |
| Surg Gen | Surgeon General |

# Limits on the Use of Personal Health Information

**Original Legislative Purpose of Collection**

15. Without the consent of the patient, no person to whom this Instruction applies shall use PHI except in accordance with section 7 of the *PA*. Section 7 of the *PA* limits the use of personal health information (PHI) to the purposes for which it was collected – or a use consistent with that purpose; and for purposes for which PHI may be disclosed to CFHS under subsection 8(2) of the *PA*.

16. As stated in the Info Source entries for CAF health records [6] (DND PPE 810, Medical Records, DND PPE 811 Dental Records and DND PPE 812 Psychosocial Records), CFHS collects and uses PHI for the official government purposes specified below:

**To assess an individual's fitness to perform duties as a serving member of the CAF**

17. Health care providers must describe any limitations resulting from a medical condition to optimize access to the appropriate level of health care and provide the Chain of Command (CoC) with a clear, precise medical opinion of the employment capabilities of members. This is a sequential process, which starts with a thorough medical assessment of the member, followed by a comprehensive description of limitations, and culminates in the assignment of the appropriate medical category. Where appropriate, this includes obtaining and using information from the CoC about performance requirements and conditions that normally apply to a particular individual to ensure that the member can perform his or her duties safely, reliably, efficiently and at no risk of aggravating an existing medical condition. See Ref A.

**To safely provide an individual with a health care program or service, facilitate the continuity of care, treatment or therapy and to document the care, treatment or therapy provided**

18. This includes obtaining, using and sharing PHI with other health care providers (both within and outside of the CAF) involved in the patient's treatment so that an individual's health care support and service planning can be coordinated across jurisdictions, provinces/territories or foreign countries. Health care programs or services include observations, examinations, assessments or procedures in relation to an individual that are carried out, provided or undertaken for one of the following health – related purposes:

a. The diagnosis, treatment or maintenance of an individual's physical, mental, psychosocial or dental condition;
b. The prevention of disease, illness or injury;
c. The promotion of health;
d. Rehabilitation;
e. Palliative care;
f. The taking of blood, blood products, bodily parts or other bodily substances from an individual;
g. The compounding or dispensing of a drug, dressing, health care aid, device, product, prosthetic appliances, equipment or other item to an individual or for the use of an individual, under a prescription;
h. The transportation of a patient; or
i. Any health care, service or procedure that affects the structure or a function of the body.

# Consistent Uses

19. The use of PHI is also permitted for the consistent uses specified below.

**Identification for Care/Entitlement**

20. PHI may be used to identify an individual who needs, or is receiving, a health program or service and to confirm entitlement to receive such a program or service. To receive a CAF program or service, authorized individuals must confirm whether the individual meets the eligibility criteria found in QR&O article(s) 34.07 and/or 35.04.

**Administration and Management**

21. PHI may be used for approved and documented internal administration and management activities, including planning, resource allocation, health Instruction development, approved quality assurance, quality improvement, internal audit and evaluation and processing payment for services provided to patients.

**Research**

22. PHI may be used to conduct research if:

a. all the personal information to be used is under the control of CFHS;
b. a proposal has been approved by Surgeon General's Research Program; and/or
c. the proposal meets the requirements provided under 8(2)(j) of Ref B.

**Protection and Enhancement of Occupational and Population Health Functions**

23. Where deemed by the CAF senior medical or dental authority to be in the interests of CAF health, PHI may be used as a data source to assess current clinical practice, health risks associated with certain behaviours and environmental agents and to contribute to future health promotion activities including disease and injury prevention and control activities. PHI may also be used to study the impact of patterns of health, life and safety, illness and disease, to support prevention and early detection programs, to determine optimal treatment approaches, and to identify risk factors for disease; to track and analyze demographics, statistics or trends, including the development and evaluation of new diagnostic modalities and new strategies to improve CAF member survivability and protection systems. The study of this information serves as the basis for interventions made in the interest of the CAF, and the development of policies and programs related to occupational health, clinical care (including preventive medicine), population/public health and health promotion.

**Administrative or Investigative Practice Reviews or Inspections**

24. PHI may be used by the Surg Gen/D Dent Svcs professional and technical chain to conduct administrative or investigative practice reviews or inspections:

a. to execute clinical oversight or supervisory duties (specifically by a licensed health care provider that oversees the management of other health care providers through the application of supervisory modules and techniques);
b. to review the health status of or care provided to an individual or specified group; or
c. for investigating the clinical practice or professional conduct of a health care or dental care provider.

**In Support of Pension Entitlement Decisions**

25. This use of PHI is based on the *Department of Veterans Affairs Act*, paragraph 6.6(a), the *Pension Act*, paragraph 109.1 (a), and the *Canadians Forces Members and Veterans Re-establishment and Compensation Act*, section 80 (which purposes include the determination of eligibility of individuals for benefits and services under the Acts and under other enabling legislation, such as the *Veterans Health Care Regulations*, where the use of the personal information disclosed to VAC is deemed to be consistent with the original purpose for which it was collected by DND/CAF).

**Training/Educational Programs for Health Practitioners**

26. In a clinical context, authorized individuals may use identifiable PHI to train CAF health care providers and students who are directly involved in a patient’s treatment through a need-to-know environment. In a non-clinical context, the use of PHI must respect the principle of highest anonymity possible and information that identifies individual patients must not be used.

**Forensic Identification**

27. The CAF dental record may be used to assist in the forensic identification of individuals during and following service in the CAF. This use includes the proper handling, examination and evaluation of dental evidence in the interest of justice, IAW the provisions of Ref C and D.

**Accuracy and Completeness**

28. As per subsection 6 (2) of the *PA*, before using PHI, individuals authorized to use PHI shall "take all reasonable steps" to ensure the PHI is as accurate and complete as possible. This includes ensuring that PHI is kept up-to-date and that PHI that should be in the CAF health records is on file.

## Necessary, Proportionate and Purpose Limitations on the Use of PHI

29. The extent of use of PHI by authorized persons shall be proportionate to the requirement and should extend only as far as is necessary to achieve that original purpose or consistent use.

30. This means that unless the PHI is necessary for an individual to carry out one of his/her officially assigned functions or duties, the individual shall not use PHI. Refer to Ref E and Ref F.

## Use of PHI with the Highest Degree of Anonymity Possible

31. Persons authorized to use PHI shall consider whether the use of anonymized health information will be adequate for the authorized use. For example, anonymized health information is often sufficient to achieve internal administration and management activities.

## Responsibility

**Responsibility Table**

32. Primary responsibilities associated with this Instruction are summarised in the table below.

| The | is/are responsible for |
|---|---|
| Surg Gen/Comd CF H Svcs Gp / D Dent Svcs | • Providing direction for the use of PHI; and<br>• Representing the CFHS in resolving disputes regarding the use of an individual's personal health information, as applicable (medical/dental). |
| Directorate Health Services Delivery | • Establishing policies and procedures regarding the use of PHI. |
| CFHS Privacy Office | • Advising CFHS regarding use of PHI. |
| CO/Base Surg/Clinic Mgr/Dent Det Comd/Facility Senior Authority | • Providing subordinates with guidance and training on the proper use of PHI; and<br>• Enforcing compliance with this instruction. |
| Individuals with access to CF Health Records | • Only using PHI as outlined in this instruction. |

## References

A. CANFORGEN 039/08 CMP 018/08 131851Z FEB 08, Disclosure of Medical/Social Work Info to Commanding Officers
B. *Privacy Act* and Regulations
C. CF H Svc Gp Instruction 5020-20, Disclosure of Personal Health Information
D. CF H Svc Gp Policy 1023-08, Forensic Odontology
E. CF H Svc Gp Instr 5020-30, Personal Health Information - Access, Use and Disclosure

F. CF H Svc Gp Instr 7010-03, Access Control to Personal Health Information

## Related Reading

A. DAOD 1002-0, Personal Information
B. CF H Svcs Gp Order 2000-30, Breaches of Confidentiality, Privacy and Security
C. CF H Svc Gp Instr 5020-56, Privacy of Personal Health Information

## Footnotes

1. National Information Assurance (IA) Glossary, CNSS Instruction No. 4009, Committee on National Security Systems, National Security Agency, June 2006 [Accessed 3 April 3, 2014]. Portable Document Format. Available from World Wide Web.
2. Government of Canada. Panel on Research Ethics. Types of Information (April 2013) (accessed July 2014)
3. Government of Canada. Treasury Board Secretariat. Directive on Privacy Practices. (May 2014)) (accessed July 2014)
4. Quality Improvement Program, Directorate of Health Services Delivery, Canadian Forces Health Services Group Headquarters
5. Øvretveit J. Does improving quality save money? A review of the evidence of which improvements to quality reduce costs to health service providers. London: Health Foundation, 2009, p.8.
6. Government of Canada. Info Source Sources of Federal Government and Employee Information - Institutional Functions, Programs and Activities. National Defence and the Canadian Armed Forces. (June 2014) (accessed July 2014)

Date Modified: 2014-11-25

# APPENDIX 5 TO ANNEX A1

# 5020-30 PERSONAL HEALTH INFORMATION – ACCESS, USE AND DISCLOSURE

# Personal Health Information – Access, Use and Disclosure

| | |
|---|---|
| **Document Status:** | Current |
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Latest Amendment

Revised « Application » paragraph

## Background

1. This document supersedes Canadian Forces Health Services Group (CF H Svcs Gp) Policy 5020-26, *Unacceptable Use and Disclosure of Personal Health Information* which was originally issued and effective on 01 Apr 10.

### Application

2. This Instruction applies to all Canadian Armed Forces (CAF) personnel, Department of National Defence (DND) Public Servants, contractors and sub-contractors who provide health services and/or health services support to CAF members.

### Purpose

3. The purpose of this instruction is to outline acceptable access, use and disclosure of personal health information (PHI) that is under the control of CFHS and to provide examples of both acceptable and unacceptable behaviours.

### Definitions

4. Access – Opportunity to make use of an information system. [1] The opening and / or viewing of PHI.

5. Canadian Forces Health Services – People and installations providing health services to CAF members and other entitled persons on behalf of the Department of National Defence.

6. Disclosure – The release [2] or transfer of PHI by any method to any person or organization external to CFHS. The disclosure of PHI by CFHS is governed by section 8 of the *Privacy Act (PA)*.

7. Need-to-know – The principle that only persons who have a requirement for PHI to perform their official duties shall access PHI.

8. Official Duties – Those authorized government functions, tasks and responsibilities directly connected with a person's position within CFHS.

9. Personal Health Information (PHI) – Personal information, as defined in section 3 of the *PA*, that relates to an individual's diagnosis, treatment or care. It includes any medical, dental, or psychosocial information that is collected when a health service is provided to an individual. It also includes information on the payment for a health care program or service, health services provider information and patient registration information. It does not include information on a CAF member's medical employment limitations (MELs), anticipated absences from the workplace or prognosis (chance of recovery) or general severity of an acute health condition (e.g. seriously injured or very seriously injured).

10. Personal Information Bank (PIB) – A description of personal information that is organized and retrievable by a person's name or by an identifying number, symbol or other particular assigned only to that person. The personal information described in the Personal Information Bank has been used, is being used, or is available for an administrative purpose and is under the control of a government institution. There are three types of Personal Information Banks: central, institution-specific and standard. Institution-Specific Personal Information Banks are identified with the unique identifier "PPU" or "PPE". [3]

11. Use – The exploitation of PHI or the application of PHI to a specific purpose. Use includes sharing or transfer of PHI by any method to any other person within CFHS, but does not include disclosure. Use of PHI is governed by section 7 of the *PA*.

**Abbreviations**

12. Below is a table of acronyms and abbreviations used in this Instruction.

| Acronyms / Abbreviations | Title or Term in Full |
|---|---|
| CAF | Canadian Armed Forces |
| CFHS | Canadian Forces Health Services |
| CF H Svcs Gp | Canadian Forces Health Services Group |
| CoC | Chain of Command |
| Comd | Commander (CF H Svcs Gp) |
| DAIP | Director Access to Information and Privacy |
| D Dent Svcs | Director Dental Services |
| HCP | Health Care Provider |
| *PA* | *Privacy Act* |
| PIB | Personal Information Bank |
| PHI | Personal Health Information |
| Surg Gen | Surgeon General |
| VAC | Veterans Affairs Canada |

# Direction

**Access of Personal Health Information**

13. No person to whom this Instruction applies shall access PHI unless required to do so for a purpose connected to their official duties. For greater certainty, no person shall access PHI for which they do not have a need-to-know.

14. No individual can permit another person to directly access their own PHI in records under the control of the CFHS. Persons with job-related access to PHI may request access to their own PHI in accordance with refs B and C.

15. Acceptable access of PHI includes, but is not limited to using job-related access to:

a. assess an individual's fitness to perform duties as a serving member of the Canadian Armed Forces (CAF);
b. safely provide an individual with a health care program or service;
c. confirm entitlement to receive a program or service;
d. conduct an approved and documented internal administration or management activity (e.g. approved quality assurance, quality improvement, internal audit and evaluation or processing payment for services provided to patients);
e. conduct approved internal research;
f. conduct approved occupational and population health functions;
g. conduct official clinical oversight and clinical supervisory duties (specifically. by a licensed health care provider (HCP) that oversees the management of other HCPs through the application of supervisory modules and techniques);
h. conduct an official investigative practice review or inspection; or
i. conduct other permissible uses as described in ref D.

16. Unacceptable access of PHI includes, but is not limited to using job-related access:

a. to directly access PHI about oneself, bypassing the requirements listed in ref B and C (see note below);
b. for gain, advantage or financial benefit for oneself or others (e.g. accessing PHI to gain information for custody battle or divorce proceedings);
c. to put others at a disadvantage;
d. to satisfy personal curiosity or concern regarding a family member, colleague, supervisor, subordinate, peer, neighbour, high-profile CAF member, or any other person without a professional need to know (even where written or oral patient authorization for the access has been obtained, except in accordance with ref B and C);
e. for personal satisfaction or entertainment (e.g. checking the health status of potential romantic involvement, ex-spouse, current spouse, or accessing PHI of an individual who was in the news); or
f. for any other personal or other non-work related purposes, even if it is well intended (e.g. retrieving an address to send a "get well card", checking to see when a person's birthday is).

**Note:** *In those very rare circumstances where a person's job requires him/her to access and/or use their own PHI or the PHI of a family member, colleague, supervisor, subordinate, peer, neighbour (e.g. the sole HCP on a ship), he/she may do so only to the extent required to perform his/her job. There is an expectation that, where possible, different arrangements shall be made.*

**Use of Personal Health Information**

17. No person to whom this Instruction applies shall use PHI except in accordance with section 7 of the *PA*. The specified legislative uses are described in the Info Source [4] entries for CAF health records (DND PPE 810 – Medical Records, DND PPE 811 –Dental Records and DND PPE 812 – Psychosocial Records) and are explained in ref D.

18. Acceptable use of PHI includes, but is not limited to:

a. a patient authorized use where the individual patient has provided informed written consent for the new use (e.g. using information for certain research purposes);
b. assessing an individual's fitness to perform duties as a serving member of the CAF;
c. documenting diagnosis, treatment or care provided;
d. facilitating the continuity of treatment or care (this includes sharing information internally with other CAF HCPs on a need-to-know basis);
e. confirming entitlement to receive a program or service;

f. conducting approved and documented internal administration and management activities, including but not limited to processing payment for services provided to patients;
g. conducting officially approved research;
h. conducting an official occupational and population health function;
i. conducting official clinical oversight and clinical supervisory duties (specifically by a licensed HCP that oversees the management of other HCPs through the application of supervisory modules and techniques);
j. conducting an investigative practice review or inspection;
k. preparing a record for any permissible disclosure (e.g. in support of Veterans Affairs Canada (VAC) pension entitlement decisions); or
l. forensically identifying individuals.

19. Unacceptable use of PHI includes, but is not limited to:

a. editing, deleting or making changes to one's own PHI, including, but not limited to demographic information and scheduling of appointments;
b. using PHI for personal gain, advantage or financial benefit for oneself or others (e.g. using information for custody battle or divorce proceedings);
c. using PHI to satisfy personal curiosity or concern regarding a family member, colleague, supervisor, subordinate, peer, neighbour, high profile CAF member, or others without a professional need-to-know or other non-job related purposes;
d. using PHI for any other personal reasons, even if it is well intended (e.g. using scheduler to compare your workload against that of a colleague);
e. conducting research which has not been officially approved; and
f. conducting any marketing or fundraising.

20. Additionally, as per ref E, the unauthorized or prohibited use of a DND and CAF information system, includes but is not limited to:

a. taking, saving, copying, downloading or storing the PHI about another individual without their written consent on a *personal*, removable and transportable media device (e.g. USB drives, PDAs, laptops, smart phone, etc); or
b. taking, saving, copying, downloading, or storing PHI on a *DND/CAF issued* removable and transportable media device (e;g; USB drives, PDAs, laptops, etc) except where required in the performance of official duties and as permitted by DND/CAF security instructions for the handling of Protected B information; or
c. taking, saving, copying, downloading, storing, printing, reproducing PHI about another individual except where required in the performance of official duties and as permitted in subsection 8(2) of the *PA*.

**Disclosure of Personal Health Information**

21. No person to whom this instruction applies shall disclose PHI except in accordance with section 8 of the *PA*. The purposes of disclosure, as well as acceptable uses consistent with those purposes, are described in the Info Source [5] entries for CAF health records (DND PPE 810, Medical Records, DND PPE 811 Dental Records and DND PPE 812 Psychosocial Records). The specific requirements and process for disclosure are explained in Ref F.

22. Acceptable disclosure of PHI includes, but is not limited to situations where:

a. a patient authorized disclosure (a valid written informed consent for the release of PHI);
b. PHI is transferred to non-CAF HCPs for the purpose of continuity of care;
c. printing, and/or reproducing PHI from any CAF health record where it is required in the performance of official duties and as permitted in subsection 8(2) of the *PA*;
d. PHI is requested for any purpose in accordance with any federal Act of Parliament or any regulation that requires or permits its disclosure (e.g. disclosure to a Board of Inquiry or to the Director of Access to Information and Privacy (DAIP), disclosure to VAC in support of pension entitlement decisions);

e. PHI is outlined on a court order, warrant, writ, summons, subpoena or other process issued by a court (e.g. disclosure to Military Police);
f. PHI is relevant to a Summary Investigation pursuant to QR&O 21.46(2) or 21.46(3) and any other mandated DND/CF accident or hazardous occurrence investigation;
g. PHI is requested by the Attorney General of Canada for use in legal proceedings involving the Crown in Right of Canada or the Government of Canada;
h. PHI is formally requested through the DAIP by a specified investigative body (e.g. Military Police) for the purpose of enforcing any law of Canada or a province/territory or carrying out a lawful investigation;
i. PHI is identified under an agreement or arrangement between the Government of Canada or an institution thereof and the government of a province/territory (e.g. disclosure to a regulatory college for the purpose of carrying out a lawful investigation);
j. PHI is requested by a member of Parliament for the purpose of assisting the individual to whom the information relates in resolving a problem;
k. PHI is required by officers or employees of an institution for internal audit purposes, or to the Office of the Comptroller General or any other person or body specified in the regulations for audit purposes;
l. PHI is transferred to Library and Archives of Canada (LAC) for archival purposes;
m. PHI is authorized by the DAIP to be disclosed to any person or body for research or statistical purposes when the DAIP is satisfied that the purpose for which the information is disclosed cannot reasonably be accomplished unless the information is provided in a form that would identify the individuals to whom it relates; and obtains from the person or body a written undertaking that no subsequent disclosure of the information will be made in a form that could reasonably be expected to identify the individual to whom it relates;
n. PHI is disclosed to any federal government institution for the purpose of locating an individual in order to collect a debt owing to the Federal Crown by that individual or to make a payment owing to that individual by the Federal Crown; or
o. in the opinion of the DAIP, the public interest in disclosure clearly outweighs any invasion of privacy that could result from the disclosure; or the disclosure would clearly benefit the individual to whom the information relates.

23. Unacceptable disclosure of PHI includes any disclosure not covered under section 8 of the *PA* and as illustrated in paragraph 22 of this Instruction. Such disclosures include, but are not limited to:

a. discussing PHI in the hallway, cafeteria, elevator or other public place where there is a risk of being overheard by others who have no need-to-know;
b. disclosing to any third party without documented patient consent specific clinical findings relating to the disease / injury, specific clinical findings (such as signs and symptoms), diagnosis, course of treatment (e.g. names of drugs prescribed/details of surgery, details of emergency treatment, if any), results of tests;
c. disclosing to any third party without documented patient consent specific details regarding why an individual has been referred to a specialist;
d. disclosing to any third party without documented patient consent the name of the specific institution or treatment facility/clinic or of a specific clinician/specialist if it would reveal the specific diagnosis;
e. disclosing to any third party without documented patient consent cause of injury where disclosure would unavoidably reveal the diagnosis; or
f. disclosing to any third party without documented patient consent the course of medical care where the disclosure itself would unavoidably reveal a diagnosis even if the specific disease or condition is never mentioned.

**Contravention**

24. Contravention of this instruction by any person to whom it applies may result in loss of access to PHI, disciplinary or administrative/career action, or any combination of these measures. For additional guidance refer to ref G.

# Responsibility

### Responsibility Table

25. Primary responsibilities regarding this instruction are as follows:

| The | is/are responsible for |
|---|---|
| Surg Gen/Comd CF H Svcs Gp / D Dent Svcs | • Providing direction for the access, use and disclosure of PHI; and<br>• Representing the CFHS in resolving disputes regarding the access, use, or disclosure of an individual's personal health information, as applicable (medical/dental). |
| Directorate of Health Services Delivery | • Establishing policies and procedures regarding the access, use, and disclosure of PHI. |
| CFHS Privacy Office | • Advising CFHS regarding access, use, and disclosure of PHI. |
| CO/Base Surg/Clinic Mgr/Dent Det Comd/Facility Senior Authority | • Ensuring compliance with this instruction. |
| Individuals with access to CF Health Records | • Accessing, using, or disclosing PHI only in accordance with this instruction. |

# References

A. *Privacy Act* and Regulations
B. DAOD 1002-1, Requests under the Privacy Act for Personal Information
C. DAOD 1002-2, Informal Requests for Personal Information
D. CF H Svcs Gp Instruction 5020-25, Use of Personal Health Information
E. DAOD 6002-2, Acceptable Use of the Internet, Defence Intranet, Computers and Other Information Systems
F. CF H Svcs Gp Instruction 5020-20, Disclosure of Personal Health Information
G. CF H Svcs Gp Order 2000-30, Breaches of Confidentiality, Privacy and Security

# Related Reading

A. *Library and Archives of Canada Act*
B. DAOD 1002 Series Personal Information
C. National Defence and the Canadian Armed Forces, Code of Values and Ethics
D. CF H Svcs Gp Instruction 7010-03, Access Control to Personal Health Information
E. DND PPE 810 - Medical Records
F. DND PPE 811 - Dental Records
G. DND PPE 812 - Psychosocial Records

# Footnotes

A. National Information Assurance (IA) Glossary, CNSS Instruction No. 4009, Committee on National Security Systems, National Security Agency, June 2006 [Accessed 3 April 3, 2014]. Portable Document Format. Available from World Wide Web.

B. Government of Canada. Treasury Board Secretariat. Directive on Privacy Practices. (May 2014) (accessed July 2014)
C. Government of Canada. Treasury Board Secretariat. Sources of Federal Government and Employee Information. About the ATIP program. (June 2014) (accessed July 2014)
D. Government of Canada. Info Source Sources of Federal Government and Employee Information - Institutional Functions, Programs and Activities. National Defence and the Canadian Armed Forces. (June 2014) (accessed July 2014)
E. Government of Canada. Info Source Sources of Federal Government and Employee Information - Institutional Functions, Programs and Activities. National Defence and the Canadian Armed Forces. (June 2014) (accessed July 2014)

Date Modified: 2014-11-25

# APPENDIX 5 TO ANNEX A1

# 5020-56 PRIVACY OF PERSONAL INFORMATION

# Privacy of Personal Information

| | |
|---|---|
| **Document Status:** | Current |
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| **Approval:** | Surg Gen |
| **SME:** | SSO H Svcs I |
| **OPI:** | SSO H Svcs I |
| **Effective Date:** | 12 Jan 04 |
| **Last Reviewed:** | 01 Apr 13 |

## Background

1. This document supersedes MSI CF 2000-005 "Privacy of Personal Health Information" which was originally issued and effective on 12 Jan 04. It is an Instruction that applies to all CF members, DND Public Servants of the Canadian Forces Health Services Group (CF H Svcs Gp) and civilian contractors providing service on behalf of the CF.

### Application

2. This Instruction applies to all CF personnel, Department of National Defence (DND) Public Servants, contractors and sub-contractors who provide health services to CF members.

### Definitions

Personal Health Information

see Reference D

Breach of Privacy

3. There is breach of privacy when:

a. Personal health information is collected, used, disclosed or accessed other than as authorized, or its integrity is compromised.
b. Active bypassing of system security functions to gain access to information or system resources occurs.

4. Breaches of privacy will be reported to and reviewed by the CF H Svcs Gp Privacy O, who will take such further action as is considered appropriate.

Privacy Impact Assessment

5. A Privacy Impact Analysis or Assessment (PIA) is a process that helps departments and agencies determine whether new technologies, information systems and initiatives or proposed programs and policies meet basic privacy requirements. It also assists government organizations to anticipate the public's reaction to any privacy implications of a proposal and as a result, could prevent costly program, service, or process redesign.

### Abbreviations

6. The table below contains an explanation of the abbreviations used in this instruction.

| Acronym/Abbreviation | Term in Full |
|---|---|
| CF H Svcs Gp | Canadian Forces Health Services Group |
| CSA | Canadian Standards Association |
| DGHS | Director General Health Services |
| PIPEDA | *Personal Information Protection and Electronics Documents Act* |
| Privacy O | Privacy Officer |
| SSO HSI | Senior Staff Officer Health Services Informatics |
| Surg Gen | Surgeon General |

# Direction

7. CF Health Services Privacy Policy will:

a. Comply with protecting the privacy of CF members with respect to personal health information and will provide them with a right of access to that information, as required by the *Privacy Act*;
b. Comply with the Personal Information Protection and Electronics Documents Act (PIPEDA) in so far as and to the extent that the PIPEDA requires the CF H Svcs Gp to do so in the course of its interactions with the provincially-regulated health care sector; and
c. Recognize the Canadian Standards Association Model Code principles for the protection and fair handling of personal information.

**Overview**

8. CF H Svcs Gp has a statutory obligation to comply with the *Privacy Act*. Treasury Board endorses the CSA Model Code.

**CF Responsibility**

9. The CF is responsible for the protection of personal information and the fair handling of it at all times, throughout the CF, and in dealings with third party organizations. Appropriate care will be exercised in the collection, use, disclosure and protection of personal health information. It is important to note that individuals' rights to privacy of their personal health information become limited in some situations as required by law.

**Privacy Code**

10. The CF has a statutory obligation under the *Privacy Act* to allow CF members access to information that is held about them. The Act also protects against unauthorized disclosure of personal information. In addition, it governs how the government will collect, use, store, disclose and dispose of any personal information.

**Privacy Impact Assessment Policy**

11. As a matter of general policy CF H Svcs Gp will conduct PIAs in accordance with Treasury Board guidelines, which includes the use of the CSA Model Code principles:

a. To assure Canadians that privacy principles are being taken into account when there are proposals for, and during the design, implementation and evolution of programs and services.
b. By prescribing the development and maintenance of PIAs, and routinely communicating results to the Privacy Commissioner and the public.

**Audit**

12. At any given time, upon giving reasonable notice, the CF H Svcs Gp Privacy O may audit the personal health information management practices of a facility.

**Audit Reporting**

13. After an audit, the CF H Svcs Gp Privacy O will provide the audited facility with a report of findings and any recommendations that the Privacy O considers appropriate. The Privacy O will interface with the Clinic Manager with regard to communicating and correcting problems. The audited facility will address problem areas and report back to the Privacy O in an appropriate timeframe. Upon giving reasonable notice, the Privacy O will re-audit the facility.

*NOTE: "Reasonable timeframe" will consider factors such as scope (number and breadth of issues, costs, and implications, etc.)*

**Audit Retention Period**

14. CF H Svcs Gp will retain audit reports for a period of ten (10) years.

# Responsibility

**Responsibility Table**

15. The following table identifies responsibilities regarding the privacy of personal health information.

| The | Is/are responsible for … |
|---|---|
| DGHS | • Approving orders, directives and instructions for the privacy of personal health information. |
| Surg Gen/D Dent Svcs | • Providing technical and professional direction for the privacy of personal health information. |
| SSO HSI | • Providing management direction concerning the privacy of personal health information.<br>• Establishing policies and procedures to ensure compliance with the *Privacy Act*. |
| CF H Svcs Gp Privacy Officer | • Advising SSO HSI regarding the privacy issues related to personal health information;<br>• Consulting with the Clinic Manager and the designated representative in Human Resources in a case of a breach of privacy;<br>• Conducting privacy audits;<br>• Conducting or analyzing PIAs to ensure compliance with the *Privacy Act*; and<br>• Providing guidance to the Information System Security Officer during the Threat Risk Assessment Process. |
| Clinic Managers | • Consulting with the CF H Svcs Gp Privacy O, Base/Wing Surgeon and the designated representative in Human Resources in cases of a breach of privacy.<br>• Taking disciplinary or administrative action where a breach of privacy has been confirmed. |
| | • Complying with CF H Svcs Gp Privacy Policies. |

| The | Is/are responsible for … |
|---|---|
| Health Care Providers (CF, DND Civilians, Contracted Civilians) | • Consulting with Clinic Managers, and the Privacy O in cases of a breach of privacy. |
| Health Information Custodian | • Ensuring proper protection and adequate handling of CF health records, personal health information and related forms and documents. |

# References:

A. Privacy Act
B. Access to Information Act
C. National Defence Act
D. CF H Svcs Gp PG 7000-34, General Overview – Health Information/Records Management
E. QR&Os Vol II, Disciplinary
F. CPAOs
G. National Defence Security Policy (NDSP)
H. National Defence Security Instructions (NDSI)

Date Modified: 2014-10-30

# APPENDIX 5 TO ANNEX A1

# 5020-68 SHARING OF INFORMATION AMONGST HEALTH PROFESSIONALS

# Sharing of Information Amongst Health Professionals

| | |
|---|---|
| **Document Status:** | Current |
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| **SME:** | SSO Surg Gen |
| **OPI:** | SSO Surg Gen |
| **Effective Date:** | 2002 |
| **Last Reviewed:** | 26 Apr 15 |

## Direction

1. ANALYSIS OF CASES HAS IDENTIFIED THE POTENTIAL FOR IMPORTANT INFORMATION TO BE MISSED IN THE MEDICAL AND SOCIAL WORK SCREENING PROCESS IF HEALTH CARE PROFESSIONALS DO NOT COMMUNICATE EFFECTIVELY WITH EACH OTHER, AND DO NOT ENTER RELEVANT INFORMATION INTO A PATIENT'S MEDICAL RECORD

2. ISSUES AROUND CONFIDENTIALITY OF MEMBER AND FAMILY INFORMATION, AND AROUND ESTABLISHING A RELATIONSHIP OF TRUST WITH PATIENTS / CLIENTS, ARE WELL UNDERSTOOD BY THIS HQ. MINDFUL OF AND CONSISTENT WITH THESE PRINCIPLES, THE CFHS HAS AN OVER-RIDING RESPONSIBILITY TO PROVIDE THE BEST POSSIBLE CARE TO CF MEMBERS, AND TO ASSURE, TO THE GREATEST EXTENT POSSIBLE, THE FITNESS OF CF MEMBERS TO UNDERTAKE TASKS

3. THE BROADER ISSUES OF LOCATION AND ACCESS TO MEDICAL, SOCIAL WORK, AND MENTAL HEALTH RECORDS ARE BEING ADDRESSED IN A COMPREHENSIVE POLICY REVIEW. THE MANY COMPLEX ISSUES IN THIS AREA ARE BEING ADDRESSED BY THIS REVIEW, AND THE NEEDS AND VIEWS OF ALL STAKEHOLDERS WILL BE CONSIDERED IN ARRIVING AT A FINAL POLICY

4. THIS BROADER REVIEW NOTWITHSTANDING, AS AN IMMEDIATE ACTION SOME BASIC TRUTHS NEED TO BE RE-INFORCED, AND THEIR APPLICATIONS NEED TO BE RE-EMPHASIZED ACROSS OUR CARE PROVIDING COMMUNITY

5. WHEN A PHYSICIAN REFERS A PATIENT TO ANOTHER HEALTH PROFESSIONAL, THIS IS DONE TO OBTAIN THE ADVICE AND ASSISTANCE OF THAT PROFESSIONAL IN THE OVERALL MANAGEMENT OF THE PATIENT. ANY HEALTH PROFESSIONAL SEEING A PATIENT ON A REFERRAL BASIS MUST PROVIDE A COMPREHENSIVE REPORT BACK TO THE REFERRING PHYSICIAN, AND THIS MUST BE PROVIDED IN A PROMPT AND TIMELY MANNER. THIS REPORT MUST ADDRESS THE ISSUES RAISED BY THE REFERRING PROVIDER, AND MUST ALSO IDENTIFY ANY OTHER ISSUES OF SIGNIFICANCE IN THE OVERALL MANAGEMENT OF THE PATIENT. IT MUST GO ON THE PATIENT'S MEDICAL RECORD, SO THAT IT WILL BE AVAILABLE TO OTHER CARE PROVIDERS SEEING THE PATIENT. FAILURE TO DO SO JEOPARDIZES PATIENT CARE, AND COULD POTENTIALLY PLACE THE CFHS IN A TENUOUS POSITION LEGALLY

6. WHEN A HEALTH CARE PROVIDER OF ANY DESCRIPTION SEES A PATIENT, WHETHER THE PATIENT HAS BEEN REFERRED TO THEM OR NOT, AND IDENTIFIES INFORMATION WHICH IS POTENTIALLY SIGNIFICANT TO OTHER CARE PROVIDERS WHO MAY SEE THE SAME PATIENT, THIS INFORMATION SHOULD BE DOCUMENTED IN THE MEDICAL RECORD. THIS IS BEST ACCOMPLISHED BY WAY OF A CONFIDENTIAL REPORT FROM THE HEALTH CARE PROVIDER TO THE PATIENT S PHYSICIAN. IF THERE IS DOUBT AS TO WHETHER IMPLIED CONSENT FOR THIS INFORMATION SHARING EXISTS, CONSENT SHOULD BE OBTAINED FROM THE PATIENT. SHOULD

THE PATIENT REFUSE TO GIVE CONSENT, THEN THE PROVIDER SHOULD INFORM THE PATIENT THAT HE/SHE CAN NO LONGER CERTIFY THE PATIENT AS BEING FIT FOR OPERATIONS UNTIL SUCH TIME AS THE INFORMATION IS PROVIDED TO THE MEDICAL FILE

7. TO THE GREATEST EXTENT POSSIBLE, WHEN MEDICAL SCREENINGS FOR OVERSEAS DEPLOYMENTS ARE BEING PLANNED, THE HEALTH PROFESSIONALS SCREENING A MEMBER SHOULD BE THE SAME ONES INVOLVED IN PROVIDING CARE TO THAT MEMBER. THIS WILL HELP INSURE THAT THE BEST DECISIONS, BASED ON THE MOST IN DEPTH KNOWLEDGE OF A MEMBER'S HISTORY, ARE MADE. FOR DIFFICULT CASES A SECOND OPINION CAN BE OBTAINED FROM AN IMPARTIAL THIRD PARTY

8. THIS OFFICE HAS BECOME AWARE OF INSTANCES WHERE RELEVANT INFORMATION IS NOT BEING PROVIDED TO REFERRING PHYSICIANS OR TO CF MEMBERS' MEDICAL RECORDS IN A TIMELY MANNER. THESE INSTANCES MUST CEASE. ALL CF HEALTH CARE PROVIDERS MUST BE COGNIZANT OF THE NEED FOR A HOLISTIC APPROACH TO PATIENT MANAGEMENT, AND FOR OPEN AND HONEST COMMUNICATION AMONGST THE TEAM OF CAREGIVERS PROVIDING CARE TO A PATIENT. COMMUNICATION OF RELEVANT INFORMATION AMONGST CAREGIVERS LOOKING AFTER THE SAME PATIENT IS NOT A BREACH OF CONFIDENTIALITY. IT IS A KEY ELEMENT OF CONTINUITY OF CARE

9. THE PROVISIONS OF THIS MESSAGE DO NOT REPRESENT A CHANGE TO CF POLICY, OR A NEW APPROACH TO STANDARD PRACTICES IN HEALTH CARE. THEY ARE SIMPLY A REMINDER TO OUR CAREGIVING COMMUNITY ON THE FUNDAMENTALS OF GOOD PATIENT CARE. GOOD DOCUMENTATION IS AN INTEGRAL PART OF THIS PROCESS. WHEN THE CARE AFFORDED A PATIENT IS ANALYSED AFTER THE FACT IT IS MOST OFTEN THE MEDICAL RECORD WHICH IS USED TO EVALUATE QUALITY OF CARE. ABSENCE OF PERTINENT INFORMATION FROM THE RECORD IS MOST OFTEN INTERPRETED AS FAILURE TO PERFORM THE SERVICE IN QUESTION

10. SENIOR MEDICAL AUTHORITIES AT ALL LEVELS ARE TO DISCUSS THE CONTENTS OF THIS MESSAGE WITH THEIR PROFESSIONAL / TECHNICAL STAFFS AND TAKE STEPS TO INSURE THESE MEASURES ARE BEING APPLIED ON A CONSISTENT BASIS. QUESTIONS CONCERNING THE CONTENT OF THIS MESSAGE CAN BE DIRECTED TO D MED POL / SOCIAL WORK, LCOL RODRIGUE, AT (613) 945-6703 OR CSN 849-6703

Date Modified: 2015-05-19

# APPENDIX 5 TO ANNEX A1

# 6000-04 SOCIAL MEDIA - PROTECTING INFORMATION ASSETS

# Social Media - Protecting Information Assets

| | |
|---|---|
| **Document Status:** | Current |
| **Document Type:** | **Order** |
| **Document Number:** | **6000-04** |
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## Background

### General

1. The ever-evolving use of social media and other electronic means is changing the way people, government and businesses communicate. Today, we are inundated with various social media outlets, platforms and applications, including blogs, social networking sites, video sites, and online fora and chat rooms. In using social media, records are created or received.

2. Social media can benefit health care in a variety of ways, including fostering professional connections, allowing timely communication between the health care professional and the patient, and educating and informing both military members and health care professionals; however, with their use comes the increased threat of breaches of privacy, confidentiality and security, both inside and outside of the workplace.

3. The Canadian Charter of Rights and Freedoms guarantees the fundamental freedom of thought, belief, opinion and expression. Therefore, off duty and outside of working hours, DND/CF members have the right to enter public debates and make comments. However, any comment must be made strictly as a private citizen and be separate from any reference to employment with DND. CF members must not refer to their position or profession when using social media to express an opinion in a private capacity and must act in conformity with Ref A. Any posted comment must not be seen to represent DND/CF, or compromise the member's actual or perceived ability to serve the Government of the day in a politically neutral manner.

4. Confidentiality and privacy issues are extremely important when it comes to health care provider – patient communications via social media networks. Health care providers must carefully consider not only issues of privacy and confidentiality, but also issues of record keeping, privilege, and other ethical and legal considerations.

### Purpose

5. Consistent with Ref B, the purpose of this Order is to provide guidance regarding the protection of Canadian Forces Health Services Group (CF H Svcs Gp) information assets through the practice of safe computing behaviours. These measures are intended to protect operational security and reduce the overall occurrence of theft, loss, or misuse of personal information and personal health information, while maintaining the privacy and confidentiality of patients, colleagues and CF H Svcs Gp.

### Contents

6. This Order describes the environment, outlines concerns, provides specific direction and details relevant security and personal information protection policies.

# Environment

7. There is no expectation of privacy when using DND and CF electronic networks (ENs) and computers as they are subject to monitoring for purposes of system administration, maintenance and security, and to ensure compliance with DND, CF and Treasury Board policies. With limited exceptions, (such as online banking or other permitted secured transactions) information stored or transmitted on a government system is the property of the government.

8. All comments made on social media sites should be considered public commentary, even when the site is labelled as a "private" social media site.

# Concerns

### Security

9. The primary area of concern associated with the use of social media is failure to safeguard information which may be protected, confidential, secret or top secret and which, if disclosed, could cause damage or harm to individuals, the CF and/or the DND or the national interests of Canada.

10. Many factors amplify this concern:

a. Unauthorized access, use, or disclosure of information is a security and privacy breach (Refs C and D);
b. Personnel may post personal information which violates legislation, policy, or orders (Refs E, F, G and H);
c. Unauthorized use of copyrighted material or intellectual property rights can have legal or disciplinary repercussions;
d. When sharing information and advice online, the information is not captured, retained and filed in accordance with legislation and established government procedures;
e. Personal comments may be treated as coming from an official representative of the Government, and contravene standards of conduct, bringing discredit upon the government or the department; and
f. Posting photos or other information from deployed operations can effect operational security and put CF members at risk.

### Ethics and the Protection of Personal Information on ENs

11. The importance of protecting personal information and personal health information is abundantly clear in the very first point in the CF H SVCS GP Code of Ethics, Autonomy. The code states that healthcare professionals must demonstrate respect for patient autonomy by preserving patient confidentiality, protecting the security of patient health information, and using mutual respect.

12. Treasury Board Secretariat (TBS) encourages authorized individuals to use ENs to conduct the business of government, to gather information relevant to their duties, and to develop expertise in using such networks. EN users must be aware and vigilant in how they use ENs because of the risk to operational security, and the potential to unwittingly engage in unlawful activities, to disclose classified or designated information in an unauthorized fashion that may damage work and operational environments.

# Direction

13. CF H Svcs Gp personnel will abide by the instructions detailed below.

### All Personnel

14. What to do:

a. Be aware of and understand security, privacy and confidentiality policies, standards and guidelines for protecting sensitive and personal information (Refs H through L);
b. Understand and familiarize yourself with the TBS policy on the Use of Electronic Networks (Ref G);
c. Attend information security, privacy, confidentiality and social media awareness sessions when available;
d. Examine information regarding privacy rights, copyright, intellectual property, and records management;
e. Read the CF H Svcs Gp Code of Ethics, the Department of National Defence and Canadian Forces Code of Values and Ethics and the Values and Ethics Code for the Public Service (Refs M, N and O);
f. Follow Federal and Department policies on social media; and
g. Be clear that any opinion or comment you make is a personal opinion or comment.

15. What not to do:

a. Do not post DND/CF, CF H Svcs Gp or any other military type insignia or crest without prior approval;
b. Do not provide your DND/CF e-mail address on public sites;
c. Do not post materiel that may bring discredit to the government and its bodies;
d. Do not post any materiel contrary to the NDA, or Criminal Code of Canada (prejudicial, defamatory, libellous, discriminatory, harassing obscene, threatening, or discloses another person's personal information);
e. Do not engage in any activity that could be perceived as an official act or representation of the CF or DND unless authorized to do so.
f. Do not engage in political activities at work;
g. Do not initiate or accept "friend" requests on social media of patients who are, or who have been, under your care;
h. Do not discuss patient care. It is unlawful to discuss personal health information in a public area including on social media; and
i. Do not post photos or discuss information that may affect the operational security of deployed operations.

16. What to Report:

a. Actual and suspected security, privacy and confidentiality incidents and breaches. *You must file a Preliminary Incident Report within 24 hours of the incident, breach, or loss of information (Ref H).*

**Management**

17. What to do:

a. Ensure that sensitive and personal information is properly collected, used, disclosed, retained and destroyed;
b. Ensure your personnel receive suitable training and regular reminders of privacy, confidentiality and security requirements when using social media;
c. When a privacy, confidentiality or security, breach has occurred, report the breach as per Ref H, conduct an investigation and, if necessary, refer the matter to the Military Police or CF National Investigation Service; and
d. Follow up by reviewing related policies and processes and revising them if necessary.

18. What to be aware of:

a. When and how your personnel use of social media; and
b. Refs B and I.

# References:

**Source References:**

A. QR&O Chapter 19 Conduct and Discipline (Arts 19.14 Improper Comments and 19.36 Disclosure of Information or Opinion. 19.44 Political Activities and Candidature for Office)
B. DAOD 6002-07, Internal Use of Social Media Technologies
C. DAOD 5016-0, Standards of Civilian Conduct and Discipline
D. NDSI 70 - Information System (IS) Security
E. *Privacy Act*
F. *Security of Information Act*
G. TBS Policy on the Use of Electronic Networks
H. CF H Svcs Gp Order 2000-30, Breaches of Confidentiality, Privacy, and Security of Personal Information and Personal Health Information
I. DAOD 6002-2, Acceptable Use of the Internet, Defence Intranet and Other Electronic Networks and Computers
J. CF H Svcs Gp Instruction 7010-03, Access Control of Personal Health Information
K. CF H Svcs Gp Policy 5020-26, Unacceptable Use and Disclosure of Personal Health Information (cancelled)
L. CANFORGEN 038/08 (Operational Security)
M. CF H Svcs Gp Code of Ethics
N. the Department of National Defence and Canadian Forces Code of Values and Ethics
O. Values and Ethics Code for the Public Service

**Related References**

A. *National Defence Act*
B. TBS Policy on Government Security
C. DAOD 2008-0, Public Affairs Policy

Date Modified: 2015-01-20

**APPENDIX 5 TO ANNEX A1**

**7010-01 SECURE USB MEMORY KEY – INSTRUCTIONS FOR USERS**

# Secure USB Memory Key - Instruction for Users

| | |
|---|---|
| **Document Status:** | Current |
| **Document Type:** | **Instruction** |
| **Document Number:** | **7010-01** |
| **Original Source:** | N/A |
| **Approval:** | D H Svcs Del |
| **SME:** | J6 ISSO |
| **OPI:** | CIO |
| **Effective Date:** | 21 Jun 13 |
| **Last Reviewed:** | 09 Mar 15 |

Latest Amendment

Complete revision

## Background

1. The improper use and handling of USB storage devices or the improper storage of personal information, which includes personal health information (PHI), can pose significant risks to the security of Government of Canada information and may violate Government of Canada and Department of National Defence/Canadian Armed Forces (DND/CAF) policies for security, privacy protection and information management.

2. As indicated in Reference A, steps must be taken to mitigate against the following risks associated with the usage of portable storage devices for temporary storage or movement of PHI:

1. the unauthorized access or use of information stored on the device;
2. the introduction of malicious software onto Government of Canada IT networks; and
3. the loss or theft of the device.

### Application

3. This Instruction applies to all members of the CAF posted, attached, or seconded to an establishment position within Canadian Forces Health Service Group (CF H Svcs Gp), and a directive that applies to all Public Servants, contractors, sub-contractors, and any other personnel who are attached, seconded or otherwise employed with or at Canadian Forces Health Services (CFHS). It is issued under the authority of the Director Health Services Delivery (D H Svcs Del).

### Purpose of this Instruction

4. The purpose of this Instruction is to:

1. enhance the safeguarding of PHI that resides within the CF H Svcs Gp's responsibility;
2. ensure where PHI needs to be transferred or shared for business purposes, appropriate tools are employed which mitigate the risk of loss or unauthorized access; and
3. reduce or eliminate losses of PHI that may result in injury to CF H Svcs Gp patients, damage DND/CAF applications or technology, and/or loss of confidence in CF H Svcs Gp's ability to responsibly manage patient information.

5. Notwithstanding the technical solution, all individuals to whom this Instruction applies are responsible for determining information handling requirements as stipulated by the NDSI Chapter 27, CLASSIFICATION AND DESIGNATION OF INFORMATION and or by consulting the CFHIS National Information System Security Officer (ISSO).

### Definition

6. *Portable Universal Serial Bus (USB)-based memory sticks* [1] (also known as flash drives, thumb drives, jump drives, USB drives, memory sticks or key drives). A subsystem that transfers data between components inside a computer, or between computers. Data storage devices which connect, without cable, directly to the USB port of a PC or laptop. They are usually removable and rewritable.

### Inquries

7. Direct all inquiries related to this Instruction to the Canadian Forces Health Information System (CFHIS) National ISSO [ mailto:++CFHIS National ISSO - OSSI national du SISFC@CF H Svcs Gp@Ottawa-Hull ]

## Direction

### Requirements

8. Two types of departmentally procured and issued USB Keys are approved for use at CF H Svcs Gp:

1. A Federal Information Processing Standard (FIPS) 140-2 Certified Secure USB Memory Key for Protected B information, specifically for storing PHI; and
2. all other DND/CAF procured USB keys for storing Protected A and non-PHI Protected B information, and undesignated/unclassified information.

9. The FIPS 140-2 Certified device[2] must:

1. be FIPS 140-2 Level 3 validated;
2. have military grade full-disk AES 256-bit CBC hardware encryption;
3. be PIN activated;

4. operate without device specific drivers; and
5. be OS and platform independent.

10. Non-CAF issued UBS keys are not to be connected to the DWAN network. This includes, but is not limited to personal USB keys, keys furnished by vendors, contractors, private sector organizations, or for other similar or promotional purposes.

11. When non-CAF issued media contains information that is necessary to satisfy business purposes, the user must contact his/her immediate Local ISSO for assistance in transferring the information to the DWAN network via an approved Air Gap computer to an issued USB.

## Procurement

12. Units are responsible for procurement of all approved Secure USB Memory Keys for internal use. These purchases must be made through, and approved by, the Base ISSO.

## Media Custodians

13. Directorates and Clinics shall appoint a media custodian to control the USB Keys in their locations in accordance with Reference B. A consolidated list of media custodians shall be held and maintained by the CFHIS National ISSO. Media custodians are responsible for distributing the keys, keeping a record of who has been assigned one, and recovering keys at departure/separation from the Clinic.

14. Media custodians shall create an Admin PIN prior to issue, in accordance with Annex A.

## Entitlement

15. The Secure USB Memory Keys are for storage of PHI only.

16. All personnel who require such keys to satisfy business requirements may request an approved Secure USB Memory Key. The CFHIS National ISSO must be contacted for direction for any uncertain requests.

## Approval

17. Authorization to issue approved Secure USB Memory Keys shall be granted by the CFHIS ISSO for the pertinent organization.

## Issue Instructions

18. Approved Secure USB Memory Key user password shall be changed when the device is issued. Keys and passwords SHALL NOT be shared with anyone.

19. Approved Secure USB Memory Keys shall be assigned to individuals via loan card. Personnel shall sign an agreement to abide by this Instruction. As stipulated in Reference B, any breach of the agreement shall result in an investigation by the appropriate CFHIS ISSO.

20. A record of issue, or any change to the record of issue, will be sent to the CFHIS National ISSO.

## Physical Security

21. As stipulated by ITPIN 2014-01, all approved Secure USB Memory Keys must be properly secured at all times as appropriate to the highest level of the designation of the information stored on it. When these devices are in use, they are not to be left unattended.

22. CAF issued USB Keys must be labelled to indicate the highest designation of information that has been stored on the device.

23. CAF issued Secure USB Memory Key for storing PHI must additionally include a tag with the telephone number of the CFHIS helpdesk. This makes the key more visible when it is plugged into a PC. The tag encourages someone finding the key to call the CFHIS helpdesk and increases the likelihood that it will be returned if misplaced. The tag is therefore not to be removed from the key for any reason.

## Return of Keys

24. At end of term/posting or termination of employment, all approved Secure USB Memory Keys shall be returned to the media custodian of the directorate/ clinic. If a custodian has not been appointed or is not available, the approved Secure USB Memory Keys shall be returned to the CFHIS Help Desk or Clinic Manager. Where possible, this shall be part of the Out-Clearance process.

## Lost Keys

25. Loss of any approved Secure USB Memory Keys shall be replaced at the expense of the individual who signed the loan card.

26. If an approved Secure USB Memory Key is found, it shall be returned to appropriate CFHIS ISSO immediately or, if not possible, the CFHIS Helpdesk must be contacted.

27. Any loss of a departmentally procured and issued USB Key must be reported according to Reference B Chap 70.51, which indicates that positive control must be kept of all designated material, and Reference C Chap 18.13, which indicates responsibility for addressing the immediate operational requirements of any ITSEC incident or breach.

## Storage

28. Secure USB Memory Keys are intended for temporary storage of PHI only, and must not be used as a permanent document repository. These devices must be used only when absolutely necessary and the information must be removed when the immediate need no longer exists.

29. When storing PHI to an approved Secure USB Memory Key, ensure that a backed-up copy exists in a secure environment and any Protected B information stored on a DWAN PC must be PKI encrypted. This will protect the PHI against loss of the information if the device is lost, stolen, damaged, the user forgets the encryption key, or if the encryption software fails.

30. Handling and Storage of approved Secure USB Memory Keys shall be in accordance with Ref A. Approved Secure USB Memory Keys shall be protected and marked commensurate with the highest level of information stored on the device.

## Clearing and Disposal

31. When these devices are no longer functional or at the end of their lifecycle, particular care must be taken in their disposal or destruction to ensure that the information stored on them is no longer accessible. The risk of unauthorized information disclosure, user need-to-know, and user security clearance must be considered when preparing storage media for reuse or disposal.

32. **Reuse** means the redistribution and reassignment of storage media and its control to different environments **within** DND.

33. **Clearing** is **changing** or **replacing** sensitive information existing on media. The accepted method of clearing is to overwrite. Clearing provides assurance that the data may not be reconstructed by normal means such as at the workstation **keyboard**.

34. The following are general security standards for handling storage media containing sensitive information:

1. Media containing sensitive information shall be cleared prior to reuse within the Department where physical security level is the same or higher and the IS processes at the same or higher sensitivity level or when the IS changes security modes of operation.
2. Cleared media retains its previous sensitivity marking unless reused in a higher sensitivity environment at which time the media shall be marked at the highest sensitivity level.

35. **Disposal** means the release or transfer of magnetic storage media **outside** the control of the Department.

36. **Purging** is the **removal** of data from storage media so that the information is erased. Purging provides confidence that the data cannot be reconstructed using **laboratory** techniques.

37. If the Media contains UNCLASSIFIED, PROTECTED A or PROTECTED B:

| **and IF…** | **BUT…** | **THEN…** |
|---|---|---|

| | | |
|---|---|---|
| | | 1x overwrite; and |
| media is to be reused in, at least, the **same or higher** Departmental secure environment; and | | media retains original security marking, |
| can be overwritten | | in a higher sensitivity environment, the media shall be marked to the highest sensitivity level processed on the IS. |
| media is to be reused | media is inoperative; or | media is inoperative; or |
| | **cannot** be overwritten | **cannot** be overwritten |
| media is to be disposed of; and | | should be purged; or<br>shall be, at least, overwritten 3 times; or |
| can be overwritten | | may be destroyed; and<br>sensitivity level removed. |
| media is to be disposed of | media is inoperative; or | should be purged; and<br>sensitivity level marking removed; and |
| | **cannot** be overwritten | shall be destroyed. |

### Other Instructions

38. Destruction of approved Secure USB Memory Keys shall be in accordance with Reference D.

39. Usage of approved Secure USB Memory Keys shall be in accordance with Reference E.

40. Use of approved Secure USB Memory Keys for Data Transfer between systems of differing classifications shall be conducted in accordance with applicable DND/CAF Security Orders for those systems.

41. Additional information pertaining to responsibilities and referential documentation can be found in Annexes B and C.

42. A breach of this Instruction may lead to administrative or disciplinary measures being taken, up to and including termination of employment. The level of discipline will depend on the severity of the breach and the circumstances surrounding it, as well as any mitigating or aggravating factors.

# References:

1. TPIN 2014-01, Secure use of portable data storage devices within the Government of Canada
2. National Defence Security Instructions (NDSI)
3. National Defence Security Policy (NDSP)
4. ITSG-06 – Clearing and Declassifying Electronic Data Storage Devices
5. DAOD 6002-2, Acceptable Use of the Internet, Defence Intranet, Computers and Other Information System

## Related Documents:

1. DWAN Security Orders
2. CFHIS Security Orders and Policy
3. IM Group USB Stick Policies
4. Government Security Policy
5. 7010-03, Access Control to Personal Health Information

## Annexes:

1. Annex A (PDF, 8 Kb) – Acknowledgement of Responsibility for Receipt of USB Memory Key
2. Annex B (PDF, 13 Kb) – Sample Approved Secure USB Memory Key Tracking Form
3. Annex C (PDF, 46 Kb) – Sample Secure USB Memory Key – Protected B Usage Instructions

## Footnotes:

[1] Definition provided for the purpose of this Instruction.

[2] The device must be certified by the National Institute of Standards and Technology and the Communications Security Establishment Canada, and be listed on the FIPS 140-2 Consolidated Validation Certificate.

## APPENDIX 5 TO ANNEX A1

## 7010-02 FAX COMMUNICATION OF PERSONAL HEALTH INFORMATION BY NON-SECURE MEANS

# Fax Communication of Personal Health Information by Non-Secure Means

| | |
|---|---|
| **Document Status:** | Current |
| **Document Type:** | **Instruction** |
| **Document Number:** | **7010-02** |
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| **Approval:** | D H Svcs Del |
| **SME:** | J6 ISSO |
| **OPI:** | D H Svcs Del |
| **Effective Date:** | 23 Feb 15 |
| **Last Reviewed:** | 23 Feb 15 |

## Background

### Purpose

1. The purpose of this Instruction is to provide a framework for safeguarding the privacy, security and integrity of personal health information (PHI) when it is being transmitted (sent and/or received) by non-secure facsimile (fax).

### Application

2. This Instruction applies to all CAF personnel, Department of National Defence (DND) Public Servants, contractors and sub-contractors who provide health services and/or health services support to entitled personnel.

### Abbreviations

3. The list below explains the abbreviations used through this Instruction.

| Acronyms / Abbreviations | Title or Term in Full |
|---|---|
| CF H Svcs Gp HQ | Canadian Forces Health Services Group Headquarters |
| DGHS | Director General Health Services |
| DHSD | Director Health Services Delivery |
| HI/RM | Health Information/Records Management |
| ISSO | Information System Security Officer |

### Definitions

**De-Identified Information**

4. Personal information, as defined in section 3 of the *Privacy Act*, from which any information that may reasonably be expected to identify an individual has been removed, suppressed or modified.[1]

**Need-to-know principle**

5. Access to (including knowledge of) sensitive information is restricted to those whose duties require such access. [2]

**Personal Health Information (PHI)**

6. Personal information, as defined in section 3 of the *Privacy Act* that relates to an individual's diagnostic, treatment or care information. It includes any medical, dental, or psychosocial information that is collected when a health program or service is provided to an individual. It includes information on the payment for a health care program or service, health services provider information and patient registration information. It does not include a CAF member's medical employment limitations (MELs), anticipated absences from the workplace or prognosis (chance of recovery).

**Release Authority**

7. The Release Authority is the person who authorizes the release of PHI by non-secure fax. He/she is the one who takes responsibility should a breach occur in the transmission of the non-secure fax. Normally, the Release Authority should be a physician, nurse, or other regulated health care provider.

# Direction

## General

8. Each transmission of PHI by non-secure fax is considered a non-secure method for transmitting designated (e.g., Protected B) information and shall only be used:

1. to facilitate continuity of care across jurisdictions, provinces/territories or foreign countries where the transmission is to another health care provider (both within and outside of the CAF) involved in an individual's health care support and service planning **and** the sender or the recipient of the information does not have secure faxing capability;
2. in exceptional circumstances;
3. on a need-to-know basis;
4. using ONLY the minimum amount of information necessary to accomplish the purpose for which the PHI is being released (see Note);
5. when the requirement for PHI is time-sensitive; and
6. an alternative secure method (i.e., secure fax, mail, courier service, encrypted email) will not meet the reasonable needs of the sender or recipient.

*Note: Information shall be de-identified, where possible, to limit identification of the patient.*

9. The person who initiates transmission (either the person asking for it to be sent by non-secure fax, or the person deciding to meet a request for information by replying via non-secure fax) must, if challenged, be able to demonstrate that there are reasonable grounds to do so, and that proper procedures have been followed, as per this Instruction (see Annex A).

10. Only information that is essential to the purpose of facilitating continuity of care shall be included in the document that is being faxed. Unrelated and irrelevant information shall be severed or omitted before transmission. Consideration shall be given to removing some personal identifiers and communicating baseline identifiers (e.g., Service Number) during the initial contact call to the recipient of the fax.

11. Non-secure fax machines where PHI is received or sent shall be placed in a secure environment where only authorized personnel have access to incoming or outgoing documents. Access to the equipment shall be limited to those persons authorized in the department/area that the fax serves.

12. See Annex A for procedures and safeguards which shall be implemented to prevent privacy breaches involving transmission of PHI by fax and circumstances when non-secure faxes should not be used.

## Documentation Requirements

13. All faxes containing PHI shall be logged for audit purposes. As a minimum, the log shall contain:

1. a copy of the fax cover sheet; and
2. the transmission slip from fax machine of transmission success/failure.

14. If it is available, a printout should be produced periodically from the fax machine showing usage of the fax line. This printout should be compared against the usage log created by Health Records. Anomalies should be followed up and corrective action taken where necessary. Should an anomaly represent a threat, or possible threat, to information security, the event should be reported to the ISSO or appropriate authority.

## Release Authority

15. Actual release of the PHI using non-secure fax machines will be under the direction of the Health Records Manager and as determined by the Release Authority. The name and title of the designated Release Authority shall be specified on the fax cover sheet.

## Breaches Involving PHI

16. Any incidents where incoming or outgoing non-secure faxes have compromised PHI shall be immediately reported in accordance with CF H Svcs Gp Instruction 5020-28, Management of Breaches Involving Personal (Health) Information (Reference A).

### Compliance Monitoring

17. Compliance with this Instruction will be monitored through Staff Assistance Visits or Staff Inspection Visits by DHSD Primary Care Services.

## Responsibility

### Responsibility Table

18. The following table outlines the responsibilities associated with this Instruction.

| The... | Is responsible for... |
|---|---|
| DHSD | • Monitoring compliance with this Instruction. |
| CAF personnel, DND Public Servants, contractors and sub-contractors who provide health services and health services support to CAF members | • Protecting an individual's PHI from unauthorized disclosure;<br>• Complying with federal laws with respect to disclosure of confidential PHI;<br>• Complying with this Instruction and completing a CF Health Records Fax Cover Sheet for all faxes transmitting PHI; and<br>• Completing a breach report and notifying security and the CF H Svcs Gp Privacy Office of any incidents of improper or unauthorized transmission of PHI via fax. |
| Release Authority | • Authorizing the release of the PHI via non-secure fax. |
| HI/RM personnel | • Keeping a log of faxes received/sent containing PHI; and<br>• Reporting any adverse events incidents of improper or unauthorized transmission of PHI via fax. |
| Clinic Managers | • Ensuring all fax machines in their clinic which are used to transmit PHI are in a secure area, restricted to authorized persons only; |

| | |
|---|---|
| | • Ensuring received faxes are only accessible to those who need to know the information for the performance of their duties; and<br>• Ensuring adverse events are properly documented and reported to the CF H Svcs Gp Privacy Office as per Reference A. |
| ISSOs | • Investigating all security incidents involving designated information |

# References:

## Source Reference

1. CF H Svc GP Instruction 5020-28 Management of Breaches Involving Personal (Health) Information (In development)

## Related References

1. CF H Svcs Gp Instruction 5020-20 (PDF, 176 Kb), Disclosure of Personal Health Information
2. Privacy Act and Regulations
3. National Defence Security Instructions, Chapter 26 - Access to and Release of Information
4. National Defence Security Instructions, Chapter 70 - Information System (IS) Security
5. National Defence Security Policy, Chapter 18 – Breaches and Violations – Investigation and Reporting

# Annex:

1. Annex A – Procedures and Safeguards When Sending PHI by Non-Secure Fax

# Footnotes:

[1] Government of Canada. Panel on Research Ethics. Chapter 5 Privacy and Confidentiality. http://www.pre.ethics.gc.ca/eng/archives/revised-revisee/chapter5-chapitre5/ (accessed February 2015)

[2] Government of Canada. Communications Security Establishment Canada, Baseline Security Requirements for Network Security Zones in the Government of Canada.<https://www.cse-cst.gc.ca/en/publication/itsg-22> (accessed February 2015)

# Annex A to CF H Svcs Gp Inst 7010-02

## Procedures and Safeguard When Sending PHI by Non-secure Fax

### Circumstances when Non- secured Fax SHALL NOT be Used

- To areas not providing patient care (such as Insurance Companies);
- For routine matters when other methods will suffice;
- To an unknown recipient;
- When other transmission methods will meet the reasonable needs of the sender or recipient; and/or
- When there is particularly sensitive PHI such as Mental Health, STD results, etc.

### Transmission and Receiving Procedures

- A fax cover sheet shall always be used when sending faxes containing PHI.
- To prevent unauthorized disclosure of PHI, the individual sending the fax shall ensure that the recipient is available to receive the fax.
- Personnel assigned to monitor faxes shall regularly retrieve/remove documents for routing and immediate action.
- Fax machine are not to be left unattended while the fax is being transmitted.
- No printout shall be left unattended at the fax machine or in the print tray.
- Discarded fax rollers shall be disposed of securely.
- Where the print process uses a transfer file, the film shall be disposed of using confidential waste procedures.
- Where the print mechanisms uses an image drum (plain paper faxes), a few blank sheets shall be printed off to clear the static image held on the drum.
- Where the fax machine houses a memory capability, the memory shall be flushed and the saved items deleted at regular intervals.

Date modified:
2015-10-26

# APPENDIX 5 TO ANNEX A1

# 7010-03 ACCESS CONTROL OF PERSONAL HEALTH

# Access Control of Personal Health Information

| | |
|---|---|
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| **Document Type:** | **CF H Svcs Gp Instruction** |
| **Document Number:** | **7010-03** |
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| **SME:** | SSO H Svcs I |
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| **Effective Date:** | 12 Nov 03 |
| **Last Reviewed:** | 22 Jan 14 |

Latest Amendment

Effective 22 Jan 14 the "Document Number" is changed from 5020-23 to 7010-03.

## Background

1. This document supersedes MSI CF 2000-002 "Access Control of Personal Health Information" which was originally issued and effective on 12 Nov 03.

**Note:** *This document was originally numbered 5020-23.*

### Application

2. This Instruction applies to all CF personnel, Department of National Defence (DND) Public Servants, contractors and sub-contractors who provide health services to CF members.

### Table of Abbreviations

3. The table below contains an explanation of the abbreviations used in this instruction.

| Acronyms/Abbreviation | Term in Full |
|---|---|
| CFHIS | Canadian Forces Health Information System |
| CF H Svcs | Canadian Forces Health Services |
| CF H Svcs Gp | Canadian Forces Health Services Group |
| DGHS | Director General Health Services |
| Surg Gen | Surgeon General |
| ERC | Enhanced Reliability Check |

| Acronyms/Abbreviation | Term in Full |
|---|---|
| HIACC | Health Information Access Control Committee |
| HI/RM | Health Information/Records Management |
| HRMS | Human Resources Management System |
| IS | Information Systems |
| ISSO | Information System Security Officer |
| Privacy O | Privacy Officer |
| RCMP | Royal Canadian Mounted Police |
| SSO HSI | Senior Staff Officer Health Services Informatics |

## Definitions

**Note:** *Definitions are provided for the purpose of this Instruction.*

**Audit Report**

4. A document containing the results of an independent examination of work product or set of work products to assess compliance with specifications, policies and standards, contractual agreements, or other criteria.

**Audit Trail**

5. Data collected for potential use in a security audit (Ref. ISO/IEC 2382-08); a recording of activity by individual users who have accessed the health information or health services information systems.

**Breach of Security**

6. A breach of security occurs when any sensitive information and assets have been compromised which may result in loss of confidentiality, loss of personal privacy, or data corruption, destruction or theft. Without restricting its scope, a breach may include a compromise in circumstances that make it probable that a breach has occurred. A breach may also occur whenever personal health information is collected, used, disclosed or accessed other than as authorized, or its integrity is compromised.

**Personal Health Information**

Reference G.

**Health Record**

Reference G.

**Position**

7. The CF H Svcs Gp position as identified in the HRMS database. Within HRMS, a Departmental identifier uniquely identifies each position.

**Privileges / Rights**

8. The authorization to access or manipulate personal health information, regardless of media. These privileges/rights can be granted either in their entirety or in part to individuals employed, contracted or engaged within health services.

**Profile**

9. All role(s) assigned to a position. A profile may contain more than one role. A profile may be assigned to more than one position in the management of personal health information.

**Role**

10. A specific set or group of privileges/rights.

**Security Violation**

11. Any act or omission that contravenes any provision of DND and CF H Svcs Gp security policies.

**User**

12. The actual person employed or engaged in a position within the CF H Svcs Gp. This person has a unique identifier within the HRMS. While employed or engaged in a position, the user's unique identifier is mapped to the position's Departmental identifier in HRMS.

# Direction

13. CF H Svcs Gp will:
    a. Provide general information and direction on access control of personal health information: and
    b. Enforce access control of personal health information, regardless of media, by ensuring compliance with security and privacy policies and practices.

## Access

14. Access to personal health information will be:
    a. Granted based on a "need to know" basis in order to perform specific functions related to an individual's employment or contract;

b. Limited to those individuals and/or groups to whom CF H Svcs Gp personnel are providing direct care, consultation, referred clinical care/advice or administrative services/review;
c. Provided through the use of a role and location-based access control model, meaning that users will be granted privilege to access information based on roles assigned to the position(s) occupied by specific individuals, and their location. This will ensure the security and privacy of the personal health information; and
d. Violations or breaches, which may be identified in security audits, among other things, could result in administrative or disciplinary action being taken.

15. The Clinic Manager will:

    a. Designate a Health Information Custodian at every Base/Unit for which they are responsible for the access control of the health information; and
    b. Approve and control users assignment to positions that have access rights previously defined. Users access and control access will be managed centrally at CF H Svcs Gp HQ.

### Changes to Privileges

16. Changes to privileges, roles or profiles positions accessing the personal health information will require CF H Svcs Gp HQ approval.

### Circumstances Governing Access to Personal Health Information

17. Personal health information will be accessible under the following circumstances:
    a. Direct Care – Where access to personal health information is required to provide direct care to the patient;
    b. Individual Use – Where access to member's personal health record is requested by the individual and/or their legally authorized representative;
    c. Secondary Use – Where access to personal health information is required for use by authorized persons or agencies for purposes other than the provision of direct care;
    d. Legal Use – Where access to personal health information is authorized or required by law; or
    e. Consensual Use – Where the individual consents to the use of their personal health information for purposes not related to direct care.

### Designation of Information

18. Health Records and personal health information are designated as PROTECTED B and will be handled and transmitted in accordance with DND policy. The minimum requisite security clearance level for those personnel required to access PROTECTED B information is an Enhanced Reliability Check (ERC).

## Audit

## Audit Schedule

19. CF H Svcs SSO HSI will ensure that an appropriate audit of access control within CF H Svcs occurs at intervals not exceeding five years. An audit must also be conducted when standards are not maintained or when a security violation or breach of access occurs.

## Audit Content

20. The audit will address, but will not be restricted to, a verification of compliance of CF H Svcs access control, positions and the efficiencies of the implementation process, as they pertain to:
    a. Compliance with policies and standards;
    b. Appropriateness and effectiveness of policies and standards;
    c. Security/privacy impact assessment;
    d. Recommended corrective action as applicable;
    e. Follow up activities.
21. The audit content can also include observations and findings from informal investigations involving physical breaches of security (e.g.: break-ins and theft of information assets).

## Audit of Electronic Access Control Safeguards

22. Under the directory of SSO HSI the Manager of Health Information/Records Management (HI/RM), ISSO and Privacy O will ensure the implementation of an overall audit of electronic access control safeguards related to personal health information.

## Audit of Access Control

23. The audit of access control will include:
    a. Review of the positions' roles restrictions on the collection of personal health information, including electronic review;
    b. Review of the effectiveness of the safeguards in place to protect the confidentiality, integrity and security of personal health information;
    c. Ensuring appropriate policies and standard operating procedures are in place to allow only authorized individuals to access personal health information for authorized purposes;
    d. Confirmation that occurrence reports are filed, reviewed and acted upon; and
    e. Compilation of reports of breaches of access, corrective procedures implemented and any disciplinary action taken.

## Audit Trail

24. An audit trail will be maintained on all CFHIS components to record all designated activities by individual users who have accessed the CF personal health information regardless of media.

## Audit Report

25. The Manager of HI/RM, ISSO and Privacy O will document the findings of the audit along with any recommendations to monitor and ensure compliance. This report will be presented to SSO HSI.
26. After an audit, the CF H Svcs Gp Privacy O will provide the audited facility with a report that contains the findings of the audit and any recommendations that the Privacy O considers appropriate. The Privacy O will interface with the Clinic Manager with regard to communicating and correcting problems. The audited facility will address problem areas and report back to the Privacy O in an appropriate timeframe (Note: Reasonable timeframe will consider factors such as scope (number and breadth of issues), costs, and implications, etc.) Upon giving reasonable notice, the Privacy O will re-audit the facility.

### Audit Retention Period

27. Audit reports and audit trails will be retained for a minimum period of ten (10) years.

# Security

### Reporting of Security Violations and Breaches

28. Any security violation or breach of access must be reported to SSO HSI, CF H Svcs Gp Privacy O and Manager of Health Information/Records Management. Responses to breaches of access will normally be based upon the consideration of:
    a. The seriousness of the breach or violation involved;
    b. The nature of the security interest concerned;
    c. The circumstances of the breach of access;
    d. The intent of the alleged offender;
    e. The consequences of the breach of access;
    f. The previous security record of the alleged offender, if any, and
    g. Whether the offender is a civilian employee or contractor of the DND or a member of the CF.

### Disciplinary Process

29. If it is determined that a breach of confidentiality/access of personal health information has occurred, the decision to take appropriate remedial action will be made by the responsible Commanding Officer in consultation with the CF H Svcs SSO HIS, the CF H Svcs Gp Privacy O and the appropriate prof/tech authority. Such action may be disciplinary or administrative action up to and including termination of employment/contract/association with CF H Svcs. The Clinic Manager, in consultation with the Base/Wing Surgeon, should also consult with the designated representative in Human Resources to establish the appropriate level of disciplinary action to be applied. In the case of a DND civilian contractor, administrative response available will be governed by the terms of the contract.

# Responsibility

## Responsibility Table

30. The following table identifies responsibilities regarding the access control of paper and/or electronic DND health information.

| The... | Is/are responsible for ... |
|---|---|
| DGHS | • Approving orders, directives and instructions for the access control of paper and/or electronic DND health information. |
| Surgeon General/D Dental Svcs | • Providing technical and professional direction concerning the access to CF personal health information. |
| SSO HSI | • Establishing policies and procedures regarding the protection, use, security and integrity of paper and/or electronic personal health information;<br>• Providing management direction concerning the access control of personal health information;<br>• Chairing the HIACC; and,<br>• Ensuring that an appropriate audit of access control within CF H Svcs occurs at intervals not exceeding five years, and that an audit is conducted when standards are not maintained or when a security violation or breach of access occurs. |
| CF H Svcs Gp ISSO | • Advising SSO HSI on policies and procedures regarding the protection, use, security and integrity of CF H Svcs Gp IS;<br>• Under the directory of SSO HSI, and along with the Manager of HI/RM and the Privacy O, implementing an overall audit of electronic access control safeguards related to personal health information<br>• Documenting the findings of such audits, along with recommendations to monitor and ensure compliance in the Audit Report; and<br>• Presenting the Audit Report to SSO HSI. Advising SSO HSI regarding the privacy issues related to personal health information;<br>• Consulting with the Clinic Manager and the designated representative in Human Resources in a case of a breach of privacy; and<br>• Conducting audits as required. |
| CF H Svcs Gp Privacy Officer | • Under the direction of SSO HSI, and along with the Manager of HI/RM and the Privacy O, implementing an |

| | |
|---|---|
| | overall audit of electronic access control safeguards related to personal health information;<br>• Documenting the findings of such audits, along with recommendations to monitor and ensure compliance in the Audit Report; and<br>• Presenting the Audit Report to SSO HSI. |
| HIACC | • Approving changes to privileges, roles or profiles of CF H Svcs positions within HRMS; and<br>• Coordinating access after Clinic Manager approves the assignment. |
| Clinic Managers | • Designating a Health Information Custodian at every Base/Unit for which they are responsible for the access control of the health information;<br>• Determining, approving and controlling users assignment to positions; and<br>• Consulting with the Manager of HI/RM, the Privacy O, the ISSO and the designated representative in Human Resources in a case of security violation or breach of access. |
| Base/Wing Surgeons | • Consulting with the Clinic Manager regarding disciplinary or administrative action related to alleged breaches of confidentiality/access of (personal health information involving health care providers. |
| CF HS Svcs Gp Manager of Health Information/Records Management | • Advising SSO HSI regarding the issues related to the management of CF Health Records and personal health information;<br>• Under the directory of SSO HSI, and along with the Privacy O and the ISSO, implementing an overall audit of electronic access control safeguards related to personal health information;<br>• Documenting the findings of such audits, along with recommendations to monitor and ensure compliance in the Audit Report; and<br>• Presenting the Audit Report to SSO HSI. |
| Health Information Custodian | • Controlling access to personal health information;<br>• Releasing personal health information to those authorized access;<br>• Protecting personal health information from unauthorized access;<br>• Storing and archiving health records; |

- Collecting, processing and maintaining personal health information;
- Analyzing and distributing personal health information; and,
- Monitoring and auditing personal health information.

# References:

1. National Defence Security Policy (NDSP)
2. National Defence Security Instructions (NSDI)
3. *Privacy Act*
4. *Access to Information Act*
5. QR&Os Vol ll Disciplinary
6. CPAOs
7. CF H Svcs Gp PD 7000-34, General Overview – Health Information/Records Management

Date modified:
2015-10-30

## APPENDIX 6 TO ANNEX A1

## DISCLOSURE OF MEDICAL/SOCIAL WORK INFO TO COMMANDING OFFICERS

http://vcds.mil.ca/vcds-exec/pubs/default-eng.asp?path=/vcds-exec/pubs/canforgen/2008/039-08_e.asp

# CANFORGEN 039/08 CMP 018/08 131851Z FEB 08

## DISCLOSURE OF MEDICAL/SOCIAL WORK INFO TO COMMANDING OFFICERS

UNCLASSIFIED

REFS: A. CANFORGEN 026/00 ADMHRMIL 016 181430Z FEB 00
B. CFMO 8-02 (VERSION: CH 50 - 1988-03-24)
C. QR O 19.18
D. QR O CHAPTERS 4, 5
E. PRIVACY ACT R.S.C. 1985 C.P-21

1. REF A WAS ISSUED TO SUPPORT AND PROMOTE COMMUNICATION BETWEEN HEALTH CARE PROVIDERS AND CO S REGARDING MEDICAL EMPLOYMENT LIMITATIONS (MEL) IN RESPECT TO CF PERSONNEL UNDERGOING MEDICAL TREATMENT AND TO PROVIDE GREATER CLARITY AND OPERATIONAL FOCUS. REF A IS CANCELLED EFFECTIVE IMMEDIATELY, PENDING DEVELOPMENT OF A COMPREHENSIVE POLICY DIRECTION. THIS CANFORGEN PROVIDES INTERIM GUIDANCE TO CLARIFY THE OBLIGATIONS OF CONCERNED PARTIES FOR THE EFFECTIVE SHARING OF INFORMATION
2. HEALTH CARE PROVIDERS IN THE CF HEALTH SYSTEM HAVE OBLIGATIONS TO SERVICE PERSONNEL THEY SEE FOR TREATMENT AND TO THE CHAIN OF COMMAND. THEIR PRIMARY OBLIGATION TO SERVICE MEN AND WOMEN IS TO MAINTAIN THEIR HEALTH AND MENTAL WELL-BEING, PREVENT DISEASE, DIAGNOSE OR TREAT ANY INJURY, ILLNESS, OR DISABILITY AND FACILITATE THEIR RAPID RETURN TO OPERATIONAL FITNESS. THE HEALTH CARE PROVIDERS PRIMARY OBLIGATION TO THE CHAIN OF COMMAND IS TO SUSTAIN OR RESTORE SERVICE PERSONNEL TO OPERATIONAL EFFECTIVENESS AND DEPLOYABILITY. IN SOME CIRCUMSTANCES THIS WILL REQUIRE THEM TO REPORT A SERVICE PERSON S MEL TO THE CHAIN OF COMMAND. SUCH REPORTING ENSURES PERSONNEL CAN PERFORM THEIR DUTIES SAFELY, RELIABLY, EFFICIENTLY AND AT NO RISK OF AGGRAVATING AN EXISTING MEDICAL CONDITION. THE DISCLOSURE OF INFORMATION ON SERVICE PERSONNEL MEL SHALL BE GUIDED BY THE FOLLOWING OBJECTIVES
3. FIRST, CF PERSONNEL MUST HAVE CONFIDENCE IN THE CF HEALTH CARE SYSTEM TO OPENLY DISCLOSE INFORMATION REQUIRED FOR EFFECTIVE TREATMENT. WITHOUT THIS DETAILED INFORMATION THE HEALTH CARE PROVIDER CANNOT OFFER THE BEST POSSIBLE TREATMENT AND THIS COULD JEOPARDIZE THE SERVICE PERSON S HEALTH. THE CHAIN OF COMMAND AND WORK ENVIRONMENT MUST RESPECT MEL BOTH IN TERMS OF SUPPORTING THE INDIVIDUAL S LIMITATIONS AND MAINTAINING APPROPRIATE CONFIDENTIALITY
4. SECOND, COMMANDING OFFICERS ARE CHARGED WITH THE MAINTENANCE OF OPERATIONAL EFFECTIVENESS, CAPABILITY AND THE WELFARE AND SAFETY OF THEIR SUBORDINATES. IN DISCHARGING THEIR RESPONSIBILITIES A CO MUST ENSURE THAT INDIVIDUALS ARE ASSIGNED ONLY THOSE DUTIES THAT CAN BE PERFORMED SAFELY AND EFFECTIVELY. TO PROPERLY EMPLOY A SAILOR, SOLDIER, AIRMAN OR AIRWOMAN AND ENSURE THE CONDITIONS FOR HIS/HER SUCCESSFUL TREATMENT AND RETURN TO FULL DUTY A CO REQUIRES INSIGHT ON MEL AND PROGNOSIS. THIS MAY BE FACILITATED BY ADDITIONAL NON-CLINICAL INFORMATION WHICH MAY BE PROVIDED

IF IT IS RELEVANT TO THE ASSIGNMENT OF APPROPRIATE DUTIES TO THE SERVICE PERSON

5. THIRD, HEALTH CARE PROVIDERS HAVE A PROFESSIONAL DUTY TO SAFEGUARD PATIENT MEDICAL INFORMATION FROM INAPPROPRIATE DISCLOSURE. PATIENTS DISCUSS WITH HEALTH CARE PROVIDERS INTIMATE AND PERSONAL DETAILS. HEALTH CARE PROVIDERS ARE PARTICULARLY COGNIZANT OF AND SENSITIVE TO THE NEED TO MAINTAIN A SERVICE PERSON S CONFIDENCE WHEN CONFERRING WITH THEM ON HEALTH CARE ISSUES. HEALTH CARE PROVIDERS MUST EXERCISE DUE DILIGENCE IN THE CONTEXT OF SUPPORTING OPERATIONAL EFFECTIVENESS WHILE RESPECTING THE LEGAL AND REGULATORY FRAMEWORK IN WHICH THEY WORK
6. THE ABSENCE OF CLEAR COMMUNICATION BETWEEN THE HEALTH CARE PROVIDER AND THE CO IS DETRIMENTAL TO THE CF MISSION. WHILE SPECIFIC INFORMATION SUCH AS DIAGNOSIS AND DETAILED TREATMENT SHOULD NOT BE DISCLOSED, AN OPEN DIALOGUE TO SHARE RELEVANT INFORMATION ON A NEED TO KNOW BASIS IS ESSENTIAL IN ORDER TO MAINTAIN THE INTEGRITY OF THE CF HEALTH CARE SYSTEM AND TO ENSURE THAT NEITHER THE INDIVIDUAL NOR THE MISSION IS COMPROMISED. SHARING APPROPRIATE INFORMATION AND TREATING THAT INFORMATION IN A SENSITIVE RESPECTFUL MANNER FOR THE GOOD OF THE SOLDIER, SAILOR, AIRMAN OR AIRWOMAN AND CF OPERATIONAL EFFECT IS A JOINT RESPONSIBILITY OF THE SERVICE PERSON, HEALTH CARE PROVIDER AND CO. THE FOLLOWING PROVIDES SPECIFIC DIRECTION TO FULFILL THAT OBJECTIVE
7. EVERY MBR HAS THE FOLLOWING DUTIES:
    A. TO SELF REPORT AS SICK WITHOUT DELAY WHEN SUFFERING FROM OR SUSPECTING HE OR SHE MIGHT BE SUFFERING FROM A DISEASE IAW REF C
    B. TO REPORT ANY MEDICALLY BASED INABILITY TO PERFORM DUTIES TO HIS/HER CO
    C. TO INFORM HIS/HER CO OR OTHER SUPERIORS WHEN REQUIRED ANY MEL SPECIFIED BY HIS/HER HEALTH CARE PROVIDER AND
    D. TO FOLLOW THOSE MEL
8. EVERY CO HAS THE FOLLOWING DUTIES:
    A. TO ASSIST HEALTH CARE PROVIDERS IN UNDERSTANDING THE PERFORMANCE REQUIREMENTS AND CONDITIONS THAT NORMALLY APPLY TO A PARTICULAR SERVICE PERSON, SO THAT THE MOST APPROPRIATE MEL CAN BE ASSIGNED
    B. TO INFORM HEALTH CARE PROVIDERS WHEN OTHER EMPLOYMENT EXISTS WITHIN THE UNIT THAT THE MEMBER MAY BE ABLE TO PERFORM WHILE UNDER MEL
    C. TO INFORM HEALTH CARE PROVIDERS, WHEN ASSIGNED MEL APPEAR VAGUE OR INAPPROPRIATE IN THE PARTICULAR WORKING ENVIRONMENT
    D. TO RAISE CONCERNS ABOUT IMPOSED MEL WITH THE HEALTH CARE PROVIDER OR BASE SURGEON AS REQUIRED
    E. IN CONSULTATION WITH THE MO, TO IDENTIFY THOSE UNIT SUPERVISORS WHO ARE AUTHORIZED TO RECEIVE ADDITIONAL INFORMATION ON MEL AND
    F. TO ENSURE INFORMATION ABOUT A SERVICE PERSON S MEL IS HANDLED IN CONFIDENCE WITHIN THE UNIT WITHOUT DISCLOSURE TO UNAUTHORIZED PERSONNEL
9. EVERY HEALTH CARE PROVIDER HAS THE FOLLOWING DUTIES:
    A. PROVIDE CLEAR, DETAILED AND RELEVANT MEL INFORMATION ON SICK REPORT FORM CF2018. THIS INFORMATION SHOULD INCLUDE, BUT IS NOT LIMITED TO, THE TYPE AND DURATION OF WORK THAT THE INDIVIDUAL CAN OR CANNOT DO, IN VIEW OF THE INDIVIDUAL S MEDICAL CONDITION. IN THOSE CIRCUMSTANCES WHERE THE PATIENT WOULD BENEFIT FROM AN OPEN COMMUNICATION BETWEEN THE MO AND THE PATIENT S CHAIN OF COMMAND WITH RESPECT TO THE DISCLOSURE OF CLINICAL INFORMATION, THE PATIENT S WRITTEN CONSENT TO THE DISCLOSURE OF THAT INFORMATION SHOULD BE SOUGHT

B. TO DISCLOSE TO THE CO, LIMITATIONS ON THE SERVICE PERSON S ABILITY TO USE WEAPONS, COMPLEX MACHINERY OR EQUIPMENT
C. TO DISCLOSE ADDITIONAL NON-CLINICAL INFORMATION NECESSARY FOR THE CO TO ASSIGN APPROPRIATE DUTIES TO THE SERVICE PERSON
D. TO DISCLOSE PRESCRIBED INFORMATION TO APPROPRIATE AUTHORITIES WHEN REQUIRED BY FEDERAL AND APPLICABLE PROVINCIAL LAWS AND
E. TO INFORM THE BASE/AREA SURGEON WHEN THE HEALTH CARE PROVIDER HAS INDICATIONS THAT A CO IS NOT PROVIDING THE REQUIRED SUPPORT TO THE MEMBER OR IS NOT RESPECTING MEL

10. SIGNED BY MGEN W. SEMIANIW, CMP

**APPENDIX 7 TO ANNEX A1**

**CF H SVCS GROUP INSTRUCTION 4030-06**
**PROVIDING MEDICAL ADVICE IN SUPPORT OF ADMINISTRATIVE OR DISCIPLINARY PROCEEDINGS**

## Providing Medical Advice in Support of Administrative or Disciplinary Proceedings

### Background

### Application

1. This Instruction applies apply to all CF personnel, Department of National Defence (DND) Public Servants, contractors and sub-contractors who provide health services to CF members.

### Purpose

2. The Surgeon General has overall responsibility for providing professional and technical direction for the management and administration of medical and mental health conditions. The purpose of this Instruction is to provide guidance to Health Care Providers (HCPs) working within the CF health system on dealing with patients who are undergoing legal, disciplinary, and/or administrative action.

### General

3. HCPs are frequently called upon by CF members or their chain of command (CoC) to provide advocacy or advice. A multidisciplinary team delivers CF health care and there can be differing opinions on how the member's health status influenced their legal, disciplinary and/or administrative circumstance. If presented to the CoC in entirety and without context, these differing opinions can result in discordance, confusion, loss of CF H Svcs Gp institutional credibility, and an unfair interpretive burden on the Chain of Command. It is partly for this reason that QR&O 34.011 establishes a single advisory authority by statutorily making the Senior Medical Officer (B/WSurg at base level) "the responsible adviser to the senior officer exercising the function of command or executive authority on all matters pertaining to the health or physical efficiency of all personnel under his jurisdiction".

4. Common examples of situations where this issue may arise include:

    1. a Commanding Officer (CO) calls the General Duty Medical Officer (GDMO) to request an opinion regarding a member's fitness for detention and how this may influence his/her mental health;

    2. a member requests a letter from an HCP advocating that his medical condition is the "cause" of his disciplinary or administrative issue;

    3. a member requests a letter from an HCP after sentencing to indicate that sentencing will adversely affect their health or treatment; or

    4. a presiding officer or assisting officer requests advice on mitigating factors to be considered during sentencing.

### Direction

5. When asked by CF members or their CoC to intervene in career, administrative or disciplinary proceedings, HCPs are acting in an official capacity on behalf of the CF H Svcs Gp. As such, they shall provide professional advice which is consistent with their area of expertise, CF H Svcs Gp policies and instructions, and subject to the approval of the senior medical authority (SMA) in accordance with QR&O 34.011.

6. The SMA is responsible to advise the CoC of the member's health status and, if required, to make recommendations on the disposition of a case. Only the SMA is authorized to communicate directly with the CoC in this regard.

7. Accordingly, the SMA, usually the Base/Wing Surgeon (B/W Surg), must ensure that any advice balances the needs of the individual with the operational, organizational and disciplinary imperatives of the CF. Where differences of professional opinion arise, the SMA will endeavour to reach an internal agreement prior to issuing official advice on behalf of CF H Svcs Gp. HCP teams will use the process described later in this instruction as a means to this end.

**Requirements**

8. Upon being approached for provision of a professional opinion, in the presence of co-existing administrative or disciplinary issues, all HCPs shall consult with the Care Delivery Unit (CDU) Team Leader. A standardized approach (Annex A) will guide the health care team beginning with the initial request and concluding with an opinion communicated to the CoC by the B/W Surg.

**Case Conference**

9. The CDU Team Leader, in consultation with the B/W Surg, will decide whether to convene a case conference. If a case conference is not required, the CDU Team Leader, as delegated by the B/W Surg, will provide an opinion to the CoC.

10. If a case conference is deemed to be necessary, the GDMO will schedule the case conference in a timely fashion and all HCPs involved in the care of the member will participate. Complex cases may occasionally generate divergent professional opinions where patient advocacy by a team member may appear to conflict with the patient's overall best interests or broader CF organizational needs. Team members must resolve disputes on professional questions amongst themselves before any advice is communicated externally.

11. The Record of Decision for the case conference will include a summary of the significant aspects of the case that were considered by conference attendees. The final outcome will also be recorded along with a brief rationale supporting any decision made. Detail regarding the individual opinions of conference attendees that may have been presented during the discussions will not be included. The Record of Decision will be placed on the member's health record.

**Communicating the Advice**

12. If an agreement is reached during the conference, the B/W Surg or designate will communicate the appropriate medical advice to the CoC. The CDU Team Leader or the most appropriate clinician will communicate the recommendations to the member.

13. If an agreement is not reached, the B/W Surg as the SMA will resolve such professional disputes and may seek outside assistance from higher professional-technical authorities, legal advisors, or regulatory bodies. The SMA remains responsible for providing advice to external parties.

**Dissention**

14. Dissenting HCPs may submit their opinion in writing to the SMA but shall not distribute this opinion externally to CF members or to the CoC. Nothing in this instruction, however, limits the professional and ethical rights and obligations of an HCP to provide clinical advice to a CF member or to provide a personal opinion as a clinical expert witness on behalf of a member in a legal proceeding. An HCP who is in disagreement with the SMA's decision may also bring their concerns to the next individual in the professional-technical chain, having first informed the SMA of their intention to do so.

**Responsibility**

**Responsibility Table**

15. The table below details the responsibilities associated with this Instruction.

| **The...** | **Is/are responsible for…** |
|---|---|
| B/W Surg | • Chairing case conferences;<br>• Consolidating case-related medical information and opinion;<br>• Seeking professional and technical advice as required; and<br>• Providing advice to CoC. |
| CDU Team Leader | • Briefing the B/W Surg regarding case specifics;<br>• Providing professional and technical guidance to the GDMO; and<br>• Ensuring communication of recommendations to the member. |
| Mental Health Clinical Leader | • Providing mental health professional and technical guidance to the B/W Surgeon. |
| GDMO | • Collecting relevant information from the CoC, reviewing case with CDU Team Leader; assessing the need for holding a case conference and identifying case conference attendees;<br>• Scheduling case conference;<br>• Providing the medical summary to the case conference |

| | |
|---|---|
| Mental Health Care Provider (SW, BAC, Psychiatrist, Psychologist) | • Documenting the result of the case conference in the Record of Decision; and<br>• Communicating recommendations to the member.<br>• Providing information regarding the diagnosis, treatment, and prognosis of any mental health or psychosocial condition related to the subject case; and<br>• Providing an opinion regarding the impact on the member of any potential administrative or disciplinary action that might be taken by the CoC. |
| Other Healthcare Providers (Physio, OT, Pharm) | • Providing relevant additional professional and technical opinions / advice to the case conference. |
| Case Manager | • Providing a summary of the member's current overall medical and administrative status. |

**References:**

1. CF H Svcs Gp Instruction 5020-20 (PDF, 176 Kb), Disclosure of Personal Health Information
2. CF H Svcs Gp Instruction 5100-03 (PDF, 67 Kb), Medical Investigations for Substance Use Disorders
3. CF H Svcs Gp Instruction 5100-16 (PDF, 113 Kb), Guidelines for the Application of MELs to Personnel Suffering from Mental Illness
4. CF H Svcs Gp Instruction 5100-20, Mental Disorders - Medical Examination, Treatment and Disposition
5. CF H Svcs Gp Instruction 5100-47 (PDF, 61 Kb), Recruitment and Hiring of Mental Health Professionals Working Within/for the Canadian Forces
6. DAOD 5017-0, Mental Health
7. CFAO 34-56, Mental Disorders
8. CANFORGEN 039/08 CMP 018/08 131851Z FEB 08, Disclosure of Medical/Social Work Info to Commanding Officers
9. QR&O 34.011, Responsibilities of Medical Officers

**Annexes:**

1. Annex A (PDF, 48 Kb) - Process Flowchart
2. Annex B - Case Conference Tasks/ Responsibilities

**Annex B to CF H Svcs Gp Inst 4030-06**

**Case Conference Tasks/ Responsibilities**
**Pre-Conference Tasks**

| Task | Responsibility | Comments |
|---|---|---|
| 1. Liaise with CoC (CO/AO) | CDU Team Leader/ Delegate | Inform B/W Surg as required |
| 2. ID of the Stakeholder | CDU Team Leader/ Delegate | |
| 3. Urgency of Conference | CDU Team Leader/ Delegate | |
| 4. Announce/ Organize Conference | CDU Team Leader/ Delegate | Inform all Stakeholders(B/W Surg, Scribe, GDMO, MH, SW, Psychology, Psychiatry, BAC, PT, OT, Case Mgr) |
| 5. Collect Pertinent Information | All Stakeholders | Guidelines as presented in Section 2. |

**Case Conference Considerations**

1. Information Required:

    1. Medical Diagnosis (to include Axis II)
    2. Physical & Mental Health Status
    3. Compliance / Accountability Issues
    4. Medical Administration (TCat, PCat)
    5. Disposition (JPSU, Release)
    6. Reference

2. Important Points to Remember:

    1. Advocacy [1]
    2. All members of conference voice their opinion
    3. Notes must be taken
    4. Medical Fitness to Stand Trial [2]

**Post-Conference Considerations**

1. Decision reached by B/W Surg
2. Document decision
3. Liaise with CoC if appropriate (Formally)
4. Liaise with member if appropriate (Formally)

**Note**: *If dissenting opinions, B/W Surg may seek higher guidance*

**Footnotes for Annex B**

[1] Genuine concern as to the patient's best interest is the cornerstone of patient advocacy and appropriate advocacy is an important component of the care that HCPs are expected to provide to CF members. Failure to maintain objectivity in advocacy, such that the clinician advocates for what the patient wishes and not what is necessarily in their best interests, however, should be avoided. Helping a patient accept and understand the consequences of behaviours leading to disciplinary action, while undesired by the member, is arguably the most therapeutically appropriate course of action.

[2] The determination of whether a person is medically fit to stand trial or be considered not legally responsible due to a mental illness is a highly specialized field of forensic psychiatry. Situations where a member would meet the civilian legal criteria necessary to be considered not legally responsible are extraordinarily rare in the CF. Should such a situation arise, the assessment of fitness is to be deferred to an expert in the field and the prof-tech chain notified immediately. In keeping with the Canadian legal view of medical fitness to stand trial, clinicians should avoid trying to determine if a member should or should not be tried or convicted of an offense or in any way influence this decision. Instead, and in terms of advocacy, clinicians can focus on presenting extenuating circumstances to the CoC via the B/W Surg. This input can be considered when determining sentencing and punishments.

**APPENDIX 8 TO ANNEX A1**

**CF HEALTH SERVICE GROUP INSTRUCTION**
**2000-09**
**INCIDENT MANAGEMENT – PATIENT SAFETY**

# Incident Management – Patient Safety

| | |
|---|---|
| **Document Status:** | Current |
| **Document Type:** | **CF H Svcs Gp Instruction** |
| **Document Number:** | **2000-09** |
| **Original Source:** | CF H Svcs Gp Insts 2000-04 and 2000-06 |
| **Approval:** | Surgeon General |
| **SME:** | Quality and Patient Safety |
| **OPI:** | D H Svc Del |
| **Effective Date:** | 22 Sep 15 |
| **Last Reviewed:** | 22 Sep 15 |

## Background

### Abbreviations, Acronyms and Definitions

1. A list of abbreviations, acronyms and definitions related to the management of patient safety incidents is contained in Annex A.

### General

2. The Canadian Forces Health Service Group (CF H Svcs Gp) is committed to fostering a culture of safety that includes the continuous examination of, and improvements to care/service systems with the aim of reducing risk and the potential for harm to patients.
3. Recognizing that patient safety incidents do occur and that many causes are due to the systemic factors within the organization; this Instruction provides direction on how to effectively manage patient safety incidents within our complex system.
4. There is a shared commitment across the organization to promote patient safety through open reporting of incidents and fair investigation with the intent to improve the system rather than to assign blame to individuals.

### Supersession

5. This Instruction supersedes CF H Svcs Gp Instruction 2000-04, Patient Safety and CF H Svcs Gp Instruction 2000-06, Patient Safety Incident Reporting and Follow-up.

**Note:** *This Instruction does NOT supersede, amend or conflict with the DND General Safety Program. Personnel must follow all guidelines and instructions associated with that corporate program. In cases where overlap exists there may be a requirement to comply with both processes.*

### Application

6. This Instruction applies to all Canadian Armed Forces (CAF) personnel, Department of National Defence (DND) Public Servants, contractors and sub-contractors who provide health services and health service support to CAF members.

### Purpose

7. The purpose of this Instruction is to:
    a. Describe the responsibilities for patient safety incident management;
    b. Detail how patient safety incidents are identified, contained, reported, analyzed, and followed up in an appropriate and timely manner;
    c. Identify the processes for aggregate analysis, recommendations and sharing lessons learned for patient safety incidents; and,
    d. Facilitate open communication when a patient safety incident occurs and throughout the management thereof at all levels of the organization.

### Related Documents

8. The list of references used in the creation of this document is located at the end of this document
9. This Instruction should be read in conjunction with References A, B and C.

## Context

### Authority

10. Patient Safety Officers (PSO) and Quality and Patient Safety (Q&PS) staff at all levels of the organization are authorized to conduct a patient safety analysis in accordance with this Instruction on behalf of the Deputy Surgeon General (D Surg Gen) and Director of Dental Services (D Dent Svcs) in the completion of this responsibility.

### Patient Safety Officer

11. Each clinic/detachment shall appoint, at minimum, one primary and one alternate PSO to support patient safety initiatives at the local level. It is important that the PSO be an individual who supports patient safety and can champion the program within the clinic/detachment. Once selected, confirmation of this appointment should be made with the National Q&PS Office. If the local PSOs are out of the office for a period of a day or more and not able to fulfill their duties in the patient safety incident reporting process, they shall arrange coverage with the Regional Q&PS Advisor so that local staff have a point of contact for continued reporting.

### Patient Safety Culture

12. The reporting of patient safety incidents shall not subject staff to punitive or disciplinary actions unless there is clear evidence of the following:
    a. A breach of criminal or other law;
    b. Gross professional or personal misconduct;
    c. Falsified information about an incident; and/or,
    d. Repeated instances of unacceptable behaviour or practice despite the CF H Svcs Gp having provided training, counselling and supervision to prevent a reoccurrence.
13. These instances will be dealt with by the Chain of Command (CoC) and/or Professional-Technical (Prof/Tech) chain through the appropriate separate and independent process (refer to Annex B – Patient Safety Incident Triage Process for additional information).

### Access to Information Act, Privacy Act and Confidentiality

14. Patient safety reports and the supporting analysis files may be accessed, under specific circumstances, through the federal *Privacy Act* and/or *Access to Information Act* (ATIA).
15. Incident analysis is most effective in a confidential environment where participants can safely report, participate and express their opinions about underlying contributing factors to the incident without fear of reprisal. Information and opinions shared with the analysis team are not to be transmitted or disclosed outside of the communication mechanisms within the patient safety network and by applicable policies.

### Adverse Reactions

16. Adverse reactions to health products are not normally subject to the patient safety incident management process and should be addressed via CF H Svcs Gp Instruction 4200-57 Reporting Adverse Reactions to Health Products.

### Roles and Responsibilities

17. A table of responsibilities associated with the management of patient safety incidents is found in Annex C – Roles and Responsibilities.

### Training

18. Training to support patient safety is important to promote current and effective fundamental patient safety practices and continuous improvement in the culture of patient safety. There is an ongoing Patient Safety Education Program with the general intent to provide all staff with the appropriate level of training. The Patient Safety Education Program uses an inter-professional team approach using a train-the-training-team model to strengthen internal attitudes, knowledge, skills, and behaviours with the aim of improved outcomes and norms within the organization.

# Requirements

19. CF H Svcs Gp leadership at all levels throughout the organization support a culture of patient safety that encourages staff to report both near misses and incidents that reach the patient whether they cause harm or not.
20. A critical requirement of the Patient Safety Program is reporting incidents. When incidents that potentially or actually compromise patient safety are reported, failures can be analyzed to identify causes, and recommendations. To achieve this, patient safety incident reporting shall be supported within CF H Svcs Gp.
21. All patient safety incidents reported will be analyzed in accordance with this Instruction, unless at any point the incident is determined to not be a patient safety incident or is referred out to be investigated and managed through another mechanism in accordance with the Patient Safety Incident Triage Process (Annex B). The emphasis of any patient safety analysis must be on system-based learning from incidents and employing appropriate recommendations within that system for improvement purposes.
22. Each patient safety incident shall be taken seriously. Immediate action shall be taken on each patient safety incident to ensure the safety of affected patients, a safe environment for staff and prevent imminent recurrence of the incident. The decision on how to respond to each incident should be made on a case-by-case basis; however, management of all patient safety incidents will follow these four steps:
    a. Step 1: Identification, containment and immediate action;
    b. Step 2: Notifications and preparation for analysis;
    c. Step 3: Analysis and recommendations; and,
    d. Step 4: Follow through.
23. A flow chart summarizing the patient safety incident management process is provided at Annex D – Patient Safety Incident Management Process.

# Process

## Step 1 – Identification, Containment and Immediate Action

### Incident identification

24. Staff must be trained to recognize and identify when a patient safety incident occurs and how to differentiate these from other incidents that occur within the health care setting. The Classification of Patient Safety Incidents (Annex E) provides a common language for categorizing and describing patient safety information. It is important to note that categorizing an incident as a patient safety incident does not preclude categorization as an additional incident type (e.g. privacy breach, workplace injury) and activating other processes. However, a patient safety incident does require a specific and separate process.
25. An incident may be identified by those who: are involved in the incident; discovered the incident; and/or witnessed the incident. The incident may also be identified at any time, such as before an incident reaches a patient as in the case of a near miss, at the time it occurs, or after the incident has occurred.

**Containment**

26. When an incident is identified, immediate action shall be taken to mitigate any harmful consequences and ensure a safe environment for patients and staff to prevent further harm and avoid imminent recurrence of the incident.
27. Consideration should be made to securing the site and/or records related to the incident for the analysis team. This includes, but is not limited to, equipment, products, documentation, etc., and may include photographs of the area if deemed beneficial for the analysis.
28. With incidents involving equipment (e.g., malfunction), the equipment should be taken out of service immediately unless this is detrimental to the care of the patient or staff. Equipment involved in an incident should not be used, experimented with, or taken apart, as doing so could compromise information that may lead to the cause(s) and effect recommendations. Subject matter experts (e.g. Biomedical Equipment Technicians) should be called immediately to assist in any procedures for securing the equipment.

**Initial Notification**

29. Individuals who are involved in, witnessed and/or became aware of a patient safety incident should report the incident to their PSO as soon as practicable after immediate measures, as necessary, have been taken to look after any patients affected.
30. Upon being advised of a patient safety incident, the PSO will work with the responsible area supervisor/manager to ensure containment of the incident (where possible), review the available facts, and gather any additional information to understand the basic events.

**Immediate Escalation**

31. Harmful incidents that are serious in nature require immediate reporting to the CoC, the Senior Medical Authority (SMA) or Senior Dental Authority, higher Prof/Tech Authorities, and to the National Q&PS Office by the responsible area supervisor/manager or PSO. The same applies to any incident that could result in litigation, ministerial or media inquiry, or impact negatively on DND/CAF or CF H Svcs Gp (References D and E).

**Patient Safety Incident Reports**

32. The DND 850 (Annex F – Patient Safety Incident Report) is the primary mechanism to report a patient safety incident. However, the PSO will accept a report by other methods, including email, telephone or in person and will prepare a DND 850 for information gathering and tracking purposes when no DND 850 has been completed by the reporter.
33. At minimum, the following information must be included in a report:
    a. Date of incident;
    b. Time of incident;
    c. Exact location of incident;
    d. Description of the incident;
    e. Immediate actions to secure safety;

f. Reporter's name and contact, unless the reporter wishes to remain anonymous; and,
g. Date of report.

34. The description of the incident should be factual without speculation, opinion or blame. Name, gender, service number or any other personal identifying information relating to patients, staff or witnesses involved in the incident shall not be mentioned anywhere in the report with the exception of the person reporting. If personal identifiers have been included, the form must be destroyed and a new one generated.
35. The DND 850 does not supersede or act as a substitute for any existing reporting requirements.

## Step 2 – Notifications and Preparation for Analysis

### Initial Risk Assessment

36. An initial Risk Assessment (Reference A) will be promptly completed by the PSO and the responsible supervisor/manager for all incidents, including near misses, to help determine urgency of actions to be taken. This also helps to inform next steps such as level of analysis, resources required and additional notifications. For incidents that are clinical in nature, the PSO shall consult an appropriate clinician when completing the risk assessment unless the PSO is a clinician who possesses the necessary scope of practice and clinical expertise to do the risk assessment independently.

### Additional Notification

37. The table below suggests additional CoC, Prof/Tech chain and Q&PS notifications, based on risk grade assigned to the incident during initial assessment. Note: The Regional Q&PS Advisor may be consulted as a resource at any point in this process.

| Incident Risk Grade | Reported to medical | Reported to dental |
|---|---|---|
| Low risk | • Applicable supervisor/manager<br>• Unit/Detachment PSO | • Dental Clinic Coordinator<br>• Unit/Detachment PSO |
| Medium risk | • Commanding Officer<br>• Base/Wing Surgeon<br>• Regional Q&PS Advisor | • Dental Detachment Commander<br>• Regional Q&PS Advisor |
| High and extreme risk | • Commanders of HSGs<br>• Regional Surgeon<br>• National Q&PS office (who will inform D Surg Gen as applicable) | • Commanding Officer 1 Dental Unit HQ<br>• Deputy Commanding Officer 1 Dental Unit HQ<br>• 1 Dental Unit HQ Q&PS Team Leader<br>• National Q&PS office (who will |

| Incident Risk Grade | Reported to medical | Reported to dental |
|---|---|---|
| | | inform D Dent Svcs as applicable) |

38. Staff involved in the incident: Any staff involved in an incident, as well as other affected or involved services/sections, shall be promptly made aware of the incident.
39. Informing the patient and/or family: Notification shall be done in accordance with Reference B - Communication of Patient Related Incidents.

**Patient Safety Incident Triage Process**

40. Before proceeding further with the patient safety incident analysis, all incidents shall be triaged to identify those that are not recommended for this process (Annex B – Patient Safety Incident Triage Process).

**Level of Analysis and Team Members**

41. The level of analysis (local, regional or national), will be determined as well as the individual or team charged with the responsibility the incident analysis. Detailed information on selecting the level of analysis and the analysis team is found in Annex G – Preparing for the Analysis.

**Completion of the DND 850 Form (Annex F)**

42. Once the initial risk assessment, notifications and level of analysis have been determined, the PSO will complete Part B of the DND 850 and securely send a copy to the Regional Q&PS Advisor who will enter the information into the national patient safety incident report database. This should occur within 48 hours of receipt of the incident report.

## Step 3 - Analysis and Recommendations

**Analyzing the Incident**

43. All reported incidents, including near misses, shall have some degree of analysis focusing on identifying system failures related to the incident by determining:
    a. What happened;
    b. How and why it happened; and,
    c. What recommendations might reduce the risk of recurrence and make the health care system safer.
44. Incidents in health care almost never stem from a single, linear cause. They come from a mix of factors (i.e., active failures, work conditions, and latent failures, that all align to slip through existing defenses).

45. It must be emphasized that the purpose of the analysis process is to successfully determine contributing factors and causes. The analysis must be directed toward fact-finding for the prevention of recurrence and not fault finding to assign blame to individuals.
46. Guidelines for incident analysis are included in Annex H – Patient Safety Incident Analysis.

**Analysis Terms of Reference**

47. Clear terms of reference (Annex I –Terms of Reference Template) issued by the appropriate level of authority are required for all national level analysis and may be indicated for regional analysis depending on complexity (e.g. number and location of team members).

**Post-Analysis Risk Assessment**

48. Once the analysis is complete, the analysis team will perform a second risk assessment, in accordance with Reference A. This post-analysis risk assessment is based on the full knowledge of the events surrounding the incident and will either confirm the initial risk grade or result in a new grade. In either instance, the grade will help determine the urgency of identifying and implementing recommendations, as well as confirm that communication about the incident has been completed to the extent warranted.

**Validation of Recommendations**

49. On completion of a patient safety incident analysis, a validation process lead by the applicable patient safety level will then occur in four steps:
    a. Assignment of the recommendations to the proper PS level (local or system-level);
    b. Verify the recommendations to determine if it is acceptable according to guidelines provided in Annex H;
    c. Perform a pre-coordination between the patient safety network and the action organization/key stakeholders; and,
    d. Feedback to the originating office.

**Patient Safety Incident Summary Report**

50. A DND 2343 Patient Safety Incident Summary Report (Annex J) shall be drafted by the analysis team that captures factual information, analysis findings and recommendations pertaining to the incident.
51. The final report is to be sent to the Regional Q&PS Advisor and National Q&PS Office to maintain report and update database with results of the analysis.

## Step 4 - Follow Through

**Follow-up on Recommendations**

52. Transfer to CoC: Following the analysis, a clear transfer of all recommendations from the patient safety network to the appropriate level of CoC is required.
53. CoC has the option of accepting the recommendations and tasking the appropriate action organization; modifying the recommendation while maintaining the original intent; or refusing the recommendation where implementation may not be possible or practical. In the situation of modification or refusal, communication with the appropriate patient safety level should take place. If there is agreement between CoC and the patient safety network with the modification or refusal, the rationale shall be recorded and the recommendations amended or closed as required. However, if there is no agreement, the situation will be raised one level within the patient safety network for vetting or to the CF H Svcs Gp Q&PS Advisory Committee (Q&PSAC).
54. Implementation of recommendations: The responsibility to implement a recommendation rests with the CoC. CoC will officially task the action organization to complete the recommendation. It is suggested that the implementation of recommendations follow the model for improvement.
55. Tracking of Recommendations: Tracking means monitoring all recommendations until they have been fully implemented or rejected by the appropriate authority. Tracking is the responsibility of Commanders at all levels, with advice from their patient safety staff. Tracking also ensures that the entire user community is kept up-to-date on the nature, status and effectiveness of the recommendation.
56. Closure of recommendations: Recommendations can be closed once implemented to the satisfaction of the responsible patient safety level. Once a recommendation is completed, the action organization will provide the specific records/documentation to the patient safety network.

**Communicating Lessons Learned**

57. With the patient: When an incident has reached a patient, the patient should be informed of the outcome of the patient safety analysis in accordance with Reference B.
58. With the incident reporter: Once the patient safety incident report has been closed, it is essential that the PSO follow-up with the individual who reported the incident on the recommendations and actions taken as detailed in the DND 2343 (Annex J – Patient Safety Incident Summary Report). Follow-up with the reporter is an important component in fostering a culture of safety that encourages and values patient safety incident reporting.
59. Across the organization: The Q&PS office will communicate recommendations and lessons learned to the Q&PSAC and the responsible National level Director or Program Manager. The DND 2343 will also be uploaded to a central repository for the patient safety network to access and in turn share with their region, units and frontline. The Q&PSAC will determine how the recommendations and lessons learned will be shared within the organization and executed by CoC.

# Additional Considerations

## Multi-incident Reporting

60. A series of similar incidents that occurred within a short timeframe may be grouped and reported together. The date, time, and location of each incident must be included, in addition to any other factors or outcomes that may differ.

## Inter-unit Reporting

61. If an incident is reported in Clinic A, but happened in Clinic B, Clinic A will obtain the initial report and forward this to Clinic B for follow-up without delay.

## Anonymous Reporting

62. Anonymous reports are accepted though significantly limit the ability to fully analyze the incident to determine cause(s) and implement recommendations.

## Reconvening a Patient Safety Incident Analysis

63. An analysis shall be re-opened by Regional or National Q&PS if it appears that information was not considered, was omitted, a relevant aspect was not covered adequately, or additional information is available which could lead to a new recommendations. Such actions should not be taken unless the benefit is considered to be significant to the system.

## Support to the Care Team

64. It is essential to support members of the care team following any incident or near miss. This support is specific to the situation and is not meant to take the place of individual counselling where needed.
65. Examples of support include:
    a. Opportunity for staff members to talk in a structured environment about events and ask questions;
    b. Provision of a named person or service for staff member to contact if further support is anticipated or desired;
    c. Information about what will happen next regarding the patient safety incident; and,
    d. Referral to internal or external sources of advice.
66. All levels of Management are responsible to monitor staff involved in a patient safety incident to determine if assistance is needed to cope with the situation that has occurred.

# Documentation

## General Documentation

67. All documentation associated with this Instruction, including the DND 850, is prepared for quality improvement purposes only, and shared on a need-to-know basis and in accordance with values of a positive patient safety culture. Documentation and actions taken as a part of an investigation into an individual's conduct or clinical practice are separate from those taken as a result of a patient safety incident, and fall outside the purview of patient safety.
68. Patients and staff involved in a patient safety incident must be de-identified in all documentation. Nonetheless, given the specific information gathered through this process, there is risk for an individual to be identified; therefore, all documentation associated with this Instruction will be designated Protected B including the database.
69. Unique patient safety incident numbers will be assigned to each reported incident in the database in sequential order according to the following format: Year (YY) - number (NNNN). Note that the file plan is under revision and file numbers will be amended following review of the file plan.
70. Documents should not be duplicated and distribution shall be restricted to those within the patient safety network and relevant stakeholders.
71. The file plan and subsequent guidance regarding retention and disposition of Patient Safety Incident Records is currently under review. In the interim, all documents are to be maintained in their entirety with the unit/detachment PSO until further direction is provided.

## Patient Health Record

72. Under no circumstances shall incident report numbers, reports, or any reference to patient safety incident reports be included in the patient's health record.
73. When an incident reaches a patient, the health record should contain a complete and accurate record of the clinical information pertaining to the event. No assumptions, speculation, opinions, justifications or mention of an incident report should be included; only facts about the incident and surrounding events. As applicable and in accordance with Reference F, this should include:
    a. Objective details of the situation, written in neutral, non-judgmental language;
    b. The patient's condition immediately prior to the incident;
    c. The intervention after the incident and the patient response;
    d. Notification of the primary care physician/treating dentist; and,
    e. Information shared with the patient.

## Incident Database

74. Each Regional Q&PS Advisor will input patient safety incident report information into the National Patient Safety Incident Report Database, which will be continually updated

as information is made available. The database will hold summary information about all reported incidents and track the implementation of recommendations and actions.

### Patient Safety Incident Classification

75. Patient safety incidents will be classified according to the World Health Organization International Classification for Patient Safety found in Annex F – Classification of Patient Safety Incidents for purposes of trending and tracking (Reference G).
76. Classification will be completed in the database by the National Q&PS Office following entry of the patient safety incident report. The classification will be subsequently reviewed following the submission of the summary report, and therefore, may change based on the findings of the analysis.

## Aggregate Analysis

### Aggregate Incident Reports

77. The following table outlines the aggregate reports that may be generated and disseminated using the information from the patient safety incident report database. The reports will be flexible based on the needs of the audience and available data.

| Report | Frequency | Audience |
|---|---|---|
| Newly reported incidents at unit/detachment level | Monthly | Unit/detachment leadership, PSO and Regional Q&PS Advisor |
| Newly reported incidents in region | Monthly | 1 and 4 CF H Svcs Gp HQ, 1 Dent Unit HQ and National Q&PS |
| Newly reported harmful or high risk incidents; | Regularly scheduled Q&PSAC meetings | Q&PSAC with further dissemination to the Directorates and down the CoC to the Regions. |
| Annual Report | Annually | Q&PSAC with further dissemination to the directorates and down the CoC to the Regions. |

78. Reports disseminated via e-mail must be sent with encrypted security settings due to Protected B designation.

## References


1. CF H Svcs Gp Policy 2000-11, Risk Assessment (in development)
2. CF H Svcs Gp Instruction 2000-13, Communication of Patient Related Incidents (in development)
3. CF H Svcs Gp Instruction 4200-57, Reporting Adverse Reactions to Health Products
4. DAOD 2008-3, Issue and Crisis Management

5. CF H Svcs Gp Order 6020-10, Significant Incident Report
6. KFHP/HP and The Permanente Federation, LLC, Communicating Unanticipated Adverse Outcomes - Implementation Guidelines (2002) (english only)
7. Conceptual Framework for International Classification for Patient Safety (v.1.0) for use in field testing in 2007-2008 (ICPS)", World Health Organization and World Alliance for Patient Safety Taxonomy (2007) (english only)

# Annexes

- Annex A (PDF, 28 Kb) - Abbreviations, Acronyms and Definitions
- Annex B (PDF, 25 Kb) – Patient Safety Incident Triage Process
- Annex C (PDF, 29 Kb) - Roles and Responsibilities for the Management of Patient Safety Incidents
- Annex D (PDF, 91 Kb) - Patient Safety Incident Management Process
- Annex E (PDF, 37 Kb) - Classification of Patient Safety Incidents
- Annex F – DND 850 Patient Safety Incident Report
- Annex G (PDF, 33 Kb) - Preparing for the Analysis
- Annex H (PDF, 25 Kb) - Patient Safety Incident Analysis
    - Appendix 1 (XLSX, 20 Kb) – Analysis Worksheet - 5 Whys
    - Appendix 2 (XLSX, 24 Kb) – Analysis Worksheet - Timeline
    - Appendix 3 (XLSX, 22 Kb) – Recommendations Worksheet
- Annex I (PDF, 14 Kb) - Terms of Reference Template
- Annex J (XLSX, 30 Kb) - DND 2343 Patient Safety Incident Summary Report

Date modified:
2016-04-20

**APPENDIX 9 TO ANNEX A1**

**DEFENCE ADMINISTRATIVE ORDERS AND DIRECTIVES 6002-2**
**ACCEPTABLE USE OF THE INTERNET, DEFENCE INTRANET, COMPUTERS AND OTHER INFORMATION SYSTEMS**

# DAOD 6002-2, Acceptable Use of the Internet, Defence Intranet, Computers and Other Information Technology Systems

## Table of Contents



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# 1. Introduction

**Date of Issue:** 1999-02-12

**Date of Last Modification:** 2015-06-01

**Application:** This DAOD is a directive that applies to employees of the Department of National Defence (DND employees) and an order that applies to officers and non-commissioned members of the Canadian Armed Forces (CAF members).

**Approval Authority:** Assistant Deputy Minister (Information Management) (ADM(IM))

**Enquiries:** Director Defence Information Management Planning (DDIMP)

# 2. Definitions

**defence intranet** (*intranet de la défense*)
The DND and CAF internal electronic network that uses a common communication protocol to enable DND and CAF computers of all kinds to directly and transparently communicate and share services. (Defence Terminology Bank record number 43036)

**electronic network** (*réseaux électroniques*)
A group of computers and computer systems that can communicate with each other, including: the Internet; the defence intranet; or a public or private network not operated by the DND and the CAF. (Defence Terminology Bank record number 43056)

**information technology system** (*système de technologie de l'information*)
An assembly of computer hardware, software or firmware, either stand-alone or interconnected, that is used to process or transmit data, or to control mechanical or other devices. (Defence Terminology Bank record number 48262)

**mobile wireless device** (*dispositif mobile sans fil*)
A cellular telephone, smart phone, pager, personal digital assistant, cellular modem or any other mobile device with an integrated capability for utilizing wireless telecommunication services. (Defence Terminology Bank record number 47433)

# 3. Overview

### Authorized Users

**3.1** For purposes of this DAOD, authorized users are:

a. DND employees;
b. CAF members; and
c. contractors and other persons who have been authorized by or on behalf of the Deputy Minister (DM) or the Chief of the Defence Staff (CDS) to use a DND and CAF information technology (IT) system and who have agreed to comply with the terms of this DAOD.

### Statement of Use

**3.2** This DAOD provides instructions to authorized users on the use of DND and CAF IT systems. Additional instructions in respect of the management of mobile wireless devices are set out in DAOD 6002-3, *Management of Mobile Wireless Devices*.

**3.3** For purposes of this DAOD, there are official, authorized, unauthorized and prohibited uses of DND and CAF IT systems.

**3.4** Authorized users must only use DND and CAF IT systems for official or authorized uses.

**3.5** Authorized users must not use DND and CAF IT systems for any unauthorized or prohibited uses. Section 5 outlines actions that may be taken in the event of such use.

### Values and Ethics Codes

**3.6** DND employees and CAF members are entrusted with the responsible use and care of Government of Canada, DND and CAF resources, including IT systems. DND employees and CAF members must ensure they maintain the highest ethical standards and values in all uses of the Internet, the defence intranet, computers and other IT systems. Additional instructions and guidance on values and ethics are set out in the:

a. *Values and Ethics Code for the Public Sector*;
b. *Department of National Defence and Canadian Forces Code of Values and Ethics*; and
c. DAOD 7023-1, *Defence Ethics Program*.

### Expectation of Privacy

**3.7** There should be no expectation of privacy when using DND and CAF IT systems as they are subject to monitoring for the purposes of system administration, maintenance and security, and to ensure compliance with Treasury Board, DND and CAF policies, instructions, directives and standards.

### IM and IT Policy Framework

**3.8** This DAOD should be read in conjunction with the *DND and CF IM and IT Policy Framework* and other relevant ADM(IM) policies, instructions, directives, standards and guidance.

# 4. Types of Use

### Official Use

**4.1** “Official use” is any use of a DND and CAF IT system that is necessary to carry out duties and official functions in furtherance of DND and CAF goals and objectives, and includes:

a. communicating with other DND and CAF authorized users, other government departments, allies and the private sector; and
b. conducting research for DND and CAF purposes.

**4.2** This DAOD does not restrict or modify the mandate or legitimate activities of any organization that uses DND and CAF IT systems as a means to conduct DND and CAF business and operations.

### Authorized Use

**4.3** “Authorized use” is any use of a DND and CAF IT system that, while not necessary to carry out duties and official functions in furtherance of DND and CAF goals and objectives, is permitted, including:

a. engaging in professional development activities in accordance with DAOD 5031-0, *Learning and Professional Development*;
b. communicating with family, friends and other persons, for other than official use;
c. accessing news and other electronic network information sources, provided such access is not an unauthorized or prohibited use;
d. conducting personal banking transactions;
e. shopping for personal and family items;
f. conducting any union business specifically pre-authorized in writing by a manager or supervisor (see DAOD 5008-1, *Use of Departmental Premises and Equipment, and Electronic Networks, for Bargaining Agent or Union Business*); and
g. any other use that is consistent with the Treasury Board *Policy on Acceptable Network and Device Use* and this DAOD, and is specifically authorized in writing by a manager, supervisor, commander or commanding officer (CO).

**4.4** Authorized use of a DND and CAF IT system is subject to the following limitations, it must:

a. only be of a reasonable duration and frequency;
b. not impact negatively the performance of DND and CAF IT systems; and
c. not interfere with the performance of the duties and official functions of the authorized user or any other authorized user.

**4.5** The ADM(IM), a DND manager or supervisor, or a commander, CO or military supervisor, may restrict or prohibit any otherwise-authorized use if:

a. the use threatens the capability or integrity of a DND and CAF IT system; or
b. the restriction or prohibition is necessary for operational or administrative reasons.

### Unauthorized Use

**4.6** “Unauthorized use” is any use of a DND and CAF IT system that is not an official, authorized or prohibited use, and includes:

a. authorized use that is not of a reasonable duration or frequency;
b. authorized use that interferes with the performance of the duties and official functions of an authorized user;
c. authorized use that is restricted under paragraph 4.5;
d. use that would result in personal profit, e.g. electronic gaming or a business venture;
e. union business not specifically pre-authorized in writing by a manager or supervisor (see DAOD 5008-1);
f. use contrary to any order, instruction or other DAOD issued by or on behalf of the DM or the CDS; and
g. use that would reflect discredit upon the DND and the CAF.

**Prohibited Use**

**4.7** "Prohibited use" is any use of a DND and CAF IT system that:

a. is illegal, including contrary to the *Criminal Code*, any other federal statute or regulation, or a provincial statute or regulation, including any non-criminal statute or regulation;
b. causes or could reasonably cause harm to others;
c. is an intentional act that jeopardizes or could reasonably jeopardize the integrity of a DND and CAF IT system;
d. accesses or distributes any material whose main focus is pornography, nudity or sexual acts; or
e. is prohibited under paragraph 4.5.

# 5. Consequences

**Consequences of Non-Compliance**

**5.1** Non-compliance with this DAOD may have consequences for both the DND and the CAF as institutions, and for authorized users as individuals. Suspected non-compliance may be investigated. The nature and severity of the consequences resulting from actual non-compliance will be commensurate with the circumstances of the non-compliance. Consequences of non-compliance may include one or more of the following:

a. the ordering of the completion of appropriate learning, training or professional development;
b. the entering of observations in individual performance evaluations;
c. revocation of access to DND and CAF IT systems, either in whole or in part;
d. investigations which may result in charges being laid under the *Criminal Code*, the *National Defence Act*, another federal statute or regulation, or a provincial statute or regulation;
e. civil liability; and
f. administrative action, up to and including termination of employment or a contract or, in the case of a CAF member, release.

**Note –** In respect of the compliance of DND employees, see the Treasury Board *Framework for the Management of Compliance* for additional information.

**5.2** The following table identifies the potential consequences of any unauthorized or prohibited use of a DND and CAF IT system by the type of authorized user:

| For … | unauthorized or prohibited use of a DND and CAF IT system may result in one or more of the following, depending on the circumstances: |
|---|---|
| a DND employee, | ▪ administrative action, up to and including termination of employment; and<br>▪ criminal charges. |
| a CAF member, | ▪ administrative action, up to and including release from the CAF;<br>▪ disciplinary proceedings; and<br>▪ criminal charges. |
| a contractor or other person authorized to use a DND and CAF IT system, | ▪ contract termination; and<br>▪ criminal charges. |

**Guidance**

**5.3** In any case of unauthorized use, a manager, supervisor, commander or CO should consider, as a minimum, the following circumstances before taking any action set out in paragraph 5.1:

a. the nature of the unauthorized use;
b. the frequency of similar activity within their DND organization, CAF unit or other CAF element;
c. the impact of the unauthorized use on the morale and discipline of their DND organization, CAF unit or other CAF element; and
d. any impact the unauthorized use had or may have had on the operational capabilities of their DND organization, CAF unit or other CAF element.

**Additional Guidance Relating to CAF members**

**5.4** In the case of any unauthorized use by a CAF member, unit authorities should normally take administrative action, but disciplinary proceedings may be taken if the circumstances so warrant.

**5.5** In the case of any prohibited use by a CAF member, unit authorities should normally take disciplinary proceedings, in conjunction with any necessary administrative action.

# 6. Responsibilities

**Responsibility Table**

**6.1** The following table identifies the responsibilities associated with this DAOD:

| The ... | is or are responsible for ... |
|---|---|
| Director General Information Management Technology and Strategic Planning | ▪ providing policies, instructions and guidance on the management and use of information in respect of the Internet, defence intranet and other DND and CAF IT systems. |

| The ... | is or are responsible for ... |
|---|---|
| Canadian Forces Provost Marshal | ▪ investigating allegations of unauthorized or prohibited use of DND and CAF IT systems. |
| Director Information Management Security | ▪ developing, implementing and maintaining a security awareness and education programme in respect of the proper use of DND and CAF IT systems. |
| ADM (Human Resources – Civilian) Service Centres | ▪ providing advice and guidance in relation to administrative matters relating to DND employees, contractors and other persons authorized to use DND and CAF IT systems. |
| operational authorities of DND and CAF networks | ▪ providing user application forms for network access, along with user agreements, that incorporate all applicable provisions in this DAOD. |
| DND managers and supervisors, commanders, COs and military supervisors | ▪ ensuring their subordinates are provided with guidance and training on the proper use of DND and CAF IT systems;<br>▪ ensuring authorized users are aware of monitoring policies, instructions, directives and standards applicable to the use of DND and CAF IT systems;<br>▪ ensuring authorized users are aware that there should be no expectation of privacy when using DND and CAF IT systems;<br>▪ enforcing compliance with this DAOD; and<br>▪ investigating allegations of unauthorized or prohibited use of DND and CAF IT systems. |
| IT security practitioners | ▪ notifying the Director Information Management Security of any non-compliance with this DAOD. |
| authorized users | ▪ only using DND and CAF IT systems for official and authorized uses. |

# 7. References

### Acts, Regulations, Central Agency Policies and Policy DAOD

- *Criminal Code*
- *National Defence Act*
- *Framework for the Management of Compliance*, Treasury Board
- *Policy on Acceptable Network and Device Use*, Treasury Board
- *Values and Ethics Code for the Public Sector*, Treasury Board
- DAOD 6002-0, *Information Technology*

### Other References

- DAOD 2008-0, *Public Affairs Policy*
- DAOD 2008-6, *Internet Publishing*
- DAOD 5008-1, *Use of Departmental Premises and Equipment, and Electronic Networks, for Bargaining Agent or Union Business*
- DAOD 5016-0, *Standards of Civilian Conduct and Discipline*

- DAOD 5031-0, *Learning and Professional Development*
- DAOD 6000-0, *Information Management and Information Technology*
- DAOD 6002-3, *Management of Mobile Wireless Devices*
- DAOD 7023-1, *Defence Ethics Program*
- *Department of National Defence and Canadian Forces Code of Values and Ethics*
- *National Defence Security Instructions (NDSI)*, Chapter 70, *Information System (IS) Security*
- *DND and CF IM and IT Policy Framework*

# APPENDIX 10 TO ANNEX A1

# DND OCCUPATIONAL GROUPS AND CATEGORIES

**Appendix 10 – DND Occupational Groups and Categories**

| Count | Stream | Group | Category |
|---|---|---|---|
| 1 | 1 | Chiropractor | Chiropractor |
| 2 | 1 | Dietician | Dietician |
| 3 | 1 | Technologist | Medical Laboratory Assistant |
| 4 | 1 | Technologist | Medical Laboratory |
| 5 | 1 | Mental Health | Addictions Counsellor |
| 6 | 1 | Mental Health | Clinical Chaplain |
| 7 | 1 | Mental Health | Clinical Psychologist |
| 8 | 1 | Mental Health | Clinical Psychologist-Acting Prog manager |
| 9 | 1 | Mental Health | Clinical Social Worker |
| 10 | 1 | Nurse | Licensed Practical Nurse or Registered Practical Nurse |
| 11 | 1 | Nurse | Nurse Practitioner |
| 12 | 1 | Nurse | RN - Case Manager |
| 13 | 1 | Nurse | RN - Community Health Nurse |
| 14 | 1 | Nurse | Mental Health Nurse |
| 15 | 1 | Nurse | Perioperative Registerd Nurse |
| 16 | 1 | Nurse | Post Anaesthetic Recovery Room Registered Nurse (PARR) |
| 17 | 1 | Nurse | RN - Primary Care Nurse |
| 18 | 1 | Occupational Therapy | Occupational Therapist |
| 19 | 1 | Pharmacy | Pharmacist |
| 20 | 1 | Pharmacy | Pharmacy Assistant |
| 21 | 1 | Physical therapy | Physiotherapist |
| 22 | 1 | Physical therapy | Physiotherapy Assistant |
| 23 | 1 | Physician | Primary Care Physician |
| 24 | 1 | Physician | Physician Deputy Base Surgeon Senior Medical Authority |
| 25 | 1 | Physician Assistant | Physician Assistant |
| 26 | 1 | Technologist | Cardiac Sonographer / Cardiovascular Technologist |
| 27 | 1 | Technologist | Diagnostic Medical Sonographer |
| 28 | 1 | Technologist | Medical Radiological Technologist |
| 29 | 2 | Dental Nurse | Registered Nurse (Conscious Sedation) |
| 30 | 2 | Dental Support | Dental Assistant |
| 31 | 2 | Dental Support | Dental Hygienist |
| 32 | 2 | Dentist | Comprehensive Dentist |
| 33 | 2 | Dentist | General Dentist |
| 34 | 2 | Dentist | Oral and Maxillofacial Surgeon |
| 35 | 2 | Dentist | Periodontist |
| 36 | 2 | Dentist | Prosthodontist |

| Count | Stream | Group | Category |
|---|---|---|---|
| 37 | 3 | Physician Specialist | Anesthesiologist |
| 38 | 3 | Physician Specialist | Cardiologist |
| 39 | 3 | Physician Specialist | Dermatologist |
| 40 | 3 | Physician Specialist | Gastroenterologist |
| 41 | 3 | Physician Specialist | General Surgeon |
| 42 | 3 | Physician Specialist | Internist |
| 43 | 3 | Physician Specialist | Neurologist |
| 44 | 3 | Physician Specialist | Obstetrician / Gynecologist |
| 45 | 3 | Physician Specialist | Ophthalmologist |
| 46 | 3 | Physician Specialist | Orthopaedic Surgeon |
| 47 | 3 | Physician Specialist | Otolaryngologist (Ear, Nose and Throat) |
| 48 | 3 | Physician Specialist | Physiatrist / Rehabilitation |
| 49 | 3 | Physician Specialist | Plastic Surgeon |
| 50 | 3 | Physician Specialist | Psychiatrist |
| 51 | 3 | Physician Specialist | Radiologist |
| 52 | 3 | Physician Specialist | Rheumatologist |
| 53 | 3 | Physician Specialist | Urologist |
| 54 | 4 | Mental Health | Mental Health Policy, Adjudication and Analysis |
| 55 | 4 | Nurse | Cadet Regional Medical Liaison Officer - Nurse/PA |
| 56 | 4 | Physician | Medical Standards Analyst |
| 57 | 4 | Clinician | Health Informatics, Clinical Advisor |
| 58 | 4 | Physician Specialist | Aerospace Medicine |
| 59 | 4 | Physician Specialist | Cardiologist Operational |
| 60 | 4 | Physician Specialist | Internist - Operational Specialist |
| 61 | 4 | Physician Specialist | Occupational Medicine |
| 62 | 4 | Physician Specialist | Ophthalmologist -Operational Specialist |
| 63 | 4 | Physician Specialist | Undersea Medicine |
| 64 | 4 | Clinician | Injury Prevention Specialist |
| 65 | 4 | Technologist | Neurophysiology Technologist (Electromyography) |
| 66 | 4 | Technologist | Pulmonary Function Technologist |
| 67 | 4 | Technologist | Preventative Medicine (Occupational Health Services) |
| 68 | 5 | Nurse | Cadet Licensed Preactical Nurse / Registered Practical Nurse |
| 69 | 5 | Nurse | Cadet Nurse Practicitioner |
| 70 | 5 | Nurse | Cadet Primary Care Nurse |
| 71 | 5 | Paramedic | Cadet Paramedic PCP |
| 72 | 5 | Physician | Cadet Primary Care Physician |
| 73 | 5 | Physician Assistant | Cadet Physician Assistant |

# APPENDIX 11 TO ANNEX A1

# HCP QUALIFICATIONS AND TASKS
# GENERAL INSTRUCTIONS

## Appendix 11 – HCP Qualifications and Tasks
## General instructions

### HCP Qualifications and Tasks

1. Requests for Health Care Providers will identify the HCP Category and Level of Experience required to satisfy the demands of the work.

2. The Qualifications and Tasks Sheet for each specific HCP category defines:

   a. the Educational and Credential Requirements that a proposed resource must meet to qualify for the Category;

   b. the experience that a proposed resource must have accumulated to meet each of the experience levels associated with the category; and

   c. the tasks that the HCP will be expected to be able to perform.

3. Unless otherwise specified: all licences are to be Canadian; all licences are to be for independent, active, clinical practice and must be free of terms, conditions or limitations. All licences are to be in good standing order.

4. When proposing a HCP the Contractor will be required to demonstrate that the individual meets all of the requirements identified for the category and level requested.

### HCP Common requirements

5. Throughout the duration of the Contract, the HCP is responsible to maintain the following Certification IAW their individual Task and Qualification Sheet:

   a. the HCP working in CF H Svcs Cs and CF Dent Dets is responsible to have a current N-95 Fit Test certification and that the fitting certification remains current, in accordance with the most current national standard (CSA Standards Z94.4). Testing is to be completed once every two (2) years.

   b. Basic Life Support (BLS) certificate for Healthcare Provider or equivalent, such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C Annual recertification;

   c. Advance Cardiac Life Support certificate. (every two (2) years);

d. Workplace Hazardous Material Information System (WHMIS) Certification (every two (2) years);

**General Task Descriptions - HCPs working with DND**

6. In addition to the tasks outlined for each HCP in the HCP specific Qualifications and Tasks Sheets, the following are tasks applicable to all HCPs:

a. Health Information and Records Management:

(1) follow all applicable documentation standards and polices as directed by CF Health Services including statutes such as the Federal Privacy Act;

(2) HCPs must complete personal health information and records for each member encounter in accordance with relevant CF Health Services and professional standards;

(3) maintain patient medical and dental information in the department`s patient health records system;

(4) the HCP must use approved Departmental forms or electronic health records to document the services provided. The use of non-approved forms, shadow files, temporary files, or any other unofficial member related health records to document service provided is not permissible;

(5) Documentation such as medical records, forms, reports, orders must be accurately completed in accordance with Departmental policies and must be signed and dated promptly; and

(6) written information must be legible.

b. In-clearance Activities. HCPs must perform all Departmental in-clearance activities within the first two (2) weeks of their Task Authorization. The In-clearance process may include activities such as requesting access to Departmental information systems, receiving and reviewing Departmental specific information;

c. Tele-health Service. HCPs may be required to perform certain tasks related to their work, such as diagnosis, consultation, treatment, transfer of medical data, using interactive audio, video, or data communications. Video conferencing may be used for real-time patient-provider consultations and for provider-to-provider discussions to improve health outcomes, access to care, and make health care delivery systems more efficient and cost-effective. There may be a requirement for HCPs to travel in order to perform an initial assessment of a member to determine the feasibility of providing service to the member via a tele-health

approach. The equipment required for tele-health will be provided by DND;

d. Participation in a Working Group, Committee, Board, Military Board or Court. HCPs may be required by the Department, on occasion, to participate as a member of a working group, committee, or board inside or outside the department or attend court proceedings in relation to work performed by the HCP under the Contract;

e. Collaborative Practice. HCPs must operate within a collaborative practice and interdisciplinary care environment that supports continuity of care to the member;

f. Clinical Preceptorship. HCPs may be required, on occasion, to provide clinical preceptorship to CF Health Services approved trainees (military or civilian), such as medical students, physician assistants, nurses, physiotherapists, etc. Preceptorship includes, but is not limited to:

(1) performing ongoing assessment of clinical competency of the provider;

(2) assigning clinical tasks, including the delegation of medical acts;

(3) ensuring that the scope of practice and competency of the provider aligns with the complexity of care required for the patient;

(4) evaluating clinical performance through direct or indirect observation, chart review, case review, provision of co-signature, etc; and

(5) providing verbal and written feedback on clinical skills, knowledge, and judgement to the student, educational institution, and Senior Medical Authority.

g. Clinical Supervision. Clinical supervision of unlicensed health care providers employed by DND, such as Physician Assistants, Medical Technicians, Dental Assistants;

h. Quality Assurance. Regular participation in quality assurance and quality improvement activities as members of the clinical community including, but not limited to, clinical audits, peer review, chart audits, morbidity and mortality rounds, utilization reviews;

i. Delivery of Instruction. HCPs may be required, on occasion, to deliver instruction in their area of expertise to support teaching activities that the Department has initiated or agreed to support. Such activities will be considered as part of their regularly scheduled working hours; and

j. Participation in Research. HCPs may be required, on occasion, to support research activities that the Department has initiated or agreed to support. Such activities will be considered as part of their regularly scheduled working hours.

7. A Task Authorization for Task i. (deliver of instruction) or Task j. (conduct research) above will include a detailed description of the course(s) to be delivered and/or the research to be supported. The description will specify the specific subject matter to be addressed, the deliverables that will be required and the schedule to be followed.

8. Qualification and Task Sheets per HCP are included in the following pages.

# APPENDIX 11 TO ANNEX A1

# MENTAL HEALTH - ADDICTION COUNSELLOR

**STREAM** **1**

**OCCUPATIONAL GROUP AND CATEGORY** **Mental Health - Addiction Counsellor**

## WORK AND ENVIRONMENT

1. Addiction Counsellors provide counselling and support to patients and families experiencing addictions. Their works include confidential individual, family or group counselling about the causes and effects of addictions; support for families dealing with addictions; and referrals to treatment for individuals. Addiction Counsellors also provide educational sessions to individual and groups in the CF community. Addiction counsellors receive patients either through self-referral or referral from other health care providers. Addiction counsellors functions as a member of CF health care team in the CF Health Services clinic.

2. Language of work may be English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. All Addiction Counsellors must possess, as a minimum:

   a. a Diploma or Baccalaureate Degree in Nursing; or

   b. a Baccalaureate or Master's degree in Social Work from a recognized university;

   c. a licence from the provincial or territorial professional college or association in the location of practice;

   d. a certification as an International Certified Alcohol and Drug Counselor (I.C.A.D.C) through the Canadian Addiction Counsellors Certification Association (CACCF), or from the Association des intervenants en toxicomanie du Québec (Quebec province only); and

   e. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required.

## EXPERIENCE

4. The Addiction Counsellor will have a minimum of 2 years full time equivalent experience performing a range of related clinical services in the area of addictions including addiction assessment, treatment planning, and counselling and therapy.

## TASKS

5. The required tasks for this occupational group include the following:

a. assess substance-use disorders, including a differential assessment of concurrent disorder;

b. assess process addictions such as pathological gambling, sexual behaviour, and gaming;

c. participate in the development of a treatment plan with the patient and the inter-disciplinary health care team to address the patient's addiction;

d. provide therapeutic interventions such as Secondary Substance-Abuse Intervention (SSI) Programs consistent with the established addiction assessment for patients in an individual or group setting;

e. evaluate the effectiveness of counselling program, interventions, and patient's progress in resolving identified problems and movement toward personalized objectives;

f. familiarize with other internal or external community services and resources;

g. deliver psycho-educational sessions such as addiction-free living; and

h. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# TECHNOLOGIST - CARDIAC SONOGRAPHER / CARDIOVASCULAR TECHNOLOGIST

**STREAM 1**

**OCCUPATIONAL GROUP AND CATEGORY** **Technologist - Cardiac Sonographer / Cardiovascular Technologist**

## WORK ENVIRONMENT

1. The Cardiac Sonographer/Cardiovascular Technologist is a technical expert in the field of echocardiographic image acquisition and other cardiovascular testing methodologies that provide useful medical diagnostic information to Medical Consult Services (MCS) physicians in the fulfillment of the Canadian Forces Environmental Medicine Establishment's (CFEME) mandates. They perform testing on Canadian Armed Forces (CAF) aircrew, divers, and other operational medicine patients. Patients access Sonographer/Cardiovascular Technologist services on a booked appointment basis as referred by members of the MCS and external healthcare team.

## EDUCATION / QUALIFICATIONS

2. The Cardiac Sonographer/Cardiovascular Technologist will be, as a minimum:

   a. a Certified Cardiovascular Technologist/Canadian Society Cardiology Technologists (CSCT); and

   b. a Certification as a Cardiac Sonographer from Sonography Canada (formerly the Canadian Association of Registered Diagnostic Ultrasound Professionals (CARDUP) or Registration as a Diagnostic Cardiac Sonographer (RCDS) with the American Registry for Diagnostic Medical Sonography (ARDMS).

## EXPERIENCE

3. The Cardiac Sonographer/Cardiovascular Technologist will possess a minimum of 2 years of experience providing a full range of cardiovascular testing services.

## TASKS

4. The required tasks for this occupational group include the following:

   a. provide echocardiographic services in accordance with the standards of practice established by the CARDUP/ARDMS;

   b. obtain patient medical history information pertinent to the interpretation of test results;

   c. perform echocardiographic studies requisitioned by physicians;

d. carry out the technologist's portion of the following tests in accordance with standards of practice established by the CCST:

(1) exercise stress tests;

(2) holter monitors;

(3) carotid dopplers;

(4) 24 hour ambulatory blood pressure monitors; and

(5) electrocardiogram.

e. provide care and assistance to patients during procedures keeping the patients comfort as the highest priority;

f. operate and maintain cardiovascular equipment, including routine maintenance, disinfection, cleaning, and troubleshooting technical problems. Notify MCS staff when supplies are low (gel, electrodes);

g. prepare test results for interpretation by the CFEME physician;

h. enter patient information into the Canadian Forces Health Information System (CFHIS) and to other patient health records;

i. provide procedural technical advice to researchers pertaining to the implementation of research and clinical protocols in the area of sonography;

j. provide orientation training to new staff members on the equipment;

k. assist with Aerospace and Undersea Medical Board (AUMB) database entry;

l. language of work may be French and/or English, depending on geographic location; and

m. other associated tasks relevant to this occupational group.

**DELIVERABLES**

5. The required deliverables relevant to this occupational group IAW the required tasks are as follows:

a. produce reports for all clinical testing completed; and

b. Maintain an accurate investigations log of all imaging and cardiac stress test events.

# APPENDIX 11 TO ANNEX A1

# CHIROPRACTOR – CHIROPRACTOR

**STREAM** **1**

**OCCUPATIONAL GROUP AND CATEGORY** **Chiropractor – Chiropractor**

## WORK AND ENVIRONMENT

1. Chiropractors are regulated primary health care providers having specialized skills in spinal manipulation. A Chiropractor receives patient referrals from the primary health care team in a CF Health Services Centre and provides comprehensive consultation, assessment and treatment during scheduled appointments. Chiropractors work as an integral part of a MSK care team which also includes some or all of the following professionals, General Duty Medical Officers, Physician Assistants, Nurse Practitioners, Primary care Nurses, Physiotherapists, Occupational Therapists and Physiatrists.

2. Language of work may be English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. All Chiropractors must, as a minimum:

   a. have a current licensure in good standing in the provincial/ territorial regulatory organization of employment; and

   b. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required.

## EXPERIENCE

4. The Chiropractor must possess a minimum of 2 years of experience providing Chiropractic services.

## TASKS

5. The required tasks for this occupational group include the following:

   a. deliver safe, efficient and effective chiropractic interventions using evidence-based approaches and best practices in accordance with applicable regulatory standards, scope of practice and CFHS clinical care programs;

   b. provide assessment, differential diagnosis and treatment of conditions related to the spine, primarily by the adjustment of

dysfunctions or disorders arising from the structures or functions of the spine and the effects of those dysfunctions or disorders on the nervous system;

c. determine appropriate care including referral where necessary, in conjunction with the rest of the health care team;

d. obtain and document informed patient consent for assessment and treatment through an accurate explanation and instruction;

e. provide screening assessments and education in areas of expertise such as back injury prevention;

f. perform daily clinical documentation, health information and records management for all patients; and

g. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# MENTAL HEALTH – CLINICAL CHAPLAIN

**STREAM 1**

**OCCUPATIONAL GROUP AND CATEGORY** **Mental Health – Clinical Chaplain**

## WORK AND ENVIRONMENT

**1.** Mental Health Clinical Chaplains (MH CL CHAP) is a recognized religious leader, endorsed by the Inter-faith Committee on Canadian military Chaplaincy (ICCMC) and is responsible to the Operational Trauma and Stress Support Centre (OTSSC) Program Leader. He/she fulfills, in an ecumenical and inter-faith setting, the functions of Pastor, Clinician, and Advisor in CF Health Services Clinics, specifically within (OTSSC) Mental Health Departments. His/her scope of practice on is to work as part of the interdisciplinary mental health care team to provide specialized psycho-spiritual care, treatment and educational services primarily to CAF personnel with Operational Stress Injuries. Clinical Chaplains may also support family members within the established parameters. A secondary duty may include providing psycho-spiritual care and treatment to patients engaged in care in other mental health programs.

2. Language of work may be English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. All Mental Health Clinical Chaplains (MH CL CHAP) shall possess, as a minimum:

a. a Master's Degree in Counselling and Spirituality/Counselling and Psychotherapy. Degrees shall be awarded from an accredited university, have a spiritual focus, and be recognized by the RCChS as acceptable for use by Chaplains serving CAF personnel;

b. a membership with the applicable provincial association of Registered Psychotherapists; and

c. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required.

## EXPERIENCE

4. The Mental Health Clinical Chaplains (MH CL CHAP) , as a minimum, must have three years full time equivalent experience performing specialized psycho-spiritual care, treatment and educational services to clients with operational stress injuries, such as, crisis intervention, outreach, psycho-spiritual assessment and treatment planning in an adult mental health care environment, using various evidence-based psychosocial

counselling approaches, such as Cognitive Behavioural Therapy (CBT) and Solution-focused therapy, and providing psychosocial assessment, therapy and counselling services to adult clients and their families.

**TASKS**

5. The required tasks for this occupational group include the following:

   a. provide psycho-spiritual care and treatment to OTSSC patients, facilitating symptom reduction and improved functioning within a prescribed scope of practice, supervision as required, and, limits of competency;

   b. provide psycho-spiritual assessment regarding specified clients who struggle with loss of purpose and meaning in life, conflicts in values, needs, beliefs, emotions and behaviour, etc.;

   c. provide psycho-spiritual care and treatment to the patients of other mental health programs, in accordance with limits of competencies and availability;

   d. co-facilitate group therapy;

   e. provide Marital and Family Therapy (for those qualified);

   f. provide psycho-education for operational stress injury (OSI) members and families;

   g. provide education for other health care providers with special focus in spirituality, religiosity and existentialism;

   h. provide advice to other mental health programs with special focus in spirituality, religiosity and existentialism;

   i. participate in appropriate clinical rounds of mental health programs where there is indication that existential, religious or spiritual issues are present;

   j. maintain patient's health records appropriately by documenting in the patient's electronic health record progress notes and reports as required, and in a timely manner, in accordance with Canadian Forces Health Information System (CFHIS) directives and guidelines;

   k. support research and development in the field of psycho-spiritual care, assessment, and, treatment, in collaboration with CAF SR MH CHAP;

   l. maintain applicable membership with relevant College of

Psychotherapists or another professional body of similar membership;

m. participate in CAF SN MH CHAP meeting/working group/teleconferences, as necessary;

n. apply the clinical practice guidelines for discipline and related specific policies; and

o. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# DIETITIAN – CLINICAL DIETITIAN

**STREAM 1**

**OCCUPATIONAL GROUP AND CATEGORY** **Dietitian – Clinical Dietitian**

## WORK AND ENVIRONMENT

1. Clinical Dietitians are responsible for the nutritional care of clients through assessment of nutritional status; prescription, implementation and management of nutrition care plans; and counseling and teaching. Clinical Dietitians also provide expert advice and professional education to other health care professionals who work with clients who have specific nutritional requirements. Clinical Dietitians function independently and act as a member of CF health care team. Clinical Dietitians receive patient referrals from other health care providers. Their work includes individual or group appointments and group educational sessions. Clinical Dietitians use teaching resources and displays for dietetic instructional materials.

## EDUCATION / QUALIFICATIONS

2. All Clinical Dietitians must possess, as a minimum:

   a. a baccalaureate Degree in Science in Nutrition or Dietetics from a recognized university accredited by Dietitians of Canada;

   b. the completion of a Canadian accredited dietetic internship program;

   c. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C; and

   d. a licence from the provincial or territorial professional college or association in the province of practice.

## EXPERIENCE

3. The Clinical Dietitian shall possess a minimum of 2 years' experience working as a clinical dietitian in a Canadian primary health care setting; detecting and evaluating the patient's nutritional state in accordance with the physician's nutritional prescription; preparing, implementing, managing and evaluating a nutritional care plan; developing managing and providing clinical nutrition related educational sessions to clients and their families, and to other health care professionals.

## TASKS

4. The required tasks for this occupational group include the following:

a. evaluate the nutritional status of an individual by interviewing the client and the client's family to gather dietary history, eating habits, previous diets, and weight history;

b. design and implement a personalized nutrition care plan by providing nutrition counselling and educational sessions, and performing ongoing evaluation of the care plan;

c. convey the nutritional care plan and progress to the multi-disciplinary team through CFHIS. The communication includes nutritional screening, evaluation, care plan, clinical follow-ups, client comprehension and motivation, adherence to treatments and attainment of goals;

d. evaluate the nutritional content of commercial food supplements and menus for both macro and micronutrient components and analyze the data according to the client's nutritional needs. Provide clinical inputs and recommendations on nutritional supplements;

e. design, develop and conduct nutrition education sessions to clients and their families according to their needs. The educational sessions are to include nutritional principles, dietary plans, dietary restrictions, nutrition label reading, and food selection and preparation;

f. develop, maintain and distribute current nutritional resources, dietary guidelines, educational tools, and teaching aides;

g. provide clinical education sessions to other health service and health promotion personnel on the current nutritional management of various diseases, such as diabetes, hypertension, hyperlipidemia, obesity including new best practices and current research projects; and

h. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# MENTAL HEALTH – CLINICAL PSYCHOLOGIST – ACTING PROGRAM MANAGER

**STREAM 1**

**OCCUPATIONAL GROUP AND CATEGORY** **Mental Health – Clinical Psychologist – Acting Program Manager**

## WORK AND ENVIRONMENT

1. The Clinical Psychologist - Acting Program Manager's work and environment are based on Mental Health (MH) Clinical Psychologist work and environment, with the addition of functions related to the coordination of MH Program and the provision of clinical program guidance and clinical advice, as a subject matter expert within the clinic, for the clinical administration and management of other MH professionals.

2. The Clinical Psychologist - Acting Program Manager provide professional services relating to the diagnosis, assessment, evaluation, treatment and prevention of psychological, emotional, psycho-physiological and behavioural disorders with the adult population. Clinical Psychologists focus on promotion of physical, intellectual, emotional, interpersonal and social well-being. Clinical Psychologists receive patients through referrals from other health care providers. The Clinical Psychologist – Acting Program Manager provides advice to other members of the health care team in the areas of medical administration, and is an integral component of quality and patient safety activities within the clinic. The Clinical Psychologist – Acting Program Manager function as a member of CF health care team in the CF Health Services clinic.

3. Language of work may be English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

4. All Clinical Psychologists must possess, as a minimum:

   a. will be registered for autonomous practice of psychology by a provincial or a territorial regulatory body in the location of practice.

   b. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required; and

   c. a Doctoral Degree, with a specialization in adult Clinical Psychology, from a university:

      (1) accredited by the Canadian Psychological Association; or

      (2) accredited by the American Psychological Association; or

(3) an equivalence to an accredited university will be considered if the Psychologist is licenced for clinical practice by the provincial or territorial regulatory body and approved by the Credentialing Committee of CF H SVCS Group.

**EXPERIENCE**

5. The Clinical Psychologist – Acting Program Manager must have, as a minimum, within the past 10 years:

a. 7 years of autonomous practice in the provision of psycho-diagnostic assessment services to adults including differential diagnosis, the provision of cognitive-behavioural therapy and, for employment at an OTSSC, the provision of trauma-processing therapy; and

b. a mimimum of 1 year of experience in clinical administration and management of other MH professionals.

**TASKS**

6. The required tasks for this occupational group include the following:

a. provide therapeutic interventions based on clinical best practices including the delivery and evaluation of cognitive behavioural treatment interventions;

b. provide clinical guidance and consultation to other mental health care providers in the provision of mental health services to patients;

c. lead or participate in group counselling and psychoeducational sessions for specific mental illnesses such as anxiety, PTSD, depression, and stress management;

d. administer psychometric tests for assessment, interpret results, and prepare psychological evaluations within scope of practice;

e. provide psycho-diagnostic and cognitive assessments;

f. administer a full range of psychometric tests for assessment, interpret results, and prepare psychological evaluations;

g. provide patient clinical reports including the results and interpretations of tests, interviews, and evaluations to the interdisciplinary team in order to generate a care plan;

h. provide clinical advice as a subject matter expert;

i. be knowledgeable about professional standards of practice and clinical best practices;

j. identify and provide guidance on potential options for the resolution of professional practice issues with individual clinicians;

k. provide clinical program guidance to the clinical team;

l. provide input into program, policy and process development;

m. coordinate work effort to ensure proper patient care is provided and patient safety measure are followed;

n. organize the work schedule to ensure quality patient care; and

o. other associated tasks relevant to this occupational group.

**APPENDIX 11 TO ANNEX A1**

**MENTAL HEALTH – CLINICAL PSYCHOLOGIST**

**STREAM** **1**

**OCCUPATIONAL GROUP AND CATEGORY** **Mental Health – Clinical Psychologist**

## WORK AND ENVIRONMENT

1. Clinical Psychologists provide professional services relating to the diagnosis, assessment, evaluation, treatment and prevention of psychological, emotional, psycho-physiological and behavioural disorders with the adult population. Clinical Psychologists focus on promotion of physical, intellectual, emotional, interpersonal and social well-being. Clinical Psychologists receive patients through referrals from other health care providers. Clinical Psychologists function as a member of CF health care team in the CF Health Services.

2. Language of work may be English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. All Clinical Psychologists must possess, as a minimum:

   a. will be registered for autonomous practice of psychology by a provincial or a territorial regulatory body in the location of practice;

   b. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required; and

   c. a Doctoral Degree, with a specialization in adult Clinical Psychology, from a university:

      (1) accredited by the Canadian Psychological Association; or

      (2) accredited by the American Psychological Association; or

      (3) an equivalence to an accredited university will be considered if the Psychologist is licenced for clinical practice by the provincial or territorial regulatory body and approved by the Credentialing Committee of CF H SVCS Group.

   OR

   d. a Master's Degree, with a specialization in adult Clinical Psychology, may be considered as an alternative to a Doctoral Degree if the Psychologist is

licenced for clinical practice by the provincial or territorial regulatory body and approved by the Credentialing Committee of CF H SVCS Group.

OR

e. a Doctoral or Master's Degree, without a specialization in adult Clinical Psychology, may be considered as an alternative to a Doctoral Degree, with a specialization in adult Clinical Psychology, if the Psychologist is licenced for psychological practice by the provincial or territorial regulatory body and approved by the Credentialing Committee of CF H SVCS Group.

**EXPERIENCE**

4. The levels for the Clinical Psychologist are:

   a. Level 1 – Provide Treatment: The Psychologist must have a minimum of two years full time equivalent autonomous practice experience, within the past five years, in the provision of cognitive behavioural therapy and, for employment at an OTSSC, the provision of trauma-processing therapy; and

   b. Level 2 - Provide Assessment and Treatment: The Psychologist must have a minimum of two years full time equivalent autonomous practice experience, within the past five years, in the provision of psycho-diagnostic assessment services to adults including differential diagnosis, the provision of cognitive-behavioural therapy and, for employment at an OTSSC, the provision of trauma-processing therapy.

**TASKS**

5. The required tasks for this occupational group include the following:

   a. provide therapeutic interventions based on clinical best practices including the delivery and evaluation of cognitive behavioural treatment interventions;

   b. provide clinical guidance and consultation to other mental health care providers in the provision of mental health services to patients;

   c. lead or participate in group counselling and psychoeducational sessions for specific mental illnesses such as anxiety, PTSD, depression, and stress management;

   d. administer psychometric tests for assessment, interpret results, and prepare psychological evaluations within scope of practice;

e. Level 2 Psychologists - Additional tasks:

(1) provide psycho-diagnostic and cognitive assessments;

(2) administer a full range of psychometric tests for assessment, interpret results, and prepare psychological evaluations; and

(3) provide patient clinical reports including the results and interpretations of tests, interviews, and evaluations to the interdisciplinary team in order to generate a care plan.

f. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# MENTAL HEALTH - CLINICAL SOCIAL WORKER

**STREAM** **1**

**OCCUPATIONAL GROUP AND CATEGORY** **Mental Health - Clinical Social Worker**

## WORK AND ENVIRONMENT

1. Clinical Social Workers specialize in helping clients to enhance their social functioning and overall well-being through counselling, therapy, and referral to other internal or external social services. Clinical Social Workers also respond to other social needs and issues such as deployment screening, case consultation, patient advocacy for accessing a full spectrum of services, and crisis intervention. The mental health services within the CF Health Services consist of several programs: the Psychosocial program (which includes programs such as crisis intervention and addiction services); the General Mental Health program; and Operational Trauma and Stress Support Centre (OTSSC). Clinical Social Workers function as a member of the overall mental health care team and primary health care team within the CF Health Services Clinic. A Clinical Social Worker works in one of the above mentioned programs. Clinical Social Workers receive clients through self-referrals, referrals from other health care providers, or referrals from clients' family, friends or supervisor. Their work includes walk-in and scheduled appointments with individuals or family and group therapy sessions.

2. Language of work may be in English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. All Clinical Social Workers must possess, as a minimum:

   a. a Baccalaureate Degree or a Master's Degree in Social Work (Specialization: Clinical or Mental Health) from a recognized university accredited by Canadian Association for Social Work Education (CASWE);

   b. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required; and

   c. a Social Work licence from the provincial or territorial regulatory body in the province of practice.

## EXPERIENCE

4. The Clinical Social Worker must have, as a minimum, a minimum of 3 years full time equivalent experience performing clinical social work related activities such as intake and assessment, crisis intervention, outreach, psychosocial assessment and

treatment planning in an adult mental health care environment, using various evidence-based psychosocial counselling approaches, such as Cognitive Behavioural Therapy (CBT) and Solution-focused therapy, and providing psychosocial assessment, therapy and counselling services to adult clients and their families.

## TASKS

5. The required tasks for this occupational group include the following:

    a. provide individual, family, and crisis or emergency assessments;

    b. perform psychosocial and mental health interventions such as individual, family or group assessment, treatment planning and therapy, followed by evaluation of treatment and therapeutic outcome;

    c. analyze clients' needs and provide information and advice to them and their families related to access to appropriate services and resources;

    d. present client's case with recommendations to the inter-disciplinary health care teams to develop an individualized treatment plan;

    e. provide advice and support with and on behalf of clients in relation to rights, services and resources to ensure that clients are receiving the full spectrum of care;

    f. participate in the provision of multi-disciplinary care by ensuring clients receive prescribed treatment and services by the multi-disciplinary team and monitor the clients' progress;

    g. facilitate educational activities and group interventions such as pre-deployment briefings, psychosocial services overview presentations, and group psycho-educational sessions;

    h. implement new interventions or treatment approaches such as telemedicine and virtual reality therapy;

    i. document client interactions in the Canadian Forces Health Information System (CFHIS) and personal health records (CF2016) in accordance with relevant CF Health Services policies and standards and with the provincial regulatory organization's Standards of Practice for Social worker's related to documentation;

    j. distribute local outreach material such as mental health awareness materiel, to bases and units;

k. provide clinical advice, within social work scope of practice, to other health care providers; and

l. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# NURSE – COMMUNITY HEALTH NURSE

**STREAM 1**

**OCCUPATIONAL GROUP AND CATEGORY** **Nurse – Community Health Nurse**

## WORK AND ENVIRONMENT

1. Community Health Nurses (CHNs) are responsible for seven major functions: disease and injury prevention, health protection, health surveillance, population health assessment, health promotion, emergency preparedness and response and infection control. CHNs work in the community and primary care setting and act as a member of the CF Primary Health care team. Their work includes individual or group appointments, public health campaigns, and individual or group health education sessions within or outside the CF health services facility.

2. Language of work may be in English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. All Community Health Nurses must possess, as a minimum:

   a. a Baccalaureate Degree in Nursing from a recognized university;

   b. a Registered Nurse licence from the provincial or territorial professional college or association in the province of practice; and

   c. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C.

## EXPERIENCE

4. The Community Health Nurse shall possess, as a minimum, 3 full time equivalent years of clinical experience within the last 5 years in nursing practice:

   a. applying the principles of immunization and communicable diseases management including immunization schedules, vaccine storage and handling, and infection prevention and control;

   b. delivering patient education such as Chronic Disease Self-Management programs; and

   c. working in Public or Community Health - Communicable Disease Control Program, Travel Health, Primary Care, or Occupational Health environment.

## TASKS

5. The required tasks for this occupational group include the following:

   a. deliver the required National CFHS Community Health programs at the clinic based on the local community needs. Examples of these Chronic Disease Self-Management programs include diabetes management, cardiovascular disease education, and asthma control;

   b. maintain current immunization competency as a Primary Immunizer IAW Immunization Competency Training Program for Primary Immunizers in the Canadian Armed Forces;

   c. establish and deliver the immunization program at the CF Health Services Centre level, including travel immunization services to individual and deploying CF members, and mass immunization clinics such as the influenza clinics in order to maximize immunological protection of the CF population;

   d. implement and deliver the tuberculosis (TB) screening and control program at the unit level including performing tuberculin skin tests;

   e. act as the unit vaccine coordinator by implementing protocols for vaccine management including ordering and controlling vaccine inventory, storage, handling, cold-chain management and transport procedures that safeguard vaccine, and by ensuring full compliance with the protocols by staff who handle vaccines;

   f. implement quality assurance and quality improvement strategies to minimize risks for Adverse Event Following Immunization (AEFI), vaccination errors, or other untoward events following immunization;

   g. develop and maintain local Standard Operating Procedures (SOPs) that reflect national CF Health Service standards and reinforce best practices such as the response to an AEFI, the maintenance of immunization records, and the process of reporting immunization and TB data;

   h. respond to any anaphylaxis emergency and adverse events following immunization in a timely manner IAW local SOPs;

   i. collect and analyze immunization and TB screening data (e.g., vaccine coverage);

   j. prepare and present immunization-related presentations to pre-deployment and training groups;

k. organize and provide immunization campaigns and mass immunization clinics by performing activities such as establishing date, times, locations, distributing information, setting-up of clinics, conducting vaccine management, and coordinating logistical requirements;

l. provide nursing care appropriate to the immunization setting:

(1) assess patients by evaluating their relevant medical history, current health status, and educational needs;

(2) identify and plan appropriate interventions e.g., vaccination and patient education;

(3) obtain informed consent;

(4) implement interventions e.g., conduct health teaching, prepare, administer and dispose of routine and travel vaccines safely;

(5) document the intervention in CFHIS and personal health records;

(6) facilitate additional care as needed (e.g., follow-up visits for booster immunizations); and

(7) evaluate the care provided by monitoring the patient, assessing and addressing symptoms and changes in patient's conditions.

m. monitor and maintain equipment (e.g., vaccine storage unit) and supplies (e.g., syringes, sharps containers) required for immunization service;

n. develop customized travel health consultations for individual military travellers with Preventive Medicine Technician (PMed Tech);

o. research travel health expert guidelines, such as the Committee to Advise on Tropical Medicine and Travel (CATMAT) and Directorate of Force Health Protection Advisories, to develop a care plan for individual travellers;

p. resolve and plan patient care with other members of healthcare team in non-routine situations such as reported vaccine contraindications or precautions, compressed or interrupted vaccine schedules;

q. read and apply immunization related CF Health Services policy and guidance documents, immunization and travel health statements from the National Advisory Committee on Immunization (NACI), and the

CATMAT, vaccine product monographs, and other vaccine and communicable disease control documents;

r. administer allergy desensitization therapy as per physician's order and monitor patient for anaphylaxis reaction;

s. promote the CF Strengthening the Forces (STF) health promotion program by establishing alignment with clinic community health activities in order to increase awareness and accessibility within the military population;

t. develop and implement community health related components of local emergency preparedness plans as part of the health care team in response to emergency situations such as a pandemic influenza outbreak;

u. organize and provide annual Infection Prevention and Control (IPAC) education for CF Health Services Centre staff to promote compliance with unit IPAC policies and Standard Operating Procedures (SOPs). The education topics include:

(1) Use of routine practices, chain of infection transmission, and additional precautions;

(2) Procedures for the proper donning and removal of personal protective equipment (PPE);

(3) Hand Hygiene; and

(4) Biomedical waste management.

v. conduct annual hand hygiene audit and housekeeping audit IAW the current CF Health Services Group policy, Infection Prevention and Control in Canadian Forces Health Services Centres, provided by Task Manager;

w. develop, implement, and review when warranted CF Health Services Centre IPAC Standard Operating Procedures (SOPs), IAW the current CF Health Services Group policy, Infection Prevention and Control in Canadian Forces Health Services Centres, provided by Task Manager, a member of the healthcare team;

x. resolve any local CF Health Services Centre and detachment IPAC issues such as local risk of infectious disease outbreaks within the clinic through early identification, investigation, contact tracing, preventive measures, and activities to promote safe behaviours;

y. develop and distribute local IPAC and Community Health educational program for patients and staff such as information sessions, posters, pamphlets, and educational signage;

z. make IPAC clinical and technical recommendations on the required environmental cleaning requirements to the Task Manager;

aa. ensure local alignment with changes or improvements in the national IPAC program or communicate local IPAC issues by participating as a team member in activities such as CF Health Services IPAC workshops, education sessions, teleconferences, and other communications;

bb. generate health surveillance data and trends by identifying the infections and infectious agents most common at the local level, conducting investigations of suspected healthcare acquired infections or disease outbreaks within the CF Health Services Centre, tracking infection rates and surgical site infection rates where applicable, and analyzing the data;

cc. organize N95 mask fit-testing sessions with the Preventative Medicine Technician (P Med Tech) for clinic staff. Generate an annual status report to the Task Manager;

dd. monitor, provide guidance and support clinic central sterilization processing staff on IPAC practices and maintain related records;

ee. complete the clinic accreditation IPAC self-assessment survey as per direction from Task Manager;

ff. provide IPAC guidance and input on the clinic pandemic planning and outbreaks to the Task Manager when warranted; and

gg. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN – DEPUTY BASE SENIOR MEDICAL AUTHORITY

**STREAM 1**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician – Deputy Base Senior Medical Authority**

## WORK AND ENVIRONMENT

1. The Deputy Base Senior Medical Authority's work and environment are based on the Primary Care Physician work and environment, with the addition of functions related to the delivery of occupational health services within the clinic to the patient population.

2. Deputy Base Senior Medical Authority function independently as health care providers and act as members of a multi-disciplinary team in the primary care setting such as the Care Delivery Unit or treatment room. Within the Care Delivery Unit, rostered patients are assigned to a specified Primary Care Physician, including the Deputy Base Senior Medical Authority, who is ultimately responsible for coordinating and managing the care of their assigned patients. Patients access the Deputy Base Senior Medical Authority services through scheduled appointments walk-ins, and at other times during the day when medically indicated. The Deputy Base Senior Medical Authority provides advice to other members of the health care team in the areas of occupational health and medical administration, reviews and second signs medical files, and is an integral component of quality and patient safety activities within the clinic. On rare occasion, the Deputy Base Senior Medical Authority may be required to conduct evening or weekend clinics and function as the on-call physician.

## EDUCATION / QUALIFICATIONS

3. The Deputy Base Senior Medical Authority must, as a minimum:

   a. possess a licence from the provincial or territorial regulatory organization in the province or territory of practice;

   b. hold a Certification from the College of Family Physicians of Canada (CCFP); and

   c. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required.

## EXPERIENCE

4. The Deputy Base Senior Medical Authority must, as a minimum:

   a. 1 year equivalent full time experience working in a CF Health Services Centre as a physician;

b. have 5 years of experience directly providing patient medical care in an ambulatory primary care, occupational medicine, urgent care or emergency medicine setting;

c. have 3 years occupation health experience (this experience may have been acquired in the 5 years of experience noted above). Occupational Health aims for the promotion and maintenance of the highest degree of physical, mental and social wellbeing of workers in all occupations; the prevention among workers of departures from health caused by their working conditions; the protection of workers in their employment from risks resulting from factors adverse to health; placing and maintenance of a worker in an occupational environment adapted to his physiological and psychological equipment. Areas of practice would include:

(1) health evaluation of employees, including pre-assignment, periodic medical surveillance, and post-illness or injury;

(2) diagnosis and treatment of occupational and environmental injuries and illnesses, including rehabilitation;

(3) determination of medical causation;

(4) establishment of medical employment limitations;

(5) implementation of programs for the use of indicated personal protective devices – ear protection, safety spectacles, respirators;

(6) evaluation, inspection, and abatement of workplace hazards;

(7) toxicological assessments including advice on chemical substances that have not had adequate toxicological testing;

(8) maintenance of occupational medical records;

(9) immunization against possible occupational infections;

(10) periodic evaluation of the occupational or environmental health program;

(11) communication with employers;

(12) disaster preparedness planning for the workplace and the community; or

(13) assistance in rehabilitation and return to work programmes.

d. have 1 year of experience working with an Electronic Health Record or Microsoft Office (this experience may have been acquired in the 5 years of experience noted above); and

e. have successfully completed at least one of the following:

(a) CF Basic Aviation Medicine course; or

(b) CF Basic Dive Medicine course.

**TASKS**

5. The required tasks for this occupational group include the following:

a. practice medicine in accordance with the applicable provincial and national regulatory standards and in accordance with CFHS policy and guidance;

b. deliver occupational health services such as, but not limited to:

(1) assessments of medical fitness for duty of CAF members, including pre and post deployment, Periodic Health Assessment, hazardous occupation assessments, and post-illness or injury;

(2) diagnosis and treatment of occupational and environmental injuries and illnesses, including rehabilitation;

(3) establishment of patient Medical Employment Limitations (MEL), approve and/or recommend sick leave, and recommend changes in medical category in accordance with Canadian Forces Publication (CFP) 154: Medical Standards;

(4) referral of patients for participation in programs for the use of indicated personal protective devices – hearing conservation, respiratory protection program;

(5) maintenance of occupational health records through Electronic Health Record System and other health records forms;

(6) communication with Chain-of-Command on member's medical fitness for duty and medical employment limitations; and

(7) assist in return to work and transition programs.

c. provide comprehensive primary medical care to patients with acute and chronic health conditions including referral to other health care providers when warranted.;

d. communicate with the Senior Medical Advisor on relevant clinical matters such as CF Spectrum of Care, complex patients requiring multi-disciplinary intervention, individual operational readiness;

e. maintain patient medical information in Electronic Health Record System and patient health records;

f. provide clinical supervision and oversight to other members of the health care team within the Care Delivery Unit that are delivering care to patients assigned to the Primary Care Physician, including Physician Assistants, Nurse Practitioners, Medical Technicians, and Primary Care Nurses. All patients will be required to have a Most Responsible Physician and the physician will fill this role for a designated group of patients within the CDU. This will include patients that are routinely seen by other members of the health care team. Clinical supervision is comprised of the following:

(1) perform ongoing assessment of clinical competency of the provider;

(2) perform the role of consulting or collaborating physician in support of the clinical practice of CDU NPs;

(3) assign clinical tasks in accordance with CAF practice privileges and provincial scopes of practice;

(4) supervise delegated medical acts;

(5) ensure that the scope of practice, practice privileges and competency of the provider aligns with the complexity of care required for the patient;

(6) evaluate clinical performance through direct or indirect observation, chart review, case review, provision of co-signature;

(7) provide verbal and written feedback on clinical skills, knowledge, and judgement to the provider and Senior Medical Authority; and

(8) specific to HCP Physician Assistants: Serve as the clinical supervisor through the establishment of a Physician Assistant Practice Agreement outlining the clinical duties and terms of supervision between the HCP Physician Assistant and the Primary Care Physician. The agreement becomes the essential determinant of the HCP Physician Assistant`s individual clinical role, within the context of the Physician Assistant`s competencies, the CF Health Services scope of practice for PAs, and provincial jurisdictions.

g. provide clinical preceptorship to CF Health Services trainees, such as medical students, residents and Physician Assistant trainees, including:

(1) perform ongoing assessment of clinical competency of the provider;

(2) assign clinical tasks, including the delegation of medical acts;

(3) ensure that the scope of practice and competency of the provider aligns with the complexity of care required for the patient;

(4) evaluate clinical performance through direct or indirect observation, chart review, case review, provision of co-signature; and

(5) provide verbal and written feedback on clinical skills, knowledge, and judgement to the student, educational institution, and Base surgeon as required.

h. provide occupational health care to CAF Aircrew or Divers, including:

(1) perform specialized medicals, such as Periodic Health Assessments, as follows:

(a) Aircrew medicals IAW Aerospace Medical Authority Directive 100-01, Medical Standards for CF Aircrew, http://winnipeg.mil.ca/cms/Files/AMA%20Aircrew%20Medical%20Standards.pdf; or

(b) Dive medicals IAW CF Health Services Group Instruction 4000-04, Shallow Water Divers Periodic Health Assessment and Medical Administration found at Appendix 1.

(2) assign occupational flight or dive restrictions; and

(3) clinically investigate and report aeromedical or diving incidents involving aircrew or divers.

i. Deputy Base Senior Medical Authority specific tasks when delegated by the Base Surgeon:

(1) perform second level review of completed Periodic Health Assessments in accordance with Canadian Forces Publication (CFP) 154: Medical Standards and other CFHS policy and instructions;

(2) provide occupational health and health services advice to the local military chain of command in areas such as individual patient limitations or restrictions, general workplace or occupational hazards, unit or base level occupational health issues;

(3) provide occupational health and medical administration advice to other members of the healthcare team, such as physicians, physician assistants, and nurse practitioners, in areas including assignment of MEL, change in medical categories;

(4) perform quality assurance activities such as file reviews of health records, chart audits, peer reviews, as part of the clinical quality and patient safety program;

(5) deliver the occupational health and medicine components of the clinic level orientation program to new clinical staff.

(6) identify and raise issues and specific patient cases for discussion and review at intra and inter-disciplinary meetings;

(7) prepare medical responses to administrative processes such as Summary Investigations, Boards of Inquiry, patient complaint investigations, patient safety incidents, privacy breaches; and

(8) act as the Base Surgeon in the Base Surgeon's absence by performing liaison with the Area Surgeon and national professional-technical staff in areas such as clinical programs and associated clinical administrative processes (e.g. extended sick leave requests, Spectrum of Care exemptions), oversight of professional standards of clinical practice, and population health.

j. language of work may be French and/or English, depending on geographic location; and

k. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# TECHNOLOGIST – DIAGNOSTIC MEDICAL SONOGRAPHER

**STREAM 1**

**OCCUPATIONAL GROUP AND CATEGORY** **Technologist – Diagnostic Medical Sonographer**

## WORK AND ENVIRONMENT

1. Diagnostic Medical Sonographers provide diagnostic imaging services to radiologists, specialists, physicians and other health care providers. The images are used to diagnose and treat medical and surgical conditions or injury and disease.

2. The primary responsibilities of Diagnostic Medical Sonographers are to:

   a. provide patient care;

   b. produce diagnostic examinations;

   c. maintain equipment, accessories and supplies; and

   d. maintain a Quality Assurance Program.

3. Diagnostic Medical Sonographers operate ultrasound equipment, such as static and portable ultrasound units, and work in fully-equipped clinics in diagnostic imaging services as part of a multi-disciplinary team. Patients are seen as booked appointments as well as walk-ins for sick parade and urgent cases.

## EDUCATION / QUALIFICATIONS

4. All Diagnostic Medical Sonographers must possess, as a minimum:

   a. a certification from and current membership (Full Practice Membership) with Sonography Canada; and

   b. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required.

## EXPERIENCE

5. The Diagnostic Medical Sonographer must have a minimum of 2 years of experience:

   a. working in a clinic or hospital as a Diagnostic Medical Sonographer performing general, special, emergency and interventional ultrasound examinations;

   b. applying Diagnostic Imaging quality assurance and quality control practices and programs; and

c. operating and maintaining digital imaging equipment and accessories such as ultrasound equipment, Radiology Information Systems, Computed Radiography, and Picture Archival and Communication Systems.

**TASKS**

6. The required tasks for this occupational group include the following:

a. provide ultrasound services in accordance with Sonography Canada standards and scope of practice;

b. provide diagnostic imaging reception services by recording and completing the patient's medical documentation in the Radiology Information System (RIS), Computed Radiography (CR) System, Picture Archival and Communication System (PACS), and Canadian Forces Health Information System (CFHIS);

c. receive and complete requisitions;

d. prepare patients for examination and obtain patient consent (e.g. implied, verbal, or written) for procedures through an accurate explanation and instruction;

e. perform general, special, emergency and interventional ultrasound examinations by applying ultrasound procedures and techniques;

f. operate ultrasound equipment to produce diagnostic images of the human body for the diagnosis by radiologists or health care providers to treat disease or injury;

g. provide direct patient care throughout the entire ultrasound experience to include pre and post teaching and instruction;

h. evaluate ultrasound examinations for technical and diagnostic quality and provide corrective action as warranted;

i. enter relevant data into the radiology information system;

j. provide technical impressions regarding ultrasound examinations;

k. communicate ultrasound technical impressions to radiologists, the referring healthcare provider, or member of the healthcare team;

l. establish and maintain referral networks with local hospitals and clinics for the provision of diagnostic imaging services at off-site locations;

m. maintain quality assurance programs for ultrasound procedures and equipment, including the recording and evaluation of ultrasound quality assurance data, in order to maintain a safe environment for patients, self, and health care colleagues;

n. maintain a clean and appropriately stocked work area to include proper disinfecting procedures of all ultrasound probes, equipment and accessories;

o. maintain and order ultrasound products and consumable supplies;

p. maintain digital processors, ultrasound equipment, and accessories;

q. participate in performance measurement and utilization review by recording and tracking Diagnostic Imaging statistics;

r. participate as a team specialist in weekly team meetings, committees and working groups;

s. track and record section work activities in the Diagnostic Imaging Workload Measurement System;

t. language of work may be French and/or English, depending on geographic location; and

other associated tasks relevant to this occupational gr

# APPENDIX 11 TO ANNEX A1

# TECHNOLOGIST – MEDICAL LABORATORY

**STREAM 1**

**OCCUPATIONAL GROUP AND CATEGORY: Technologist – Medical Laboratory**

## WORK AND ENVIRONMENT

1. Medical Laboratory Technologists (MLTs) perform a variety of laboratory tests and procedures to assist physicians in diagnosing, monitoring, treating and preventing disease. The laboratory tests include chemistry, hematology, and immunology. MLTs see patients on a walk-in basis.

## EDUCATION / QUALIFICATIONS

2. All MLTs must, as a minimum, have:

   a. a Certificate of registration as a Medical Laboratory Technologist with the Canadian Society of Medical Laboratory Science (CSMLS), and have a licence from or be registered with the provincial or territorial regulatory organization in the province of practice (where applicable); and

   b. a Certificate of Basic Life Support (BLS) for Health Care Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C.

## EXPERIENCE

3. The MLT will have a minimum of 2 years of experience working with Laboratory Information System(s) and performing laboratory tests including, but not limited to, Haematology, Urinalysis, Chemistry, and Phlebotomy.

## TASKS

4. The required tasks for this occupational group include the following:

   a. perform, communicate and record diagnostic procedures;

   b. interact with patients, provide patient instruction, and collect specimens for analysis while maintaining the sample integrity standard;

   c. perform venipuncture;

   d. recognize and assess unusual or abnormal findings and notify the laboratory specialist. Abnormal is defined as any deviation to the norm, average, or expected;

e. perform and document quality control tests daily on each analyzer;

f. operate, maintain and perform troubleshooting on all laboratory instruments to ensure their functioning;

g. monitor and order department supply inventory;

h. perform validation testing and procedure validation on equipment;

i. enter patient and specimen data into the Laboratory Information System and log sheets;

j. investigate and locate missing or inaccurate information on requisitions;

k. retrieve results from internal or external sources and perform additional reflex tests. Reflex tests are follow-up testing automatically initiated when certain test results are observed in the laboratory and used to clarify or elaborate on primary test results;

l. label and centrifuge all collected samples and separate some samples for external testing;

m. measure body fluid collection, pour off and send out samples for further testing such as 24 hours urine collection;

n. process specimens including labelling samples as diagnostic or infectious, packaging samples in accordance with Transport of Dangerous Good (TDG) regulations, preparing waybills for transportation, and data entry. Maintain records according to TDG regulations;

o. answer telephone inquiries such as testing times, results and nature of samples for patient specimens;

p. collect and process samples based on the priority of requested testing such as immediate or routine;

q. sort and distribute results, requisitions and specimens via courier and postal services including faxing reports, photocopying requisitions and documents, and preparing transportation buckets;

r. clean and tidy laboratory work area and all laboratory equipment;

s. language of work may be French and/or English, depending on geographic location; and

t. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# TECHNOLOGIST – MEDICAL LABORATORY ASSISTANT

**STREAM 1**

**OCCUPATIONAL GROUP AND CATEGORY** **Technologist – Medical Laboratory Assistant**

## WORK AND ENVIRONMENT

1. Medical Laboratory Assistants (MLAs) perform basic laboratory procedures to assist physicians in diagnosing, monitoring, treating and preventing disease. MLAs collect, process, and prepare patient specimens that are tested and analyzed by Medical Laboratory Technologists (MLTs). Medical Laboratory assistants see patients on a walk-in basis.

## EDUCATION / QUALIFICATIONS

2. All Medical Laboratory Assistant must, as a minimum, possess:

   a. a Certificate of registration as a Medical Laboratory Assistant from the Canadian Society of Medical Laboratory Science (CSMLS); and

   b. a Certificate of Basic Life Support (BLS) for Health Care Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C.

## EXPERIENCE

3. The MLA must, as a minimum of 2 years of experience working in a clinical laboratory setting and performing Phlebotomy.

## TASKS

4. The required tasks for this occupational group include the following:

   a. perform venipuncture on adult population;

   b. interact with patients, provide patient instruction, and collect specimens for analysis while maintaining the sample integrity standard;

   c. perform specific lab analysis such as urinalysis and pregnancy tests;

   d. enter patient and specimen data into the Laboratory Information System and log sheets;

   e. investigate and locate missing or inaccurate information on requisitions;

f. label and centrifuge all collected samples and separate some samples for external testing;

g. measure body fluid collection, pour off and send out samples for further testing such as 24 hours urine collection;

h. process specimens including labelling samples as diagnostic or infectious, packaging samples in accordance with Transport of Dangerous Good (TDG) regulations, preparing waybills for transportation, and data entry. Maintain records according to TDG regulations;

i. answer telephone inquiries such as testing times, results and nature of samples for patient specimens;

j. collect and process samples based on the priority of requested testing such as immediate or routine;

k. sort and distribute results, requisitions and specimens via courier and postal services including faxing reports, photocopying requisitions and documents, and preparing transportation buckets;

l. maintain and restock department supply inventory;

m. clean and tidy laboratory work area and all laboratory equipment;

n. language of work may be French and/or English, depending on geographic location; and

o. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# TECHNOLOGIST – MEDICAL RADIOLOGICAL TECHNOLOGIST

**STREAM 1**

**OCCUPATIONAL GROUP AND CATEGORY** **Technologist – Medical Radiological Technologist**

## WORK AND ENVIRONMENT

1. Medical Radiological Technologists provide diagnostic imaging services to radiologists, specialists, physicians and other health care providers. The images are used to diagnose and treat medical and surgical conditions or injury and disease.

2. The primary roles and responsibilities of Medical Radiological Technologists are to:

   a. provide patient care;

   b. produce diagnostic examinations;

   c. maintain equipment, accessories and supplies; and

   d. maintain a quality assurance program.

3. Medical Radiological Technologists operate x-ray equipment, such as computed radiography (CR), digital radiography (DR) and work in fully-equipped clinics in diagnostic imaging services as part of a multi-disciplinary team. Patients are seen as booked appointments as well as walk-ins for sick parade and urgent cases.

## EDUCATION / QUALIFICATIONS

4. All Medical Radiological Technologists must, as a minimum:

   a. have a current certification from and current membership (Full Practice Membership) with the Canadian Association Medical Radiation Technologists (CAMRT) or by other professional associations that have reciprocal agreements with CAMRT such as the Ordre des technologues en imagerie médicale, en radio-oncologie et en électrophysiologie médicale du Québec (OTIMROEPMQ);

   b. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C; and

   c. have a current license from the Medical Radiation Technologists regulatory body in the province of work.

## EXPERIENCE

5. The Medical Radiological Technologist must, as a minimum, have of 2 years of experience:

a. working in a clinic or hospital as a Medical Radiation Technologist performing general, special, emergency, interventional, and operative radiology examinations observing safe radiation protection practices or procedures;

b. applying diagnostic imaging quality assurance and quality control practices and programs; and

c. operating and maintaining digital imaging equipment and accessories such as digital radiography, Radiology Information Systems, Computed Radiography, and Picture Archival and Communication Systems.

**TASKS**

6. The required tasks for this occupational group include the following:

a. provide diagnostic imaging services in accordance with CAMRT and provincial Medical Radiation Technologist Association standards and scope of practice;

b. provide diagnostic imaging reception services by recording and completing the patient's medical documentation in the Radiology Information System (RIS), Computed Radiography (CR) System, Picture Archival and Communication System (PACS), and Canadian Forces Health Information System (CFHIS);

c. receive and process X-ray requisitions;

d. prepare patients for examination and obtain patient consent (e.g. implied, verbal, or written) for procedures through accurate explanation and instruction;

e. perform general, special, and emergency diagnostic imaging examinations by applying diagnostic radiographic and/or fluoroscopic and diagnostic imaging procedures or techniques;

f. operate X-ray, radiographic and fluoroscopic equipment, computerized tomography (CT) scanners to produce radiographic images of the human body for the diagnosis by radiologists or health care providers to treat disease or injury;

g. provide direct patient care throughout the entire diagnostic imaging experience to include pre and post teaching and instruction;

h. evaluate diagnostic images for technical and diagnostic quality and provide corrective action as needed;

i. enter data into the radiology information system;

j. apply radiation protection measures by observing safe radiation protection practices;

k. communicate medical and technical findings to radiologists, the referring healthcare provider, or member of the healthcare team;

l. establish and maintain referral networks with local hospitals and clinics for the provision of diagnostic imaging services at off-site locations;

m. perform basic verification and quality control checks on radiographic and digital processing equipment by monitoring equipment performance;

n. maintain quality assurance programs for diagnostic imaging procedures and equipment, including the recording and evaluation of radiology quality assurance data, in order to maintain a safe environment for patients, self, and health care colleagues;

o. maintain a clean and appropriately stocked work area to include proper disinfecting procedures of all diagnostic imaging equipment and accessories;

p. maintain and order diagnostic imaging products and consumable supplies;

q. maintain digital processors, diagnostic equipment and accessories;

r. participate in performance measurement and utilization review by recording and tracking diagnostic imaging statistics;

s. participate as a team member specialist in weekly team meetings, committees and working groups;

t. track and record section work activities in the Diagnostic Imaging Workload Measurement System;

u. language of work may be French and/or English, depending on geographic location; and

v. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# NURSE – MENTAL HEALTH NURSE

**STREAM 1**

**OCCUPATIONAL GROUP AND CATEGORY** **Nurse – Mental Health Nurse**

## WORK AND ENVIRONMENT

1. Mental Health Nurses are responsible for assessment, nursing diagnosis, development and implementation of a care plan, and evaluation of mental health nursing care. Mental Health nurses provide crisis intervention and counselling and life skills programming to clients in the mental health clinic. Mental Health Nurses act as a member of CAF health care team working in the Mental Health Service Delivery, which includes: Psycho Social Services (PSS), Mental Health Services (MHS) or the Operational Trauma Stress and Support Centers (OTSSC). Mental Health nurses receive clients through self-referrals, referrals from other health care providers, or referrals from clients' family, friends or supervisor. Their work includes walk-in and scheduled appointments with individuals or family and group therapy sessions.

2. Language of work may be in English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. All Mental Health Nurses must, as a minimum, possess:

   a. a Registered Nurse Diploma or Baccalaureate Degree in Nursing from a recognized college or university with either a certificate in Mental Health Nursing or certification in Psychiatric/Mental Health Nursing from the Canadian Nurses Association (CNA);

   b. a Registered Nurse licence from the provincial or territorial professional college or association in the province of practice; and

   c. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required.

## EXPERIENCE

4. The Mental Health Nurse must, as a minimum, 3 years of experience within the last 5 years in nursing practice performing a variety of mental health nursing activities such as supportive psychotherapy, cognitive behavioural therapy, solution-focused therapy, counselling, and crisis intervention or management in an adult community setting to clients suffering from mental illnesses or psycho-social difficulties.

## TASKS

5. The required tasks for this occupational group include the following:

a. perform within the defined scope of practice in accordance with the regulatory organization in the province of work;

b. conduct bio-psychosocial assessments;

c. develop individualized treatment plans with the CAF member;

d. provide direct client care and interventions based on the prescribed treatment plan consistent with psychiatric illness and diagnosis in the Diagnostic and Statistics Manual of Mental Health Disorders version V (DSM-V);

e. monitor client progress and evaluate the treatment plan;

f. revise the treatment plan based on the clients' progress;

g. provide supportive counselling that is evidence-based and corresponds with professional best practices such as Cognitive Behavioural therapy, Solution Focused therapy, Strengths Perspectives, and Motivational therapy;

h. teach relaxation training, as well as, stress and anger management to individuals and groups;

i. provide support and health education for members, their support networks and others associated with their care;

j. monitor medications for therapeutic responses and provide client education on medications including purpose, proper administration, intended effects and side effects;

k. provide brief interventions to clients in acute distress and ensure the client has full access to internal and external health care services;

l. participate in inter-disciplinary team meetings related to clinical care and service delivery by presenting clients' case and providing status updates;

m. complete deployment health related activities, such as pre-deployment and/or enhanced post-deployment interviews;

n. perform all administrative tasks associated with delivery of clinical care such as scheduling appointments, identifying resources, and arranging case conferences;

o. document client interactions in the Canadian Forces Health Information System (CFHIS) and personal health records (CF2016) in accordance with relevant CF

Health Services policies and standards and with the provincial regulatory organization's Standards of Practice for Nurses related to documentation;

p. provide recommendations to the client's primary care provider on employment limitations based on the clinical interpretation of the client's health status;

q. communicate and liaise with other health care professionals and service agencies such as Veteran's Affairs Canada (VAC) and Military Family Resource Centers (MFRC);

r. design or revise PowerPoint presentations for psycho-educational sessions such as anger or stress management and relaxation;

s. distribute local outreach material such as Mental Health awareness materiel to bases and units; and

t. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# NURSE – NURSE CASE MANAGER

**STREAM** **1**

**OCCUPATIONAL GROUP AND CATEGORY** **Nurse –**
**Nurse Case Manager**

## WORK AND ENVIRONMENT

1. Nurse Case Managers (NuCMs) are responsible for providing case management services to CAF members who suffer from protracted and complex health issues. NuCMs promote and optimize the health and well-being of members by facilitating access to health services based on the clients' needs and programs and benefits for which they are eligible. NuCM's are involved in patient care coordination as part of the CFHS primary health care team. NuCM's conduct comprehensive case management assessments using the case management process; provide client centred case management services to assist clients return to active duty (Return to Work Program) or to civilian life; coordinate and monitor clients engaged in the case management program and consult with other professionals to ensure a comprehensive plan is developed.

2. Language of work may be in English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. Nurse Case Managers must, as a minimum, possess:

   a. a Baccalaureate Degree in Nursing from a recognized university;

   b. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required; and

   c. a current licence to practise from a provincial or territorial College of Nurses in the province of practice.

## EXPERIENCE

4. The Nurse Case Manager shall possess, as a minimum, 3 full time equivalent years of experience within the last 4 years in nursing practice:

   a. performing assessments and developing care plans that reflect the client's individual health care needs and personal goals in the community health or primary health care setting; and

   b. providing adult health education programs in a community health, primary health care or case management setting.

## TASKS

5. The required tasks for this occupational group include the following:

   a. assess, organize, evaluate and monitor patient's health care needs in accordance with the CF Health Services case management process as directed by the National Program Leadership;

   b. monitor client medical treatment plans and initiate case management action plans based on client needs and goals. These clients have complex, protracted, health care conditions likely to exceed a 3 month period and require care management or are deemed chronic and are preparing for the transition to civilian life;

   c. identify health care and community services supports required in order to meet clients' specific needs;

   d. participate in multidisciplinary team meetings and working groups, as a member of the primary health care team, to share client's progress and provide recommendations and suggestions to decision makers such as the client's primary care provider for the purpose of developing action plans that meet client service standards and achieve health care goals;

   e. refer clients to specialty services as prescribed by their primary care provider such as occupational therapists, physiotherapist and monitor patient follow-ups;

   f. facilitate access to care and benefits for the serving CAF Members and their families in accordance with the CF Spectrum of Care (SoC);

   g. educate clients and families about their health condition(s) and provide them with information and eligibility criteria on benefits and entitlements;

   h. provide current health and services information to patients and their families in order for them to make informed decisions and to access a broad range of community, provincial, and federal services. The services include Service Income Security Insurance Plan (SISIP), Veterans Affairs Canada (VAC), Canada Pension Plan (CPP), Public Service Health Care Plan or Public Service Dental Plan (PSHCP or PSDP), provincial health-care card, etc.;

   i. manage, track, and follow up benefit applications with various departments and agencies such as Human Resources and Skills Development Canada (HRSDC), VAC, and SISIP;

   j. develop and maintain a network of partnerships with internal and external community organizations within the Case Manager's geographical area to streamline the transfer of patient care, to expand community resources to address service gaps, and provide patient a smooth transition to civilian life. These internal and external health and community organizations

include CF Health Services Rehabilitation Program, Joint Personnel Support Unit (JPSU), Integrated Personnel Support Centre (IPSC), VAC, Service Income Security Insurance Plan, homecare agencies, local and regional hospitals, etc.;

k. implement and incorporate CF Health Services Group specific information such as standard operating procedures, instructions, guidelines, orders, standards related to the delivery of case management services;

l. contribute to the clinic's continuous Quality Improvement program within the clinic by conducting peer chart and process reviews and analyzing case management client satisfaction surveys in a quarterly basis;

m. provide the case management perspective at various meetings such as case conference;

n. conduct quarterly presentations to units, internal and external agencies to promote the Case Management program and the Integrated Personnel Support Centre outreach program;

o. conduct group information sessions on a monthly basis and provide individual consultations to educate clients and their families on services, benefits and programs, in conjunction with external organizations and other federal departments such as VAC and HRSDC;

p. promote the case management program at the Medical Second Career Assistance Seminars (Med Scans) on a quarterly or semi-annual basis;

q. promote and enhance peer development by sharing individual skills and knowledge through mentorship and case management clinical meetings; and

r. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# NURSE – LICENSED PRACTICAL NURSE (LPN) OR REGISTERED PRACTICAL NURSE (RPN)

**STREAM 1**

**OCCUPATIONAL GROUP AND CATEGORY** **Nurse – Licensed Practical Nurse (LPN) or Registered Practical Nurse (RPN)**

## WORK AND ENVIRONMENT

1. A Licensed Practical Nurse (LPN) or a Registered Practical Nurse (RPN) provides direct patient care under the direction of physicians, registered nurses, or other health care providers. These activities include conducting patient history and physical assessments; performing selected diagnostic and therapeutic interventions; and counseling patients on preventive health care. A LPN or a RPN provides services to patients on a walk-in and appointment basis in various primary and ambulatory care settings such as the Care Delivery Unit (CDU), treatment room, and specialty clinic.

2. Language of work may be in English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. All LPNs and RPNs must, as a minimum, have:

   a. graduated from a Practical Nursing Program approved by Council of the College of Nurses;

   b. a licence from the provincial or territorial professional college or association in the province of practice; and

   c. a Certificate of Standard First Aid and Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C.

## EXPERIENCE

4. The LPN or RPN shall possess, as a minimum, 1 full time equivalent year of experience within the last 3 years in nursing practice conducting patient assessment and providing direct nursing care for a broad range of diseases in the adult population in a primary care or ambulatory care setting.

## TASKS

5. The required tasks for this occupational group include the following:

a. perform within defined scope of practice in accordance with the regulatory organization in the province of work;

b. perform triage assessment during walk-in hours and patient assessments that include medical or incident history, physical examinations, and Periodic Health Assessments (PHAs) Part I including vital signs measurement and vision acuity test;

c. perform nursing interventions such as taking vital signs, applying aseptic techniques including sterile dressing, ensuring infection control, and conducting specimen collection;

d. develop a nursing care plan based on the result of the assessment and refer to a physician or other health care provider;

e. administer medication as per doctor's order as per provincial scope of practice and observe and document therapeutic effects;

f. complete nursing documentation immediately after each patient interaction;

g. communicate any changes or abnormal findings of the patient's status or condition to the senior clinician. Abnormal is defined as any deviation to the norm, average, or expected;

h. perform therapeutic procedures such as injections and wound care;

i. administer and monitor established respiratory therapy and intravenous therapy, where competency has been demonstrated;

j. monitor patient's progress and evaluate effectiveness of nursing interventions;

k. provide health education to patients;

l. perform administrative tasks including written or telephone responses to patient queries, preparation of medical files for physicians or other health care providers, and to return of medical files to health record department;

m. assist physicians or other health care providers with treatments and procedures;

n. act as the point of contact for the care coordination and preparation of responses, information requests, and patient inquiries in the specialty clinic;

o. monitor all medical supplies and inventory including ordering and replenishing;

p. clean all patient care areas between patients;

q. clean, sterilize and package surgical instruments;

r. provide pre-operative and post-operative patient teaching such as clinical and procedural information or instructions and comfort care;

s. prepare patients for minor surgery procedures by shaving and washing with antiseptic solution on the patient's operative areas; and

t. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# NURSE – NURSE PRACTITIONER

**STREAM 1**

**OCCUPATIONAL GROUP AND CATEGORY** **Nurse – Nurse Practitioner**

## WORK AND ENVIRONMENT

**1.** Nurse Practitioners (NPs) are registered nurses, with advanced education and the competence to provide comprehensive health assessment, to diagnose health/illness conditions, and to treat and manage acute and chronic illness. NPs order and interpret screening and diagnostic tests, perform procedures, prescribe medication, in accordance with their legislated scope of practice. Nurse Practitioners provide direct patient care across the health-illness continuum of care, in a primary care setting, such as a Care Delivery Unit (CDU) and receive patients on both a walk-in and appointment basis. Their work encompasses health promotion, disease and injury prevention, and illness management including rehabilitation and supportive care. NPs practice independently as a health care provider and act as a member of a multi-disciplinary team in the primary care setting such as Care Delivery Units and treatment rooms. NPs also work collaboratively with physicians for the management of complex care patients IAW the Nurse Practitioner Role and Practice Privileges in the Canadian Armed Force.

2. Language of work may be English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. All NPs shall possess, as a minimum:

   a. a Baccalaureate Degree in Nursing from a recognized university;

   b. successful completion of a Nurse Practitioner Program approved or recognized by the provincial regulatory authority with a specialty certificate in either Nurse Practitioner – Adult (NP-Adult) or Nurse Practitioner – Primary Health Care (NP-PHC). In some provinces, a Master Degree in Nursing with a Nurse Practitioner stream is required;

   c. registration or license to practice as an Nurse Practitioner {NP, RN(EC), or RN(EP)} from the regulatory organization in their respective province/territory; and

   d. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C.

4. A Master Degree in Nursing, in the jurisdictions where a Master Degree is not a requirement to be a NP is considered an Asset Qualification.

## EXPERIENCE

5. The NP must, as a minimum, possess experience:

    a. directly providing patient medical care as a NP in primary care, ambulatory care, or acute care setting; and

    b. working independently as a nurse practitioner, performing advanced health assessment, diagnosis, therapeutic interventions and health care management of various acute and chronic illnesses.

6. The level of experience for the NP Category are :

    a. Level 1: a minimum of 1 full time equivalent year of clinical experience;

    b. Level 2: meet the requirements for Level 1 and have successfully completed one the following:

        (i) CAF Basic Aviation Medicine course; or

        (ii) CAF Basic Dive Medicine course.

## TASKS

7. The required tasks for this occupational group include the following:

    a. perform Standards of Practice of Nurse Practitioner IAW Nurse Practitioner Role and Practice Privileges in the Canadian Armed Force, provincial regulatory authority and Canadian Nurse Practitioner Core competency Framework 2010;

    b. perform patient assessments that include complete wellness, acute episodic, management of stable chronic illnesses and periodic health assessments (PHAs), recruiting medicals;

    c. provide patient education, supportive counselling or treatment, and any follow-up requirements;

    d. participate in the CDU interdisciplinary team meeting such as case conferences and a minimum of bi-weekly meetings to discuss updates, follow-up care, outcomes of treatments and/or patient feedback;

    e. provide current health, wellness, disease management and psychosocial information to patients to ensure timely access of services, and allows patients to make informed choices and decisions;

f. provide patient education and counselling related to their health care management;

g. consult with physicians and other health care professionals in accordance with the NP's scope of practice and practice privileges in the CAF to ensure the health care needs of their patients are met;

h. identify, provide, and manage occupational health medicine and return to work of patients IAW Surgeon General Guidelines provided by the Task Manager;

i. identify any dangers related health and safety and takes preventative measures or makes appropriate recommendations to the Task Manager;

j. provide clinical preceptorship to CF Health Services approved trainees, such as medical students, new NPs, nurses and Med Techs, including:

(1) perform ongoing assessment of clinical competency of the trainees;

(2) assigning clinical tasks;

(3) evaluating clinical performance through direct or indirect observation; and

(4) providing verbal and written feedback on clinical skills, knowledge, and judgement to the student, educational institution, and Senior Medical Authority.

k. implement new evidence-based practice;

l. participate in group developmental activities in the clinic by providing recommendations or suggestions for the development of policies and procedures documents as required;

m. function as a member of the duty care team to respond to walk-in cases throughout the work hours; and

n. other associated tasks relevant to this occupational group.

8. Additional required tasks for Level 2 NPs include performing occupational care to CF Aircrew or Divers:

a. performing specialized medicals, such as Periodic Health Assessments, as follows:

(1) Aircrew Medicals IAW Aerospace Medical Authority Directive 100-01, Medical Standards for CF Aircrew; or

(2) Dive Medicals IAW CF Health Services Group Instruction 4000-04, Shallow Water Divers Periodic Health Assessment and Medical Administration found at Appendix 1.

b. assigning occupational flight or dive restrictions.

# APPENDIX 11 TO ANNEX A1

# OCCUPATIONAL THERAPY – OCCUPATIONAL THERAPIST

**STREAM 1**

**OCCUPATIONAL GROUP AND CATEGORY** **Occupational Therapy – Occupational Therapist**

## WORK AND ENVIRONMENT

1. Occupational therapists work with ill and/or injured military personnel to reduce/eliminate barriers impacting participation in valued roles and routines in order for the member to attain optimal potential. Valued roles and routines are what military personnel want to do and are expected to do and can be considered 'occupation'. The occupational therapist's role is twofold: (1) direct one to one or group time to assess and treat military personnel with varying levels of injury or illness and (2) consult/advise regionally with medical authorities on the area of occupational therapy practice and, if necessary, provide oversight of regional or local occupational therapy services.

2. It is the occupational therapist's role to utilize qualitative and quantitative tools to assess factors shown to impact on roles and routines, particularly in the area of self-care and productivity. Interventions with ill and/or injured military personnel are diverse. Typically occupational therapists are tasked to design rehabilitation plans with goals that prevent, develop, increase and restore a CAF member's work participation (e.g., return to duty, sustained return to duty or transition to civilian life) and adapt or modify environments impeding return to roles and routines (i.e., home modification and vehicle prescriptions).

3. Assessment, treatment, consultation/advising and oversight most often occurs within a multi-disciplinary team setting and can transpire within the garrison clinic, at the member's workplace, within the community or member's home, via secured tele-communications or at regional assets (e.g., Centres of Excellence, rehabilitation centres). Patients are seen by booked appointment and walk-ins.

4. Language of work may be English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

5. All Occupational Therapists must, as a minimum:

   a. possess a Licence in good standing order with the provincial or territorial professional college or association in the province of practice; and

   b. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required.

## EXPERIENCE

6. The Occupational Therapist must:

a. must possess a minimum of 1 year experience working as an Occupational Therapist with various orthopaedic, musculoskeletal, neurological, pre and post-surgical adult populations including complex injuries such as poly-trauma, traumatic brain injuries, and amputations;

b. have experience with at least four of the following specific rehabilitation fields:

(1) upper extremity injuries including amputation and training in splinting and bracing;

(2) Assessment and treatment of chronic pain patients using occupation-based methods;

(3) Cognitive and/or mental health rehabilitation;

(4) home access assessment and modifications that includes discharge planning, housekeeping/grounds keeping assessment, safe medication and health management;

(5) Provision of assistive devices/adaptive equipment ;

(6) injury prevention and ergonomics;

(7) driving rehabilitation and vehicle modification prescription; or

(8) Vocational rehabilitation, which includes experience in functional capacity assessments, work evaluation, or community re-engagement.

c. Experience with at least two of the following:

(1) Multi-disciplinary rehabilitation experience at a physical rehabilitation facility;

(2) Providing consultation regarding occupational therapy practices;

(3) Providing oversight on occupational therapy services;

(4) Leading the management of pre and post-surgical conditions including complex injures such as poly-trauma, traumatic brain injuries and amputations; or

(5) The design and implementation of comprehensive rehabilitation and return to duty/work or transitioning plans.

## TASKS

7. The required tasks for this occupational group include the following:

   a. perform full scope of practice of occupational therapy in accordance with CF H Services policies/directives and follow the standard of practice in accordance with the regulatory body and CF Health Services;

   b. assess and manage physical, cognitive, conative (e.g. meaning, values) and affective components related to occupation and occupational participation such as:

      (1) agility, ability to maintain physical stamina, endurance, range of motion, postural tolerance, transfers, balance, body mechanics, sensation, gross and fine manual dexterity, strength, gait, prehension;

      (2) motor coordination, visual acuity, depth perception, form perception abilities;

      (3) accommodation, general learning ability, numerical aptitude, concentration skills, frustration tolerance, self-confidence, ability to follow instructions, communication skills, decision-making skills;

      (4) functional capacities, work simulations, home modification assessments, wheelchair skills, ergonomic assessment, driving abilities and skills; and

      (5) self-care, productivity, and leisure.

   c. use evidence-based, objective and validated outcome-measures, disability questionnaires and performance indicators specific to rehabilitation;

   d. create and implement targeted intervention plans relevant to the person, occupation, and environment;

   e. develop specific, measurable, attainable, realistic and timely goals to achieve targeted outcomes consistent with patients values . Empower patients to be active team members in their intervention plan;

   f. consult, advocate, educate, and engage the patient through occupations to implement the intervention plan;

   g. analyze tasks and activities relevant to occupational participation issues from a holistic perspective including physical, mental, sociocultural and spiritual components;

h. perform occupation and occupational participation advocacy, promotion, and prevention with patients and other members of the inter-professional team such as client supervisors, support units, healthcare providers, etc.;

i. perform health promotion activities, such as annual stress management briefings, ergonomic assessments and recommendations etc., in support of base military units;

j. formulate and document possible recommendations based on the patients specific needs in patient health records;

k. comply with occupational therapy standards of charting in accordance with CF Health Services policies/directives and as prescribed by the provincial regulatory body such as the SOAPIE (subjective, objective, assessment, plan, intervention, evaluation) format;

l. provide occupational therapy advice and consultation to other healthcare providers including regional medical authorities and other CF Health Services Centres by way of case consultations, requests for assistive devices and adaptive equipment approval, referral practices for occupational therapy, etc.;

m. provide occupational therapy services in the garrison clinic, at the member's workplace, within the community or member's home, via secured tele-communications or at regional assets (e.g., Centres of Excellence, rehabilitation centres);

n. establish and maintain referral networks and relationships with regional rehabilitation facilities and subject matter experts, such as hand therapists, prosthetists, orthotists, etc., in order to meet the rehabilitation needs of CAF patients when accessing off-site care and maintain continuity of care between providers;

o. when necessary, refer to and/or provide oversight of patients outsourced occupational therapy services;

p. when necessary attained approved training sessions, grand rounds, team meetings, conferences, CF OT training meetings and prepare and present pre-approved presentations at said locations;

q. promote the value of occupational therapy services to both clients and the inter-professional team by communicating during case reviews, team meetings, informal communications etc.;

r. operate, monitor, and maintain equipment (e.g. function capacity evaluation tool, wheelchairs, etc.) and supplies (e.g. orthotics, foam and cushions, etc.) required for occupational therapy services;

s. review and write reports regarding spectrum of care exceptions;

t. participate and/or present in CFHS approved quality improvement initiatives;

u. participate in the CF Health Services national level occupational therapy workshops, meetings, and teleconferences; and

v. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# NURSE – PERIOPERATIVE REGISTERED NURSE

**STREAM 1**

**OCCUPATIONAL GROUP AND CATEGORY** **Nurse – Perioperative Registered Nurse**

## WORK AND ENVIRONMENT

1. Perioperative Registered Nurse (Periop RN) is responsible for the nursing activities associated with the needs of the surgical patient throughout the perioperative experience which encompasses the pre-operative, intra-operative and post-operative phases. The Periop RNs function either as a scrub nurse or a circulating nurse. A scrub nurse is sterile and is responsible for handling instruments and supplies used during surgery whereas a circulating nurse oversees the overall surgical case including the resource and instrumentation/materials requirements as well as the quality of care given during the patient's three phases of surgical treatment. The circulating nurse, being the non-scrubbed member of the surgical team, represents the link between the scrub team and all other departments such as blood bank and laboratory. The Periop RNs work in pre-operative clinics, operating rooms (ORs) in the civilian hospital during the assigned military OR time, and ambulatory care settings such as Specialists Clinic within the CF Health Services Centres. Their patient interactions are always scheduled and they function as a part of Military OR team.

2. Language of work may be in English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. All Periop RNs must, as a minimum, possess:

   a. a Baccalaureate Degree in Nursing from a recognized university;

   b. a Registered Nurse licence from the provincial or territorial professional college or association in the province of practice;

   c. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required; and

   d. a Certificate from a hospital-based or ORNAC approved Perioperative Nursing Certification Program.

## EXPERIENCE

4. The Periop RN shall possess, as a minimum, 2 full time equivalent years of clinical experience:

a. performing scrub and circulating roles within General, Orthopaedic, Ear/Nose/Throat (ENT), and Plastic surgical specialties.

**TASKS**

5. The required tasks for this occupational group include the following:

a. act in accordance with scope of practice of the Periop RN;

b. attend the civilian hospital's general and operating room-specific orientation programs;

c. perform the role of the scrub nurse for various specialty surgeries such as General, Orthopaedic, ENT, and Plastic:

(1) prepare and set up a sterile area;

(2) assist the surgical team with gowning and gloving;

(3) manage instruments within the operative site and sterile back table; and

(4) maintain the accuracy of record counts for all instruments and supplies such as gauzes for the procedure.

d. perform the role of the circulating nurse for various specialty surgeries such as General, Orthopaedic, ENT, and Plastic:

(1) develop a care plan;

(2) review pre-operative assessment with patient;

(3) transfer patient to and from the operating room;

(4) position the patient IAW the specific surgery, anaesthetist and surgeon;

(5) perform surgical skin preparation;

(6) keep precise documentation during the procedure;

(7) dispense instruments, supplies and medications to the surgical sterile field;

(8) handle specimens and special apparatus;

(9) maintain the accuracy of record counts for all instruments and supplies; and

(10) organize and oversee all the activities in the operating room.

e. assist with the induction and emergence phase of anaesthesia as per the anaesthetist's direction;

f. transfer surgical patient to the Post Anaesthesia Care Unit (PACU) and handover the patient to the accepting PACU nurse by giving a verbal nursing report;

g. set-up, clean and turnover the operating room in between surgical cases;

h. prepare and manage all military and civilian hospital's documentation associated with surgical patients such as CF 100 and post-op instructions;

i. comply with all relevant patient safety related procedures and programs as directed by CF Health Services or the civilian hospital; and

j. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHARMACY – PHARMACIST

**STREAM 1**

**OCCUPATIONAL GROUP AND CATEGORY** **Pharmacy – Pharmacist**

## WORK AND ENVIRONMENT

1. Pharmacists compound, dispense and prescribe pharmaceuticals and provide pharmaceutical expert services to both patients and other health care providers. Pharmacists are the medication management experts of the health care team. Pharmacists work within the Pharmacy department in the primary care clinic and work collaboratively in a multi-disciplinary team. Pharmacists receive walk-in clients during work hours.

## EDUCATION / QUALIFICATIONS

2. All Pharmacists must, as a minimum, have:

   a. a Bachelor degree in Pharmacy from a recognized Canadian University accredited by the Canadian Council for Accreditation of Pharmacy Programs (CCAPP), or any graduate of a foreign university who has successfully met the provincial requirements to obtain a pharmacy license;

   b. completed a national board examination through the Pharmacy Examining Board of Canada (PEBC) (with the exception of Québec);

   c. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required; and

   d. registration and licence from the provincial or territorial regulatory organization in the province of practice.

## EXPERIENCE

3. The Pharmacist shall possess, as a minimum, 3 years of experience within the last 5 years, providing direct patient care as a clinical or community pharmacist and working in one or more clinical settings such as hospital or community.

## TASKS

4. The required tasks for this occupational group include the following:

   a. compound, dispense and prescribe pharmaceuticals to patients and educate them on indications, contraindications, adverse effects, drug interactions and dosage in accordance with the Canadian Armed Forces (CAF) approved practice privileges for pharmacists and CF Health Service policies and standards. Prescribing

includes initiating a prescription for a prescribed list of conditions, prescribing in an emergency, adapting a prescription, substituting a therapeutic equivalent for a prescribed pharmaceutical, and renewing a prescription for continuity of care;

b. monitor the use of pharmaceuticals and order, access and make use of lab results in accordance with prescribing authority;

c. maintain an accurate patient record by documenting prescribing of pharmaceuticals and any other decisions or follow-up plans necessary to provide continuity of care;

d. communicates with patients and other health care providers to provide efficient and effective collaborative care;

e. practice in accordance with the National Association of Pharmacy Regulatory Authorities (NAPRA) Model Standards of Practice for Canadian Pharmacists;

f. respond to inquiries from health care providers and patients on medications and drug administration;

g. participate in case conferences with physicians by reviewing and updating patients' medication profile on both the pharmacy database and Canadian Forces Health Information System (CFHIS);

h. provide pharmacy support to Departure Assistance Groups (DAGs) including prescribing of pharmaceuticals, documenting the prescribing as per Restricted Acts: Pharmaceuticals policy as well as any local policy and communicating effectively with patients and the health care team;

i. review and reconcile patients' medication to obtain accurate medication record;

j. maintain medication and pharmacy inventory;

k. be familiar with the Medical Materiel Manual (MMM) and provide medical supplies to all local units;

l. enforce proper return and disposal of pharmaceuticals and medical materiel;

m. maintain current catalogues and other reference material for the Pharmacy library;

n. apply procedures for Narcotic and Controlled drugs in accordance with Narcotic and Controlled Drugs policy;

o. perform monthly maintenance checks on all pharmacy equipment;

p. enforce orders, plans and instructions related to pharmaceuticals and medical supplies;

q. review and resolve patient complaints;

r. assess requests for pharmaceutical care and medical supply services provided by non-medical units or non-CF facilities by determining if the requests are eligible for those services and if they meet the necessary requirements such as possession of a financial code, authorization to hold the item, or prescribe the medication;

s. oversee the pharmacy operation when no other pharmacist is present;

t. language of work may be French and/or English, depending on geographic location; and

u. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHARMACY – PHARMACY ASSISTANT

**STREAM 1**

**OCCUPATIONAL GROUP AND CATEGORY** **Pharmacy – Pharmacy Assistant**

## WORK AND ENVIRONMENT

1. Pharmacy Assistants assist pharmacists in providing pharmacy service such as compounding, packaging and labelling pharmaceutical products, and maintaining prescription records and inventories of medications and pharmaceutical products. Their work includes providing customer services and assisting the day-to-day operation of a pharmacy in the primary care clinic setting including the cadet camp. Pharmacy Assistants work under the direction of a Pharmacist and act as a part of the health care team.

## EDUCATION / QUALIFICATION

2. All Pharmacy Assistants must, as a minimum, have:

   a. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required; and

   b. in provinces of practice that have Canadian Council for Accreditation of Pharmacy Programs (CCAPP) accredited institutions: A diploma in a Pharmacy Assistant or Pharmacy Technician program from a post-secondary school accredited by CCAPP or experience equivalent defined as minimum of 3 years of experience in practicing as a Pharmacy Assistant in the last 5 years;

   OR

   c. in provinces of practice that do not have CCAPP accredited institutions: A diploma in a Pharmacy Assistant or Pharmacy Technician program from a post-secondary school or experience equivalent defined as a minimum of 3 years of experience in practicing as a Pharmacy Assistant in the last 5 years.

## EXPERIENCE

3. The Pharmacy Assistant must have a minimum of 3 years of experience within the last 5 years providing direct patient care as a pharmacy assistant and working in one or more clinical settings such as hospital or community.

TASKS

4. The required tasks for this occupational group include the following:

   a. assist in the dispensing and distribution of medications to entitled patients supported by the pharmacy department;

   b. assist in the ordering, receiving and distribution of medical supplies to eligible units;

   c. enforce proper return and disposal of drugs and medical supplies;

   d. receive prescriptions, ensure entitlement, review and update patient profiles;

   e. process and file inpatient and outpatient prescriptions;

   f. prepare and package drugs, ointments and compound medications for dispensing to patients or supported units;

   g. prepare patient medication such as pain control cassette, solutions, bulk compounds, various dermatological recipes or pre-packs of medications;

   h. follow standards as established for preparation, storage and issue of drug products;

   i. package prescriptions for delivery or mailing;

   j. ensure proper storage, maintenance and security of stocked drugs and medical supplies within the pharmacy department;

   k. maintain stock medication and pharmacy inventory;

   l. provide medical supplies to all units supported by the pharmacy department as per established local guidelines and policies and keep records of orders issued to each unit;

   m. enforce proper return and disposal of pharmaceuticals and medical materiel in accordance with Medical Materiel Manual (MMM). MMM is to be provided by the Task Manager;

   n. maintain current catalogues and other reference material;

   o. maintain building security procedures to ensure Narcotic and Controlled drugs are always secured in accordance with Narcotic and Controlled Drugs policy. The policy is to be provided by the Task Manager or the Pharmacist;

p. perform monthly user maintenance on pharmacy equipment;

q. ensure that Work Hazardous Materials Information System (WHMIS) standards are followed when working with chemicals for compounding;

r. gather financial information to prepare budget plan for medications and other medical supplies and provide input for operating and program resources;

s. update and create patient records concerning their medication in both pharmacy database and Canadian Forces Health Information System (CFHIS);

t. maintain records required for quality control and workload statistics;

u. answer telephone and address technical questions but redirect clinical and professional questions to a pharmacist;

v. language of work may be French and/or English, depending on geographic location; and

w. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN ASSISTANT - PHYSICIAN ASSISTANT

**STREAM 1**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Assistant - Physician Assistant**

## WORK AND ENVIRONMENT

1. Physician Assistants provide a broad range of medical services in emergency care, primary care, and preventive medical education. These activities include conducting patient history and physical assessments; performing selected diagnostic and therapeutic interventions; and counseling patients on preventive health care. Physician Assistants provide services to patients on both a walk-in and appointment basis. Physician Assistants work under the supervision of a physician in a primary care setting such as a Care Delivery Unit (CDU).

2. Physician Assistants are physician extenders and not independent practitioners. Physician Assistants complement the provision of services within the Canadian Armed Forces (CAF) Health Services Centre and CAF Cadet Camp and are part of the healthcare team. The Physician Assistant works under the direction of a Contract Physician, as designated by the Contractor, who is providing clinical supervision. While the Physician Assistant works with a degree of autonomy, their Scope of Practice and National Competency Profile is specified by Canadian Association of Physician Assistants (CAPA) and may be further defined by Surgeon General Policies and Directives. As a physician extender their actual scope of practice to be applied in a clinical setting is negotiated and agreed to by the Physician Assistant and the Physician providing clinical supervision. The Physician Assistant Practice Agreement must comply with the Surgeon General level policies such as the Restricted Acts Pharmaceuticals.

## EDUCATION / QUALIFICATIONS

3. All Physician Assistants must, as a minimum:

   a. have graduated from a Physician Assistant Program accredited or recognized by Canadian Medical Association (CMA);

   b. possess a Certification by the Physician Assistant Certification Council of Canada (PACCC) through the Canadian Association of Physician Assistants (CAPA);

   c. hold and maintain a current membership with CAPA;

   d. hold and maintain registration with the College of Physicians and Surgeons in the province of work. For provinces without a registry, the Technical Authority (TA) will consider proposed CCPAs on a case by case basis; and

   e. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required.

## EXPERIENCE

4. The Physician Assistant must possess, as a minimum, experience conducting patient assessment, diagnosis, and medical management of a broad range of diseases and performing various types of diagnostic and therapeutic interventions such as electrocardiography, injections, immunizations, suturing, minor surgery, splinting, and casting.

5. The Levels of Experience for the Physician Assistant category are:

a. Level 1: a minimum of 2 years of experience; and

b. Level 2: The Physician Assistant must, as a minimum:

(1) meet the requirements for level 1; and

(2) have successfully completed at least one of the following:

(a) CF Basic Aviation Medicine course; or

(b) CF Basic Dive Medicine course.

**TASKS**

6. The required tasks for this occupational group include the following:

a. perform patient assessments that include medical or incident history, physical examinations, Periodic Health Assessments (PHAs), recruiting medicals and routine medical screenings;

b. obtain and interpret routine diagnostic tests such as complete blood count (CBC), chest X-ray, electrocardiography (ECG), and other diagnostic tests;

c. develop a diagnosis and a treatment plan based on the result of the assessment or refer to a physician or other specialist in accordance with CF Health Services polices and directives, their scope of practice, and their Physician Assistant Practice Agreement with the physician providing clinical supervision;

d. implement a monitoring program and conduct ongoing assessment for outpatients as warranted by clinical condition;

e. prescribe and dispense Authorized Pharmaceuticals and Over-the-Counter medications in accordance with CF Health Services polices and directives, their scope of practice, and their Physician Assistant Practice Agreement with the physician providing clinical supervision;

f. perform therapeutic procedures such as injections, immunizations, suturing, minor surgery, splinting and casting fractures;

g. perform emergency interventions in the case of trauma management and cardiac emergencies in a rural environment;

h. language of work may be French and/or English, depending on geographic location; and

i. other associated tasks relevant to this occupational group.

7. Additional required tasks for Level 2 Physician Assistants include performing occupational care to CF Aircrew or Divers :

a. performing specialized medicals, such as specific Periodic Health Assessments, as follows:

(1) Aircrew Medicals IAW Aerospace Medical Authority Directive 100-01, Medical Standards for CF Aircrew, http://winnipeg.mil.ca/cms/Files/AMA%20Aircrew%20Medical%20Standards.pdf; or

(2) Divers Medicals IAW CF Health Services Group Instruction 4000-04, Shallow Water Divers Periodic Health Assessment and Medical Administration found at Appendix 1.

b. assigning occupational flight or dive restrictions.

# APPENDIX 11 TO ANNEX A1

# PHYSICAL THERAPY – PHYSIOTHERAPIST

**STREAM** **1**

**OCCUPATIONAL GROUP AND CATEGORY** **Physical Therapy – Physiotherapist**

## WORK AND ENVIRONMENT

1. Physiotherapists are regulated primary health care providers having specialized skills in the neuro-musculoskeletal assessment and rehabilitation of physical disability and impairments. Physiotherapists in the Canadian Forces Health Services Centre provide comprehensive consultation, assessment and treatment in both the physiotherapy section, by booked appointment and walk-ins, and the Care Delivery Unit (CDU) via sick parade and/or consultation, as part of the collaborative practice model.

## EDUCATION / QUALIFICATIONS

2. All Physiotherapists must, as a minimum:

   a. have a current licensure in good standing from a provincial/ territorial regulatory organization; and

   b. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required.

## EXPERIENCE

3. The levels of experience for the Physiotherapist Category are:

   a. Level 1: The Physiotherapist must possess a minimum of 1 year experience working in orthopaedics or sports medicine; or either:

      (1) Manual Therapy Level 1 in accordance with Orthopaedic Division of Canadian Physiotherapist Association found at http://orthodiv.org/education; or

      (2) McKenzie Part A in accordance with The Robin McKenzie Institute Canada (http://www.mckenziemdt.org/index_ca.cfm).

   b. Level 2: The Physiotherapist must possess a minimum of experience working in orthopaedics or sports medicine and either:

      (1) Manual Therapy Level 2;

      (2) McKenzie Part B; or

(3) Acupuncture Certification such as AFCI or Dry Needling Certification.

c. Level 3: The Physiotherapist must possess a minimum of experience working in orthopaedics or sports medicine and either:

(1) a Diploma of Advanced Orthopaedic Manual and Manipulative therapy; or

(2) a Diploma of Mechanical Diagnosis and Therapy (McKenzie).

**TASKS**

4. The required for this occupational group include the following:

a. deliver physiotherapy and rehabilitation interventions using evidence-based approaches and best practices in accordance with applicable regulatory standards and scope of practice;

b. carry a full orthopaedic caseload of 12-18 patients per day; including 2 New Assessments per 7.5 hour clinical day, and up to 3 follow-up patients per hour. This may include 60 minutes charting time if required, provided the 12-18 patients per day range is still attained;

c. provide assessment and treatment of neuro-musculoskeletal conditions resulting mainly from sports and training injuries as well as work injuries and accidents;

d. obtain and document informed patient consent for assessment and treatment through an accurate explanation and instruction;

e. provide screening assessments, education and orthoses recommendations in a direct access setting such as CDU walk-ins;

f. prescribe exercises to optimally rehabilitate and prevent injuries and promote fitness;

g. provide manual therapy and soft tissue techniques for neuro-musculoskeletal conditions, scar tissue, muscle tension, circulatory disorders and lymphatic problems;

h. utilize pain management techniques that may include acupuncture (needling below the dermis);

i. provide ergonomics education including the provision of on-site assessments in the patient's workplace;

j. provide physiotherapy related education to patients and members of the health care team in topics such as injury prevention and health promotion issues;

k. perform Biomechanical Foot Assessments including orthotics fitting and fabrication;

l. contribute to the design, preparation and provision of programs integral to the operation of the physiotherapy clinic as a member of the healthcare team for the purpose of education and rehabilitation such as programs specializing in proprioceptive rehabilitation, reintegration, or back pain self-management;

m. participate in ongoing management of patient care by presenting cases during inter-disciplinary meetings, attending clinical rounds, conducting patient conferences, and in scheduling additional follow-up care;

n. perform daily clinical documentation for all patient interactions in accordance with CF and provincial regulatory body clinical documentation and record keeping requirements;

o. monitor and maintain equipment (e.g., ultrasound unit) and supplies (e.g., needles, sharps containers) required for physiotherapy service;

p. language of work may be French and/or English, depending on geographic location; and

q. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICAL THERAPY - PHYSIOTHERAPY ASSISTANT

**STREAM** **1**

**OCCUPATIONAL GROUP AND CATEGORY** **Physical Therapy - Physiotherapy Assistant**

## WORK AND ENVIRONMENT

1. Physiotherapy assistants work under the direction of the physiotherapist and are responsible for ensuring the delivery of the treatment program as prescribed by the physiotherapist. Physiotherapy Assistants augment the capacity of physiotherapists as directed and taught, in areas such as performing prescribed treatment procedures, delivering patient education, documenting client progress, reporting outcomes to the physiotherapist and maintaining physiotherapy equipment and supplies, etc.

## EDUCATION / QUALIFICATIONS

2. All Physiotherapy assistants must, as a minimum, have the following:

   a. completed a college-level education program for physiotherapy support personnel accredited by the Occupational Therapist Assistant and Physiotherapist Assistant Education Program or a Bachelor Degree in Kinesiology or Human Kinetics;

   OR

   b. a current licence in good standing as a Physiotherapy Assistant (thérapeute en réadaptions physique) from the Ordre professionnel de la physiothérapie du Québec (OPPQ);

   OR

   c. on the job training as physiotherapy support personnel with direct physiotherapy assistant work experience of at least 2 years within a military physiotherapy setting; and

   d. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required.

## EXPERIENCE

3. The Physiotherapy Assistant must have a minimum of 1 year of experience working in an orthopaedic physiotherapy clinic. (Note: time worked within a military physiotherapy setting may be counted for this requirement)

## TASKS

4. The required tasks for this occupational group include the following:

   a. assist with the treatment of a variety of musculoskeletal, neurological and respiratory conditions in physiotherapy patients in accordance with the physiotherapy treatment plan provided by the physiotherapist;

   b. provide education and monitoring of the patient's performance of therapeutic exercises, apply ultrasound therapy, and assist with patient transfers, as directed by physiotherapist;

   c. communicate any changes or unusual findings in patient's condition, such as increased pain levels, decreased function or any other physical responses that deviate from those expected, to the Physiotherapist before proceeding or continuing with any assigned treatments or interventions;

   d. document each client visit under their responsibility, including observations, findings and interventions in CFHIS and patient health records;

   e. assist with the fitting and use of basic orthopaedic equipment such as crutches, canes, splints, slings, supports and non-complex devices, as indicated by Physiotherapist assessment or prescribed by Medical Officer; and assist with related education and ambulation training;

   f. assist with the management of disposable supplies and stock by identifying and communicating deficiencies in inventory to the physiotherapist and tracking shipping, arrivals, ordering, and invoices;

   g. complete physiotherapy section daily routines such as infection control procedures, routine equipment cleaning (including ultrasound heads) and equipment organization and maintenance for the safety of patients and staff;

   h. track and record section work activities in the physiotherapy workload measurement system;

   i. language of work may be French and/or English, depending on geographic location; and

   j. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# NURSE – POST-ANAESTHETIC RECOVERY ROOM REGISTERED NURSE

**STREAM 1**

**OCCUPATIONAL GROUP AND CATEGORY** **Nurse – Post-Anaesthetic Recovery Room Registered Nurse**

## WORK AND ENVIRONMENT

1. Post-Anaesthetic Recovery Room Registered Nurses (PARR RN) are responsible for caring for patients before and after surgery. Their work includes providing pre-operative nursing care and patient teaching in the holding area, providing continuous assessment after surgery to identify patient needs and post-operative complications, and discharging patients home or transferring patient to a ward within the hospital. The PARR RNs work in a pre-operative holding area and/or a post-anaesthetic care unit in the civilian hospital during the assigned military operating room (OR) time. The PARR RN functions as part of the Military OR team. Their patient interactions are always scheduled and they function as a part of the Military Surgical Services team, which includes surgeons, anesthetists, Perioperative Nursing Officers (Periop NOs) and Operating Room Technicians. Unless complications occur, most patients require short stays in the PARR, before discharging home or transferring to another department of the hospital.

2. Language of work may be English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. All PARR RNs must, as a minimum, have:

   a. a Registered Nurse Diploma or Baccalaureate Degree in Nursing from a recognized university;

   b. a licence from the provincial or territorial professional college or association in the province of practice;

   c. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C;

   d. a Certificate of Advanced Cardiac Life Support (ACLS) in accordance with the Heart and Stroke Foundation ACLS Provider program; and

   e. successfully completed a Peri-Anesthetic Care certification course or Critical Care course with a PARR component or Anesthesia Assistant Program recognized by the National Association of Peri-Anesthesia Nurses of Canada (NAPAN), or Perioperative Nurse certification.

## EXPERIENCE

4. A PARR RN shall possess, as a minimum, 2 full time equivalent years of clinical experience within the last 3 years in a PARR or equivalent acute clinical settings, such as an emergency department or an intensive care unit.

## TASKS

5. The required tasks for this occupational group include the following:

    a. act within nursing scope of practice according to the provincial regulatory organization;

    b. conduct pre-operative patient teaching and assessment as well as ensure the pre-operative checklist including consent for a surgical procedure has been completed;

    c. provide pre-operative nursing care to patients in the holding area;

    d. provide continuous post-operative patient assessment and care in the PARR, including:

        (1) ongoing patient assessments to include:

            (i) vital signs (blood pressure, heart rate, respiration rate, and temperature);

            (ii) level of consciousness or sedation; and

            (iii) neurological status including pain assessment.

        (2) post-operative symptoms management such as pain, nausea, vomiting, and post-anesthetic shivering; and

        (3) surgical site(s) monitoring for excessive bleeding, discharge, swelling, and hematoma.

    e. identify post-operative complications including any serious life-threatening complications, such as and not limit to, laryngospasm, respiratory arrest, and malignant hyperthermia, provide necessary interventions within the scope of practice, and immediately refer to the responsible clinician;

    f. perform clinical skills such as:

(1) oral or nasal extubation;

(2) urinary catheter insertion or removal;

(3) intravenous (IV) initiation; and

(4) medication administration including IV direct.

g. provide post-operative patient education such as the use of Patient-Controlled Analgesia (PCA) units, wound care, or general oral pain management;

h. liaise and communicate with the Surgical Services team regarding patient status changes as warranted;

i. act as a liaison between operating room and ward or day surgery staff regarding changes in operating room schedule and patient transfer;

j. consult with physicians, anaesthesiologists and other health care professionals when the patient's condition requires care beyond the scope or capability of the PARR team;

k. respond to all cardiac arrest codes in the OR and PARR as part of the resuscitation team;

l. complete all necessary PARR documentation including Anaesthesia Record and narcotic count IAW the local civilian hospital policies. Policies are to be provided by Task Manager;

m. provide clinical mentorship to CF Health Services trainees, such as medical technicians, medical students and nursing students. This includes PARR orientation, routine and procedures, and clinical instruction or feedback on their performance;

n. maintain and order equipment, supplies, medications, and the environment IAW local OR or PARR policies. Policies are to be provided by Task Manager;

o. attend the nursing report at time and location designated by the local hospital routine;

p. attend surgical services team in-services as warranted;

q. perform daily, weekly and monthly equipment or supply checks as indicated on the PARR duty checklist in accordance with the local hospital policies, such as:

(1) Zoll or equivalent defibrillator;

(2) Wall-mounted and portable suction;

(3) Wall-mounted O2 and O2 tank level;

(4) Epistaxis Kit;

(5) Malignant hyperthermia kit;

(6) Vital signs equipment;

(7) Warming equipment;

(8) Resuscitation cart; and

(9) Glucometer.

r. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# NURSE – PRIMARY CARE NURSE

**STREAM 1**

**OCCUPATIONAL GROUP AND CATEGORY** **Nurse – Primary Care Nurse**

## WORK AND ENVIRONMENT

1. Primary Care Nurses (PCNs) are responsible for the provision of primary health care services to members of the care delivery units (CDUs) within the CF Health Services Centres. Primary Care nurses provide patient assessment, screening, healthy lifestyle support, education, and chronic disease management with a goal of improving health outcomes and facilitating access to health services. The PCN oversees the patient flow in the Care Delivery Unit. Primary Care Nurses work within an assigned CDU and function as a member of a multi-disciplinary health care team to develop and implement care plans and to provide patient follow-up. The PCN works collaboratively with multidisciplinary team such as doctors, nurse practitioners and physician assistants by managing results and communicating with patients. Their work includes walk-in and scheduled appointments with acute or chronic physical, mental, and occupational health needs.

2. Language of work may be English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. All Primary Care Nurses must, as a minimum, have:

   a. a Baccalaureate Degree in Nursing from a recognized university or Diploma entry Registered Nurse;

   b. a Registered Nurse licence from the provincial or territorial professional college or association in the province of practice; and

   c. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C.

## EXPERIENCE

4. The Primary Care Nurse shall possess, as a minimum, 1 year full time equivalent of experience, in family practice or ambulatory care environment or in a health care settings, such as tertiary care and community health centre.

## TASKS

5. The required tasks for this occupational group include the following:

a. perform patient triage within the CDU using the principles of the Canadian Triage and Acuity Scale (CTAS);

b. manage patient flow through the CDU to ensure patients are being seen in a timely manner based on the health care providers' scope of practice;

c. provide clinical guidance to CDU Medical Technicians related to direct patient care and nursing interventions;

d. perform nursing clinical procedures such as health history and physical assessments, IV therapy, medication administration, dressing changes, blood pressure monitoring, specimen collection, and immunizations;

e. oversee CDU schedules including each practitioner's schedule within the CDU to ensure efficiency and patient access;

f. provide input on staffing requirements to Task Manager;

g. provide administrative guidance to CDU clerks such as patient tracking and managing patient inquiries;

h. initiate collaborative practice meetings for patient care coordination within the CDU;

i. refer patients to other direct access health care providers to increase access to health services and improve patient outcomes;

j. initiate the short term home care requirements for members with an expected return to work date of less than ninety days;

k. address patient complaints within CDU and forward any unresolved patient complaints to appropriate resource;

l. identify population health trends within the CDU such as infectious disease outbreaks;

m. provide patient counselling and teaching such as chronic disease management and post-operative management;

n. organize and provide annual Infection Prevention and Control (IPAC) education for CF Health Services Centre staff to promote compliance with unit IPAC policies and Standard Operating Procedures (SOPs). The education topics include:

(1) use of routine practices, chain of infection transmission, and additional precautions;

(2) procedures for the proper donning and removal of personal protective equipment (PPE);

(3) Hand Hygiene; and

(4) Biomedical waste management.

o. conduct annual hand hygiene audit and housekeeping audit IAW the current CF Health Services Group policy, Infection Prevention and Control in Canadian Forces Health Services Centres, provided by Task Manager;

p. implement, when warranted, CF Health Services Centre IPAC Standard Operating Procedures (SOPs), IAW the current CF Health Services Group policy, Infection Prevention and Control in Canadian Forces Health Services Centres, provided by Task Manager;

q. resolve any local CF Health Services Centre and detachment IPAC issues such as local risk of infectious disease outbreaks within the clinic through early identification, investigation, contact tracing, preventive measures, and activities to promote safe behaviours;

r. develop and distribute local IPAC and Community Health educational program for patients and staff such as information sessions, posters, pamphlets, and educational signage;

s. make IPAC clinical and technical recommendations on the required environmental cleaning requirements to the Task Manager;

t. ensure local alignment with changes or improvements in the national IPAC program or communicate local IPAC issues by participating as a team member in activities such as CF Health Services IPAC workshops, education sessions, teleconferences, and other communications;

u. generate health surveillance data and trends by identifying the infections and infectious agents most common at the local level, conducting investigations of suspected healthcare acquired infections or disease outbreaks within the CF Health Services Centre, tracking infection rates and surgical site infection rates where applicable, and analyzing the data;

v. organize N95 mask fit-testing sessions with the Preventative Medicine Technician (P Med Tech) for clinic staff. Generate an annual status report to the Task Manager;

w. monitor, provide guidance and support clinic central sterilization processing staff on IPAC practices and maintain related records;

x. complete the clinic accreditation IPAC self-assessment survey as per direction from Task Manager;

y. provide IPAC guidance and input on the clinic pandemic planning and outbreaks to the Task Manager when warranted; and

z. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN – PRIMARY CARE PHYSICIAN

**STREAM 1**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician – Primary Care Physician**

## WORK AND ENVIRONMENT

1. Primary Care Physicians specialize in the physical examination, diagnosis and management of common health conditions. The range of activities in which they may engage may encompass health promotion, prevention of diseases and injuries, diagnosis, occupational health, treatment, rehabilitation, palliative care, and support services.

2. Primary Care Physicians function independently as a health care provider and act as a member of a multi-disciplinary team in the primary care setting such as Care Delivery Units, treatment rooms, and cadet camps. Within the Care Delivery Unit rostered patients are generally assigned to a specified Primary Care Physician who is ultimately responsible for coordinating and managing the care of their assigned patients. Patients access Primary Care Physician services through scheduled appointments (12-15 appointments per day per physician), walk-ins, and at other times during the day when medically indicated. On occasion, the physician may be required to conduct evening or weekend clinics and function as the on-call physician.

## EDUCATION / QUALIFICATIONS

3. All Primary Care Physicians must:

    a. possess a licence from the provincial or territorial regulatory organization in the province of practice;

    b. hold Certification from the College of Family Physicians of Canada (CCFP); and

    c. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required.

## EXPERIENCE

4. The levels of experience for the Primary Care Physician Category are:

    a. Level 1: The Physician must have a minimum of:

        (1) 1 year of experience directly providing patient medical care in an ambulatory primary care, occupational medicine, urgent care or emergency medicine setting; and

b. Level 2: The Physician must:

(1) meet the requirements of level 1; and

(2) have successfully completed at least one of the following:

(a) CF Basic Aviation Medicine course; or

(b) CF Basic Dive Medicine course.

**TASKS**

5. The required tasks for this occupational group include the following:

a. practice medicine in accordance with the applicable provincial and national regulatory standards and in accordance with Canadian Forces Health Service policy and guidance;

b. deliver occupational health services such as, but not limited to:

(1) assessments of medical fitness for duty, including pre- and post-deployment, Periodic Health Assessment, recruiting medicals, hazardous occupation assessments, and post-illness or injury;

(2) diagnosis and treatment of occupational and environmental injuries and illnesses, including rehabilitation;

(3) establishment of patient Medical Employment Limitations (MEL), approve and recommend sick leave, and assign and recommend changes in medical category in accordance with policies;

(4) referral of patients for participation in programs for the use of indicated personal protective devices – hearing conservation, respiratory protection program;

(5) maintenance of occupational health records through Electronic Health Record and other health records forms;

(6) communication with Chain-of-Command; and

(7) assist in return to work and transition programs.

c. provide comprehensive primary medical care to patients with acute and chronic health conditions including referral to other health care providers when warranted;

d. communicate with Senior Medical Authority on relevant clinical matters such as CF Spectrum of Care, complex patients requiring multi-disciplinary intervention, individual operational readiness;

e. maintain patient medical information in Electronic Health Record and patient health records;

f. provide clinical supervision and oversight to other members of the health care team within the Care Delivery Unit that are delivering care to patients assigned to the Primary Care Physician, including Physician Assistants, Nurse Practitioners, Medical Technicians, and Primary Care Nurses. All patients will be required to have a Most Responsible Physician and the physician will fill this role for a designated group of patients within the CDU. This will include patients that are routinely seen by other members of the health care team. Clinical supervision is comprised of the following:

(1) perform ongoing assessment of clinical competency of the provider;

(2) perform the role of consulting or collaborating physician in support of the clinical practice of CDU NPs;

(3) assign clinical tasks in accordance with CAF practice privileges and provincial scopes of practice;

(4) supervise delegated medical acts;

(5) ensure that the scope of practice, practice privileges and competency of the provider aligns with the complexity of care required for the patient;

(6) evaluate clinical performance through direct or indirect observation, chart review, case review, provision of co-signature;

(7) provide verbal and written feedback on clinical skills, knowledge, and judgement to the provider and Senior Medical Authority; and

(8) specific to HCP Physician Assistants: Serve as the clinical supervisor through the establishment of a Physician Assistant Practice Agreement outlining the clinical duties and terms of supervision between the HCP Physician Assistant and the Primary Care Physician. The agreement becomes the essential determinant of the HCP Physician Assistant`s individual clinical role, within the context of the Physician Assistant`s competencies, the CF Health Services scope of practice for PAs, and provincial jurisdictions.

g. provide clinical preceptorship to CF Health Services approved trainees, such as medical students, residents and Physician Assistant trainees, including:

(1) perform ongoing assessment of clinical competency of the provider;

(2) assign clinical tasks, including the delegation of medical acts;

(3) ensure that the scope of practice and competency of the provider aligns with the complexity of care required for the patient;

(4) evaluate clinical performance through direct or indirect observation, chart review, case review, provision of co-signature, etc.; and

(5) provide verbal and written feedback on clinical skills, knowledge, and judgement to the student, educational institution, and Base surgeon as required.

h. other associated tasks relevant to this occupational group.

6. Additional required tasks for Level 2 Physicians include providing occupational health care to CAF Aircrew or Divers:

a. performing specialized medicals, such as Periodic Health Assessments, as follows:

(1) Aircrew Medicals IAW Aerospace Medical Authority Directive 100-01, Medical Standards for CF Aircrew, http://winnipeg.mil.ca/cms/Files/AMA%20Aircrew%20Medical%20Standards.pdf; or

(2) Dive Medicals IAW CF Health Services Group Instruction 4000-04, Shallow Water Divers Periodic Health Assessment and Medical Administration found at Appendix 1.

b. assigning and reviewing occupational flight or dive restrictions; and

c. clinically investigating and reporting aeromedical or diving incidents involving aircrew or divers.

7. Language of work may be French and/or English, depending on geographic location.

# APPENDIX 11 TO ANNEX A1

# DENTIST – COMPREHENSIVE DENTIST

**STREAM** **2**

**OCCUPATIONAL GROUP AND CATEGORY** **Dentist – Comprehensive Dentist**

## WORK AND ENVIRONMENT

1. Comprehensive Dentists specialize in multidisciplinary oral health care at a level of skill, knowledge, and complexity beyond that of a general dentist. This level of skills set is expected to have been attained upon completion of very specific 2-year programs in Comprehensive Dentistry (sometimes known as Advanced Education in General Dentistry), typically offered through the US Army, US Air Force or US Navy. No such programs exist in Canada. Comprehensive dentists provide dental examination, diagnosis and management of the full spectrum of dental conditions of the oral-facial complex and associated anatomical structures, as well as oral health prevention. Comprehensive Dentists provides post-graduate level of dental care that addresses the patient's needs and limitations. Comprehensive Dentists refer more complex procedures to other dental specialists. Comprehensive Dentists function both independently and act as a member of multi-disciplinary team in the dental clinic setting. Their work includes scheduled appointments and urgent walk-ins. It is the duty of all dentists to practice the profession of dentistry to a level commensurate with the prevailing standards of practice, in accordance with the professional code of ethics, and in compliance with all appropriate orders, regulations and standard operating procedures.

2. Language of work may be in English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. All Comprehensive Dentists must possess, as a minimum:

   a. a Doctoral Degree in Dental Surgery or Dental Medicine from a Dental School accredited by the Commission on Dental Accreditation of Canada or the U.S. Commission on Dental Accreditation (CODA);

   b. completion of a 2 year residency program in Advanced Education in General Dentistry (AEGD) or Comprehensive Dentistry accredited by Commission on Dental Accreditation Canada (CDAC) or the Commission on Dental Accreditation (CODA);

   c. an unrestricted licence from the provincial or territorial regulatory organization in the province of practice;

   d. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required;

e. a Certificate from the Federal Services Board of General Dentistry or the American Board of General Dentistry and maintained board certification in the latter; and

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f. a current Certificate of Advanced Cardiac Life Support (ACLS) in accordance with the Heart and Stroke Foundation ACLS Provider program (for Level 2 experience only).

**EXPERIENCE**

4. The Comprehensive Dentist shall possess, as a minimum, clinical experience as a Comprehensive Dentist working in Canada performing various therapeutic procedures such fixed and removable prosthodontics, operative dentistry, oral surgery, endodontics, periodontics, preventive dentistry, orthodontics, oral pathology and oro-facial pain management:

a. Level 1: licenced, certified and educated as per para 3; and

b. Level 2: a Certificate of Parenteral Conscious Sedation from their respective Provincial Dental Regulatory Authority (DRA).

**TASKS**

5. The required tasks for this occupational group include the following:

a. perform full scope of practice of dentistry and follow the standard of in accordance with Canadian Forces Dental Order (CFDO) 20-4 and 20-12 such as:

(1) assess the physical condition of the oral-facial complex; and

(2) diagnose, treat, and prevent disease, disorder, or dysfunction of the oral-facial complex.

b. develop a treatment plan with the patient and the multi-disciplinary health care team to address patient's oral health care needs including making recommendations on impairment, restriction, and temporary or permanent limitation, and patient education on oral health hygiene practices;

c. provide therapeutic interventions consistent with established diagnosis, such as restorative treatment, minor oral surgery, periodontics, endodontics, prosthodontics, surgical and restorative implant therapy, pharmacological intervention, and lifestyle changes;

d. provide clinical expert inputs to other practitioners;

e. provide advanced dental services or Comprehensive Dentistry such as:

(1) establishment of complex treatment plans involving several specialists;

(2) surgical and non-surgical endodontic procedures;

(3) surgical and non-surgical periodontal procedures;

(4) Management of Temporomandibular disorders (TMDs);

(5) prosthetic rehabilitation of dental implants;

(6) management of the medically compromise patients;

(7) minor orthodontics;

(8) biopsies; and

(9) surgical placement of dental implant once credentialed by D Dent Svcs.

f. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# DENTAL SUPPORT – DENTAL ASSISTANT

**STREAM** **2**

**OCCUPATIONAL GROUP AND CATEGORY** **Dental Support – Dental Assistant**

## WORK AND ENVIRONMENT

1. Dental Assistants provide clinical assistance and administrative support to all disciplines of dentistry. Dental Assistants perform their work under the direction of a licensed dentist or dental specialist and their scope of practice is listed under Canadian Forces Dental Order (CFDO) 20-5 Scope of Practice of the Dental Technician or Assistant. Dental Assistant receive patients through walk-in or scheduled appointments. It is the duty of all dental assistants to practice the profession of dental assisting to a level commensurate with the prevailing standards of practice, in accordance with the professional code of ethics, and in compliance with all appropriate orders, regulations and standard operating procedures.

2. Language of work may be English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. Dental Assistants must, as a minimum, have:

   a. completed a Level II Intra-oral dental assisting program from a college accredited by the Commission on Dental Accreditation of Canada (CDAC); and

   b. a licence from the provincial or territorial regulatory organization in the province of practice. In the province of Ontario, Ontario Dental Assistant Association (ODAA) certification and National Dental Assistant Examining Board (NDAEB) certification are required. In the province of Quebec, “Diplôme d'études professionnelles” is required.

## EXPERIENCE

4. The Dental Assistant must, as a minimum, have 1 year of full time equivalent experience in the following:

   a. providing clinical assistance in all disciplines of dentistry; and

   b. performing intra-oral procedures such as selective rubber cup polishing of coronal tooth surfaces, application of anti-cariogenic and desensitizing agents, and application of matrices and wedges.

## TASKS

5. The required tasks for this occupational group include the following:

   a. assist dentists or other dental clinicians in performing dental procedures listed in accordance with CFDO 20-5, Scope of Practice of The Dental Assistant;

   b. provide preventive dentistry measures such as selective rubber cup polishing of coronal tooth surfaces, Oral Hygiene Instructions and application of anti-cariogenic and desensitizing agents;

   c. take dental radiographs followed by processing and mounting;

   d. perform dental laboratory procedures such as making casts, custom trays and mouth guards, and repairing minor damages to acrylic appliances;

   e. perform daily, weekly and monthly user maintenance procedures on dental equipment, including sterilizing and disinfecting dental instruments, equipment and operating area;

   f. maintain dental operating area and monitor consumable supplies;

   g. provide administrative support such as updating patient databases, scheduling programs, and maintaining patient records and documentation; and

   h. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# DENTAL SUPPORT – DENTAL HYGIENIST

**STREAM 2**

**OCCUPATIONAL GROUP AND CATEGORY** **Dental Support – Dental Hygienist**

## WORK AND ENVIRONMENT

1. Dental Hygienists provide dental hygiene services including clinical administrative support for Canadian Armed Forces (CAF) personnel and other entitled persons. Dental Hygienists perform their work in accordance with their scope of practice which is listed under Canadian Forces Dental Order (CFDO) 20- 6, Scope of Practice of the Dental Hygienist. Dental Hygienists receive patients through scheduled appointments. It is the duty of all dental hygienists to practice the profession of dental hygiene to a level commensurate with the prevailing standards of practice, in accordance with the professional code of ethics, and in compliance with all appropriate orders, regulations and standard operating procedures.

2. Language of work may be English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. Dental Hygienists must, as a minimum, possess:

   a. a Diploma or bachelor Degree in Dental Hygiene Program from a recognized University or College by the Commission on Dental Accreditation of Canada; and

   b. an unrestricted licence as a dental hygienist from the provincial or territorial regulatory organization in the province of practice.

## EXPERIENCE

4. The Dental Hygienist must have, as a minimum, experience in the following:

   a. experience in conducting periodontal assessment, dental hygiene procedures, and periodontal therapy; and

   b. experience in assisting dentists to perform various types of dental procedures such as applying and removing periodontal dressings, removing sutures and polish restorations and removing overhangs.

5. The levels of experience for the Dental Hygienist Category are:

   a. Level 1: licenced and educated as per para 3; and

b. Level 2: a certificate in the administration of local anesthetics from an accredited institution by the Commission on Dental Accreditation Canada (CDAC) or the Commission on Dental Accreditation (CODA-United States).

**TASKS**

6. The required for this occupational group include the following:

a. assist dentists in performing dental procedures, such as applying and removing periodontal dressings, removing sutures and polish restorations and removing overhangs, and other procedures listed in accordance with CFDO 20-6, Scope of Practice of The Dental Hygienist;

b. perform dental hygiene procedures such as scaling, root planning, curettage and polishing and apply desensitizing agents, occlusal sealants and topical anti-cariogenic agents;

c. take dental radiographs followed by processing and mounting;

d. conduct periodontal examinations including taking plaque, calculus and bleeding periodontal indices and provide periodontal therapy and maintenance;

e. make dental impressions for study models and soft mouth guards;

f. provide oral hygiene instruction and nutritional counselling to patients;

g. perform daily, weekly and monthly user maintenance procedures on dental equipment, including sterilizing and disinfecting dental instruments, equipment and operating area;

h. conduct a preliminary examination of the oral cavity and adjacent tissues including medical history updates and document clinical findings;

i. maintain dental operating area and monitor consumable supplies;

j. provide administrative support such as updating patient databases, scheduling programs, and maintaining patient records and documentation; and

k. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# DENTIST – GENERAL DENTIST

**STREAM** **2**

**OCCUPATIONAL GROUP AND CATEGORY** **Dentist – General Dentist**

## WORK AND ENVIRONMENT

1. General Dentists specialize in the dental examination, diagnosis and management of the full spectrum of dental conditions of the oral-facial complex and associated anatomical structures, as well as oral health prevention. General Dentists often perform therapeutic procedures in fixed and removable prosthodontics, operative dentistry, oral surgery, endodontics, periodontics, preventive dentistry, and orthodontics and oro-facial pain management. General Dentists refer more complex procedures to other dental specialists. General Dentists function independently and act as a member of multi-disciplinary team in the dental clinic setting. Their work includes scheduled appointments and urgent walk-ins. It is the duty of all dentists to practice the profession of dentistry to a level commensurate with the prevailing standards of practice, in accordance with the professional code of ethics, and in compliance with all appropriate orders, regulations and standard operating procedures.

2. Language of work may be English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. All General Dentists must, as a minimum:

    a. possess Doctoral Degree in Dental Surgery or Dental Medicine from a Canadian or American Dental School accredited by the Commission on Dental Accreditation of Canada;

    b. a licence from the provincial or territorial regulatory organization in the province of practice; and

    c. hold a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required.

## EXPERIENCE

4. The General Dentist must have, as a minimum:

    a. experience managing dental diseases and the overall general oral health needs including disease prevention and patient education;

b. experience in providing various types of dentistry interventions such as restorative treatment, minor oral surgery, periodontics, endodontics, and prosthodontics;

c. experience in using dental amalgam within the last year; and

d. experience in molar non-surgical endodontic therapy within the last year.

**TASKS**

5. The required tasks for this occupational group include the following:

a. perform full scope of practice of dentistry and follow the standard of practice in accordance with Canadian Forces Dental Order (CFDO) 20-4 and 20-12 such as:

(1) assess the physical condition of the oral-facial complex; and

(2) diagnose, treat, and prevent disease, disorder, or dysfunction of the oral-facial complex.

b. develop a care plan with the patient and the multi-disciplinary health care team to address patient's oral health care and patient education on oral health hygiene practices, such as flossing and brushing;

c. provide therapeutic interventions consistent with established diagnosis, such as restorative treatment, minor oral surgery, periodontics, endodontics, prosthodontics, pharmacological intervention, and lifestyle changes;

d. provide administrative support such as but not limited to updating patient databases, referrals to other clinicians and maintaining patient records and documentation; and

e. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# DENTIST – ORAL AND MAXILLOFACIAL SURGEON

**STREAM 2**

**OCCUPATIONAL GROUP AND CATEGORY** **Dentist – Oral and Maxillofacial Surgeon**

## WORK AND ENVIRONMENT

1. Oral and maxillofacial (OMF) Surgeons specialize in dental diagnosis, surgical and adjunctive treatment of disorders, diseases, injuries and defects that involve the functional and aesthetic aspects of the hard and soft tissues of the oral and maxillofacial regions and related structures. OMF Surgeons have expertise in surgical correction of dentofacial deformities, maxillofacial trauma, maxillofacial pathology, maxillofacial reconstructive surgery, dentoalveolar surgery, implant surgery and ambulatory anesthesia. OMFS function both independently and act as a member of multi-disciplinary team in the dental clinic setting. They receive patient referrals from dentists and other dental specialists. Their work includes scheduled appointments and urgent walk-ins. It is the duty of all dentists to practice the profession of dentistry to a level commensurate with the prevailing standards of practice, in accordance with the professional code of ethics, and in compliance with all appropriate orders, regulations and standard operating procedures.

2. Language of work may be English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. All Oral and Maxillofacial Surgeons must, as a minimum:

   a. possess a Doctoral Degree in Dental Surgery or Dental Medicine from a Dental School accredited by the Commission on Dental Accreditation of Canada (CDAC) or the U.S. Commission on Dental Accreditation (CODA);

   b. have successful completed an Advanced Post-Doctoral Educational program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation Canada (CDAC) or the U.S. Commission on Dental Accreditation (CODA);

   c. possess a Certificate from the National Dental Examining Board (NDEB);

   d. possess a current and unrestricted Speciality Licence in Oral and Maxillofacial Surgery from the provincial or territorial regulatory organization in the province of practice;

   e. possess a current Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary

Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required;

f. possess a current Certificate of Advanced Cardiac Life Support (ACLS) in accordance with the Heart and Stroke Foundation ACLS Provider program and recertification every 2 years; and

g. possess a Certificate of Parenteral Sedation from their respective provincial or territorial Dental Regulatory Authority (DRA).

**EXPERIENCE**

4. The Oral and Maxillofacial Surgeon must have clinical experience as an OMF Surgeon working in Canada in a multi-practitioner dental clinic performing various OMF surgeries and interventions such as Dental Implants, Orthognathic Surgery, Craniomaxillofacial Trauma, Extraction of wisdom teeth, Temporomandibular Joint (TMJ) disorders, anaesthesia, head and neck pathology, and reconstruction. The Oral and Maxillofacial Surgeon must have worked a minimum of 2 years in Canada.

**TASKS**

5. The required tasks for this occupational group include the following:

a. perform, as required, full scope of the OMFS specialty and follow the standard of practice in accordance with Canadian Forces Dental Order (CFDO) 20-4 Scope of Practice of the Dentist/Dental Specialist and CFDO 20-12 Dental Professional Standards such as:

(1) assess the physical condition of the oral-facial complex; and

(2) diagnose, treat, and prevent disease, disorder, or dysfunction of the oral-facial complex.

b. provide OMF surgical services such as Dental Implants, Orthognathic Surgery, Craniomaxilofacial Trauma, Extraction of wisdom teeth, Temporomandibular Joint (TMJ) disorders, anaesthesia, head and neck pathology, and reconstruction;

c. provide clinical expert inputs to other practitioners;

d. provide administrative support such as but not limited to updating patient databases, referrals to other clinicians and maintaining patient records and documentation; and

e. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# DENTIST – PERIODONTIST

**STREAM** **2**

**OCCUPATIONAL GROUP AND CATEGORY** **Dentist – Periodontist**

## WORK AND ENVIRONMENT

1. Periodontics is that specialty of dentistry which encompasses the prevention, diagnosis and treatment of diseases of the supporting and surrounding tissues of the teeth or their substitutes and the maintenance of the health, function and aesthetics of these structures and tissues. Periodontists specialize in the maintenance of health, and the diagnosis and treatment of gum diseases. Periodontists perform all aspects of surgery related to site preparation and placement of dental implants. Periodontists plan their periodontal and implant treatment with other dental specialties based on the individual patient's needs. Periodontists function both independently and act as a member of multi-disciplinary team in the dental clinic setting. Their work includes scheduled appointments and urgent walk-ins. It is the duty of all dentists to practice the profession of dentistry to a level commensurate with the prevailing standards of practice, in accordance with the professional code of ethics, and in compliance with all appropriate orders, regulations and standard operating procedures.

2. Language of work may be English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. All Periodontists must, as a minimum:

   a. possess a Doctoral Degree in Dental Surgery or Dental Medicine from a Dental School accredited by the Commission on Dental Accreditation of Canada or the U.S. Commission on Dental Accreditation (CODA);

   b. successfully completed an Advanced Post-Doctoral Educational program in Periodontics accredited by the Commission on Dental Accreditation Canada (CDAC) or the U.S. Commission on Dental Accreditation (CODA);

   c. possess a Certificate from the National Dental Examining Board (NDEB);

   d. possess a current and unrestricted Specialty Licence in Periodontics from the provincial or territorial regulatory organization in the province of practice;

   e. possess a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated

External Defibrillator (CPR/AED) Level C. Annual recertification is required; and

f. possess a Certificate of Parenteral Conscious Sedation from their respective Provincial or Territorial Dental Regulatory Authority (DRA).

**EXPERIENCE**

4. The Periodontist must have clinical experience as a periodontist working in Canada in a multi-practitioner dental clinic performing various periodontal therapies such as resective and regenerative treatments. The periodontist must have worked a minimum of 2 years in Canada.

**TASKS**

5. The required tasks for this occupational group include the following:

a. perform, as required, full scope of the Periodontics specialty and follow the standard of practice in accordance with Canadian Forces Dental Order (CFDO) 20-4 Scope of Practice of the Dentist/Dental Specialist and CFDO 20-12 Dental Professional Standards such as:

(1) assess the physical condition of the oral-facial complex; and

(2) diagnose, treat, and prevent disease, disorder, or dysfunction of the oral-facial complex.

b. provide periodontics services using a therapy sequence as follows:

(1) control of periodontal risk factors;

(2) non-surgical therapy such as debridement;

(3) surgical therapy including resective treatment and regenerative treatment; and

(4) periodontal re-evaluation and maintenance.

c. provide surgical implant placement and other implant related surgical procedures (e.g. management of implant complications) in a multi-disciplinary context;

d. provide clinical expert inputs to other practitioners;

e. manage Dental Detachment Periodontal Programs as required;

f. provide administrative support such as but not limited to updating patient databases, referrals to other clinicians and maintaining patient records and documentation; and

g. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# DENTIST – PROSTHODONTIST

**STREAM** **2**

**OCCUPATIONAL GROUP AND CATEGORY** **Dentist – Prosthodontist**

## WORK AND ENVIRONMENT

1. Prosthodontists specialize in the dental diagnosis, restoration and maintenance of oral function, comfort, appearance and health of the patient by the restoration of the natural teeth and the replacement of missing teeth and contiguous oral and maxillofacial tissues with artificial substitutes. Prosthodontists provide treatment through utilization of fixed, removable, implant, and maxillofacial prosthodontics. Prosthodontists use advanced and specialized methods required for the care of complex and multidisciplinary cases, and provide treatment planning, sequencing, and execution of laboratory and clinical work within a group practice. Prosthodontists function independently. Prosthodontists, as the oral architect of the dental team, develop treatment and plans and synchronise treatment sequences with dental or medical specialists as well as with general dentists in order to provide the most comprehensive care to patients. They receive patient referral from dentists and other dental specialists. Their work includes scheduled appointments and urgent walk-ins. It is the duty of all dentists to practice the profession of dentistry to a level commensurate with the prevailing standards of practice, in accordance with the professional code of ethics, and in compliance with all appropriate orders, regulations and standard operating procedures.

2. Language of work may be English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. All Prosthodontists must, as a minimum:

   a. possess a Doctoral Degree in Dental Surgery or Dental Medicine from a Dental School accredited by the Commission on Dental Accreditation of Canada or U.S. Commission on Dental Accreditation (CODA);

   b. have successfully completed an Advanced Post-Doctoral Educational program in Prosthodontics accredited by the Commission on Dental Accreditation Canada (CDAC) or U.S. Commission on Dental Accreditation (CODA);

   c. possess a Certificate from the National Dental Examining Board (NDEB);

   d. possess a current and unrestricted Specialty Licence in Prosthodontics from the provincial or territorial regulatory organization in the province of practice; and

e. possess a current Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required.

**EXPERIENCE**

4. The Prosthodontist must have clinical experience as a prosthodontist working in Canada, performing various Prosthodontic interventions such as fixed and removal of prosthodontics including implant-supported prosthesis, and using various artificial materials for restorations such as fillings, dentures, veneers, crowns, bridges and oral implants. The prosthodontist must have worked a minimum of 2 years in Canada.

**TASKS**

5. The required tasks for this occupational group include the following:

a. perform, as required, full scope of the Prosthodontics specialty and follow the standard of practice IAW Canadian Forces Dental Order (CFDO) 20-4 Scope of Practice of the Dentist/Dental Specialist and CFDO 20-12 Dental Professional Standards such as:

(1) assess the physical condition of the oral-facial complex; and

(2) diagnose, treat, and prevent disease, disorder, or dysfunction of the oral-facial complex.

b. provide prosthodontics services such as restoration damaged teeth, replacement of missing teeth and oral implants;

c. provide clinical expert inputs to other practitioners;

d. provide administrative support such as but not limited to updating patient databases, referrals to other clinicians and maintaining patient records and documentation; and

e. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# DENTAL NURSE – REGISTERED NURSE (CONSCIOUS SEDATION)

**STREAM 2**

**OCCUPATIONAL GROUP AND CATEGORY** **Dental Nurse – Registered Nurse (Conscious Sedation)**

## WORK AND ENVIRONMENT

1. Registered Nurses assisting with conscious sedation within a dental clinic are responsible for the provision of nursing services associated with anaesthesia and post-operation recovery care, under the direction of a qualified Dental Officer, in the dental facilities. Their work includes providing pre-operation nursing care and patient teaching, initiating and maintaining parenteral conscious sedation, providing continuous cardiac and respiratory assessment during a dental procedure, identifying post-operative complications and patient needs after the procedure, and discharging patients home. Registered Nurses function as part of the dental team.

2. Language of work may be English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. All Registered Nurses working in a dental clinic providing conscious sedation must, as a minimum, possess:

a. a Registered Nurse Diploma or Baccalaureate Degree in Nursing from a recognized university;

b. a Registered Nurse licence from the provincial or territorial professional college or association in the province of practice;

c. a current Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C; and

d. a current Certificate of Advanced Cardiac Life Support (ACLS) in accordance with the Heart and Stroke Foundation ACLS Provider program.

## EXPERIENCE

4. The Dental Sedation Nurse must, as a minimum, have 1 year full time equivalent experience in the following:

a. parenteral conscious sedation protocols and procedures in an emergency room, intensive care unit, or perioperative setting; and

b. assisting anaesthetists during the induction and emergence phases of anaesthesia.

**TASKS**

5. The required for this occupational group include the following:

   a. perform sedation procedures IAW CFDO 27-2 or CFHS policy 1027-02, Conscious and Deep Sedation and associated annexes, to be provided by Task Manager;

   b. conduct pre-operative assessment and patient teaching by completing Pre-operative Medical Questionnaire and Pre-IV Sedation Patient Instructions;

   c. set up all medical equipment including all the emergency supplies and medications;

   d. prepare and administer sedation as prescribed by a dental officer qualified in the level of sedation to be administered such as Oral & Maxillofacial Surgeon;

   e. provide continuous patient assessment and nursing interventions during parenteral and inhalation conscious or deep sedation, including:

      (1) record & monitor vital signs continuously;

      (2) assess & maintain a patent airway;

      (3) apply support measure to maintain respirations when required;

      (4) provide continuous electrocardiogram (ECG) monitoring, identify life-threatening cardiac arrhythmias or any medical emergencies, and notify the responsible dental officer immediately; and

      (5) familiarize and assist in emergency procedures IAW ACLS protocols and the local dental policies.

   f. provide continuous post-operative patient assessment and care, including:

      (1) ongoing patient assessments to include:

         (i) vital signs (blood pressure, heart rate, respiration rate, and temperature);

         (ii) level of consciousness or sedation; and

         (iii) neurological status including pain assessment.

      (2) post-operative symptoms management.

g. identify post-operative complications, provide necessary interventions within the scope of practice, and immediately refer to the responsible clinician;

h. perform various nursing clinical procedures such as:

(1) oral pharyngeal and nasopharyngeal airway insertion;

(2) airway suction;

(3) ventilation;

(4) oxygen administration;

(5) oral or nasal extubation;

(6) intravenous (IV) initiation and discontinuation; and

(7) oral, IV, IM, inhalation, and IV direct medication administration.

i. complete all necessary patient records and documentation including Sedation Record and narcotic count IAW the local dental clinic. Policies are to be provided by Task Manager;

j. assess and determine if patients meet the discharge criteria IAW CFDO 27-2;

k. provide post-operative patient education;

l. maintain and order equipment, supplies, medications, and the environment IAW local dental policies. Policies are to be provided by Task Manager;

m. assist with other dental administrative tasks such as patient scheduling or booking;

n. set-up and clean-up of the surgical suite including disposal of biologically contaminated materials and sterilizing/disinfecting instrument, equipment, supplies, and contaminated areas; and

o. perform daily, weekly and monthly equipment or supply checks as indicated on the duty nurse checklist IAW the local dental policies, including:

(1) Zoll or equivalent defibrillator;

(2) cardiac monitor;

(3) wall-mounted and portable suction;

(4) wall-mounted O2 and O2 tank level;

(5) epistaxis Kit;

(6) vital signs equipment;

(7) IV pump; and

(8) Resuscitation cart.

p. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST - ANESTHESIOLOGIST

**STREAM 3**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Specialist - Anesthesiologist**

## WORK AND ENVIRONMENT

1. Anesthesiologists specialize in the management of all types of acute and chronic pain such as acute post-operative pain, neuropathic pain, musculoskeletal pain, headaches, cancer pain, as well as sympathetic and visceral pain syndromes. During surgery, anesthesiologists provide all aspects of anesthesia care including pre-operative evaluation of the patient's overall health, delivery of anesthesia, and monitoring the effects of anesthesia and surgery on the patient's vital functions.

2. Anesthesiologists are responsible for the patients during post-anesthesia recovery phase. They are a part of the military operating room (OR) team in either the civilian hospital during the designated military OR time or a part of the multi-disciplinary health care team in the specialty clinic setting or both. Their patient interactions are always scheduled. Anesthesiologists are a part of the multi-disciplinary team within the CF Clinic model where they provide higher level consultation and advice to the team. Anesthesiologists also work in the specialty clinic as a part-time basis to provide chronic pain management. They receive patient referrals from the multi-disciplinary team and see patients by booked appointments. Any procedures performed by Anesthesiologists outside the Specialty clinic or designated military OR time will be charged to DND through Federal Health Claims Processing System (FHCPS).

## EDUCATION / QUALIFICATIONS

3. All Anesthesiologists must possess, as a minimum:

   a. a licence from the provincial or territorial regulatory organization in the province of practice;

   b. a specialty certification in Anesthesiology from the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College des médecins du Quebec (after 2001);

   c. a current Fellowship with the Royal College of Physicians & Surgeons of Canada (RCPSC) or for non-fellows, participation in a continuing medical education (CME) program equivalent to a Maintenance of Competence (MOCPMP) Program; and

   d. full hospital privileges at an acute care medical facility, this should be at the hospital where there is a designated military OR team or time if this exists within the geographic location.

## EXPERIENCE

4. The Anesthesiologist must have clinical experience which demonstrates the necessary proficiency to perform the outlined tasks for a patient aged 18- 60, corroborated by two references, with emphasis on experiences in chronic pain management, and regional blocks.

## TASKS

5. The required tasks for this occupational group include the following:

   a. practice anesthesiology IAW applicable provincial and national regulatory standards;

   b. perform pre-operative patient assessment, intra-operative anesthesia care, and post-operative management of any surgical patients;

   c. provide patient education sessions on acute and chronic pain management and prescribe pain management protocol;

   d. provide clinical preceptorship or mentorship to CF Health Services approved trainees and junior clinicians, such as medical or nursing students, Physician Assistants, medical technicians, and students including:

      (1) providing education sessions such as basic airway management, intravenous cannulation, and advance pain management;

      (2) performing ongoing assessment of clinical competency of the provider;

      (3) assigning clinical tasks, including the delegation of medical acts;

      (4) ensuring that the scope of practice and competency of the provider aligns with the complexity of care required for the patient;

      (5) evaluating clinical performance through direct or indirect observation, chart review, case review, provision of co-signature; and

      (6) providing verbal and written feedback on clinical skills, knowledge, and judgement to the student, educational institution, and Senior Medical Authority.

   e. provide anesthesiology or critical care input, advice, and recommendations to the multi-disciplinary health care team regarding the formulation of

policies that govern medical fitness, diagnostic criteria, and treatment guidelines for acute and chronic pain management, and during case conference of critically ill patients;

f. communicate with Senior Medical Authority on relevant clinical matters such as acute or chronic conditions or unusual situations, CF Spectrum of Care, and complex patients requiring multi-disciplinary intervention;

g. prepare and deliver continuing education sessions at least twice a year to clinical staff related to best practices and updates in anesthesiology when warranted;

h. document patient encounters and all clinical actions and maintain patient medical information in the patient health record in a timely fashion in accordance with relevant professional and CAF standards;

i. language of work may be French and/or English, depending on geographic location; and

j. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST – CARDIOLOGIST

**STREAM 3**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Specialist – Cardiologist**

## WORK AND ENVIRONMENT

1. Cardiologists specialize in the assessment, diagnosis, management, prevention, and rehabilitation of cardiovascular diseases and associated conditions. Cardiologists work in the specialty clinic as a part-time basis. Cardiologists receive patient referrals from the primary health care team and see patients by booked appointments. Cardiologists are a part of the multi-disciplinary team within the CF Clinic model where Cardiologists provide higher level consultation and advice to the team. Cardiologists refer to a Cardiac surgeon or an Interventional cardiologist when surgical interventions or invasive procedures are indicated. Cardiologists remain as the primary care provider during the pre- and post-cardiac procedure period. Cardiologists decide when the transfer of care is appropriate back to the primary health care team.

## EDUCATION / QUALIFICATIONS

2. All Cardiologists shall possess, as a minimum:

   a. a licence from the provincial or territorial regulatory organization in the province of practice;

   b. a speciality certification in Internal Medicine and a subspecialty certification in Adult Cardiology from the Royal College of Physicians and Surgeons of Canada (RCPSC); and

   c. a current Fellowship with the Royal College of Physicians & Surgeons of Canada (RCPSC).

## EXPERIENCE

3. The Cardiologist must demonstrate the necessary scope of practice, as specified by their respective regulatory body, to perform the outlined tasks for a patient aged 18- 60, corroborated by two references.

## TASKS

4. The required tasks for this occupational group include the following:

   a. practice cardiology services IAW applicable provincial and national regulatory standards and scope of practice;

b. perform a patient assessment and generate a diagnosis based on the results of assessment;

c. provide preventive and therapeutic interventions consistent with the medical diagnosis, such as pharmacological intervention, lifestyle changes, physical therapies, nutrition, and complementary medicine;

d. provide diagnostic and therapeutic interventions such as echocardiogram (Echo), electrocardiogram (ECG), and stress test;

e. develop a care plan with the patient and the multi-disciplinary health care team to address patient's health care needs including making recommendations on temporary or permanent impairment, restriction, and prognosis;

f. provide follow-up care with patients requiring specific cardiac care, interpretation of ECG, other tests, and post-cardiac procedure;

g. communicate with Senior Medical Authority on relevant clinical matters such as acute cardiac conditions or unusual situations, CF Spectrum of Care, and complex patients requiring multi-disciplinary intervention;

h. provide clinical preceptorship to CF Health Services trainees and junior clinicians, such as medical or nursing students and Physician Assistants, including:

    i. performing ongoing assessment of clinical competency of the provider;

    ii. assigning clinical tasks, including the delegation of medical acts;

    iii. ensuring that the scope of practice and competency of the provider aligns with the complexity of care required for the patient;

    iv. evaluating clinical performance through direct or indirect observation, chart review, case review, provision of co-signature, etc.; and

    v. providing verbal and written feedback on clinical skills, knowledge, and judgement to the student, educational institution, and Senior Medical Authority.

i. provide cardiology input, advice, and recommendations regarding the formulation of policies that govern medical fitness, diagnostic criteria, and treatment guidelines for cardiovascular diseases, or during case conference to the multi-disciplinary health care team;

j. prepare and deliver continuing education sessions at least twice per year to clinical staff related to best practices and new updates in cardiology;

k. document patient encounters and all clinical actions and maintain patient medical information in CFHIS and patient health records; and

l. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST - DERMATOLOGIST

**STREAM 3**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Specialist - Dermatologist**

## WORK AND ENVIRONMENT

1. Dermatologists specialize in preventing, diagnosing, and treating diseases and conditions of the skin, mouth, external genitalia, hair, and nails, as well as sexually transmitted diseases. Dermatologists are a part of the multi-disciplinary team within the CF Clinic model where Dermatologists provide higher level consultation and advice to the team. Dermatologists receive patient referrals from the primary health care team and see patients by booked appointment at the Specialty clinic. Dermatologists perform minor outpatient surgeries such as removing legions, warts, moles, or cancerous cells from the skin in the Specialty clinic.

## EDUCATION / QUALIFICATIONS

2. All Dermatologists shall possess, as a minimum:

   a. a licence from the provincial or territorial regulatory organization in the province of practice;

   b. a specialty certification in Dermatology from the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College des médecins du Québec (after 2001); and

   c. a current Fellowship with the RCPSC or for non-fellows, participation in a continuing medical education (CME) program equivalent to a Maintenance of Competence (MOCPMP) Program.

## EXPERIENCE

3. The dermatologist must have clinical experience which demonstrates the necessary proficiency to perform the outlined tasks for a patient aged 18- 60, corroborated by two references.

## TASKS

4. The required tasks for this occupational group include the following:

   a. practice dermatology services in accordance with applicable provincial and national regulatory standards;

   b. perform a patient assessment including collecting tissue samples for biopsy analysis and generate a diagnosis;

c. prescribe dermatological interventions consistent with the medical diagnosis such as medication, surgery, and radiation therapy;

d. provide preoperative instruction and education to patient and ensure that patient understands the procedural or surgical interventions;

e. perform minor surgeries such as excisions and biopsies in the specialty clinic;

f. prescribe post-operative treatments such as analgesic, antibiotics, and post-operative instructions;

g. provide post-operative management such as post-operative complications and follow up care;

h. provide dermatological advice and recommendations to the multi-disciplinary health care team regarding the formulation of policies that govern medical fitness, diagnostic criteria, and treatment guidelines, or during case conference to the multi-disciplinary health care team;

i. perform procedures within CAF spectrum of care, excluding cosmetic procedures;

j. provide patient education sessions on the treatment and prevention of skin conditions, such as skin protection and skin or hair care products;

k. provide group education sessions including training the trainers (e.g. Medical technicians or Preventive Medicine technicians) to teach skin protection while on deployment;

l. provide clinical preceptorship to CF Health Services approved trainees, such as medical or nursing students, Physician Assistants, medical technicians, and students including:

(1) performing ongoing assessment of clinical competency of the provider;

(2) assigning clinical tasks, including the delegation of medical acts;

(3) ensuring that the scope of practice and competency of the provider aligns with the complexity of care required for the patient;

(4) evaluating clinical performance through direct or indirect observation, chart review, case review, provision of co-signature; and

(5) providing verbal and written feedback on clinical skills, knowledge, and judgement to the student, educational institution, and Senior Medical Authority.

m. communicate with Senior Medical Authority on relevant clinical matters such as acute dermatological conditions or unusual situations, CF Spectrum of Care, and complex patients requiring multi-disciplinary intervention;

n. prepare and deliver continuing education sessions at least twice a year to clinical staff related to best practices and updates in dermatology;

o. document patient encounters and all clinical actions and maintain patient medical information in the patient health record in a timely fashion in accordance with relevant professional and Canadian Armed Forces standards;

p. language of work may be French and/or English, depending on geographic location; and

q. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST - GASTROENTEROLOGIST

**STREAM** **3**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Specialist - Gastroenterologist**

## WORK AND ENVIRONMENT

1. Gastroenterologists specialize in the diagnosis and medical management of diseases and disorders of the digestive system, including the stomach, bowels, liver, gallbladder, and related organs. Gastroenterologists do not perform surgery; however, perform diagnostic and therapeutic procedures such as endoscopic examination. Gastroenterologists are a part of the multi-disciplinary team within the CF Clinic model where Gastroenterologists provide higher level consultation and advice to the team. Gastroenterologists work in the speciality clinic on a part-time basis and receive patient referrals from the primary health care team and see patients by booked appointment. Gastroenterologists refer patients to General Surgeons when abdominal operations are required.

## EDUCATION / QUALIFICATIONS

2. All Gastroenterologists must, as a minimum, have:

   a. a licence from the provincial or territorial regulatory organization in the province of practice;

   b. a speciality certification in Internal Medicine from the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College des médecins du Québec (after 2001) and a subspecialty in Gastroenterology; and

   c. a current Fellowship with the RCPSC or for non-fellows, participation in a continuing medical education (CME) program equivalent to a Maintenance of Competence (MOCPMP) Program.

## EXPERIENCE

3. The Gastroenterologist must have clinical experience which demonstrates the necessary proficiency to perform the outlined tasks for a patient aged 18- 60, corroborated by two references.

## TASKS

4. The required tasks for this occupational group include the following:

   a. practice General Gastroenterology and Endoscopy in accordance with applicable provincial and national regulatory standards;

b. perform a patient assessment and generate a diagnosis based on the results of assessment;

c. provide preventive and therapeutic interventions and advice consistent with the medical diagnosis, such as pharmacological intervention, lifestyle changes, physical therapies and nutrition;

d. develop a care plan with the patient and the multi-disciplinary health care team to address patient's health care needs including making recommendations on impairment, restriction, and temporary or permanent limitation;

e. provide instructions and education to patients prior to procedures, such as colonoscopy and upper endoscopy;

f. provide follow-up care with patients who require gastro-intestinal (GI) procedures;

g. communicate with Senior Medical Authority on relevant clinical matters such as acute or chronic GI conditions or unusual situations, CF Spectrum of Care, and complex patients requiring multi-disciplinary intervention;

h. provide gastroenterological advice and recommendations to the multi-disciplinary health care team regarding the formulation of policies that govern medical fitness, diagnostic criteria, and treatment guidelines, or during case conference to the multi-disciplinary health care team;

i. prepare and deliver continuing education sessions at least twice per year to clinical staff related to best practices and updates in Gastroenterology;

j. document patient encounters and all clinical actions and maintain patient medical information in the patient health record in a timely fashion in accordance with relevant professional and CAF standards;

k. language of work may be French and/or English, depending on geographic location; and

l. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST – GENERAL SURGEON

**STREAM** **3**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Specialist – General Surgeon**

## WORK AND ENVIRONMENT

1. General surgeons specialize in diagnosis and surgical management of medical conditions involving the alimentary tract; abdomen and its contents, including the pelvis; breast, skin and soft tissue; and endocrine system. General surgical practice includes, but is not limited to, gastrointestinal surgery and internal organs, endoscopy, endocrine surgery, repair of hernia, transplantation, trauma and critical care, diseases of the breast, cancer surgery, laparoscopic and minimally invasive surgery, head and neck, vascular, chest, genitourinary surgery and surgery of the skin.

2. General surgeons are a part of the multi-disciplinary team within the CF Clinic model where they provide higher level consultation and advice to the team. General surgeons are also a part of the military operating room (OR) team in either the civilian hospital during the designated military OR time or a part of the multi-disciplinary health care team in the specialty clinic setting or both. General surgeons work as a part-time basis in the specialty clinic and receive patient referrals from the primary health care team and see patients by booked appointments. Any procedures performed by General surgeons outside the Specialty clinic or designated military OR time will be charged to DND through Federal Health Claims Processing System (FHCPS).

## EDUCATION / QUALIFICATIONS

3. All General Surgeons must, as a minimum, have:

   a. a licence from the provincial or territorial regulatory organization in the province of practice;

   b. a specialty certification in General Surgery from the Royal College of Physicians and Surgeons of Canada (RCPSC) or the Collège des médecins du Quebec (after 2001);

   c. a current Fellowship with the RCPSC or for non-fellows, participation in a continuing medical education (CME) program equivalent to a Maintenance of Competence (MOCPMP) Program; and

   d. full hospital privileges at an acute care medical facility to perform surgery and deal with complications.

## EXPERIENCE

4. The General Surgeon must have clinical experience which demonstrates the necessary proficiency to perform the outlined tasks for a patient aged 18- 60, corroborated by two references.

## TASKS

5. The required tasks for this occupational group include the following:

a. practice General Surgery services in accordance with applicable provincial and national regulatory standards;

b. perform a patient assessment and generate a diagnosis based on the results of assessment;

c. provide pre-operative instructions and education to patients, surgical interventions, and post-operative care such as sedatives, analgesic, diets, antibiotics, and post-operative instructions;

d. develop a post-operative care plan with the patient and the multi-disciplinary health care team to address patient's health care needs including making recommendations on temporary or permanent impairment, restriction, and prognosis, and advocating services based on CF Spectrum of Care;

e. provide post-operative management such as post-operative complications and follow up care including referring patients to other health care providers;

f. perform minor surgeries in the specialty clinic;

g. communicate with Senior Medical Authority on relevant clinical matters such as acute conditions or unusual situations, CF Spectrum of Care, and complex patients requiring multi-disciplinary intervention;

h. provide clinical preceptorship to CF Health Services trainees and junior clinicians, such as medical or nursing students, Physician Assistants, medical technicians and students including:

(1) performing ongoing assessment of clinical competency of the provider;

(2) assigning clinical tasks, including the delegation of medical acts;

(3) ensuring that the scope of practice and competency of the provider aligns with the complexity of care required for the patient;

(4) evaluating clinical performance through direct or indirect observation, chart review, case review, provision of co-signature; and

(5) providing verbal and written feedback on clinical skills, knowledge, and judgement to the student, educational institution, and Senior Medical Authority.

i. provide input and clinical advice to the multi-disciplinary health care team on general surgical services regarding the formulation of policies that govern medical fitness, diagnostic criteria, and treatment guidelines, or during case conference to the multi-disciplinary health care team;

j. prepare and deliver continuing education sessions to clinical staff related to best practices and updates in general surgical practice when warranted;

k. document patient encounters and all clinical actions and maintain patient medical information in the patient health record in a timely fashion in accordance with relevant professional and CAF standards;

l. language of work may be French and/or English, depending on geographic location; and

m. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST – INTERNIST

**STREAM 3**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Specialist – Internist**

## WORK AND ENVIRONMENT

1. Internists specialize in the diagnosis and medical management of diseases involving more than one organ system. Internists are a part of the multi-disciplinary team within the CF Clinic model where Internists provide higher level consultation and advice to the team, especially caring for the critically ill patients or patients who suffer from an advanced stage of an acute or chronic illness. Internists receive patient referrals from the primary health care team and see patients by booked appointments. Internists work as a part-time basis in the specialty clinic.

## EDUCATION / QUALIFICATIONS

2. All Internists must, as a minimum, have:

   a. a licence from the provincial or territorial regulatory organization in the province of practice;

   b. a speciality certification in Internal Medicine from the Royal College of Physicians and Surgeons of Canada (RCPSC) or the Collège des médecins du Quebec (after 2001); and

   c. a current Fellowship with the RCPSC or for non-fellows, participation in a continuing medical education (CME) program equivalent to a Maintenance of Competence (MOCPMP) Program.

## EXPERIENCE

3. The Internist must:

   a. have clinical experience which demonstrates the necessary proficiency to perform the outlined tasks for a patient aged 18- 60, corroborated by two references; and

   b. have experience in performing various specialized procedures such as pulmonary function text, exercise stress test, echocardiogram, nerve conduction study (NCS), and electromyogram (EMG).

## TASKS

4. The required tasks for this occupational group include the following:

   a. practice general internal medicine services in accordance with applicable provincial and national regulatory standards;

b. perform a patient assessment and generate a diagnosis based on the results of assessment;

c. provide preventive and therapeutic interventions and advice consistent with the medical diagnosis, such as pharmacological intervention, lifestyle changes, physical therapies and nutrition;

d. develop a care plan with the patient and the multi-disciplinary health care team to address patient's health care needs including making recommendations on temporary or permanent impairment, restriction, and prognosis;

e. provide follow-up care with patients requiring extensive or long-term multi-disciplinary interventions;

f. communicate with Senior Medical Authority on relevant clinical matters such as acute or chronic medical conditions or unusual situations, CF Spectrum of Care, and complex patients requiring multi-disciplinary intervention;

g. provide internal medicine advice and recommendations to the multi-disciplinary health care team regarding the formulation of policies that govern medical fitness, diagnostic criteria, and treatment guidelines, or during case conference to the multi-disciplinary health care team;

h. prepare and deliver continuing education sessions twice a year to clinical staff related to best practices and/or updates in internal medicine when warranted;

i. document patient encounters and all clinical actions and maintain patient medical information the patient health record in a timely fashion in accordance with relevant professional and CAF standards;

j. language of work may be French and/or English, depending on geographic location; and

k. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST – NEUROLOGIST

**STREAM 3**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Specialist – Neurologist**

## WORK AND ENVIRONMENT

1. Neurologists specialize in the assessment, diagnosis, prevention and management of neurological disorders or injuries involving the brain, the spinal cord, and other nerve and muscular conditions. Neurologists are also involved in rehabilitation and in the psychological and social aspects of patients with chronic and debilitating neurological disorders. Neurologists are a part of the multi-disciplinary team within the CF Clinic model where Neurologists provide higher level consultation and advice to the team. Neurologists receive patient referrals from the primary health care team and see patients by booked appointments. Neurologists work as a part-time basis in the specialty clinic. Neurologists refer to a neurosurgeon when neurosurgical interventions are indicated.

## EDUCATION / QUALIFICATIONS

2. All Neurologists must, as a minimum, have:

   a. a licence from the provincial or territorial regulatory organization in the province of practice;

   b. a speciality certification in Neurology from the Royal College of Physicians and Surgeons of Canada (RCPSC) or the Collège des médecins du Quebec (after 2001); and

   c. a current Fellowship with the RCPSC or for non-fellows, participation in a continuing medical education (CME) program equivalent to a Maintenance of Competence (MOCPMP) Program.

## EXPERIENCE

3. The Neurologist must have clinical experience which demonstrates the necessary proficiency to perform the outlined tasks for a patient aged 18- 60, corroborated by two references. This must include experience in managing all types of Traumatic Brain Injuries.

## TASKS

4. The required tasks for this occupational group include the following:

   a. practice Neurology in accordance with applicable provincial and national regulatory standards;
   b. perform a neurological examination of the nerves in the head and neck; muscle strength and movement; balance, ambulation, and reflexes; and sensation,

memory, speech, language, and other cognitive abilities and use various investigative methods such as lumbar puncture (LP), magnetic resonance imaging (MRI) studies, and neuro-imaging;

c. generate a medical diagnosis based on the results of assessment and investigation;

d. conduct and/or interpret neurological examinations such as electroencephalogram (EEG), nerve conduction studies, and sleep studies;

e. provide preventive and therapeutic interventions and advice consistent with the medical diagnosis, such as pharmacological intervention, lifestyle changes and physical therapies;

f. develop a care plan with the patient and the multi-disciplinary health care team to address patient's health care needs including making recommendations on temporary or permanent impairment, restriction, and prognosis;

g. provide instructions and education to patients prior to procedures and interventions, such as lumbar puncture;

h. provide follow-up care and rehabilitative management with patients who have undergone neurosurgery or have a complex acute or chronic neurological disorder;

i. communicate with Senior Medical Authority on relevant clinical matters such as acute or chronic neurological conditions or unusual situations, CF Spectrum of Care, and complex patients requiring multi-disciplinary intervention;

j. provide neurological advice and recommendations to the multi-disciplinary health care team regarding the formulation of policies that govern medical fitness, diagnostic criteria, and treatment guidelines, or during case conference to the multi-disciplinary health care team;

k. prepare and deliver continuing education sessions at least twice a year to clinical staff related to best practices and updates in Neurology when warranted;

l. provide clinical preceptorship to CF Health Services approved trainees and junior clinicians, such as medical or nursing students, Physician Assistants, medical technicians, and students including:

    (1) performing ongoing assessment of clinical competency of the provider;

    (2) assigning clinical tasks, including the delegation of medical acts;

    (3) ensuring that the scope of practice and competency of the provider aligns with the complexity of care required for the patient;

(4) evaluating clinical performance through direct or indirect observation, chart review, case review, provision of co-signature; and

(5) providing verbal and written feedback on clinical skills, knowledge, and judgement to the student, educational institution, and Senior Medical Authority.

m. document patient encounters and all clinical actions and maintain the patient health record in a timely fashion in accordance with relevant professional and CAF standards;

n. language of work may be French and/or English, depending on geographic location; and

o. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST – OBSTETRICIAN/GYNECOLOGIST

**STREAM 3**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Specialist – Obstetrician/Gynecologist**

## WORK AND ENVIRONMENT

1. Obstetricians/Gynecologists (Ob/Gyn) specialize in prevention, diagnosis and management of a broad range of conditions that affect women's general and reproductive health by utilizing their medical, surgical, and obstetrical and gynecologic knowledge and skills. Obstetricians/Gynaecologists provide obstetrics care during pregnancy, labour, and 6-8 weeks postpartum care, and provide gynecology, which focus on the health of the female reproductive system. Obstetricians/Gynaecologists work in either the Care Delivery Unit (CDU) or in the Specialty clinic or both. Obstetricians/Gynaecologists are a part of the multi-disciplinary team within the CF Clinic model where Obstetricians/Gynaecologists provide higher level consultation and advice to the team. Obstetricians/Gynaecologists receive patient referrals from the primary health care team and see patients by booked appointments. Any obstetric delivery and gynecological surgery performed by Obstetricians & Gynaecologists will be charged to DND through Federal Health Claims Processing System (FHCPS).

## EDUCATION / QUALIFICATIONS

2. All Obstetrician/Gynecologists shall possess, as a minimum:

   a. a licence from the provincial or territorial regulatory organization in the province of practice;

   b. a speciality certification in Obstetrics & Gynecology from the Royal College of Physicians and Surgeons of Canada (RCPSC) or the Collège des médecins du Quebec (after 2001);

   c. a current Fellowship with the RCPSC or for non-fellows, participation in a continuing medical education (CME) program equivalent to a Maintenance of Competence (MOCPMP) Program; and

   d. full hospital privileges at an acute care medical facility to perform surgery and deal with complications.

## EXPERIENCE

3. The Obstetrician/Gynecologist must have clinical experience which demonstrates the necessary proficiency to perform the outlined tasks for a patient aged 18- 60, and completed 500 clinical hours in the last year verifiable by curriculum vitae and corroborated by two references. These hours may be as part of the final year of residency or fellowship training if the obstetrician/gynecologist is newly certified.

## TASKS

4. The required tasks for this occupational group include the following:

   a. practice Obstetrics & Gynecology services in accordance with applicable provincial and national regulatory standards;

   b. provide continuity in prenatal, ante-natal care and postpartum care, including vaginal birth, after Caesarean section, gestational diabetics, and pregnancy-induced hypertensive patients;

   c. perform preventive and therapeutic interventions relevant to Obstetrics and Gynecology, including detection of sexually transmitted diseases, Pap test screening, family planning, preventive medicine, menopause, endometriosis, and prevention & management of osteoporosis;

   d. provide preoperative instruction and education to patient and ensure that patient understands the procedural or surgical interventions;

   e. prescribe post-operative treatments such as analgesic and post-operative instructions;

   f. provide post-operative management such as post-operative complications and follow up care with the patient and the multi-disciplinary health care team to address patient's health care needs including making recommendations on temporary or permanent impairment, restriction, prognosis, and advocating services based on CF Spectrum of Care;

   g. provide Obstetrics and Gynecology advice and recommendations to the multi-disciplinary health care team regarding the formulation of policies that govern medical fitness, diagnostic criteria, and treatment guidelines, or during case conference to the multi-disciplinary health care team;

   h. provide patient education sessions on women's general and reproductive health;

   a. provide clinical preceptorship to CF Health Services approved trainees and junior clinicians, such as medical or nursing students, Physician Assistants, medical technicians, and students including:

      (1) performing ongoing assessment of clinical competency of the provider;

      (2) assigning clinical tasks, including the delegation of medical acts;

      (3) ensuring that the scope of practice and competency of the provider aligns with the complexity of care required for the patient;

(4) evaluating clinical performance through direct or indirect observation, chart review, case review, provision of co-signature; and

(5) providing verbal and written feedback on clinical skills, knowledge, and judgement to the student, educational institution, and Senior Medical Authority.

i. communicate with Senior Medical Authority on relevant clinical matters such as acute conditions or unusual situations, CF Spectrum of Care, and complex patients requiring multi-disciplinary intervention;

j. prepare and deliver continuing education sessions to clinical staff related to best practices and updates in Obstetrics and Gynecology when warranted;

k. document patient encounters and all clinical actions and maintain the patient health record in a timely fashion in accordance with relevant professional and CAF standards;

l. language of work may be French and/or English, depending on geographic location; and

m. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST - OPHTHALMOLOGIST

**STREAM 3**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Specialist - Ophthalmologist**

## WORK AND ENVIRONMENT

1. Ophthalmologists specialize in the screening, diagnosis, prevention and management of optical, medical, and surgical disorders and diseases of the eye, associated orbital structures and neuro-visual pathways. Ophthalmologists are a part of the multi-disciplinary team within the CF Clinic model where Ophthalmologists provide higher level consultation and advice to the team. Ophthalmologists receive patient referrals from the primary health care team and see patients by booked appointment at the Specialty clinic. Ophthalmologists perform minor outpatient surgeries such as stye excision/drainage, skin tags excision and other similar growth in the Specialty clinic. Any surgeries or procedures performed by Ophthalmologists outside the Specialty clinic will be charged to DND through Federal Health Claims Processing System (FHCPS).

## EDUCATION / QUALIFICATIONS

2. All Ophthalmologists shall possess, as a minimum:

   a. a licence from the provincial or territorial regulatory organization in the province of practice;

   b. a speciality certification in Ophthalmology from the Royal College of Physicians and Surgeons of Canada (RCPSC) or the Collège des médecins du Quebec (after 2001); and

   c. a current Fellowship with the Royal College of Physicians & Surgeons of Canada (RCPSC) or for non-fellows, participation in a continuing medical education (CME) program equivalent to a Maintenance of Competence (MOCPMP) Program.

## EXPERIENCE

3. The Ophthalmologist must have provided at least 500 clinical and procedural hours in ophthalmology in the past year for patients aged 18- 60, corroborated by two references. These hours may be as part of the final year of residency or fellowship training if the ophthalmologist is newly certified.

## TASKS

4. The required tasks for this occupational group include the following:
   a. practice ophthalmology services in accordance with applicable provincial and national regulatory standards;

b. perform patient assessment and routine ophthalmology examinations such as refractions and intra-ocular pressure;

c. prescribe corrective lenses and visual therapy;

d. provide post-surgical follow-up in the Specialty clinic;

e. provide other follow up care including reviewing test results done by an ophthalmology technician to evaluate interventions or arrange further consultation from other health care provider;

f. provide clinical recommendations to the multi-disciplinary health care team regarding the impact of the eye condition on person, occupation, and environment related to impairment, restriction, and temporary or permanent limitation;

g. communicate with Senior Medical Authority on relevant clinical matters such as acute or chronic eye conditions or unusual situations, CF Spectrum of Care, and complex patients requiring multi-disciplinary intervention;

h. provide clinical preceptorship to CF Health Services approved trainees and junior clinicians, such as medical or nursing students, Physician Assistants, medical technicians, and students including:

(1) performing ongoing assessment of clinical competency of the provider;

(2) assigning clinical tasks, including the delegation of medical acts;

(3) ensuring that the scope of practice and competency of the provider aligns with the complexity of care required for the patient;

(4) evaluating clinical performance through direct or indirect observation, chart review, case review, provision of co-signature; and

(5) providing verbal and written feedback on clinical skills, knowledge, and judgement to the student, educational institution, and Senior Medical Authority.

i. prepare and deliver continuing education sessions twice a year to the health care team related to best practices and provide updates in ophthalmology when warranted;

j. apply and follow established guidelines on CAF Aircrew Visual Requirements provided by the Task manager;

k. document patient encounters and all clinical actions and maintain the patient health record in a timely fashion in accordance with relevant professional and CAF standards;

l. language of work may be French and/or English, depending on geographic location; and

m. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST – ORTHOPEDIC SURGEON

**STREAM** **3**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Specialist – Orthopedic Surgeon**

## WORK AND ENVIRONMENT

1. Orthopedic Surgeons specialize in the surgical assessment and management of musculoskeletal injury and degenerative diseases and associated conditions. The musculoskeletal system includes bones, joints, ligaments, muscles and tendons. Orthopedic surgeons are a part of the multi-disciplinary team within the CF Clinic model where they provide higher level consultation and advice to the team. Orthopedic surgeons can also be part of the military operating room (OR) team in the civilian hospital during the designated military OR time. While working on a part-time basis in the Specialty clinic, they receive patient referrals from the primary health care team and see patients by appropriately referred appointments.

## EDUCATION / QUALIFICATIONS

2. All Orthopedic Surgeons must, as a minimum, have:

   a. a licence from the provincial or territorial regulatory organization in the province of practice;

   b. a specialty certification in Orthopedic Surgery from the Royal College of Physicians and Surgeons of Canada (RCPSC) or the Collège des médecins du Quebec (after 2001);

   c. a current Fellowship with the RCPSC or for non-fellows, participation in a continuing medical education (CME) program equivalent to a Maintenance of Competence (MOCPMP) Program; and

   d. full hospital privileges at an acute care medical facility to perform surgery and deal with complications.

## EXPERIENCE

3. The Orthopedic Surgeon must have provided at least 250 operative hours of orthopedic surgery in the past year verified by curriculum vitae and corroborated by two references with an emphasis on experience in arthroscopy, sport medicine, and trauma. These hours may be as part of the final year of residency or fellowship training if the orthopedic surgeon is newly certified.

## TASKS

4. The required tasks for this occupational group include the following:

a. practice orthopedic surgery in accordance with applicable provincial and national regulatory standards;

b. perform a patient assessment and generate a diagnosis based on the results of assessment;

c. provide surgical or non-surgical interventions consistent with the diagnosis;

d. provide pre-operative instructions and education to patients, surgical interventions, and post-operative care such as sedatives, analgesic, nutrition, antibiotics, and post-operative instructions;

e. develop a post-operative care plan with the patient and the multi-disciplinary health care team including physiotherapist, occupational therapist, primary care provider, and other physician specialists to address patient's health care needs including making recommendations on impairment, restriction, temporary or permanent limitation, and advocating services based on CF Spectrum of Care;

f. provide post-operative management such as post-operative complications and follow up care including referring patients to other health care providers such as physiatrist;

g. perform minor office procedures within their scope of practice as warranted such as corticosteroid or viscosupplementation injections and aspirations;

h. provide patient education on sport medicine and rehabilitation after orthopedic injuries or surgery in the Specialty Clinic;

i. communicate with Senior Medical Authority on relevant clinical matters such as acute or chronic orthopedic conditions or unusual situations, CF Spectrum of Care, and complex patients requiring multi-disciplinary intervention;

j. provide clinical preceptorship to CF Health Services approved trainees and junior clinicians, such as medical or nursing students, Physician Assistants, medical technicians, and students including:

    (1) performing ongoing assessment of clinical competency of the provider;

    (2) assigning clinical tasks, including the delegation of medical acts;

    (3) ensuring that the scope of practice and competency of the provider aligns with the complexity of care required for the patient;

    (4) evaluating clinical performance through direct or indirect observation, chart review, case review, provision of co-signature; and

(5) providing verbal and written feedback on clinical skills, knowledge, and judgement to the student, educational institution, and Senior Medical Authority.

k. provide input and clinical advice on orthopedic surgery regarding the formulation of policies that govern medical fitness, diagnostic criteria, and treatment guidelines, or during case conference to the multi-disciplinary health care team;

l. prepare and deliver continuing education sessions to clinical staff related to best practices and updates in orthopedic surgery a minimum of 2 times per year;

m. document patient encounters and all clinical actions and maintain the patient health record in a timely fashion in accordance with relevant professional and CAF standards;

n. language of work may be French and/or English, depending on geographic location; and

o. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST – OTORHINOLARYNGOLOGIST (EAR, NOSE AND THROAT)

**STREAM 3**

**OCCUPATIONAL GROUP AND CATEGORY: Physician Specialist – Otorhinolaryngologist (Ear, Nose and Throat)**

## WORK AND ENVIRONMENT

1. Otorhinolaryngologists specialize in screening, diagnosis and management of medical and surgical disorders of the ear, the upper respiratory and digestive tract, and related structures of the head, face and neck, including the special senses of hearing, balance, taste and olfaction. They are often referred to as ear, nose and throat (ENT) specialists or Head and Neck Surgeons. Otorhinolaryngologists treat virtually all diseases and lesions above the shoulders, with the exception of eye-related disorders (ophthalmology) and lesions of the brain (neurology and neurosurgery). Otorhinolaryngologists are a part of the multi-disciplinary team within the CF Clinic model where Otorhinolaryngologists provide higher level consultation and advice to the team. Otorhinolaryngologists receive patient referrals from the multi-disciplinary health care team and see patients by booked appointments at the Specialty clinic for patient consultation and ENT examination. They also function as a part of the military operating room (OR) team in the civilian hospital during the designated military OR time to perform ENT surgery. Any procedures performed by Otorhinolaryngologists outside the Specialty clinic or designated military OR time will be charged to DND through Federal Health Claims Processing System (FHCPS).

## EDUCATION / QUALIFICATIONS

2. All Otorhinolaryngologists must, as a minimum, have:

   a. a licence from the provincial or territorial regulatory organization in the province of practice;

   b. a speciality certification in Otorhinolaryngology – Head and Neck Surgery from the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College des médecins du Quebec (after 2001);

   c. a current Fellowship with the Royal College of Physicians & Surgeons of Canada (RCPSC) or for non-fellows, participation in a continuing medical education (CME) program equivalent to a Maintenance of Competence (MOCPMP) Program; and

   d. full hospital privileges at an acute care medical facility to perform surgery and deal with complications.

## EXPERIENCE

3. The Otorhinolaryngologist must have clinical experience which demonstrates the necessary proficiency to perform the outlined tasks for a patient aged 18 - 60, corroborated by two references, with emphasis on experiences in managing auditory dysfunction related to noise exposure.

## TASKS

4. The required tasks for this occupational group include the following:

a. practice Otorhinolaryngology – Head and Neck Surgery in accordance with applicable provincial and national regulatory standards;

b. perform a patient assessment using various investigative methods such as diagnostic imaging of the head and neck, immunologic and genetic testing, specialized laboratory testing including, biopsy and fine-needle aspiration, and vestibular and audiological testing in order to generate a diagnosis;

c. provide preventive and therapeutic interventions to prevent or address ENT related disorders, including counselling on smoking cessation, responsible alcohol use, ultraviolet A/ultraviolet B (UVA/UVB) exposure and protection, and prevention of noise-induced hearing loss;

d. provide pre-operative instructions and education to patients, surgical interventions, and post-operative care such as sedatives, analgesic, diets, antibiotics, and post-operative instructions;

e. develop a post-operative care and follow-up plan with the patient and the multi-disciplinary health care team to address patient's health care needs including making recommendations on temporary or permanent impairment, restriction, and prognosis;

f. perform minor surgeries in the Specialty Clinic;

g. communicate with Senior Medical Authority on relevant clinical matters such as acute conditions or unusual situations, CF Spectrum of Care, and complex patients requiring multi-disciplinary intervention;

h. provide clinical preceptorship to CF Health Services approved trainees and junior clinicians, such as medical or nursing students, Physician Assistants, medical technicians, and students including:

(1) performing ongoing assessment of clinical competency of the provider;

(2) assigning clinical tasks, including the delegation of medical acts;

(3) ensuring that the scope of practice and competency of the provider aligns with the complexity of care required for the patient;

(4) evaluating clinical performance through direct or indirect observation, chart review, case review, provision of co-signature; and

(5) providing verbal and written feedback on clinical skills, knowledge, and judgement to the student, educational institution, and Senior Medical Authority.

i. provide otorhinolaryngology clinical input or advice regarding the formulation of policies that govern medical fitness, diagnostic criteria, and treatment guidelines, or during case conference to the multi-disciplinary health care team;

j. prepare and deliver continuing education sessions at least twice per year to clinical staff related to best practices and updates in otolaryngology;

k. document patient encounters and all clinical actions and maintain the patient health record in a timely fashion in accordance with relevant professional and CAF standards;

l. language of work may be French and/or English, depending on geographic location; and

m. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST – PHYSIATRIST/REHABILITATION

**STREAM 3**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Specialist – Physiatrist/Rehabilitation**

## WORK AND ENVIRONMENT

1. Physiatrists specialize in diagnosis, medical management, and rehabilitation of patients with neuro-musculoskeletal disorders and associated disabilities. Physiatrists are a part of a rehabilitation team within CF Rehabilitation Program and a member of the multi-disciplinary team within the CF Clinic model where Physiatrists provide higher level consultation and advice to the teams. Physiatrists work in the specialty clinic as a part-time basis and receive patient referrals from the primary health care team and see patients by booked appointments.

## EDUCATION / QUALIFICATIONS

2. All Physiatrists shall, as a minimum, have:

   a. a licence from the provincial or territorial regulatory organization in the province of practice;

   b. a speciality certification in Physical Medicine and Rehabilitation from the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College des médecins du Quebec (after 2001); and

   c. a current Fellowship with the RCPSC or for non-fellows, participation in a continuing medical education (CME) program equivalent to a Maintenance of Competence (MOCPMP) Program.

## EXPERIENCE

3. The Physiatrist must have clinical experience which demonstrates the necessary proficiency to perform the outlined tasks for a patient aged 18- 60, corroborated by two references. This must include Physiatry experience in Chronic Pain Management, Sport Medicine, and neuro-musculoskeletal conditions.

## TASKS

4. The required tasks for this occupational group include the following:

   a. practice Physiatry in accordance with applicable provincial and national regulatory standards;

   b. perform a patient assessment and generate a diagnosis based on the results of assessment;

c. prescribe and perform preventive and therapeutic interventions consistent with the medical diagnosis. These interventions include, but are not limited to: exercise prescriptions, physical modality prescriptions, rehabilitation therapies, pharmacotherapy, and use of variety of assistive device such as mobility aids, orthoses, prostheses, and interventional pain management procedures such as guided nerve blocks, epidural steroid injections and soft tissue injections;

d. develop a care plan with the patient and the multi-disciplinary health care team, such as physiotherapists, occupational therapists, mental health professionals and primary care professionals, to address patient's health care needs including making recommendations on impairment, restriction, and temporary or permanent limitation;

e. communicate individualized care plan to patient and educate patient on their roles and responsibilities;

f. provide follow-up care with patients requiring extensive or long-term multi-disciplinary interventions;

g. Interpret Electromyography (EMG) or Nerve Conduction Studies (NCS);

h. carry a standard caseload of 7-14 patients per day, which are approximately 7 new cases or 14 follow-up cases;

i. communicate with Senior Medical Authority on relevant clinical matters such as acute or chronic conditions or unusual situations, CF Spectrum of Care, and complex patients requiring multi-disciplinary intervention;

j. provide clinical preceptorship to CF Health Services approved trainees and junior clinicians, such as medical or nursing students, Physician Assistants, medical technicians, and students including:

    (1) performing ongoing assessment of clinical competency of the provider;

    (2) assigning clinical tasks, including the delegation of medical acts;

    (3) ensuring that the scope of practice and competency of the provider aligns with the complexity of care required for the patient;

    (4) evaluating clinical performance through direct or indirect observation, chart review, case review, provision of co-signature; and

    (5) providing verbal and written feedback on clinical skills, knowledge, and judgement to the student, educational institution, and Senior Medical Authority.

k. provide physical medicine and rehabilitation advice and recommendations to the multi-disciplinary team regarding the formulation of policies that govern medical fitness, diagnostic criteria, and treatment guidelines, or during case conference to the multi-disciplinary health care team;

l. prepare and deliver continuing education sessions at least twice per year to clinical staff related to best practices and updates in Physiatry related to inter-professional care for complex care patients;

m. document patient encounters and all clinical actions and maintain the patient health record in a timely fashion in accordance with relevant professional and CAF standards;

n. language of work may be French and/or English, depending on geographic location; and

o. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST – PLASTIC SURGEON

**STREAM** **3**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Specialist – Plastic Surgeon**

## WORK AND ENVIRONMENT

1. Plastic Surgeons specialize in the management of complex composite tissue defects including repairing or reconstructing defects or imperfections in the form and function of the skin and its underlying muscles and bones. These defects often can be the result of injury, aging, or disease. Plastic Surgeons perform a variety of plastic and reconstructive surgery to restore function and appearances. Plastic Surgeons are a part of the multi-disciplinary team within the CF Clinic model where Plastic Surgeons provide higher level consultation and advice to the team. Plastic Surgeons receive patient referrals from the primary health care team and see patients by booked appointment at the Specialty clinic. Plastic Surgeons perform minor outpatient surgeries at the Specialty Clinic. Any procedures performed by Plastic Surgeons outside the Specialty clinic will be charged to DND through Federal Health Claims Processing System (FHCPS).

## EDUCATION / QUALIFICATIONS

2. All Plastic Surgeons shall possess, as a minimum:

   a. a licence from the provincial or territorial regulatory organization in the province of practice;

   b. a speciality certification in Plastic Surgery from the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College des médecins du Quebec (after 2001);

   c. a current Fellowship with the RCPSC or for non-fellows, participation in a continuing medical education (CME) program equivalent to a Maintenance of Competence (MOCPMP) Program; and

   d. full hospital privileges at an acute care medical facility to perform surgery and deal with complications.

## EXPERIENCE

3. The Plastic Surgeon must demonstrate the necessary scope of practice, as specified by their respective regulatory body, to perform the outlined tasks for a patient aged 18 – 60, corroborated by two references with emphasis on experience in hand procedures.

## TASKS

4. The required tasks for this occupational group include the following:

   a. practice Plastic Surgery in accordance with applicable provincial and national regulatory standards;

   b. perform a patient assessment and generate a diagnosis based on the results of assessment;

   c. provide pre-operative instructions and education to patients, surgical interventions, and post-operative care such as sedatives, analgesic, diets, antibiotics, and post-operative instructions;

   d. develop a post-operative care plan with the patient and the multi-disciplinary health care team to address patient's health care needs including making recommendations on temporary or permanent impairment, restriction, and prognosis, and advocating services based on CF Spectrum of Care;

   e. perform minor surgeries in the Specialty Clinic;

   f. perform procedures within CAF spectrum of care, excluding cosmetic procedures;

   g. communicate with Senior Medical Authority on relevant clinical matters such as unusual situations, CF Spectrum of Care, and complex patients requiring multi-disciplinary intervention;

   h. provide clinical preceptorship to CF Health Services approved trainees and junior clinicians, such as medical or nursing students, Physician Assistants, medical technicians, and students including:

      (1) performing ongoing assessment of clinical competency of the provider;

      (2) assigning clinical tasks, including the delegation of medical acts;

      (3) ensuring that the scope of practice and competency of the provider aligns with the complexity of care required for the patient;

      (4) evaluating clinical performance through direct or indirect observation, chart review, case review, provision of co-signature, etc.; and

      (5) providing verbal and written feedback on clinical skills, knowledge, and judgement to the student, educational institution, and Senior Medical Authority.

   i. provide clinical input or advice on plastic surgery to the multi-disciplinary team regarding the formulation of policies that govern medical fitness, diagnostic

criteria, and treatment guidelines, or during case conference to the multi-disciplinary health care team;

j. prepare and deliver continuing education sessions twice per year to clinical staff related to best practices and provide updates in plastic surgery when warranted;

k. document patient encounters and all clinical actions and maintain the patient health record in a timely fashion in accordance with relevant professional and CAF standards;

l. language of work may be French and/or English, depending on geographic location; and

m. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST – PLASTIC SURGEON

**STREAM 3**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Specialist – Plastic Surgeon**

**WORK AND ENVIRONMENT**

1. Psychiatrists specialize in the psychiatric assessment, treatment, rehabilitation care, and prevention of mental, emotional and behavioural disorders. Psychiatrists utilize a combination of biological, psychological and social treatment modalities to work with patients in order to help treat or manage these disorders and to promote wellness. Psychiatrists function as a part of an interdisciplinary mental health care team within Mental Health Service or with Operational Trauma & Stress Support Centre (OTSSC) as well as the Primary Care Services. Psychiatrists receive patient referrals from the primary health care team or the mental health care team. On occasion, psychiatrists may provide psychiatric care outside the clinic such as home visit, civilian hospital, and CF detention centre.

**EDUCATION / QUALIFICATIONS**

2. All Psychiatrists shall, as a minimum, have:

   a. a licence from the provincial or territorial regulatory organization in the province of practice;

   b. a speciality certification in Psychiatry from the Royal College of Physicians and Surgeons of Canada (RCPSC) or the Collège des médecins du Quebec (after 2001); and

   c. a current Fellowship with the RCPSC or for non-fellows, participation in a continuing medical education (CME) program equivalent to a Maintenance of Competence (MOCPMP) Program.

**EXPERIENCE**

3. The Psychiatrist must demonstrate the necessary scope of practice to perform the outlined tasks for adult population (18 – 60 years of age), corroborated by two references, with the following emphasis:

   a. Trauma related disorders;

   b. Depressive disorders;

   c. Anxiety disorders; and

   d. Substance-Related and Addictive disorders.

**TASKS**

4. The required tasks for this occupational group include the following:

   a. practice psychiatry services in accordance with applicable provincial and national regulatory standards and all relevant CAF policies, guidance, and instructions, provided by the Task Manager;

   b. perform psychiatric assessments using various investigative methods to generate a psychiatric diagnosis based on the most current Diagnostic and Statistical Manual of Mental Disorders (DSM). Given the occupational medicine component of the CAF Health Services, all consultation and follow-up notes must include making recommendations on temporary or permanent impairment, restriction, and prognosis;

   c. implement evidence-based therapeutic interventions as part of the larger multi-disciplinary team. These preventive and therapeutic interventions may include psychopharmacological treatment, psychological treatments such as cognitive behavioural therapy, family or group therapy, and psychodynamic psychotherapy;

   d. respond to crisis intervention or psychiatric emergencies during work hours;

   e. provide psychiatric assessment and interventions via tele-mental health (video);

   f. provide clinical preceptorship to CF Health Services approved trainees and junior clinicians, such as medical or nursing students, Physician Assistants, medical technicians, and students including:

      (1) performing ongoing assessment of clinical competency of the provider;

      (2) assigning clinical tasks, including the delegation of medical acts;

      (3) ensuring that the scope of practice and competency of the provider aligns with the complexity of care required for the patient;

      (4) evaluating clinical performance through direct or indirect observation, chart review, case review, provision of co-signature, etc.; and

      (5) providing verbal and written feedback on clinical skills, knowledge, and judgement to the student, educational institution, and Senior Medical Authority.

   g. provide psychiatric input, advice, and recommendations to the multi-disciplinary team regarding the formulation of policies that govern medical fitness, diagnostic criteria, and treatment guidelines for all psychiatric disorders, or during case conference to the multi-disciplinary health care team;

h. prepare and deliver education sessions on various types of mental, emotional and behavioural disorders to individuals, families and CF community including special groups such as Military police) to generate awareness and prevention of mental illnesses (including suicide prevention);

i. communicate with Senior Clinical Director and/or Senior Medical Authority on relevant clinical matters such as acute or chronic psychiatric conditions, CF Spectrum of Care, complex patients requiring multi-disciplinary intervention, and individual operational readiness;

j. prepare and deliver continuing education sessions to clinical staff related to best practices and new updates in psychiatry when warranted; as well as participate in teaching activities (e.g., supervision of students, other health care professionals), if approved by local management;

k. document patient encounters and all clinical actions and maintain the patient health record in a timely fashion in accordance with standards of professional practice and CF H Svcs Group Policies/Instructions;

l. participate in relevant research projects and associated activities (e.g., conference presentations), if approved by local management and by the Surgeon General's Science and Technology program;

m. participate in individual and group learning events, if approved by local management;

n. language of work may be French and/or English, depending on geographic location; and

o. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST – RADIOLOGIST

**STREAM** **3**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Specialist – Radiologist**

## WORK AND ENVIRONMENT

1. Radiologists specialize in the study, diagnosis and treatment of disease by using various imaging techniques such as radiography, computed tomography (CT), Magnetic resonance imaging (MRI), ultrasound, and radioactive substances. Radiologists are a part of a rehabilitation team within CF Rehabilitation Program and a member of the multi-disciplinary team within the CF Clinic model where Radiologists provide higher level consultation and advice to the teams. Radiologists work in the specialty clinic on a part-time basis and receive patient referrals from the primary health care team and see patients by booked appointments when the diagnostic imaging is performed by radiologists at the Specialty clinic or Diagnostic Imaging area.

## EDUCATION / QUALIFICATIONS

2. All Radiologists shall possess, as a minimum:

    a. a licence from the provincial or territorial regulatory organization in the province of practice;

    b. a speciality certification in Diagnostic Radiology from the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College des médecins du Quebec (after 2001); and

    c. a current Fellowship with the RCPSC or for non-fellows, participation in a continuing medical education (CME) program equivalent to a Maintenance of Competence (MOCPMP) Program.

## EXPERIENCE

3. The Radiologist must demonstrate the necessary scope of practice to perform the outlined tasks for a patient aged 18- 60, corroborated by two references. This must include experience in musculoskeletal radiology.

## TASKS

4. The required tasks for this occupational group include the following:

    a. practice diagnostic radiology services in accordance with applicable provincial and national regulatory standards;

    b. interpret various radiological examinations and generate radiologic reports including the description of imaging findings, most likely differential diagnoses,

and when clinically indicated, recommend further testing and management to the referring physician or other health care providers;

c. perform and/or interpret various radiological procedures such as interventional radiology, upper gastrointestinal (UGI) series, Barium Enema, Intravenous Pyelogram (IVP), CT scan, MRI and emergency ultrasounds when no technologist is available;

d. provide clinical preceptorship to CF Health Services approved trainees and junior clinicians, such as medical or nursing students, Physician Assistants, medical technicians, and students including:

(1) performing ongoing assessment of clinical competency of the provider;

(2) assigning clinical tasks, including the delegation of medical acts;

(3) ensuring that the scope of practice and competency of the provider aligns with the complexity of care required for the patient;

(4) evaluating clinical performance through direct or indirect observation, chart review, case review, provision of co-signature, etc.; and

(5) providing verbal and written feedback on clinical skills, knowledge, and judgement to the student, educational institution, and Senior Medical Authority.

e. provide radiology input, advice, and recommendations to the multi-disciplinary health care team regarding the formulation of policies that govern medical fitness, diagnostic criteria, and treatment guidelines for cardiovascular diseases, or during case conference to the multi-disciplinary health care team;

f. prepare and deliver continuing education sessions twice per year to clinical staff related to best practices and provide new updates in radiology when warranted;

g. document patient encounters and all clinical actions and the patient health record in a timely fashion in accordance with relevant professional and CAF standards;

h. language of work may be French and/or English, depending on geographic location; and

i. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST – RHEUMATOLOGIST

**STREAM** **3**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Specialist – Rheumatologist**

## WORK AND ENVIRONMENT

1. Rheumatologists specialize in the assessment, diagnosis, management, and rehabilitation of patients with rheumatological, autoimmune, and related musculoskeletal health disorders such as arthritis, common athletic injuries, and collagen diseases. Rheumatologists are a member of the multi-disciplinary team within the CF Clinic model where Rheumatologists provide higher level consultation and advice to the teams. Rheumatologists work in the specialty clinic on a part-time basis and receive patient referrals from the primary health care team and see patients by booked appointments. Rheumatologists refer patients to other health care providers such as physiotherapists, occupation therapists, and orthopedic surgeons.

## EDUCATION / QUALIFICATIONS

2. All Rheumatologists shall possess, as a minimum:

   a. a licence from the provincial or territorial regulatory organization in the province of practice;

   b. a speciality certification in Internal Medicine and a subspecialty certification in Adult Rheumatology from the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College des médecins du Quebec (after 2001); and

   c. a current Fellowship with the RCPSC or for non-fellows, participation in a continuing medical education (CME) program equivalent to a Maintenance of Competence (MOCPMP) Program.

## EXPERIENCE

3. The Rheumatologist must demonstrate the necessary scope of practice to perform the outlined tasks for a patient aged 18-60, corroborated by two references.

## TASKS

4. The required tasks for this occupational group include the following:

   a. practice Adult Rheumatology services in accordance with applicable provincial and national regulatory standards;

b. perform a patient assessment and generate a diagnosis based on the results of assessment;

c. provide preventive and therapeutic interventions and advice consistent with the medical diagnosis, such as non-pharmacological intervention, pharmacologic and biologic therapy, join and soft tissue injection, lifestyle changes, physical therapies, nutrition;

d. develop a care plan with the patient and the multi-disciplinary health care team to address patient's health care needs including making recommendations on temporary or permanent impairment, restriction, and prognosis;

e. provide follow-up care and rehabilitative management with patients with chronic or complex rheumatological disorders;

f. communicate with Senior Medical Authority on relevant clinical matters such as acute or chronic conditions or unusual situations, CF Spectrum of Care, and complex patients requiring multi-disciplinary intervention;

g. provide rheumatology advice and recommendations to the multi-disciplinary health care team regarding the formulation of policies that govern medical fitness, diagnostic criteria, and treatment guidelines, or during case conference to the multi-disciplinary health care team;

h. prepare and deliver continuing education sessions twice per year to clinical staff related to best practices and provide updates in rheumatology practice when warranted;

i. document patient encounters and all clinical actions and the patient health record in a timely fashion in accordance with relevant professional and CAF standards;

j. language of work may be French and/or English, depending on geographic location; and

k. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST – UROLOGIST

**STREAM 3**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Specialist – Urologist**

## WORK AND ENVIRONMENT

1. Urologists specialize in the assessment, diagnosis, medical and surgical management of disorders and diseases of the male urogenital system and the female urinary tract. Urologists are a part of the multi-disciplinary team within the CF Clinic model where Urologists provide higher level consultation and advice to the team. Urologists work on a part-time basis in the specialty clinic and receive patient referrals from the primary health care team and see patients by booked appointments. Urologists are also a part of the military operating room (OR) team in either the civilian hospital during the designated military OR time or a part of the multi-disciplinary health care team in the specialty clinic setting or both. Any procedures performed by Urologist outside the Specialty clinic or designated military OR time will be charged to DND through Federal Health Claims Processing System (FHCPS).

## EDUCATION / QUALIFICATIONS

2. All Urologists shall possess, as a minimum:

   a. a licence from the provincial or territorial regulatory organization in the province of practice;

   b. a speciality certification in Urology from the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College des médecins du Quebec (after 2001);

   c. a current Fellowship with the RCPSC or for non-fellows, participation in a continuing medical education (CME) program equivalent to a Maintenance of Competence (MOCPMP) Program; and

   d. full hospital privileges at an acute care medical facility to perform surgery and deal with complications.

## EXPERIENCE

3. The Urologist must demonstrate the necessary scope of practice, as specified by their respective regulatory body, to perform the outlined tasks for a patient aged 18-60, corroborated by two references.

## TASKS

4. The required tasks for this occupational group include the following:

   a. practice Urology services in accordance with applicable provincial and national regulatory standards;

   b. perform a patient assessment and generate a diagnosis based on the results of assessment;

   c. provide pre-operative instructions and education to patients, surgical interventions, and post-operative care and instructions such as sedatives, analgesic, diets, antibiotics;

   d. develop a post-operative care plan with the patient and the multi-disciplinary health care team to address patient's health care needs including making recommendations on impairment, restriction, temporary or permanent limitation, and recommending services;

   e. perform minor surgeries such as vasectomies, circumcisions, and cystoscopy in the specialty clinic;

   f. communicate with Senior Medical Authority on relevant clinical matters such as acute or chronic conditions or unusual situations, CF Spectrum of Care, and complex patients requiring multi-disciplinary intervention;

   g. provide clinical preceptorship to CF Health Services approved trainees and junior clinicians, such as medical or nursing students, Physician Assistants, medical technicians, and students including:

      (1) performing ongoing assessment of clinical competency of the provider;

      (2) assigning clinical tasks, including the delegation of medical acts;

      (3) ensuring that the scope of practice and competency of the provider aligns with the complexity of care required for the patient;

      (4) evaluating clinical performance through direct or indirect observation, chart review, case review, provision of co-signature, etc.; and

      (5) providing verbal and written feedback on clinical skills, knowledge, and judgement to the student, educational institution, and Senior Medical Authority.

   h. provide input and clinical advice to the multi-disciplinary health care team on urology regarding the formulation of policies that govern medical fitness,

diagnostic criteria, and treatment guidelines, or during case conference to the multi-disciplinary health care team;

i. prepare and deliver continuing education sessions twice per year to clinical staff related to best practices and provide updates in urology practice when warranted;

j. document patient encounters and all clinical actions and maintain the patient health record in a timely fashion in accordance with relevant professional and CAF standards;

k. language of work may be French and/or English, depending on geographic location; and

l. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST –
# INTERNIST - OPERATIONAL SPECIALIST

**STREAM 4**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Specialist – Internist - Operational Specialist**

## WORK AND ENVIRONMENT

1. Internists are a medical specialists concerned with the recognition, investigation, diagnosis and medical management of diseases involving more than one organ system.

2. The Specialist in Internal Medicine is part of a health care team that provides higher level consultation and advice to military primary care physicians and senior medical advisors in addition to the clinical assessment and care of military personnel within the Canadian Forces Environmental Medicine Establishment's (CFEME). They also have a role in providing advice to CAF medical policymakers regarding personnel selection, personnel retention, and support to military operations, and perform research and deliver instruction on operational medicine courses.

## EDUCATION / QUALIFICATIONS

3. All Internists must, as a minimum, have:

   a. a licence from the provincial or territorial regulatory organization in the province of practice;

   b. a speciality certification in Internal Medicine from the Royal College of Physicians and Surgeons of Canada (RCPSC) or the Collège des médecins du Québec (after 2001);

   c. a current Fellowship with the RCPSC or for non-fellows, participation in a continuing medical education (CME) program equivalent to a Maintenance of Competence (MOCPMP) Program; and

   d. hold and maintain a Certificate of Advanced Cardiac Life Support (ACLS) in accordance with the Heart and Stroke Foundation ACLS Provider program.

## EXPERIENCE

4. The Internist must:

   a. have clinical experience which demonstrates the necessary proficiency to perform the outlined tasks for a patient aged 18- 60, corroborated by two references;

   b. have experience in performing various specialized procedures such as pulmonary function text, exercise stress test, echocardiogram, nerve conduction study (NCS),

and electromyogram (EMG);

c. have experience of at least 100/hours/year of clinical occupational related health assessments in five of the last ten years, corroborated by two references; and

d. have completed or be willing to complete CAF courses in Aviation Medicine and Diving Medicine.

**TASKS**

5. The required tasks for this occupational group include the following:

a. practice general internal medicine services in accordance with applicable provincial and national regulatory standards and scope of practice;

b. perform a patient assessment and generate a diagnosis based on the results of assessment;

c. provide preventive and therapeutic interventions consistent with the medical diagnosis, such as pharmacological intervention, lifestyle changes, physical therapies, nutrition, and complementary medicine;

d. develop a care plan with the patient and the multi-disciplinary health care team to address patient's health care needs including making recommendations on temporary or permanent impairment, restriction, and prognosis;

e. provide follow-up care with patients requiring extensive or long-term multi-disciplinary interventions;

f. communicate with Senior Medical Authority on relevant clinical matters such as acute or chronic medical conditions or unusual situations, CF Spectrum of Care, and complex patients requiring multi-disciplinary intervention;

g. provide internal medicine advice and recommendations regarding the formulation of policies that govern medical fitness, diagnostic criteria, and treatment guidelines, or during case conference to the multi-disciplinary health care team;

h. prepare and deliver continuing education sessions twice a year to clinical staff related to best practices and/or updates in internal medicine when warranted;

i. document patient encounters and all clinical actions and maintain patient medical information in CFHIS and patient health records;

j. review Undersea and Aerospace medical cases and make recommendations to the Aerospace and Undersea Medical Board (AUMB) on questions of Undersea and Aerospace medical fitness in accordance with relevant medical standards such as

but not limited to: CF Health Services Group Instruction 4000-04, Shallow Water Divers Periodic Health Assessment and Medical Administration, and AMA Directive 100-01, and 1 Canadian Air Division Flight Surgeon Guidelines found at Appendix 1;

k. review and perform initial aircrew medical examination in accordance with AMA Directive 100-01 and 1 Canadian Air Division Flight Surgeon Guidelines found at Appendix 1;

l. provide higher level advice to primary care physicians who have advanced diving and/or operational flight surgeon training and who routinely care for divers and aircrew where they operate;

m. provide advice and recommendations to AUMB regarding the formulation of policies that govern medical fitness to fly or dive, diagnostic criteria, and treatment guidelines for diving or aerospace related disorders;

n. participate in meetings of the AUMB and other committees such as Aeromedical Policy and Standards Committee, CF Dive Policy Committee, Defence Research and Directorate of Medical Policy etc by providing Internal Medicine input and advice on patient files, Undersea and Aerospace medicine policies, diagnostic criteria and treatment guidelines for diving or aerospace related disorders. Participation in meetings may require travel;

o. deliver subject matter expert level lectures on School of Operational Medicine (SOM) courses in accordance with CF Health Services national training calendar (as provided by the Task Manager) e.g. Dive Medicine Advanced and Operational Flight Surgeon courses each offered once per year. Specific tasks include: prepare and deliver lectures identified within the SOM course Training Plan;

p. provide medical screening and medical response for human subject experimentation at Canadian Forces Environmental Medicine Establishment (CFEME) and DRDC by conducting medical examinations on subjects for Human Research Ethics Committee approved experimental protocols and by providing ACLS level emergency services;

q. conduct research that advances knowledge on policy, prevention, diagnosis, and treatment of disorders relevant to military health and occupations. Research activities may include:

(1) synthesizing hypotheses in the fields of undersea and aerospace medicine;

(2) planning experimental protocols in accordance with Canadian Armed Forces policy and Experimental Protocol Guidelines (as provided by the Task Manager);

(3) obtaining Human Research Ethics Board (HREC) approval based on guidelines provided by the Task Manager;

(4) preparing research proposals, including research schedule, and funding applications for approval by the Surgeon General Health Research Board IAW CF Health Services Group Instruction 4030-51, Authority to Engage in Research, found at Appendix 26;

(5) executing the experimental protocol;

(6) analyzing data;

(7) writing reports in accordance with CF Health Services publishing approval process, standards, and guidelines as provided by the Task Manager including at minimum the following components:

(a) Abstract;

(b) Background;

(c) Literature review;

(d) Methodology;

(e) Data collection;

(f) Analysis;

(g) Findings;

(h) Recommendations; and

(i) Conclusion.

(8) presenting a report to AUMB meetings which occur on a quarterly basis; and

(9) publishing in a scientific journal and presenting at scientific conferences.

r. other associated tasks relevant to this occupational group.

6. A Task Authorization for Task o. (deliver specialist Internal Medicine subject matter expert level lectures) or Task q. (conduct research) above will include a detailed description of the course(s) to be delivered and/or the research to be undertaken. The description will specify the specific subject matter to be addressed, the deliverables that will be required and the schedule to be followed.

## DELIVERABLES

7. The required deliverables relevant to this occupational group IAW the required tasks are as follows:

a. produces written consult reports documented in the medical chart for all patients clinically assessed;

b. produces written reports providing diagnostic interpretations of electrocardiograms, exercise stress tests, echocardiograms, stress echocardiograms with and without contrast, carotid Doppler studies, and pulmonary function tests;

c. produces written recommendations and case presentations for discussion at AUMB;

d. produces written reports and analysis of discipline specific research studies;

e. drafts Flight Surgeon Guidelines for approval on discipline specific topics;

f. reviews and updates assigned Flight Surgeon Guidelines annually;

g. prepares power-point presentations related to aviation and diving medicine for delivery on School of Operational Medicine courses;

h. completes assessments on initial aircrew and diver candidates in accordance with AMA 100-01 and documents the assessment and recommendations in the medical chart;

i. conducts aeromedical file reviews on aircrew trade applicants other than pilot and documents the file review and recommendations in the medical chart;

j. conducts medical examination for fitness to participate in human research and documents the examination and assessment in the medical chart;

k. produce written reports on evidence based aeromedical and diving medicine policies, standards, and guidelines;

l. produces written executive summaries and power-point presentations of discipline specific scientific best practice analysis;

m. produces written research proposals for discipline and Health Services relevant topics; and

n. produces written research reports for all research completed.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST - AEROSPACE MEDICINE

**STREAM** **4**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Specialist - Aerospace Medicine**

## WORK AND ENVIRONMENT

1. Aerospace Medicine is a medical specialty concerned with the recognition, investigation, diagnosis, and management of all aspects of medical, surgical, performance, health and safety issues concerned with flight as they pertain to aircrew, controllers, and passengers.

2. The Specialist in Aerospace Medicine is part of a health care team that provides higher level consultation and advice to military primary care physicians and senior medical advisors in addition to the clinical assessment and care of military personnel within the Canadian Forces Environmental Medicine Establishment's (CFEME). They also have a role in providing advice to CAF medical policymakers regarding personnel selection, personnel retention, and support to military operations, perform research, and deliver instruction on Aerospace Medicine courses.

## EDUCATION / QUALIFICATIONS

3. The Specialist in Aerospace Medicine Physician must, as a minimum:

   a. possess a medical licence in good standing from the provincial or territorial regulatory organization in the province or territory of practice;

   b. one or more of the following:

      (1) hold a Diploma in Aviation Medicine conferred by the Faculty of Occupational Medicine of the College of Physicians and Surgeons of London; or

      (2) be Board Certified in Aerospace Medicine by the American College of Preventive Medicine; or

      (3) hold an Area of Focused Competence Diploma or Affiliate Diploma in Aerospace Medicine from the Royal College of Physicians and Surgeons of Canada.

   c. hold a current Advanced Cardiac Life Support certificate in accordance with the Heart and Stroke Foundation ACLS Provider program;

## EXPERIENCE

4. The Aerospace Medicine Physician must, as a minimum, have provided at least 120 hours/year of clinical Aerospace Medicine in 5 of the last 10 years in Canada, the United States (U.S.), United Kingdom (U.K.), New Zealand (N.Z.) or Australia.

5. The work experience offered to meet the above requirements must be verifiable by a curriculum vitae which has been corroborated by two references.

**TASKS**

6. The required tasks for this occupational group include the following:

a. provide Aerospace Medicine specialty services by conducting medical examinations and file reviews on referred patients and completing medical documentation that may include medical employment limitations, diagnosis, medical recommendations;

b. maintain patient health records, including the use of CFHIS to receive and respond to consults;

c. review and perform initial aircrew medical examination in accordance with AMA Directive 100-01 and 1 Canadian Air Division Flight Surgeon Guidelines found at Appendix 1;

d. review aircrew medical cases and make recommendations to the Aerospace and Undersea Medical Board (AUMB) on questions of aircrew medical fitness in accordance with AMA Directive 100-01 and 1 Canadian Air Division Flight Surgeon Guidelines found at Appendix 1;

e. provide higher level advice to primary care physicians who have operational flight surgeon training and who routinely care for aircrew where they operate;

f. provide Aerospace Medicine input, advice, and recommendations to AUMB regarding the formulation of policies that govern medical fitness to fly, diagnostic criteria, and treatment guidelines for aerospace related disorders;

g. participate in meetings of the AUMB and other committees such as Aeromedical Policy and Standards Committee, Defence Research and Directorate of Medical Policy by providing Aerospace Medicine input and advice on patient files, Aerospace Medicine policies, diagnostic criteria and treatment guidelines for aerospace related disorders. Participation in meetings may require travel;

h. provide medical screening and medical response for human subject experimentation at Canadian Forces Environmental Medicine Establishment (CFEME) and DRDC by conducting medical examinations on subjects for HREC approved experimental protocols and by providing ACLS level emergency services IAW Medical Consult Services SOPs, as provided by the Task Manager;

i. provide medical screening and medical response for personnel participating in human centrifuge training as well as hypobaric chamber exposures;

j. deliver specialist Aerospace Medicine subject matter expert level lectures at the School of Operational Medicine (SOM) in accordance with CF Health Services national training calendar (as provided by the Task Manager) e.g. Basic Aviation Medicine and Operational Flight Surgeon courses, each offered once per year. Specific tasks include:

(1) prepare and deliver lectures identified within the Basic Aviation Medicine course Training Plan and the Operational Flight Surgeon course Training Plan; and

(2) evaluate written assignments, tests, homework etc. and provide written and verbal feedback to students.

k. conduct research that advances knowledge on policy, prevention, diagnosis, and treatment of aerospace related disorders. Research activities may include:

(1) synthesizing hypotheses in the fields of aerospace medicine;

(2) planning experimental in accordance with Canadian Armed Forces policy and Experimental Protocol Guidelines as provided by the Task Manager;

(3) obtaining Human Research Ethics Board (HREC) approval based on guidelines provided by the Task Manager;

(4) preparing research proposals, including research schedule, and funding applications for approval by the Surgeon General Health Research Board IAW CF Health Services Group Instruction 4030-51, Authority to Engage in Research;

(5) executing the experimental protocol;

(6) analyzing data;

(7) writing reports in accordance with CF Health Services publishing approval process, standards, and guidelines as provided by the Task Manager including at minimum the following components:

(a) Abstract;

(b) Background;

(c) Literature review;

(d) Methodology;

(e) Data collection;

(f) Analysis;

(g) Findings;

(h) Recommendations; and

(i) Conclusion.

(8) presenting reports to AUMB meetings which occur on a quarterly basis; and

(9) publishing in a scientific journal and presenting at scientific conferences.

l. other associated tasks relevant to this occupational group.

7. A Task Authorization for Task j. (deliver specialist Aerospace Medicine subject matter expert level lectures) or Task k. (conduct research) above will include a detailed description of the course(s) to be delivered and/or the research to be undertaken. The description will specify the specific subject matter to be addressed, the deliverables that will be measured and the schedule that will be followed.

**DELIVERABLES**

8. The required deliverables relevant to this occupational group IAW the required tasks are as follows:

a. produces written consult reports documented in the medical chart for all patients clinically assessed;

b. produces written recommendations and case presentations for discussion at AUMB;

c. produces written reports and analysis of discipline specific research studies;

d. drafts Flight Surgeon Guidelines for approval on discipline specific topics;

e. reviews and updates assigned Flight Surgeon Guidelines annually;

f. prepares power-point presentations related to aviation medicine for delivery on School of Operational Medicine courses;

g. completes assessments on initial aircrew candidates in accordance with AMA 100-01 and documents the assessment and recommendations in the medical chart;

h. conducts aeromedical file reviews on aircrew trade applicants other than pilot and documents the file review and recommendations in the medical chart;

i. conducts medical examination for fitness to participate in human research and documents the examination and assessment in the medical chart;

j. produce written reports on evidence based aeromedical policies, standards, and guidelines;

k. produces written executive summaries and power-point presentations of discipline specific scientific best practice analysis;

l. produces written research proposals for discipline and Health Services relevant topics; and

m. produces written research reports for all research completed.

# APPENDIX 11 TO ANNEX A1

# NURSE OR PHYSICIAN ASSISTANT - CADET REGIONAL MEDICAL LIAISON OFFICER – NURSE OR PHYSICIAN ASSISTANT

**STREAM 4**

**OCCUPATIONAL AND GROUP CATEGORY** **Nurse or Physician Assistant - Cadet Regional Medical Liaison Officer – Nurse or Physician Assistant**

**WORK AND ENVIRONMENT**

1. Regional Medical Liaison Officer is a Registered Nurse or Physician Assistants who provides occupational medical expertise and recommendations regarding Medical Employment Limitations (MELs) for Cadet Instructors Cadre and Participation Limitations (PLs) for Cadets and the Junior Canadian Rangers. The Regional Medical Liaison Officer liaises with staff from the Directorate of Cadets and CF Health Services Group on matters related to Cadet and Junior Canadian Ranger medical fitness. They work with the medical staff at the Cadet Summer Training Camps (CSTCs) and the Regional Cadet Support Unit (RSCU) personnel in support of the Canadian Cadet Organization and Junior Canadian Ranger programs. They do not provide direct patient care.

2. Language of work may be English and/or French, depending on geographic location.

**EDUCATION / QUALIFICATIONS**

3. All Regional Medical Liaison Officer will, as a minimum be a Registered Nurse or a Physician Assistant:

a. Registered Nurse requirement:

(1) a current licence in good standing from a provincial/territorial regulatory organization in Canada; or

b. Physician Assistant requirement:

(1) have graduated from a Physician Assistant Program accredited or recognized by Canadian Medical Association (CMA); and

(2) possess a Certification from the Physician Assistant Certification Council of Canada (PACCC) through the Canadian Association of Physician Assistants (CAPA) or have a minimum 10 years full time equivalent active practice as a PA; and

(3) hold a current membership with CAPA; and

(4) possess documented registration with the College of Physicians and Surgeons in the province of work. For provinces and territories without a registry, the Technical Authority (TA) will consider proposed PAs on a case by case basis.

**EXPERIENCE**

4. The Cadet Regional Medical Liaison Officer will have, as a minimum,1 year experience as a Registered Nurse or Physician Assistant providing patient care in an ambulatory primary care, occupational medicine, urgent care or emergency medicine setting.

**TASKS**

5. The required tasks for this occupational group include the following:

a. review Cadet Instructors Cadre, Cadet and Junior Canadian Ranger medical files and determine Medical Employment Limitations (MEL) and Participation Limitations (PL) in accordance with Directives and Instructions from SSO Primary Care;

b. review medical documents provided by family and health care providers and other available medical information related to individual Cadet and Junior Canadian Rangers. Review medical documents in CFHIS for Cadet Instructors Cadre;

c. liaise and communicate with families, treating physicians, and specialists, etc. regarding health conditions through phone, email, memo, letter, forms etc.;

d. discuss difficult cases with higher medical authority in the Professional-Technical Chain. For example: Base Surgeon, Area Surgeon, or Senior Staff Officer Primary Care/ DMed Pol.;

e. determine MELs and PLs and input the information into FORTRESS;

f. liaise with SSO Primary Care regarding the health status of Cadet Instructors Cadre, Cadets and Junior Canadian Rangers through submission of statistics and through phone, email, memo, letters, forms, etc.;

g. liaise with Commanding Officers (and their assigned delegates) of the local Cadet Unit and Cadet Summer Training Centre (CSTC) regarding the health status of Cadet Instructors Cadre, Cadets and Junior Canadian Rangers through phone, email, memo, letter, forms etc.;

h. provide education and advice to local Chain of Command regarding medical standards processes and MEL and PL guidelines;

i. provide health advice to selection boards for Cadet Instructors Cadre, Cadets or Junior Canadian Ranger activities such as international exchanges and specialized courses;

j. review medical files and provide information to higher medical authorities in order to assist with responses to Ministerial Inquiries, Redress of Grievance, Canadian Human Rights Commission complaints, Summary Investigations, Access to Information and Privacy Act Requests in accordance with Directives and Instructions from SSO Primary Care;

k. gather information and perform preliminary clinical analysis of public or population health incidents, such as communicable disease outbreaks, adverse exposure etc, at Cadet Summer Training Centres in accordance with Directives and Instructions from SSO Primary Care/ Directorate Force Health Protection;

l. collate medical utilization statistics from Cadet Summer Training Centres and Junior Canadian Ranger camps as per direction from SSO Primary Care;

m. Occupational Health. Occupational Health aims for the promotion and maintenance of the highest degree of physical, mental and social wellbeing of workers in all occupations; the prevention among workers of departures from health caused by their working conditions; the protection of workers in their employment from risks resulting from factors adverse to health; placing and maintenance of a worker in an occupational environment adapted to his physiological and psychological equipment. Areas of practice would include:

(1) review of health evaluations of employees;

(2) periodic medical surveillance, and post-illness/injury surveillance;

(3) establishment of Medical Employment Limitations and Participation Limitations;

(4) implementation of programs for the use of indicated personal protective devices – ear protection, safety spectacles, respirators, etc.;

(5) evaluation, inspection, and abatement of workplace hazards;

(6) maintenance of occupational medical records;

(7) periodic evaluation of the occupational or environmental health program;

(8) communication with employers; and

(9) provide advice/guidance in rehabilitation and return to work programmes.

n. other associated tasks relevant to this occupational group.

**DELIVERABLES**

6. The required deliverables relevant to this occupational group IAW the required tasks are as follows:

a. produces written reports on evidence based programs, policies, standards and guidelines;

b. produces written reports and recommendations on medical strategic plans and direction;

c. produces written reports and analysis of discipline specific research studies; and

d. produces written reports for risk communication to assist an administrative decision body, the chain of command or other medical professionals.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST - CARDIOLOGIST OPERATIONAL

**STREAM 4**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Specialist-Cardiologist Operational**

## WORK AND ENVIRONMENT

1. Cardiologists specialize in the assessment, diagnosis, management, prevention, and rehabilitation of cardiovascular diseases and associated conditions. Cardiologists refer to a Cardiac surgeon or an Interventional cardiologist when surgical interventions or invasive procedures are indicated. Cardiologists remain as the primary care provider during the pre- and post-cardiac procedure period.

2. Cardiologists are part of a health care team that provides higher level consultation and advice to military primary care physicians and senior medical advisors in addition to the clinical assessment and care of military personnel within the Canadian Forces Environmental Medicine Establishment's (CFEME). They also have a role in providing advice to CAF medical policymakers regarding personnel selection, personnel retention, and support to military operations, perform research, and deliver instruction on operational medicine courses.

## EDUCATION / QUALIFICATIONS

3. All Cardiologists shall possess, as a minimum:

   a. a licence from the provincial or territorial regulatory organization in the province of practice;

   b. a speciality certification in Internal Medicine and a subspecialty certification in Adult Cardiology from the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College des médecins du Québec (after 2001);

   c. a current Fellowship with the RCPSC; and

   d. hold and maintain a Certificate of Advanced Cardiac Life Support (ACLS) in accordance with the Heart and Stroke Foundation ACLS Provider program.

## EXPERIENCE

4. The Cardiologist must, as a minimum have:

   a. clinical experience which demonstrates the necessary proficiency to perform the outlined tasks for a patient aged 18- 60, corroborated by two references.

   b. have experience of at least 100/hours/year of clinical occupational related health assessments in five of the last ten years, corroborated by two references; and

c. have successfully completed or be willing to complete the CAF environmental courses in Aviation Medicine and Diving Medicine.

**TASKS**

5. The required tasks for this occupational group include the following:

a. practice cardiology services IAW applicable provincial and national regulatory standards;

b. perform a patient assessment and generate a diagnosis based on the results of assessment;

c. provide preventive and therapeutic interventions and advice consistent with the medical diagnosis, such as pharmacological intervention, lifestyle changes, physical therapies and nutrition;

d. perform and/or interpret diagnostic and therapeutic procedures such as echocardiogram (Echo), electrocardiogram (ECG), and stress test;

e. develop a care plan with the patient and the multi-disciplinary health care team to address patient's health care needs including making recommendations on temporary or permanent impairment, restriction, and prognosis;

f. provide follow-up care with patients requiring specific cardiac care, interpretation of ECG, other tests, and post-cardiac procedure;

g. communicate with Senior Medical Authority on relevant clinical matters such as acute cardiac conditions or unusual situations, CF Spectrum of Care, and complex patients requiring multi-disciplinary intervention;

h. provide clinical preceptorship to CF Health Services approved trainees and junior clinicians, such as medical or nursing students, Physician Assistants and students including:

i. performing ongoing assessment of clinical competency of the provider;

ii. assigning clinical tasks, including the delegation of medical acts;

iii. ensuring that the scope of practice and competency of the provider aligns with the complexity of care required for the patient;

iv. evaluating clinical performance through direct or indirect observation, chart review, case review, provision of co-signature, etc.; and

v. providing verbal and written feedback on clinical skills, knowledge, and judgement to the student, educational institution, and Senior Medical Authority.

i. provide cardiology input, advice, and recommendations to the multi-disciplinary health care team regarding the formulation of policies that govern medical fitness, diagnostic criteria, and treatment guidelines for cardiovascular diseases, or during case conference to the multi-disciplinary health care team;

j. prepare and deliver continuing education sessions at least twice per year to clinical staff related to best practices and new updates in cardiology;

k. document patient encounters and all clinical actions and maintain patient medical information in the patient health record in a timely fashion in accordance with relevant professional and CAF standards;

l. review Undersea and Aerospace medical cases and make recommendations to the Aerospace and Undersea Medical Board (AUMB) on questions of Undersea and Aerospace medical fitness in accordance with relevant medical standards such as but not limited to: CF Health Services Group Instruction 4000-04, Shallow Water Divers Periodic Health Assessment and Medical Administration, and AMA Directive 100-01, and 1 Canadian Air Division Flight Surgeon Guidelines found at Appendix 1;

m. review and perform initial aircrew medical examination in accordance with AMA Directive 100-01 and 1 Canadian Air Division Flight Surgeon Guidelines found at Appendix 1;

n. provide higher level advice to primary care physicians who have advanced diving and/or operational flight surgeon training and who routinely care for divers and aircrew where they operate;

o. provide advice and recommendations to AUMB regarding the formulation of policies that govern medical fitness to fly or dive, diagnostic criteria, and treatment guidelines for diving or aerospace related disorders;

p. participate in meetings of the AUMB and other committees such as Aeromedical Policy and Standards Committee, CF Dive Policy Committee, Defence Research and Directorate of Medical Policy etc. by providing Internal Medicine input and advice on patient files, Undersea and Aerospace medicine policies, diagnostic criteria and treatment guidelines for diving or aerospace related disorders. Participation in meetings may require travel;

q. deliver subject matter expert level lectures on School of Operational Medicine (SOM) courses in accordance with CF Health Services national training calendar (as provided by the Task Manager) e.g. Dive Medicine Advanced and Operational

Flight Surgeon courses each offered once per year. Specific tasks include: prepare and deliver lectures identified within the SOM course Training Plan;

r. provide medical screening and medical response for human subject experimentation at Canadian Forces Environmental Medicine Establishment (CFEME) and DRDC by conducting medical examinations on subjects for Human Research Ethics Committee approved experimental protocols and by providing ACLS level emergency services;

s. conduct research that advances knowledge on policy, prevention, diagnosis, and treatment of disorders relevant to military health and occupations. Research activities may include:

i. synthesizing hypotheses in the fields of undersea and aerospace medicine;

ii. planning experimental protocols in accordance with Canadian Armed Forces policy and Experimental Protocol Guidelines (as provided by the Task Manager);

iii. obtaining Human Research Ethics Board (HREC) approval based on guidelines provided by the Task Manager;

iv. preparing research proposals, including research schedule, and funding applications for approval by the Surgeon General Health Research Board IAW CF Health Services Group Instruction 4030-51, Authority to Engage in Research, found at Appendix 26;

v. executing the experimental protocol;

vi. analyzing data;

vii. writing reports in accordance with CF Health Services publishing approval process, standards, and guidelines as provided by the Task Manager including at minimum the following components:

(1) Abstract;

(2) Background;

(3) Literature review;

(4) Methodology;

(5) Data collection;

(6) Analysis;

(7) Findings;

(8) Recommendations; and

(9) Conclusion.

viii. presenting a report to AUMB meetings which occur on a quarterly basis; and

ix. publishing in a scientific journal and presenting at scientific conferences.

t. other associated tasks relevant to this occupational group.

6. A Task Authorization for Task q. (deliver specialist Internal Medicine subject matter expert level lectures) or Task s. (conduct research) above will include a detailed description of the course(s) to be delivered and/or the research to be undertaken. The description will specify the specific subject matter to be addressed, the deliverables that will be required and the schedule to be followed.

**DELIVERABLES**

7. The required deliverables relevant to this occupational group IAW the required tasks are as follows:

a. produces written consult reports documented in the medical chart for all patients clinically assessed;

b. produces written reports providing diagnostic interpretations of electrocardiograms, exercise stress tests, echocardiograms, stress echocardiograms with and without contrast, carotid Doppler studies, and pulmonary function tests;

c. produces written recommendations and case presentations for discussion at AUMB;

d. produces written reports and analysis of discipline specific research studies;

e. drafts Flight Surgeon Guidelines for approval on discipline specific topics;

f. reviews and updates assigned Flight Surgeon Guidelines annually;

g. prepares power-point presentations related to aviation and diving medicine for delivery on School of Operational Medicine courses;

h. completes assessments on initial aircrew and diver candidates in accordance with AMA 100-01 and documents the assessment and recommendations in the medical chart;

i. conducts aeromedical file reviews on aircrew trade applicants other than pilot and documents the file review and recommendations in the medical chart;

j. conducts medical examination for fitness to participate in human research and documents the examination and assessment in the medical chart;

k. produce written reports on evidence based aeromedical and diving medicine policies, standards, and guidelines;

l. produces written executive summaries and power-point presentations of discipline specific scientific best practice analysis;

m. produces written research proposals for discipline and Health Services relevant topics; and

n. produces written research reports for all research completed.

# APPENDIX 11 TO ANNEX A1

# HEALTH INFORMATICS – CLINICAL ADVISORS

**STREAM 4**

**OCCUPATIONAL GROUP AND CATEGORY** **Health Informatics – Clinical Advisors**

## WORK AND ENVIRONMENT

1. Health Informatics Clinical Advisors are experienced healthcare professionals who are employed by the Canadian Forces Health Services Group (CFHSG) to support the operations of the existing electronic health record (EHR) solution and planning for a future digital health environment (DHE).

2. Health Informatics Clinical Advisors define the healthcare business processes and requirements that are unique to their speciality to ensure that health information systems are designed and operated to support the clinical needs of Canadian Armed Forces (CAF) members and the business needs of the CAF healthcare team.

3. Health Informatics Clinical Advisors work in a team-based environment with other clinical advisors, privacy, security, technical and engineering, and project management experts in order to ensure that all aspects of the healthcare delivery process are incorporated in the design, testing, implementation and operation of health information systems.

4. For the purposes of advising IM/IT teams, a Clinical Advisor is classified as an experienced licensed clinical professional responsible for delivering healthcare services. Specifically this includes: Physicians; Nurses, Physiotherapists; Social Workers, Radiology Technicians; Laboratory Technicians; Physician's Assistants; Dentists; Dental Specialists; and Dental Technicians.

5. Health Informatics Clinical Advisors are responsible for representing the health information requirements of the stakeholder group in their area of specialty. Clinical Advisors act as spokesperson for their area of expertise. As a result, clinical advisors must be aware of and promote best practices in their area of specialty.

6. Health Informatics Clinical Advisors are responsible to the Strategic Informatics Officer (SIO) and/or the Chief Information Officer (CIO) within the Health Services Delivery (HS Del) Directorate of the CFHSG.

## EDUCATION / QUALIFICATIONS

7. All Health Informatics Clinical Advisors must possess a valid clinical license from their professional regulatory body from one of the provinces or territories and also hold a university degree or diploma at a level required by their profession.

8. A Health Informatics Clinical Advisor will as minimum be:

a. **Physician**:

i. Degree in medicine from a University accredited by the Committee on Accreditation of Canadian Medical Schools or the Liaison Committee on Medical Education; and
ii. Current medical licence in good standing from a provincial/territorial regulatory organization.

OR

b. **Dentist:**

i. Degree in dentistry from a University accredited by the Canadian Dental Association; and
ii. Current dentistry licence in good standing from a provincial/territorial regulatory organization.

OR

c. **Nurse**:

i. Degree in nursing from a University accredited by the Canadian Nurses Association; and
ii. Current nursing licence in good standing from a provincial/territorial regulatory organization.

OR

d. **Pharmacist**:

i. Degree in pharmacy from an accredited Canadian University pharmacy program; and
ii. Current pharmacy licence in good standing from a provincial/territorial regulatory organization.

OR

e. **Physiotherapist**:

i. Degree in physiotherapy from an accredited Canadian University physiotherapy program; and
ii. Current physiotherapist licence in good standing from a provincial/territorial regulatory organization.

OR

f. **Social Worker**:

i. Degree in social work from an accredited Canadian University social work program; and
ii. Current social worker licence in good standing from a provincial/territorial regulatory organization.

OR

g. **Medical Radiology Technician**:

i. Completion of a radiology technician program from an accredited Canadian University or College program in radiology technician; and
ii. Current radiology technician licence or certification in good standing from a provincial/territorial regulatory organization.

OR

h. **Medical Laboratory Technician**:

i. Completion of a laboratory technician program from an accredited Canadian University or College program in laboratory technician; and
ii. Current laboratory technician licence or certification in good standing from a provincial/territorial regulatory organization.

## EXPERIENCE

9. Experience is key to the role of Clinical Advisor to Health Informatics. As a result, all sub-categories of Clinical Advisors, as a minimum must have worked in a clinical environment where electronic health records were used by them to document the provision of healthcare for a period of at least two (2) years.

a. Sub-Category 1: Clinical Advisor to Health Informatics Physician;

b. Sub-Category 2: Clinical Advisor to Health Informatics Dentist;

c. Sub-Category 3: Clinical Advisor to Health Informatics Nurse;

d. Sub-Category 4: Clinical Advisor to Health Informatics Pharmacist;

e. Sub-Category 5: Clinical Advisor to Health Informatics Physiotherapist;

f. Sub-Category 6: Clinical Advisor to Health Informatics Social Worker;

g. Sub-Category 7: Clinical Advisor to Health Informatics Radiology Technician; and

h. Sub-Category 8: Clinical Advisor to Health Informatics Laboratory Technician.

**TASKS**

10. The required tasks for this occupational group include the following:

a. Defines user requirements for digital health records associated with their clinical area of expertise;

b. Evaluates, as a member of a team, digital health proposals from industry as a part of requests for information (RFI) and requests for proposals (RFP);

c. Conduct analysis of potential issues and challenges associated with the adoption of digital health solutions in the CAF environment;

d. Proposes solutions and strategies to issues and challenges that will ensure the successful adoption of a digital health environment within the CAF;

e. Liaises with current users of digital health solutions in other organizations and jurisdictions on behalf of the CAF;

f. Develops training and implementation strategies, relevant to their area of clinical expertise, for new digital health solutions;

g. Participates in the development of business transformation and communication strategies, relevant to their area of clinical expertise, for new digital health solutions;

h. Liaises with clinical professionals within the CFHSG to ensure that they clearly understand unique needs and requirements of CF members and CAF clinical professionals;

i. Tests digital health solutions and recommends adoption or changes that will improve safety, health delivery and ultimately, successful implementation; and

j. Prepares and delivers presentations to clinical groups within CFHSG in order to facilitate clinical business transformation.

**DELIVERABLES**

11. The required deliverables relevant to this occupational group IAW the required tasks are as follows:

    a. Produces user requirements relevant to their area of clinical expertise;

    b. Documents results of analysis including recommendations;

    c. Documents strategies for training, implementation, business transformation and communication to support the adoption of a new digital health environment;

    d. Documents test results of proposed changes to existing EHR and the proposed digital health environment; and

    e. Prepares and delivers presentations to clinical professionals within CFHSG.

# APPENDIX 11 TO ANNEX A1

# CLINICIAN – INJURY PREVENTION SPECIALIST (PHYSIOTHERAPIST, OT, NURSE, KINESIOLOGIST)

## STREAM 4

**OCCUPATIONAL GROUP AND CATEGORY** **Clinician – Injury Prevention Specialist (Physiotherapist, OT, Nurse, Kinesiologist)**

## WORK AND ENVIRONMENT

1. Injury prevention specialists are health care providers with specialized knowledge in musculoskeletal and other injuries through their clinical practice, work experience or research background. Physiotherapists are often recognized in this role. Occupational therapists, nurses and kinesiologists are also health care providers that have the potential to provide support at this level. Injury prevention specialists have the ability to recognize the mechanism of injuries, to identify evidence-based injury prevention approaches and to promote scientific knowledge to the general population. They can provide support in the development of injury prevention projects and educational material. Other activities in which they may be engaged are occupational health, active living, health promotion and health promotion support services. In summary, their work will be aimed at supporting Canadian Armed Force operational readiness through injury prevention and active living developments and communication.

2. Injury prevention specialists will be working closely with the Injury Prevention Educator located in Directorate Force Health Protection (DFHP) at the Canadian Force Health Services Group Headquarter. They will act as a member of a multi-disciplinary headquarters health promotion team. Their working environment will be an office.

## EDUCATION / QUALIFICATIONS

3. All physiotherapists, occupational therapists and nurses will possess, as a minimum, a current license in good standing from their provincial or territorial regulatory college/organization.

4. All kinesiologists will possess, as a minimum, a CSEP-CEP certification and a current license in good standing from their provincial or territorial regularity college/organization.

## EXPERIENCE

5. The injury prevention specialist will, as a minimum:

   a. have experience working in unintentional injury prevention, sports medicine or orthopedics with an adult population;

   b. possess two continuing training certificates in the field of injury prevention, sports medicine or orthopedics; and

c. have produced two scientifically recognized MSK injury prevention educational packages or an educational brochure/information sheet based on current scientific literature, or conducted an injury prevention project with a final summary report.

**TASKS**

6. The required tasks for this occupational group include the following:

a. search medical, health, sports and science databases to find injury prevention scientific literature;

b. read complex scientific research articles and extract injury prevention findings;

c. produce evidence-based injury prevention information sheets with scientific literature references and/or military statistics;

d. produce or bring up-to-date injury prevention educational material (i.e. PowerPoint presentations, participant manuals, educational brochures, articles) using evidence-based approaches and best practices taking into account the military culture;

e. produce practical educational material, such as preventative exercises programs and tips for injury prevention in sports, to answer the injury preventative needs of the military population;

f. develop injury prevention self-assessment tools for military personnel;

g. describe musculoskeletal conditions and injury prevention educational materials using simple written language understood by the general population;

h. provide injury prevention and active living education to health promotion personnel, military health care personnel and military members;

i. contribute to the design, preparation and support of injury prevention and active living programs;

j. respond to directions given from the Injury Prevention Educator; and

k. other associated tasks relevant to this occupational group.

**DELIVERABLES**

7. The required deliverables relevant to this occupational group IAW the required tasks are as follows:

a. written reports on evidence based injury prevention program, policies, standards and guidelines with a description of the organized scientific literature searches and how quality resources were retained and used in the report;

b. printable education material such as information sheets, brochures and articles that use simple language to communicate in a practical way existing injury prevention scientific references and/or military statistics;

c. injury prevention educational material adapted to military personnel (i.e. PowerPoint presentations, participant manuals) using up-to-date scientific literature;

d. report on the impact of injury prevention and active living education sessions delivered to health promotion personnel, military health care personnel and/or military members;

e. written reports that provide recommendations of injury prevention and active living programs; and

f. written progress reports, the first week of each month, based on the approved work plan.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN – MEDICAL STANDARDS ANALYST

**STREAM 4**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician – Medical Standards Analyst**

**WORK AND ENVIRONMENT**

1. Medical Standards Analysts are experienced physicians, who are employed at the Directorate of Medical Policy (D Med Pol) Medical Standards section, which is responsible for developing and implementing medical standards for enrolment and employment in the Canadian Armed Forces (CAF). The Medical Standards section reviews all medical files of CAF members who have been assigned a permanent change in medical category or a prolonged temporary medical category status of over 12 months duration by CF Health Services Centre health care providers. Final adjudication/approval of medical files is performed by Medical Standards Analysts in a consistent and standardized approach, utilizing evidence-based medicine and in accordance with the CAF Medical Standards.

2. Under the direction of the Head of Medical Policy and Standards the Medical Standards Analysts provides occupational medical expertise and direction regarding permanent change of medical employment limitations (MELs), using all available medical information related to CAF members' medical condition(s). MELs are applied in accordance with CAF Universality of Service principles, as specified by DAOD 5023-0/5023-01/CFP 154 Medical Standards and in relation to the functional impact of specific medical condition(s). MEL decisions are recorded and promulgated to internal DND authorities, primarily the Directorate of Military Career Administration (DMCA), Commanding Officers and CF Health Services Centres. Medical Standards Analysts also liaise with staff from other DND agencies as well as outside agencies on matters related to occupational medicine.

3. Medical Standards Analysts participate in D Med Pol Medical Boards approximately three times per year to review complex and difficult cases. They also provide advice to physicians working in CF Health Services Centres, particularly Base/Wing/Garrison Senior Medical Authorities, regarding difficult medical cases. They work in a collaborative team environment with other Medical Standards Analysts, in an office setting and do not have direct patient contact. D Med Pol Medical Standards section office reviews over 5000 medical files per year with each Medical Standards.

4. In addition, a Medical Standards Analyst may be required to work in either the Recruiting Medical Office (RMO) or the Outside of Canada Screenings office (OUTCAN). The RMO reviews all CAF applicants' medical history, to determine if they meet the Common Enrolment Medical Standard (CEMS). The RMO reviews and adjudicates over 11,000 files per year. The OUTCAN office determines medical fitness for CAF members and their dependents selected for out of Canada posting. This office reviews over 1500 files per year.

**EDUCATION / QUALIFICATIONS**

5. All Medical Standards Analyst must possess, as a minimum:

   a. possess a licence from a provincial or territorial regulatory organization in Canada; and

   b. hold Certification from the College of Family Physicians of Canada (CCFP).

**EXPERIENCE**

6. The Medical Standards Analyst must possess, as a minimum:

   a. 6 years of experience directly providing patient medical care in a primary care, occupational medicine, urgent care or emergency medicine setting; and

   b. 3 years of occupational medicine experience.

**TASKS**

7. The required tasks for this occupational group include the following:

   a. review CAF members' medical files and determine medical employment limitations and medical category in accordance with CFP 154 and D Med Pol /Medical Board decisions;

   b. update and input patient MELs and medical category into tracking system;

   c. communicate with and provide occupational health advice to CF Health Services Centre healthcare providers regarding the occupational health status and MELs of CAF members through email, memo, letter, and forms;

   d. communicate with and provide occupational health advice to the Directorate of Military Career Administration staff regarding occupational health status and MELs of CAF members through email, memo, letter, and forms;

   e. liaise and communicate with external agencies such as the Director General Military Careers (DGMC), Canadian Forces Recruiting Group (CFRG), Aerospace and Undersea Medical Board (AUMB), Aeromedical Standards and Clinical Services (ASCS), etc regarding Medical Employment Limitations (MELs) through email, memo, letter, and forms;

   f. provide education and advice to healthcare providers about medical standards processes and MEL guidelines;

g. provide occupational health advice to D med Pol/Medical Boards and Recruit Medical Office services;

h. review CAF applicants' medical files and determine medical fitness, as per CAF Common Enrolment Medical Standards;

i. review CAF personnel and dependant medical files, to determine fitness for Out of Canada postings;

j. review medical files and make recommendations to assist with communications for Ministerial Inquiries, Redress of Grievance, Canadian Human Rights Commission complaints, Summary Investigations, Access to Information, Ombudsman, and Privacy Act Requests; and

k. other associated tasks relevant to this occupational group.

**DELIVERABLES**

8. The required deliverables relevant to this occupational group IAW the required tasks are as follows:

a. produces written reports on evidence based programs, policies, standards and guidelines;

b. produces written reports and recommendations on medical strategic plans and direction;

c. produces written reports and analysis of discipline specific research studies; and

d. produces written reports for risk communication to assist an administrative decision body, the chain of command or other medical professionals.

# APPENDIX 11 TO ANNEX A1

# MENTAL HEALTH – MENTAL HEALTH POLICY, ADJUDICATION AND ANALYSIS

**STREAM 4**

**OCCUPATIONAL GROUP AND CATEGORY** **Mental Health – Mental Health Policy, Adjudication and Analysis**

## WORK AND ENVIRONMENT

1. Mental Health Policy, Adjudication and Analysis Clinicians are experienced mental health (MH) care providers, who are employed within the Canadian Forces Health Services Group (CFHSG) Directorate of Mental Health (D MH). D MH is responsible, in part, for the clinical, occupational, peer support, educational, preventive, and family support aspects of MH care delivery in all CAF health care units; the developing and analysing of mental health policy and standards for the Canadian Armed Forces (CAF) and in conducting analysis on standards of care and in identifying, defining, developing and monitoring the implementation of mental health best practice services to CFHSG mental health sections across the CAF. This includes conducting and improving professional technical communication, education and training, mentorship and quality assurance review throughout the CFHSG including responsibility for professional technical issues specific to the provision of patient care, the liaise with health care professionals and organizations involved in the mental health care of CAF members, both, internally and externally to the CAF and advises the Commander of CFHSG and subordinate commanders on allocation of resources, exercise of discipline or movement of personnel insofar as these activities impact on the provision of patient care management.

2. D MH maintains awareness of best practices and clinical research relevant to MH problems relevant to the CAF and maintains ongoing coordination with Veterans Affairs Canada, mental health professional organizations, and stakeholder groups; and acts as a preferred CAF spokesman on matters related to mental health; and professional/technical advice to the Surgeon General on mental health policy and standards issues.

3. Command and control is the direction of the Directorate of Mental Health (Colonel) and or subordinate section heads at the Lieutenant-Colonel level.

## EDUCATION / QUALIFICATIONS

4. General – For each of the occupation groups listed below, any individual supplied under this Contract to provide services to DND/CAF must be qualified in accordance with the guidelines below. As applicable, contracted HCPs must meet the credentialing requirements of the Canadian Armed Forces, must demonstrate and maintain clinical competence in their area of practice, and must hold malpractice/liability insurance commensurate with practice norms.

5. All Mental Health Policy, Adjudication and Analysis will, as a minimum be:
   a. Social Worker:

i. a Baccalaureate Degree in Social Work (Specialization: Clinical or Mental Health) from a recognized university accredited by Canadian Association for Social Work Education (CASWE);

ii. a Masters Degree in Social Work (Specialization: Clinical or Mental Health) from a recognized university accredited by Canadian Association for Social Work Education (CASWE); and

iii. a Social Work licence from a provincial or territorial regulatory body in Canada.

OR

b. Mental Health Nurse:

i. a Registered Nurse Diploma or Baccalaureate Degree in Nursing from a recognized college or university with either a certificate in Mental Health Nursing or certification in Psychiatric/Mental Health Nursing from the Canadian Nurses Association (CNA); and

ii. a Registered Nurse Licence from a provincial or territorial professional college or association in Canada.

OR

c. Clinical Psychologist:

i. possess a Doctoral Degree, with a specialization in adult Clinical Psychology, from a university:

(1) accredited by the Canadian Psychological Association; or

(2) accredited by the American Psychological Association; or

(3) an equivalence to an accredited university will be considered if the Psychologist is licenced for clinical practice by the provincial or territorial regulatory body and approved by the Credentialing Committee of CF H SVCS Group.

ii. registered for autonomous practice of psychology by a provincial or a territorial regulatory body in Canada.

OR

d. Psychiatrist:

i. possess a speciality certification in Psychiatry from the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College des médecins du Quebec (after 2001);

ii. a current Fellowship with the RCPSC or for non-fellows, participation in a continuing medical education (CME) program equivalent to a Maintenance of Competence (MOCPMP) Program; and

iii. a licence from a provincial or territorial regulatory organization in Canada.

OR

e. Addiction Counsellors:

i. all Addiction Counsellors must possess, as a minimum:

(1) Diploma or Baccalaureate Degree in Nursing; or

(2) Baccalaureate or Master's degree in Social Work from a recognized university; and

(3) licence from the provincial or territorial professional college or association in the location of practice.

OR

f. Clinical Chaplain:

i. Master's Degree in Counselling and Spirituality/Counselling and Psychotherapy. Degrees shall be awarded from an accredited university, have a spiritual focus, and be recognized by the Royal Canadian Chaplain Service (RCChS) as acceptable for use by Chaplains serving CAF personnel;

ii. Association / Professional College - Maintains a membership with the provincial or territorial regulatory organization in Canada, such as, the College of Registered Psychotherapists of Ontario.

OR

g. Physician:

i. Degree in medicine from a University accredited by the Committee on Accreditation of Canadian Medical Schools or the Liaison Committee on Medical Education;

ii. a certificate in the College of Family Physicians (CCFP) or equivalent qualification ; and

iii. current medical licence in good standing from a provincial/territorial regulatory organization.

OR

h. Physician Specialist:

i. Degree in medicine from a University accredited by the Committee on Accreditation of Canadian Medical Schools or the Liaison Committee on Medical Education;

ii. a speciality certification in from the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College des médecins du Quebec (after 2001) in public health focusing on research and or epidemiology; and

iii. current medical licence in good standing from a provincial/territorial regulatory organization.

**EXPERIENCE**

6. The Sub-Categories of mental health (MH) care providers for the Mental Health Policy, Adjudication and Analysis Category are:

a. Sub-Category 1: The Mental Health Policy, Adjudication and Analysis social work clinician shall possess, as a minimum, 3 years full time equivalent experience performing clinical social work related activities such as intake and assessment, crisis intervention, outreach, psychosocial assessment and treatment planning in an adult mental health care environment, using various evidence-based psychosocial counselling approaches, such as Cognitive Behavioural Therapy (CBT) and Solution-focused therapy, and providing psychosocial assessment, therapy and counselling services to adult clients and their families;

b. Sub-Category 2: The Mental Health Policy, Adjudication and Analysis MH mental health nurse must, as a minimum, 3 years of experience within the last 5 years in nursing practice performing a variety of mental health nursing activities such as supportive psychotherapy, cognitive behavioural therapy, solution-focused therapy, counselling, and crisis intervention or

management in an adult community setting to clients suffering from mental illnesses or psycho-social difficulties;

c. Sub-Category 3: The Mental Health Policy, Adjudication and Analysis clinical psychologist must have a minimum of 2 years full time equivalent autonomous practice experience as a clinical psychologist, within the past 5 years, in the provision of cognitive behavioural therapy;

d. Sub-Category 4: The Mental Health Policy, Adjudication and Analysis psychiatrist must have, as a minimum, 2 years full time equivalent autonomous practice experience as a psychiatrist, within the past 5 years Psychiatrist experience and demonstrate the necessary scope of practice to perform the outlined tasks for an adult population (18 – 60 years of age), corroborated by two references, with the following emphasis: Trauma related disorders; Depressive disorders; Anxiety disorders; and Substance-Related and Addictive disorders;

e. Sub-Category 5: Mental Health Policy, Adjudication and Analysis Addictions must have, in the last 10 years have a minimum of 3 years full time equivalent experience performing a range of related clinical services in the area of addictions including addiction assessment, treatment planning, and counselling and therapy;

f. Sub-Category 6: Mental Health Policy, Adjudication and Analysis Mental Health Clinical Chaplain, as a minimum, 3 years full time equivalent experience performing specialized psycho-spiritual care, treatment and educational services to clients with operational stress injuries, such as, crisis intervention, outreach, psycho-spiritual assessment and treatment planning in an adult mental health care environment, using various evidence-based psychosocial counselling approaches, such as Cognitive Behavioural Therapy (CBT) and Solution-focused therapy, and providing psychosocial assessment, therapy and counselling services to adult clients and their families;

g. Sub-Category 7 – Mental Health Policy, Adjudication and Analysis Physician. The physician must hold a current and valid license to practise medicine in the province in which he or she will be employed. Attain Royal College of Physicians and Surgeons certification with a Master's degree in Public Health. Demonstrable experience in conducting clinical research, analyzes, interpretation and evaluation of a wide range of source data, policies, standards, guidelines and published reports; and

h. Sub-Category 8 – Mental Health Policy, Adjudication and Analysis Physician Specialist. The Physician Specialist must hold a current and valid license to practise medicine in the province in which he or she will be employed. Attain Royal College of Physicians and Surgeons

certification with a Master's degree in Public Health. Demonstrable experience in conducting clinical research, analyzes, interpretation and evaluation of a wide range of source data, policies, standards, guidelines and published reports.

**TASKS**

7. The required tasks for this occupational group include the following:

a. consults with DND/CAF mental health/medical professionals on mental health program delivery issues, researches, develops and recommends discipline specific substance and direction of mental health strategic plans;

b. researches, analyzes, interprets and evaluates a wide range of national and international source data, consults with mental health professional technical clinicians, and other CFHSG professionals, determines requirements for and develops evidence based mental health programs, policies, standards and guidelines;

c. provides medical advice on the terms of reference and methodologies of DND/CAF studies/surveys and research projects in areas impacting on discipline specific occupational and environmental mental health issues;

d. directs/participates in comprehensive studies/surveys and research projects, evaluates findings from a mental health perspective;

e. determines the need for new approaches/methodologies and for incorporation of relevant policy and standards and clinical guidelines;

f. develops and delivers discipline specific training, education, and risk communication programs to other mental health/medical professionals;

g. provides medical advice and guidance to DND/CAF mental health/medical professional's leadership and non-professionals on a wide range of issues pertaining to occupational and environmental health, programs, policies, standards and guidelines;

h. represents DND/CAF on interdepartmental/Intergovernmental committees and national advisory boards and liaises with government and non-government health organizations (national/international and Allied Forces); also represents DND/CAF publicly and in the media involving discipline specific mental health issues; and

i. other associated tasks relevant to this occupational group.

**DELIVERABLES**

8. The required deliverables relevant to this occupational group IAW the required tasks are as follows:

   a. produces written reports on evidence based mental health programs, policies, standards and guidelines;

   b. produces written reports and recommendations on discipline specific mental health strategic plans and direction;

   c. produces written executive summaries and power-point presentations of discipline specific scientific best practice analysis;

   d. produces written reports and analysis of discipline specific research studies;

   e. produces written reports on specific training, education, and risk communication programs to assist other mental health/medical professionals; and

   f. produces written progress reports, the first week of each month, based on the approved work plan.

# APPENDIX 11 TO ANNEX A1

# TECHNOLOGIST - NEUROPHYSIOLOGY TECHNOLOGIST (ELECTROMYOGRAPHY)

**STREAM 4**

**OCCUPATIONAL GROUP AND CATEGORY: Technologist - Neurophysiology Technologist (Electromyography)**

## WORK AND ENVIRONMENT

1. The Neurophysiology Technologist uses specialized diagnostic equipment to assess and record electrical nerve activity resulting from stimulation of central and peripheral sensory and motor pathways. Diagnostic results assist physiatrists and other physicians, such as neurologists, orthopaedic surgeons, family physicians, etc, in diagnosing diseases and injuries of the central and peripheral nervous system. The neurophysiology technologist works within the Specialists Clinic in support of physiatrists and other physicians. Patients access neurophysiology technologist services on a booked appointment basis as referred by other members of the healthcare team.

## EDUCATION / QUALIFICATIONS

2. All Neurophysiology Technologist must possess, as a minimum, a certification as a Certified Registered Electromyography Technologist with the Board of Registration of Electromyography Technologists of Canada.

## EXPERIENCE

3. The Neurophysiology Technologist will have, as a minimum, of 2 years of experience delivering neurophysiology services including electromyography (EMG) and nerve conduction studies.

## TASKS

4. The required tasks for this occupational group include the following:

   a. provide neurophysiology services in accordance with Certified Registered Electromyography Technologist standards of practice established by the Board of Registration of Electromyography Technologists of Canada;

   b. perform electrophysiological studies based on a requisition received from a physiatrist or other physician;

   c. obtain patient medical history information pertinent to the interpretation of test results;

   d. prepare patients for neuro-diagnostic testing by explaining the procedure;

e. apply electrodes to predetermined locations on the patient;

f. assist the physiatrist and neurologist with needle examinations;

g. use and adjust monitoring equipment parameters based on the nature and significance of potentials recorded with intramuscular needle electrodes;

h. provide care and assistance to patients during procedures keeping the patients comfort as the upmost priority;

i. operate and maintain neuro-diagnostic testing equipment, such as the peripheral nerve stimulators, recording electrodes, etc, including disinfection, cleaning, and troubleshooting technical problems;

j. prepare test results for interpretation by the physiatrist or neurologist;

k. enter patient information in CFHIS and patient health records;

l. assist with the implementation of research and clinical protocols in the area of neurophysiology;

m. language of work may be French and/or English, depending on geographic location; and

n. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST – OCCUPATIONAL MEDICINE

**STREAM 4**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Specialist – Occupational Medicine**

## WORK AND ENVIRONMENT

1. Occupational Medicine aims for the promotion and maintenance of the highest degree of physical, mental and social wellbeing of workers in all occupations; the prevention among workers of departures from health caused by their working conditions; the protection of workers in their employment from risks resulting from factors adverse to health; placing and maintenance of a worker in an occupational environment adapted to his physiological and psychological capabilities. This type of evaluation is important for all military operational environments, particularly for assessments related to work in the aerospace and undersea environments. The Specialist in Occupational Medicine diagnoses and treats occupationally related disorders, considering their effects on military service, and also has a role in providing advice to Canadian Armed Forces (CAF) medical policymakers regarding personnel selection, personnel retention, and support to military operations.

2. The Specialist in Occupational Medicine is part of a health care team that provides higher level consultation and advice to primary care physicians and senior medical advisors in addition to the clinical assessment and care of military personnel within the Canadian Forces Environmental Medicine Establishment's (CFEME). They also aid in the formulation of occupational medicine related policies, perform research, and deliver instruction on occupational medicine courses.

## EDUCATION / QUALIFICATIONS

3. All Occupational Medicine Specialists must, as a minimum, have:

   a. a licence from the provincial or territorial regulatory organization in the province of practice;

   b. a Fellowship from the Royal College of Physicians and Surgeons of Canada in Occupational Medicine; and

   c. hold and maintain a Certificate of Advanced Cardiac Life Support (ACLS) in accordance with the Heart and Stroke Foundation ACLS Provider program.

## EXPERIENCE

4. The Specialist must, as a minimum:

   a. have three years of clinical experience which demonstrates the necessary proficiency to perform the outlined tasks for a patient aged 18- 60, corroborated

by two references; and

b. they must have completed or be willing to complete the CAF courses in Aviation or Diving Medicine.

**TASKS**

5. The required tasks for this occupational group include the following:

a. practice medicine in accordance with the applicable provincial and national regulatory standards and scope of practice for occupational medicine;

b. deliver occupational health services such as, but not limited to:

(1) health evaluation of employees, including pre-assignment, periodic medical surveillance, and post-illness or injury;

(2) diagnosis and treatment of occupational and environmental injuries and illnesses, including rehabilitation;

(3) determination of medical causation;

(4) establishment of medical employment limitations;

(5) implementation of programs for the use of indicated personal protective devices – ear protection, safety spectacles, respirators;

(6) evaluation, inspection, and abatement of workplace hazards;

(7) toxicologic assessments including advice on chemical substances that have not had adequate toxicological testing;

(8) maintenance of occupational medical records;

(9) immunization against possible occupational infections;

(10) periodic evaluation of the occupational or environmental health program;

(11) communication with employers;

(12) disaster preparedness planning for the workplace and the community; or

(13) assistance in rehabilitation and return to work programmes.

c. document patient encounters and all clinical actions and maintain patient medical information in CFHIS and patient health records;

d. review Undersea and Aerospace medical cases and make recommendations to the Aerospace and Undersea Medical Board (AUMB) on questions of Undersea and Aerospace medical fitness in accordance with relevant medical standards such as but not limited to: CF Health Services Group Instruction 4000-04, Shallow Water Divers Periodic Health Assessment and Medical Administration, and AMA Directive 100-01, and 1 Canadian Air Division Flight Surgeon Guidelines found at Appendix 1;

e. review and perform initial aircrew medical examination in accordance with AMA Directive 100-01 and 1 Canadian Air Division Flight Surgeon Guidelines found at Appendix 1;

f. provide higher level advice to primary care physicians who have advanced diving and/or operational flight surgeon training and who routinely care for divers and aircrew where they operate;

g. provide advice and recommendations to AUMB regarding the formulation of policies that govern medical fitness to fly or dive, diagnostic criteria, and treatment guidelines for diving or aerospace related disorders;

h. participate in meetings of the AUMB and other committees such as Aeromedical Policy and Standards Committee, CF Dive Policy Committee, Defence Research and Director of Medical Policy Boards, Director of Force Health Protection meetings etc by providing Occupational Medicine input and advice on patient files, Undersea and Aerospace medicine policies, diagnostic criteria and treatment guidelines for diving or aerospace related disorders. Participation in meetings may require travel;

i. deliver subject matter expert level lectures on School of Operational Medicine (SOM) courses in accordance with CF Health Services national training calendar (as provided by the Task Manager) e.g. Dive Medicine Advanced and Operational Flight Surgeon courses each offered once per year. Specific tasks include: prepare and deliver lectures identified within the SOM course Training Plan. May also be asked to provide expert lectures on Basic and Advanced Medical Officer courses;

j. provide medical screening and medical response for human subject experimentation at Canadian Forces Environmental Medicine Establishment (CFEME) and DRDC by conducting medical examinations on subjects for Human Research Ethics Committee approved experimental protocols and by providing ACLS level emergency services;

k. conduct research that advances knowledge on policy, prevention, diagnosis, and treatment of disorders relevant to military health and occupations. Research activities may include:

(1) synthesizing hypotheses in the fields of undersea, land and aerospace medicine;

(2) planning experimental protocols in accordance with Canadian Armed Forces policy and with Experimental Protocol Guidelines as provided by the Task Manager;

(3) obtaining Human Research Ethics Board (HREC) approval based on guidelines provided by the Task Manager;

(4) preparing research proposals, including research schedule, and funding applications for approval by the Surgeon General Health Research Board IAW CF Health Services Group Instruction 4030-51, Authority to Engage in Research, found at Appendix 26;

(5) executing the experimental protocol;

(6) analyzing data;

(7) writing reports in accordance with CF Health Services publishing approval process, standards, and guidelines as provided by the Task Manager including at minimum the following components:

(a) Abstract;

(b) Background;

(c) Literature review;

(d) Methodology;

(e) Data collection;

(f) Analysis;

(g) Findings;

(h) Recommendations; and

(i) Conclusion.

(8) presenting a report to AUMB meetings which occur on a quarterly basis; and

(9) publishing in a scientific journal and presenting at scientific conferences.

l. other associated tasks relevant to this occupational group.

6. A Task Authorization for Task i. (deliver specialist Occupational Medicine subject matter expert level lectures) or Task k. (conduct research) above will include a detailed description of the course(s) to be delivered and/or the research to be undertaken. The description will specify the specific subject matter to be addressed, the deliverables that will be required and the schedule to be followed.

**DELIVERABLES**

7. The required deliverables relevant to this occupational group IAW the required tasks are as follows:

a. produces written consult reports documented in the medical chart for all patients clinically assessed;

b. produces written recommendations and case presentations for discussion at AUMB;

c. produces written reports and analysis of discipline specific research studies;

d. drafts Flight Surgeon Guidelines for approval on discipline specific topics;

e. reviews and updates assigned Flight Surgeon Guidelines annually;

f. prepares power-point presentations related to aviation and diving medicine for delivery on School of Operational Medicine courses;

g. completes assessments on initial aircrew and diver candidates in accordance with AMA 100-01 and documents the assessment and recommendations in the medical chart;

h. conducts aeromedical file reviews on aircrew trade applicants other than pilot and documents the file review and recommendations in the medical chart;

i. conducts medical examination for fitness to participate in human research and documents the examination and assessment in the medical chart;

j. produce written reports on evidence based aeromedical and diving medicine policies, standards, and guidelines;

k. produces written executive summaries and power-point presentations of discipline specific scientific best practice analysis;

l. produces written research proposals for discipline and Health Services relevant topics; and

m. produces written research reports for all research completed.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST – OPHTHALMOLOGIST – OPERATIONAL SPECIALIST

**STREAM 4**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Specialist – Ophthalmologist – Operational Specialist**

## WORK AND ENVIRONMENT

1. Ophthalmologists specialize in dealing with the screening, diagnosis, prevention and management of optical, medical and surgical disorders of the eye, its adnexa, the visual pathways, and the visual system. The Physician – Specialist in Ophthalmology is expected to provide ophthalmological care and advice relevant to the military context of the nature of work and employment in extreme environments, such as but not limited to Aerospace, Land (Army) and Undersea Medicine domains.

2. The Specialist in Ophthalmology is part of a health care team that provides higher level consultation and advice to military primary care physicians and senior medical advisors in addition to the clinical assessment and care of military personnel within the Canadian Forces Environmental Medicine Establishment's (CFEME). The Specialist in Ophthalmology also has a role in providing advice to CAF medical policymakers regarding personnel selection, personnel retention, and support to military operations, perform research, and deliver instruction on operational medicine courses.

## EDUCATION / QUALIFICATIONS

3. The Specialist in Ophthalmology must, as a minimum, have:

   a. a licence from the provincial or territorial regulatory organization in the province or territory of practice; and

   b. a speciality certification in Internal Medicine from the Royal College of Physicians and Surgeons of Canada (RCPSC) or the Collège des médecins du Québec (after 2001).

## EXPERIENCE

4. The Specialist in Ophthalmology must, as a minimum, have 5 years of clinical experience in Ophthalmology. They must have experience in the provision of expertise of work related visual health and safety requirements , with 100 hours/year of clinical occupational related Ophthalmology as part of their practice in 5 of the last 8 years in Canada, the United States (U.S.), United Kingdom (U.K.), New Zealand (N.Z.), or Australia. The work experience offered to meet the above requirements must be verifiable by curriculum vitae which has been corroborated by two references.

## TASKS

5. The required tasks for this occupational group include the following:

a. provide Ophthalmology specialty services by conducting medical examinations and file reviews on referred patients and completing medical documentation that may include medical employment limitations, diagnosis, medical recommendations, etc.;

b. review Undersea, Land and Aerospace medical cases and make recommendations to the Aerospace and Undersea Medical Board (AUMB) on questions of Undersea and Aerospace medical fitness in accordance with relevant medical standards such as: CF Health Services Group Instruction 4000-04, Shallow Water Divers Periodic Health Assessment and Medical Administration, and AMA Directive 100-01, and 1 Canadian Air Division Flight Surgeon Guidelines found at Appendix 1;

c. provide higher level advice to primary care physicians who have advanced diving and/or operational flight surgeon training and who routinely care for divers and aircrew where they operate;

d. provide Ophthalmology input, advice, and recommendations to AUMB regarding the formulation of policies that govern medical fitness to fly or dive, diagnostic criteria, and treatment guidelines for diving or aerospace related disorders;

e. participate in meetings of the AUMB and other committees such as Aeromedical Policy and Standards Committee, CF Dive Policy Committee, Defence Research and Director of Medical Policy specialty boards, by providing Ophthalmology input and advice on patient files, Undersea and Aerospace medicine policies, diagnostic criteria and treatment guidelines for diving or aerospace related disorders. Participation in meetings may require travel;

f. deliver Ophthalmology subject matter expert level lectures on School of Operational Medicine (SOM) courses in accordance with CF Health Services national training calendar (as provided by the Task Manager) e.g. Dive Medicine Advanced and Operational Flight Surgeon courses each offered once per year. Specific tasks include: prepare and deliver lectures identified within the SOM course Training Plan;

g. conduct research that advances knowledge on policy, prevention, diagnosis, and treatment of Ophthalmology related disorders. Research activities may include:

(1) synthesizing hypotheses in the fields of undersea, land and aerospace medicine;

(2) planning experimental protocols IAW Canadian Armed Forces policy and Experimental Protocol Guidelines as provided by the Task Manager;

(3) obtaining Human Research Ethics Board (HREC) approval based on guidelines provided by the Task Manager;

(4) preparing research proposals, including research schedule, and funding applications for approval by the Surgeon General Health Research Board IAW CF Health Services Group Instruction 4030-51, Authority to Engage in Research, found at Appendix 26;

(5) executing the experimental protocol;

(6) analyzing data;

(7) writing reports in accordance with CF Health Services publishing approval process, standards, and guidelines as provided by the Task Manager including at minimum the following components:

(a) Abstract;

(b) Background;

(c) Literature review;

(d) Methodology;

(e) Data collection;

(f) Analysis;

(g) Findings;

(h) Recommendations; and

(i) Conclusion.

(8) presenting a report to AUMB meetings which occur on a quarterly basis; and

(9) publishing in a scientific journal and presenting at scientific conferences.

h. other associated tasks relevant to this occupational group.

6. A Task Authorization for Task f. (deliver specialist subject matter expert level lectures) or Task g. (conduct research) above will include a detailed description of the course(s) to be delivered and/or the research to be undertaken. The description will

specify the specific subject matter to be addressed, the deliverables that will be required and the schedule to be followed.

## DELIVERABLES

7. The required deliverables relevant to this occupational group IAW the required tasks are as follows:

a. produces written consult reports documented in the medical chart for all patients clinically assessed;

b. produces written recommendations and case presentations for discussion at AUMB;

c. produces written reports and analysis of discipline specific research studies;

d. drafts Flight Surgeon Guidelines for approval on discipline specific topics;

e. reviews and updates assigned Flight Surgeon Guidelines annually;

f. prepares power-point presentations related to ophthalmology for delivery on School of Operational Medicine courses;

g. completes ophthalmology assessments on initial aircrew candidates in accordance with AMA 100-01 and documents the assessment and recommendations in the medical chart; and

h. conducts ophthalmology file reviews on aircrew trade applicants other than pilot and documents the file review and recommendations in the medical chart.

# APPENDIX 11 TO ANNEX A1

# TECHNOLOGIST - PREVENTIVE MEDICINE – OCCUPATIONAL HEALTH SERVICES

**STREAM 4**

**OCCUPATIONAL GROUP AND CATEGORY** **Technologist - Preventive Medicine - Occupational Health Services**

## WORK AND ENVIRONMENT

1. Occupational Health Services Technologists possess specialized expertise, knowledge, and skills in the areas of occupational health, and safety. Their main roles are to develop and deliver programs that will assist in conserving life, health and property. This is accomplished through the identification of health and safety hazards in the work environment and recommending corrective action. The Occupational Health Services Technologist functions as part of the healthcare team by performing inspections of DND facilities based on established schedules to monitor compliance with laws, regulations, and policies and preparing reports outlining status and recommended courses of action.

## EDUCATION / QUALIFICATIONS

2. All Occupational Health Services Technologists must, as a minimum, have one of the following:

a. completed the Canadian Armed Forces (CAF) Qualification Level 6A – Preventive Medicine Technician Course; or

b. a certification in occupational health and safety from one of the following:

(1) Occupational Health and Safety Technologist (OHST) with the Board of Certified Safety Professionals, USA;

(2) Registered Occupational Hygienist (ROH) or Registered Occupational Hygiene Technologist (ROHT) with the Canadian Registration Board of Occupational Hygienists; or

(3) Certified Industrial Hygienist (CIH) with the American Board of Industrial Hygiene.

## EXPERIENCE

3. The Occupational Health Services Technologist must, as a minimum, have 2 years of experience:

a. delivering occupational health and safety services within an environmental health program as an Occupational Health Services Technologist;

b. applying federal and provincial environmental health and occupational health and safety legislation;

c. carrying out environmental or occupational health and safety investigations; and

d. writing technical reports in the areas of environmental, occupational health, and safety.

**TASKS**

4. The required tasks for this occupational group include the following:

a. conduct occupational health surveys and inspections related to the Canadian Forces Respiratory Protection Program, found at DAOD 5021-1 http://www.admfincs-smafinsm.forces.gc.ca/dao-doa/5000/5021-1-eng.asp - CF Health Services Group Instruction 4440-01, Chemical Hazards Surveillance Program found at Appendix 24, and other occupational health programs for DND and CF facilities;

b. conduct work site occupational health walk-through, surveillance, and compliance inspections at DND and CF facilities;

c. conduct occupational health survey inspections including:

(1) collect samples, e.g. air, soil, and perform laboratory analysis;

(2) interpret and analyze sampling data;

(3) liaise with accredited analytical laboratories as well as government and civilian regulatory agencies; and

(4) recommend administrative and engineering control measures to ensure workplace compliance with the *Canada Labour Code*.

d. prepare and submit occupational health survey reports for each inspection to the Task Manager within 30 calendar days of the inspection date. Reports must include:

(1) executive summary of analysis and recommendations;

(2) purpose of investigation;

(3) relevant laws, regulations, and policies;

(4) sampling methodology;

(5) sampling results;

(6) analysis;

(7) discrepancies observed; and

(8) recommendations to achieve compliance.

e. provide information and recommendations to senior medical authority on occupational health matters including associated legislation, regulations, policies and directives;

f. participate in briefings to senior management;

g. operate, calibrate and maintain occupational health sampling equipment and monitors and lab equipment;

h. maintain and order occupational health related products and consumable supplies;

i. language of work may be French and/or English, depending on geographic location; and

j. other associated tasks relevant to this occupational group.

**DELIVERABLES**

5. The required deliverables relevant to this occupational group IAW the required tasks are as follows:

a. written reports on evidence based injury prevention program, policies, standards and guidelines with a description of the organized scientific literature searches and how quality resources were retained and used in the report;

b. printable education material such as information sheets, brochures and articles that use simple language to communicate in a practical way existing injury prevention scientific references and/or military statistics;

c. injury prevention educational material adapted to military personnel (i.e. PowerPoint presentations, participant manuals) using up-to-date scientific literature;

d. report on the impact of injury prevention and active living education sessions delivered to health promotion personnel, military health care personnel and/or military members;

e. written reports that provide recommendations of injury prevention and active living programs; and

f. written progress reports, the first week of each month, based on the approved work plan.

# APPENDIX 11 TO ANNEX A1

# TECHNOLOGIST - PULMONARY FUNCTION TECHNOLOGIST

**STREAM 4**

**OCCUPATIONAL GROUP AND CATEGORY** **Technologist - Pulmonary Function Technologist**

## WORK AND ENVIRONMENT

1. The Pulmonary Function Technologist is a technical expert in the field of pulmonary function testing methodologies that provide useful medical diagnostic information to Medical Consult Services (MCS) physicians in the fulfillment of the Canadian Forces Environmental Medicine Establishment's (CFEME) mandates. They perform testing on CAF aircrew, divers, and other operational medicine patients. Patients access Pulmonary Function Technologist services on a booked appointment basis as referred by members of the MCS or external healthcare team.

## EDUCATION / QUALIFICATIONS

2. All Pulmonary Function Technologists will hold, as a minimum:

   a. Certified Registration as a Cardio-Pulmonary Function Technologist with the Board of Registration of Pulmonary Function Technologists of Canada; and

   b. Certified Registration with the College of Respiratory Therapists in the province of employment.

## EXPERIENCE

3. The Pulmonary Function Technologist will have, as a minimum, 2 years of experience providing a full range of pulmonary function testing services.

## TASKS

4. The required tasks for this occupational group include the following:

   a. provide pulmonary function testing services in accordance with Certified Registered Pulmonary Function Technologist standards of practice established by the Board of Registration of Pulmonary Function Technologists of Canada;

   b. perform pulmonary function studies based on a requisition received from a physician;

   c. obtain patient medical history information pertinent to the interpretation of pulmonary function test results;

d. prepare patients for pulmonary function testing by explaining the procedure;

e. perform pulmonary function testing ranging from basic spirometry through to complete comprehensive assessments including: body plethysmography , bronchial challenge testing (pre and post Ventolin$^{TM}$), lung diffusion capacity test, expiratory nitrous oxide (Nioxx) testing, and methacholine challenge testing;

f. provide routine maintenance and calibration of pulmonary function testing equipment, report any issue immediately; also notify MCS staff of any low supply of materials or gases for re-order;

g. assist with Canadian Forces Health Information System (CFHIS) and AUMB database entry;

h. language of work may be French and/or English, depending on geographic location; and

i. other associated tasks relevant to this occupational group.

**DELIVERABLES**

5. The required deliverables relevant to this occupational group IAW the required tasks are as follows:

a. produce reports for the results of all clinical investigations conducted.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN SPECIALIST - UNDERSEA MEDICINE

**STREAM 4**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Specialist - Undersea Medicine**

## WORK AND ENVIRONMENT

1. Undersea Medicine is a medical specialty concerned with the recognition, investigation, diagnosis, and management of all aspects of medical, performance, health and safety issues concerned with human underwater activity as they pertain to divers and other personnel operating in the undersea environment.

2. The Specialist in Undersea Medicine is part of a health care team that provides higher level consultation and advice to military primary care physicians in addition to clinical assessment and care of military personnel within the Canadian Forces Environmental Medicine Establishment's (CFEME). The position requires the physician to perform their duties in physically demanding environments, such as a hyperbaric chamber for extended periods. They also have a role in providing advice to CAF medical policymakers regarding personnel selection and health fitness screening, personnel retention, training, and support to military operations, perform research, and deliver instruction on Undersea Medicine courses.

## EDUCATION / QUALIFICATIONS

3. The Specialist in Undersea Medicine must, as a minimum:

   a. possess a medical licence from the provincial or territorial regulatory organization in the province or territory of practice;

   b. one or more of the following:

      (1) hold a Diploma or Fellowship in Hyperbaric and Undersea Medicine from an accredited university in Canada, United States (U.S.), United Kingdom (U.K.), New Zealand (N.Z.) , or Australia; or

      (2) have, in 5 of the past 10 years, practiced in support of diving and undersea medicine in the roles of i) policy development, ii) education and training, iii) research, iv) clinical care (including consultation from an occupational health perspective).

   c. hold a current Advanced Cardiac Life Support certificate in accordance with the Heart and Stroke Foundation ACLS Provider program; and

d. have successfully completed the Canadian Forces Advanced Diving Medicine Officer course or be willing and physically able to complete the course.

## EXPERIENCE

4. The Specialist in Undersea Medicine must, as a minimum, have provided at least 120 hours/year of clinical Undersea Medicine in 5 of the last 10 years in Canada, the United States (U.S.), United Kingdom (U.K.), New Zealand (N.Z.), or Australia.

5. Each work experience offered to meet the above requirements must be verifiable by a curriculum vitae which has been corroborated by two references.

## TASKS

6. The required tasks for this occupational group include the following:

a. provide Undersea Medicine specialty services by conducting medical examinations and file reviews on referred patients and completing medical documentation that may include medical employment limitations, diagnosis, medical recommendations, etc.;

b. review and perform initial diver and Undersea medical examinations as per CF Health Services Group Instruction 4000-04, Shallow Water Divers Periodic Health Assessment and Medical Administration, found at Appendix 1;

c. review diver and Undersea medical cases and make recommendations to the Aerospace and Undersea Medical Board (AUMB) on questions of diving and Undersea medical fitness in accordance with CF Health Services Group Instruction 4000-04, Shallow Water Divers Periodic Health Assessment and Medical Administration, found at Appendix 1;

d. provide higher level advice to primary care physicians who have advanced diving medicine training and who routinely care for divers where they operate;

e. maintenance of occupational health records through CFHIS and other health records forms;

f. provide Undersea medicine input, advice, and recommendations to AUMB regarding the formulation of policies that govern medical fitness to dive, diagnostic criteria, and treatment guidelines for diving related disorders;

g. participate in meetings of the AUMB and other committees such as Aeromedical Policy and Standards Committee, CF Dive Policy Committee, Defense Research and Directorate of Medical Policy etc. by

providing Undersea medicine input and advice on patient files, Undersea medicine policies, diagnostic criteria and treatment guidelines for diving related disorders. Participation in meetings may require travel;

h. provide medical screening and medical response for human subject experimentation at Canadian Forces Environmental Medicine Establishment (CFEME) and DRDC by conducting medical examinations on subjects for HREC approved experimental protocols and by providing ACLS level emergency services IAW Medical Consult Services SOPs, as provided by the Task Manager;

i. provide medical screening and medical response for activities involving the use of a hyperbaric chamber including acting as an inside chamber medical respondent as required and being on call after regular working hours;

j. deliver specialist Undersea medicine subject matter expert level lectures on Dive Medicine Advanced and Dive Medicine Basic courses at the School of Operational Medicine (SOM) in accordance with CF Health Services national training calendar (as provided by the Task Manager) e.g. Dive Medicine Advanced and Dive Medicine Basic courses each offered once per year. Deliver SME lectures on the Clearance Diver Course, and Basic and Advanced Medical Officer Courses. Specific tasks include:

   (1) prepare and deliver lectures identified within the Dive Medicine Advanced Training Plan and Dive Medicine Basic Training Plan; and

   (2) evaluate written assignments, tests, homework etc and provide written and verbal feedback to students;

k. conduct research that advances knowledge on policy, prevention, diagnosis, and treatment of diving and aerospace related disorders. Research activities may include:

   (1) synthesizing hypotheses in the fields of undersea and aerospace medicine;

   (2) planning experimental protocols IAW Canadian Armed Forces Policy and with Experimental Protocol Guidelines as provided by the Task Manager;

   (3) obtaining Human Research Ethics Board (HREC) approval based on guidelines provided by the Task Manager;

   (4) preparing research proposals, including research schedule, and funding applications for approval by the Surgeon General Health

Research Board IAW CF Health Services Group Instruction 4030-51, Authority to Engage in Research, found at Appendix 26;

(5) executing the experimental protocol;

(6) analyzing data;

(7) writing reports in accordance with CF Health Services publishing approval process, standards, and guidelines as provided by the Task Manager including at minimum the following components:

(a) Abstract;

(b) Background;

(c) Literature review;

(d) Methodology;

(e) Data collection;

(f) Analysis;

(g) Findings;

(h) Recommendations; and

(i) Conclusion.

(8) presenting a report to AUMB meetings which occur on a quarterly basis; and

(9) publishing in a scientific journal and presenting at scientific conferences.

l. other associated tasks relevant to this occupational group.

7. A Task Authorization for Task j. (deliver specialist Undersea Medicine subject matter expert level lectures) or Task k. (conduct research) above will include a detailed description of the course(s) to be delivered and/or the research to be undertaken. The description will specify the specific subject matter to be addressed, the deliverables that will be required and the schedule to be followed.

## DELIVERABLES

8. The required deliverables relevant to this occupational group IAW the required tasks are as follows:

a. produces written consult reports documented in the medical chart for all patients clinically assessed;

b. produces written recommendations and case presentations for discussion at AUMB;

c. produces written reports and analysis of discipline specific research studies;

d. drafts Dive Surgeon Guidelines for approval on discipline specific topics;

e. reviews and updates assigned Dive Surgeon Guidelines annually;

f. prepares power-point presentations related to undersea medicine for delivery on School of Operational Medicine courses;

g. completes assessments on initial diver candidates in accordance with AMA 100-01 and documents the assessment and recommendations in the medical chart;

h. conducts medical file reviews on diver/underwater trade applicants and documents the file review and recommendations in the medical chart;

i. conducts medical examination for fitness to participate in human research and documents the examination and assessment in the medical chart;

j. produce written reports on evidence based undersea medicine policies, standards, and guidelines;

k. produces written executive summaries and power-point presentations of discipline specific scientific best practice analysis;

l. produces written research proposals for discipline and Health Services relevant topics; and

m. produces written research reports for all research completed.

# APPENDIX 11 TO ANNEX A1

# NURSE - CADET NURSE LICENSED PRACTICAL NURSE (LPN) / REGISTERED PRACTICAL NURSE (RPN)

**STREAM 5**

**OCCUPATIONAL GROUP AND CATEGORY** **Nurse - Cadet Nurse Licensed Practical Nurse (LPN) / Registered Practical Nurse (RPN)**

## WORK AND ENVIRONMENT

1. A Licensed Practical Nurse (LPN) or a Registered Practical Nurse (RPN) provides direct patient care under the direction of physicians, registered nurses, or other health care providers. These activities include conducting patient history and physical assessments; performing selected diagnostic and therapeutic interventions; and counseling patients on preventive health care. A LPN or a RPN provides primary health care and emergency health care services to Cadets and Cadet Instructor Cadre on a walk-in and appointment basis at Cadet Training Centre Clinics. Emergency health care will be provided until care is provided by or through an external civilian health care facility. The patient care includes the provision of services to patients on a walk-in and appointment basis. The HCP must be available for either 8 or 12 hour shifts as per clinic schedule and identified on the Task Authorization Request, including weekday and weekend shifts. No overnight, on-call or field duty will be required.

2. Language of work may be English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. All LPNs and RPNs must, as a minimum, have:

   a. graduated from a Practical Nursing Program approved by Council of the College of Nurses;

   b. a licence from the provincial or territorial professional college or association in the province of practice;

   c. a Certificate of Standard First Aid and Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C; and

   d. must successfully complete the Reliability Status Check (RS) as well as the Police Records Check (PRC)/Vulnerable Sector Screening (VSS) process. These documents are mandatory and necessary as you will be working with youth.

## EXPERIENCE

4. All LPNs or RPNs must have a minimum of 1 year of experience in conducting patient assessment and direct nursing care of a broad range of diseases for both adult and child population in a primary care or ambulatory care setting.

**TASKS**

5. The required tasks for this occupational group include the following:

a. perform within defined scope of practice in accordance with the regulatory organization in the province of work;

b. perform triage assessment during walk-in hours and patient assessments that include medical or incident history, physical examinations;

c. perform nursing interventions such as taking vital signs, applying aseptic techniques including sterile dressing, ensuring infection control, and conducting specimen collection;

d. develop a nursing care plan based on the result of the assessment and refer to a physician or other health care provider;

e. administer medication as per doctor's order as per provincial scope of practice and observe and document therapeutic effects;

f. complete nursing documentation immediately after each patient interaction;

g. communicate any changes or abnormal findings of the patient's status or condition to the senior clinician. Abnormal is defined as any deviation to the norm, average, or expected;

h. perform therapeutic procedures such as injections and wound care;

i. administer and monitor established respiratory therapy and intravenous therapy;

j. monitor patient's progress and evaluate effectiveness of nursing interventions;

k. provide health education to patients;

l. perform administrative tasks including written or telephone responses to patient queries, preparation of medical files for physicians or other health care providers, and to return of medical files to health record department;

m. assist physicians or other health care providers with treatments and procedures;

n. act as the point of contact for the care coordination and preparation of responses, information requests, and patient inquiries in the specialty clinic;

o. monitor all medical supplies and inventory including ordering and replenishing;

p. clean all patient care areas between patients;

q. clean, sterilize and package surgical instruments; and

r. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# NURSE - CADET NURSE PRACTITIONER

**STREAM** **5**

**OCCUPATIONAL GROUP AND CATEGORY** **Nurse - Cadet Nurse Practitioner**

## WORK AND ENVIRONMENT

1. Nurse Practitioners (NPs) are registered nurses, with advanced education and the competence to provide comprehensive health assessment, to diagnose health/illness conditions, and to treat and manage acute and chronic illness. In accordance with CF Health Services NP Practice Privileges and legislated scopes of practice, NPs order and interpret screening and diagnostic tests, perform procedures, prescribe medication, in accordance with their legislated scope of practice. Nurse Practitioners provide direct patient care across the health-illness continuum of care, in a primary care setting, such as a Care Delivery Unit (CDU) and receive patients on both a walk-in and appointment basis. Their work encompasses health promotion, disease and injury prevention, and illness management. NPs refer to physicians or other health care professionals in the provincial healthcare system when the patient's condition requires care beyond their scope of practice. NPs function independently as a health care provider and act as a member of a multi-disciplinary team in the primary care setting such as Care Delivery Units and treatment rooms.

2. In this environment, the NP provides primary health care and emergency health care services to Cadets and Cadet Instructor Cadre at Cadet Training Centre Clinics. Emergency health care will be provided until care is provided by or through an external civilian health care facility. The patient care includes the provision of services to patients on a walk-in and appointment basis. The HCP must be available for either 8 or 12 hour shifts as per clinic schedule and identified on the Task Authorization Request, including weekday and weekend shifts. No field duty will be required. Certain camps may require on-call, please see camp staffing matrix for specific camp locations.

3. Language of work may be English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

4. All NPs shall possess, as a minimum:

   a. a Baccalaureate Degree in Nursing from a recognized university;

   b. successful completion of a Nurse Practitioner Program approved or recognized by the provincial regulatory authority with a specialty certificate in either Nurse Practitioner – Adult (NP-Adult) or Nurse Practitioner – Primary Health Care (NP-PHC). In some provinces, a Master Degree in Nursing with a Nurse Practitioner stream is required;

c. registration or license to practice as an Nurse Practitioner {NP, RN(EC), or RN(EP)} from the regulatory organization in their respective province/territory;

d. a Certificate of Basic Life Support (BLS) for Healthcare Provider orequivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C;

e. a Certificate of either Basic or Advanced International Trauma Life Support (ITLS); and

f. must successfully complete the Reliability Status Check (RS) as well as the Police Records Check (PRC)/Vulnerable Sector Screening (VSS) process. These documents are mandatory and necessary as you will be working with youth.

**EXPERIENCE**

5. The NP must, as a minimum, possess experience:

   a. directly providing patient medical care as a NP in primary care, ambulatory care, or acute care setting; and

   b. working independently as a nurse practitioner, performing advanced health assessment, diagnosis, therapeutic interventions and health care management of various acute and chronic illnesses.

6. The level of experience for the NP Category are :

   a. Level 1: a minimum of 1 year of experience as a NP;

   b. Level 2:

      (1) meet the requirements for Level 1 and have successfully completed one the following:

         (a) CAF Basic Aviation Medicine course; or

         (b) CAF Basic Dive Medicine course.

**TASKS**

7. The required tasks for this occupational group include the following:

   a. act in accordance with scope of practice of Nurse Practitioner IAW the provincial regulatory;

   b. apply the policies, procedures and rules for provision of medical services to on-site Regular Force, Reserve Force, Cadet and civilian members;

   c. assess patients who report to the clinic;

   d. administer care and urgent care treatment to patients and/or provide information to help them resolve their own health issues;

   e. record relevant observation notes, recommendations and appropriate treatments in the patient's medical file;

   f. ensure follow-up with patients whose health issues require it and keep the Charge/Head Nurse informed of situations encountered;

   g. contribute to the promotion of hygiene, safety and prevention of medical problems among camp members;

   h. participate in the performance of tasks required for proper functioning of the clininc in the interestof providing members with the best service possible;

   i. along with each cadet, reviewing and filling out the Cadet Intake Form, collecting the cadet's drugs and placing them in a bag bearing the cadet's information;

   j. handing out the cadet's drugs to the responsible officer and explaining to him/her the purpose of the drug, the respective dosages, side-effects and how to complete the Medication Record sheet;

   k. promoting cadets' hygiene, prevention of disease, and safety;

   l. provide medical oversight and review of cadet medical intake forms during camp intakes. This will include the review of medical documents provided by the family, the review of cadet medication and collection of prescribed medications. These medications will be collected, logged and provided to the camp authority with appropriate administration instructions;

m. consult with physicians and other health care professionals in accordance with the NP's scope of practice and practice privileges to ensure health care needs of the patients are met;

n. function as a member of the duty care team to respond to walk-in cases during the work hours;

o. additional required tasks for Level 2 NPs include performing occupational care to CF Aircrew or Divers:

(1) performing specialized medicals, such as Periodic Health Assessments, as follows:

(i) Aircrew Medicals IAW Aerospace Medical Authority Directive 100-01, Medical Standards for CF Aircrew, http://winnipeg.mil.ca/cms/Files/AMA%20Aircrew%20Medical%20Standards.pdf; or

(ii) Dive Medicals IAW CF Health Services Group Instruction 4000-04, Shallow Water Divers Periodic Health Assessment and Medical Administration found at Appendix 1.

(2) assigning occupational flight or dive restrictions.

p. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN ASSISTANT - CADET PHYSICIAN ASSISTANT

**STREAM 5**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician Assistant - Cadet Physician Assistant**

## WORK AND ENVIRONMENT

1. Physician Assistants provide a broad range of medical services in emergency care, primary care, and preventive medical education. These activities include conducting patient history and physical assessments; performing selected diagnostic and therapeutic interventions; and counseling patients on preventive health care. Physician Assistants provide services to patients on both a walk-in and appointment basis. Physician Assistants work under the supervision of a physician in a primary care setting such in a cadet camp.

2. Physician Assistants are physician extenders and not independent practitioners. Physician Assistants complement the provision of services within the CAF Health Services Centre and CAF Cadet Camp and are part of the healthcare team. The Physician Assistant works under the direction of a Contract Physician, as designated by the Contractor, who is providing clinical supervision. While the Physician Assistant works with a degree of autonomy, their Scope of Practice and National Competency Profile is specified by Canadian Association of Physician Assistants (CAPA) and may be further defined by Surgeon General Policies and Directives. As a physician extender their actual scope of practice to be applied in a clinical setting is negotiated and agreed to by the Physician Assistant and the Physician providing clinical supervision. The Physician Assistant Practice Agreement must comply with the Surgeon General level policies such as the Restricted Acts Pharmaceuticals.

3. Language of work may be in English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

4. All Physician Assistants must, as a minimum:

   a. have graduated from a Physician Assistant Program accredited or recognized by Canadian Medical Association (CMA);

   b. possess a Certification by the Physician Assistant Certification Council of Canada (PACCC) through the Canadian Association of Physician Assistants (CAPA);

   c. hold and maintain a current membership with CAPA;

   d. hold and maintain registration with the College of Physicians and Surgeons in the province of work. For provinces without a registry, the Technical Authority (TA) will consider proposed CCPAs on a case by case basis;

e. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required; and

f. must successfully complete the Reliability Status Check (RS) as well as the Police Records Check (PRC)/Vulnerable Sector Screening (VSS) process. These documents are mandatory and necessary as you will be working with youth.

**EXPERIENCE**

5. The Physician Assistant shall possess, a minimum, experience conducting patient assessment, diagnosis, and medical management of a broad range of diseases and performing various types of diagnostic and therapeutic interventions such as electrocardiography, injections, immunizations, suturing, minor surgery, splinting, and casting.

6. The Levels of Experience for the Physician Assistant category are:

a. Level 1: a minimum of 2 years of experience;

b. Level 2**:** The Physician Assistant must, as a minimum:

(1) meet the requirements for level 1; and

(2) have successfully completed at least one of the following:

(a) CF Basic Aviation Medicine course; or

(b) CF Basic Dive Medicine course.

**TASKS**

7. The required tasks for this occupational group include the following:

a. perform patient assessments that include medical or incident history, physical examinations, Periodic Health Assessments (PHAs), and routine medical screenings;

b. obtain and interpret routine diagnostic tests such as complete blood count (CBC), chest X-ray, electrocardiography (ECG), and other diagnostic tests;

c. develop a diagnosis and a treatment plan based on the result of the assessment or refer to a physician or other specialist in accordance with CF Health Services polices and directives, their scope of practice, and their Physician Assistant Practice Agreement with the physician providing clinical supervision;

d. implement a monitoring program and conduct ongoing assessment for outpatients as warranted by clinical condition;

e. prescribe and dispense Authorized Pharmaceuticals and Over-the-Counter medications in accordance with CF Health Services polices and directives, their scope of practice, and their Physician Assistant Practice Agreement with the physician providing clinical supervision;

f. perform therapeutic procedures such as injections, immunizations, suturing, minor surgery, splinting and casting fractures;

g. perform emergency interventions in the case of trauma management and cardiac emergencies in a rural environment;

h. additional required tasks for Level 2 Physician Assistants include performing occupational care to CF Aircrew or Divers:

(1) performing specialized medicals, such as Periodic Health Assessments, as follows:

(i) Aircrew Medicals IAW Aerospace Medical Authority Directive 100-01, Medical Standards for CF Aircrew, http://winnipeg.mil.ca/cms/Files/AMA%20Aircrew%20Medical%20Standards.pdf; or

(ii) Dive Medicals IAW CF Health Services Group Instruction 4000-04, Shallow Water Divers Periodic Health Assessment and Medical Administration found at Appendix 1;

(2) assigning occupational flight or dive restrictions.

i. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# NURSE - CADET PRIMARY CARE NURSE

**STREAM 5**

**OCCUPATIONAL GROUP AND CATEGORY** **Nurse - Cadet Primary Care Nurse**

## WORK AND ENVIRONMENT

1. The Cadet Camp Registered Nurse will work at a Cadet Training Centre (CTC) clinic and will be responsible for the provision of primary health care and first aid. This will involve direct patient care to onsite Regular Force, Reserve Force, Cadet Instructor Cadre and cadet members. They are also responsible for first aid only to cadet civilian instructors and onsite civilians. The provision of service to patients is on a walk-in basis. These activities include conducting patient history and physical assessment, patient screening, performing selected diagnostic and therapeutic interventions, counselling of patients on preventative health care as well as facilitating access to health services and referrals. The HCP must be available for either eight or twelve-hour shifts as per clinic schedule and identified on the Task Authorization Request, including weekday and weekend shifts. No overnight or field duty will be required. Certain camps may require on-call. Please see camp staffing matrix for specific camp locations.

2. Language of work may be English and/or French depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. All Cadet Camp Registered Nurses must, as a minimum, have:

   a. a Baccalaureate Degree in Nursing from a recognized Canadian university or Diploma from a Canadian College or CEGEP;

   b. a Registered Nurse licence from the provincial or territorial professional college or association in the province of practice;

   c. a current Certificate of Basic Life Support (BLS) for Healthcare Provider or Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C or HCP; and

   d. must successfully complete the Reliability Status Check (RS) as well as the Police Records Check (PRC)/Vulnerable Sector Screening (VSS) process. These documents are mandatory and necessary as you will be working with youth.

## TASKS

4. The required tasks for this occupational group include the following:

a. apply the policies, procedures and rules for provision of medical services to on-site Regular Force, Reserve Force, Cadet and civilian members;

b. assess patients who report to the clinic;

c. administer care and urgent care treatment to patients and/or provide information to help them resolve their own health issues;

d. refer cases beyond their knowledge and expertise to the Charge/Head Nurse for his/her assessment;

e. record relevant observation notes, recommendations and appropriate treatments in the patient's medical file;

f. provide OTC medication in accordance with their level of responsibility-qualification-provincial registration;

g. ensure follow-up with patients whose health issues require it and keep the Charge/Head Nurse informed of situations encountered;

h. contribute to the promotion of hygiene, safety and prevention of medical problems among camp members;

i. participate in the performance of tasks required for the proper functioning of the clinic in the interest of providing members with the best service possible;

j. assist physician during clinic hours, a physician can be a medical doctor, Physician Assistant or a Nurse Practitioner;

k. along with each cadet, reviewing and filling out Cadet Intake Form, collecting cadet's drugs and placing them in a bag bearing the cadet's identification;

l. handing out cadets' drugs to the responsible officer explaining to him/her the purpose of the drugs, the respective dosage, side effects and how to fill the Medication Record sheet;

m. promoting cadets' hygiene, prevention of disease, and safety;

n. provide medical oversight and review of cadet medical intake forms during the camp intakes; this will include the review of medical documents provided by the family, the review of cadet medication and collection of

prescribed medications. These medications will be collected, logged and provided to the camp authority with appropriate administration instructions;

o. the Head/Charge nurse is responsible to complete all of the above tasks as well as:

(1) the Head/Charge nurse is responsible to assess patients and determine appropriate levels of care as per clinic SOPs. This may include contacting the medical director, transferring patients to local civilian facilities or recommending that the patient be returned to their home; and

(2) respond to queries from local health professionals, DND/CAF Health Professionals, Cadet Regional Medical Liaison Officer and cadet camp leadership. Responses will be in accordance with the privacy Act and the Patients best interest.

p. other associated tasks relevant to this occupational group.

5. The Administrative Functions of Cadet Registered Nurse and Charge/Head Nurse are as follows:

a. answer phone calls, and emails relevant to clinic operation and patient well-being;

b. conduct follow up phone calls and emails to other health care practitioners, parents or appropriate cadet/medical authority on patient well-being;

c. faxing, photocopying and completing of various clinical, cadet and DND/CAF medical and administrative forms;

d. complete clinic stock taking, clinic medical and supply order requests and replenish clinic supplies and work areas accordingly;

e. provision of medication management and audits for the various cadet camp companies;

f. when working as the Charge/Head nurse, responsible for the overall function of the clinic to ensure patient care;

g. when working as the Charge/Head nurse, responsible for the clinic daily/weekly/monthly reports, statistics and other reports as assigned;

h. when working as the Charge/Head nurse responsible to the Regional Cadet Medical Liaison Officer for clinical matters; and

i. when working as the Charge/Head nurse responsible to the appropriate Base Surgeon in regards to medical matters in reference to Scope of Practise and Level of care.

## APPENDIX 11 TO ANNEX A1

## PARAMEDIC - CADET PRIMARY CARE PARAMEDIC (PCP)

**STREAM 5**

**OCCUPATIONAL GROUP AND CATEGORY** **Paramedic -**
**Cadet Primary Care Paramedic (PCP)**

## WORK AND ENVIRONMENT

1. A Primary Care Paramedic (PCP) provides direct patient care under the direction of physicians, registered nurses, or other health care providers. These activities include conducting patient history and physical assessments; performing selected diagnostic and therapeutic interventions; and counseling patients on preventive health care. In the clinical setting, the PCP assist in the provision of Primary health care and emergency health care services to Cadets and staff on a walk-in basis. The PCP may also be required to provide medical services within a wilderness environment, tending to both urgent and non-urgent medical needs of the cadets and staff. This may involve extended duites and the need to remain outdoors for extended periods of time during summer months with variable schedules.

2. Language of work may be English and/or French depending on geographic location.

## EDUCATION / QUALIFICATIONS

3. All PCPs must, as a minimum, have:

   a. graduated from a Primary Care Paramedic Program approved by Paramedic Association of Canada (PAC) and/or the Canadian medical Association (CMA);

   b. a current licence from the provincial or territorial professional body or association in the province of practice;

   c. a Certificate of Standard First Aid and Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C;

   d. a current Certificate of either Basic or Advanced International Trauma Life Support (ITLS); and

   e. a must successfully complete the Reliability Status Check (RS) as well as the Police Records Check (PRC)/Vulnerable Sector Screening (VSS) process. These documents are mandatory and necessary as you will be working with youth.

## EXPERIENCE

4. All PCPs have a minimum of 1 year of experience in conducting patient assessment and be able to demonstrate experience of direct patient care in a primary care or ambulatory care setting.

**TASKS**

5. The required tasks for this occupational group include the following:

a. assisting health care personnel with cadet's arrival procedures;

b. perform triage assessment during walk-in hours and patient assessments that include medical or incident history, physical examinations;

c. perform medical interventions such as taking vital signs, applying aseptic techniques including sterile dressing, ensuring infection control, and conducting specimen collection;

d. develop a medical care plan based on the result of the assessment and refer to a physician or other health care provider;

e. administer medication as per doctor's order as per provincial scope of practice and observe and document therapeutic effects; medical support;

f. provide on-site medical coverage to cadets and staff while on field operations. This will include patient assessment, intiail triage, urgen tmewdical care, stabilization and jandover to civilian paramedics or similar;

g. acting as receptionist for personnel and cadets who present themselves at the clinic and retrieving CF 2018s;

h. cleaning, wrapping and sterilizing instruments as per instructions;

i. collecting meals for patients under observation from the cafeteria;

j. maintaining an up-to-date list of general supplies, taking requests to Supply and bringing back supplies as required;

k. cleaning treatment rooms and replacing equipment and supplies;

l. perform medical duties escort;

m. communicate any changes or abnormal findings of the patient's status or condition to the senior clinician. Abnormal is defined as any deviation to the norm, average, or expected;

n. perform therapeutic procedures such as injections and wound care;

o. administer and monitor established respiratory therapy and intravenous therapy;

p. monitor patient's progress and evaluate effectiveness of nursing interventions;

q. provide health education to patients; and

r. other associated tasks relevant to this occupational group.

# APPENDIX 11 TO ANNEX A1

# PHYSICIAN – CADET PRIMARY CARE PHYSICIAN

**STREAM 5**

**OCCUPATIONAL GROUP AND CATEGORY** **Physician – Cadet Primary Care Physician**

## WORK AND ENVIRONMENT

1. Primary Care Physicians specialize in the physical examination, diagnosis and management of common health conditions. The range of activities in which they may engage may encompass health promotion, prevention of diseases and injuries, diagnosis, occupational health, treatment, rehabilitation, palliative care, and support services.

2. Primary Care Physicians function independently as a health care provider and act as a member of a multi-disciplinary team in the primary care setting such as Care Delivery Units, treatment rooms, and cadet camps.

3. The Cadet camp Physician will work at a Cadet Training Centre (CTC) clinic and will be responsible for the provision of Primary Health care and First Aid. This will involve direct patient care to onsite Regular Force, Reserve Force, Cadet Instructor Cadre and cadet members; they are also responsible for First Aid only to Cadet Civilian Instructors and onsite civilians. The provision of service to patients is on a walk-in basis. These activities include conducting patient history and physical assessment, patient screening, performing selected diagnostics and therapeutic interventions, counselling of patients on preventative health care as well as facilitating access to health services and referrals. The HCP must be available for either 8 or 12 hour shifts as per clinic schedule and identified on the Task Authorization Request, including weekday and weekend shifts. No overnight, or field duty will be required. Certain camps may require on-call, please see camp staffing matrix for specific camp locations.

4. Language of work may be English and/or French, depending on geographic location.

## EDUCATION / QUALIFICATIONS

5. All Primary Care Physicians must:

   a. possess a licence from the provincial or territorial regulatory organization in the province of practice;

   b. hold Certification from the College of Family Physicians of Canada (CCFP);

   c. a Certificate of Basic Life Support (BLS) for Healthcare Provider or equivalent such as Cardio-pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) Level C. Annual recertification is required; and

d. must successfully complete the Reliability Status Check (RS) as well as the Police Records Check (PRC)/Vulnerable Sector Screening (VSS) process. These documents are mandatory and necessary as you will be working with youth.

**EXPERIENCE**

6. The levels of experience for the Primary Care Physician Category are:

a. Level 1: The Physician must have a minimum of one year of experience working with an Electronic Health Record or Microsoft Office; this experience may be as part of their residency training;

b. Level 2: The Physician must, as a minimum:

(1) meet the requirements for Level 1; and

(2) have successfully completed at least one of the following:

(i) CF Basic Aviation Medicine course; or

(ii) CF Basic Dive Medicine course.

**TASKS**

7. The required tasks for this occupational group include the following:

a practice medicine in accordance with the applicable provincial and national regulatory standards and in accordance with CFHS policy and guidance;

b. deliver occupational health services such as, but not limited to:

(1) assessments of medical fitness for duty of CAF and Cadet members;

(2) diagnosis and treatment of occupational and environmental injuries and illnesses;

(3) maintenance of occupational health records through the use of cadet health records forms; and

(4) communication with Chain-of-Command.

c. provide primary medical care to patients with acute health conditions including referral to other health care providers when warranted;

d. communicate with Senior Medical Authority as required;

e. maintain patient medical health records;

f. provide clinical supervision and oversight to other members of the health care team within the Care Delivery Unit that are delivering care to patients assigned to the Primary Care Physician, including Physician Assistants, Nurse Practitioners, Medical Technicians, and Primary Care Nurses. Clinical supervision is comprised of the following:

(1) perform ongoing assessment of clinical competency of the provider;

(2) perform the role of consulting or collaborating physician in support of the clinical practice of CDU NPs;

(3) assign clinical tasks in accordance with CAF practice privileges and provincial scopes of practice;

(4) supervise delegated medical acts;

(5) ensure that the scope of practice, practice privileges and competency of the provider aligns with the complexity of care required for the patient;

(6) evaluate clinical performance through direct or indirect observation, chart review, case review, provision of co-signature, etc.;

(7) provide verbal and written feedback on clinical skills, knowledge, and judgement to the provider and Senior Medical Authority; and

(8) specific to HCP Physician Assistants: Serve as the clinical supervisor through the establishment of a Physician Assistant Practice Agreement outlining the clinical duties and terms of supervision between the HCP Physician Assistant and the Primary Care Physician. The agreement becomes the essential determinant of the HCP Physician Assistant`s individual clinical role, within the context of the Physician Assistant`s competencies, the CF Health Services scope of practice for PAs, and provincial jurisdictions.

g. additional required tasks for Level 2 Physicians include providing intake review of cadet and staff pilots:

(1) performing an intake review of cadet and staff pilots medical questionnaire on arrival to cadet flight training programs. The physician would deem whether the pilot/staff member is fit to take part in the training; and/or

(2) assigning occupational flight or dive restrictions.

h. other associated tasks relevant to this occupational group.

**APPENDIX 12 TO ANNEX A1**

**DND HCP WORK LOCATION**

## APPENDIX 12 – DND HCP WORK LOCATIONS

Departments may request resources for any of the identified locations. DND will normally use the locations listed in Tables 1 to 5 by Stream 1 to 5

The language column is meant to indicate the general language of work at the work location and is presented for information purposes only. The HCP language requirement shall be specified on the Task Authorization.

Some locations may have HCPs at more than one site within the geographical area e.g. HCPs providing services at CF Support Unit Ottawa could be at different addresses across the National Capital Region.

### TABLE 1- STREAM 1 - DND HCP WORK LOCATIONS

| | WORK LOCATION | LANG-UAGE E=English F=French B=Both bilingual | GEOGRAPHIC LOCATION | NEAREST POPULATED CENTRES |
|---|---|---|---|---|
| Atlantic | 9 WING GANDER | E | Gander, NFLD | St John's, NFLD |
| | 5 WING GOOSE BAY | E | Happy Valley, NFLD | St John's, NFLD |
| | CFB ST. JOHN'S | E | St.John's, NFLD | St.John's NFLD |
| | | | | |
| | 14 WING GREENWOOD | B | Greenwood, NS | Kentville, NS |
| | CFB HALIFAX/ SHEERWATER | B | Halifax, NS | Halifax, NS |
| | SYDNEY DETACHMENT | E | Sydney, NS | Sydney, NS |
| | | | | |
| | MONCTON DETACHMENT | B | Moncton, NB | Moncton, NB |
| | CFB GAGETOWN | B | Oromocto, NB | Fredericton, NB |
| Quebec | 3 WING BAGOTVILLE | F | Alouette, QC | Bagotville, Chicoutimi, La Baie, Jonquière, QC |
| | CFB MONTREAL | B | Montreal, QC | Montreal QC |
| | CFB ST. JEAN | F | St.Jean, QC | Montreal, QC |
| | CFB VALCARTIER | F | Valcartier, QC | Quebec City, QC |
| O | 22 WING NORTH BAY | B | North Bay, ON | North Bay, ON |

| | WORK LOCATION | LANG-UAGE E=English F=French B=Both bilingual | GEOGRAPHIC LOCATION | NEAREST POPULATED CENTRES |
|---|---|---|---|---|
| | 8 WING TRENTON | B | Trenton, ON | Belleville, ON |
| | CF SUPPORT UNIT OTTAWA | B | Ottawa, ON | Ottawa, ON |
| | CFB BORDEN | B | Angus, ON | Barrie, Alliston, ON |
| | CFB KINGSTON | B | Kingston, ON | Kingston, ON |
| | CFB PETAWAWA | E | Petawawa, ON | Pembroke, ON |
| | CFB TORONTO | E | Toronto, ON | Toronto, ON |
| | LONDON DETACHMENT | E | London, ON | London, ON |
| | MEAFORD DETACHMENT | E | Meaford, ON | Owen Sound, ON |
| | SAULT STE MARIE DETACHMENT | E | Sault Ste Marie, ON | Sault Ste Marie, ON |
| | THUNDER BAY DETACHMENT | E | Thunder Bay, ON | Thunder Bay, ON |
| Western | CFB SHILO | E | Shilo, MB | Brandon, MB |
| | PORTAGE LA PRAIRIE | E | Portage la Prairie, MB | Winnipeg, MB |
| | 17 WING WINNIPEG | E | Winnipeg, MB | Winnipeg, MB |
| | | | | |
| | DUNDURN DETACHMENT | E | Dundurn, SK | Saskatoon, SK |
| | 15 WING MOOSE JAW | E | Moose Jaw, SK | Regina, SK |
| | | | | |
| | CALGARY DETACHMENT | E | Calgary, AB | Calgary, AB |
| | CFB EDMONTON | E | Edmonton, AB | Edmonton, AB |
| | 4 WING COLD LAKE | E | Grand Centre, AB | Grand Centre, Bonnyville, AB |
| | CFB SUFFIELD | E | Suffield, AB | Medicine Hat, AB |
| | CFB WAINWRIGHT | E | Wainwright, AB | Edmonton, AB |
| | | | | |
| | 19 WING COMOX | E | Courtney, BC | Courtney, Nanaimo, Victoria, BC |
| | VANCOUVER DETACHMENT | E | Vancouver, BC | Vancouver, BC |

| | WORK LOCATION | LANG-UAGE E=English F=French B=Both bilingual | GEOGRAPHIC LOCATION | NEAREST POPULATED CENTRES |
|---|---|---|---|---|
| | CFB ESQUIMALT | E | Victoria, BC | Victoria, BC |
| | | | | |
| | YELLOWKNIFE DETACHMENT | E | Yellowknife, NT | Yellowknife, NT |

## TABLE 2 - STREAM 2 - DND HCP WORK LOCATIONS

| | WORK LOCATION | LANG-UAGE E=English F=French B=Both bilingual | GEOGRAPHIC LOCATION | NEAREST POPULATED CENTRES |
|---|---|---|---|---|
| Atlantic | 9 WING GANDER | E | Gander, NFLD | St John's, NFLD |
| | 5 WING GOOSE BAY | E | Happy Valley, NFLD | St John's, NFLD |
| | CFB ST. JOHN'S | E | St.John's, NFLD | St.John's NFLD |
| | | | | |
| | 14 WING GREENWOOD | B | Greenwood, NS | Kentville, NS |
| | CFB HALIFAX/ SHEERWATER | B | Halifax, NS | Halifax, NS |
| | SYDNEY DETACHMENT | E | Sydney, NS | Sydney, NS |
| | | | | |
| | MONCTON DETACHMENT | B | Moncton, NB | Moncton, NB |
| | CFB GAGETOWN | B | Oromocto, NB | Fredericton, NB |
| Quebec | 3 WING BAGOTVILLE | F | Alouette, PQ | Bagotville, Chicoutimi, La Baie, Jonquière, Qc |
| | CFB MONTREAL | B | Montreal, Qc | Montreal Qc |
| | CFB ST. JEAN | F | St.Jean, Qc | Montreal, Qc |
| | CFB VALCARTIER | F | Valcartier, Qc | Quebec City, Qc |
| Ontario | 22 WING NORTH BAY | B | North Bay, ON | North Bay, ON |
| | 8 WING TRENTON | B | Trenton, ON | Belleville, ON |
| | CF SUPPORT UNIT OTTAWA | B | Ottawa, ON | Ottawa, ON |
| | CFB BORDEN | B | Angus, ON | Barrie, Alliston, ON |
| | CFB KINGSTON | B | Kingston, ON | Kingston, ON |
| | CFB PETAWAWA | E | Petawawa, ON | Pembroke, ON |
| | CFB TORONTO | E | Toronto, ON | Toronto, ON |
| | LONDON DETACHMENT | E | London, ON | London, ON |
| | MEAFORD DETACHMENT | E | Meaford, ON | Owen Sound, ON |
| | SAULT STE MARIE DETACHMENT | E | Sault Ste Marie, ON | Sault Ste Marie, ON |
| | THUNDER BAY DETACHMENT | E | Thunder Bay, ON | Thunder Bay, ON |
| W | CFB SHILO | E | Shilo, MB | Brandon, MB |

| | WORK LOCATION | LANG-UAGE E=English F=French B=Both bilingual | GEOGRAPHIC LOCATION | NEAREST POPULATED CENTRES |
|---|---|---|---|---|
| | PORTAGE LA PRAIRIE | E | Portage la Prairie, MB | Winnipeg, MB |
| | 17 WING WINNIPEG | E | Winnipeg, MB | Winnipeg, MB |
| | | | | |
| | DUNDURN DETACHMENT | E | Dundurn, SK | Saskatoon, SK |
| | 15 WING MOOSE JAW | E | Moose Jaw, SK | Regina, SK |
| | | | | |
| | CALGARY DETACHMENT | E | Calgary, AB | Calgary, AB |
| | CFB EDMONTON | E | Edmonton, AB | Edmonton, AB |
| | 4 WING COLD LAKE | E | Grand Centre, AB | Grand Centre, Bonnyville, AB |
| | CFB SUFFIELD | E | Suffield, AB | Medicine Hat, AB |
| | CFB WAINWRIGHT | E | Wainwright, AB | Edmonton, AB |
| | | | | |
| | 19 WING COMOX | E | Courtney, BC | Courtney, Nanaimo, Victoria, BC |
| | VANCOUVER DETACHMENT | E | Vancouver, BC | Vancouver, BC |
| | CFB ESQUIMALT | E | Victoria, BC | Victoria, BC |
| | | | | |
| | YELLOWKNIFE DETACHMENT | E | Yellowknife, NT | Yellowknife, NT |

## TABLE 3 – STREAM 3 - DND HCP WORK LOCATIONS

| | WORK LOCATION | LANG-UAGE E=English F=French B=Both bilingual | GEOGRAPHIC LOCATION | NEAREST POPULATED CENTRES |
|---|---|---|---|---|
| Atlantic | CFB ST. JOHN'S | E | St.John's, NFLD | St.John's NFLD |
| | 14 WING GREENWOOD | B | Greenwood, NS | Kentville, NS |
| | CFB HALIFAX/ SHEERWATER | B | Halifax, NS | Halifax, NS |
| | CFB GAGETOWN | B | Oromocto, NB | Fredericton, NB |
| Quebec | 3 WING BAGOTVILLE | F | Alouette, PQ | Bagotville, Chicoutimi, La Baie, Jonquière, Qc |
| | CFB MONTREAL | B | Montreal, Qc | Montreal Qc |
| | CFB ST. JEAN | F | St.Jean, Qc | Montreal, Qc |
| | CFB VALCARTIER | F | Valcartier, Qc | Quebec City, Qc |
| Ontario | 8 WING TRENTON | B | Trenton, ON | Belleville, ON |
| | CF SUPPORT UNIT OTTAWA | B | Ottawa, ON | Ottawa, ON |
| | CFB BORDEN | B | Angus, ON | Barrie, Alliston, ON |
| | CFB KINGSTON | B | Kingston, ON | Kingston, ON |
| | CFB PETAWAWA | E | Petawawa, ON | Pembroke, ON |
| | CFB TORONTO | E | Toronto, ON | Toronto, ON |
| Western | CFB SHILO | E | Shilo, MB | Brandon, MB |
| | PORTAGE LA PRAIRIE | E | Portage la Prairie, MB | Winnipeg, MB |
| | 17 WING WINNIPEG | E | Winnipeg, MB | Winnipeg, MB |
| | CFB EDMONTON | E | Edmonton, AB | Edmonton, AB |
| | 4 WING COLD LAKE | E | Grand Centre, AB | Grand Centre, Bonnyville, AB |
| | CFB WAINWRIGHT | E | Wainwright, AB | Edmonton, AB |
| | 19 WING COMOX | E | Courtney, BC | Victoria, BC |
| | CFB ESQUIMALT | E | Victoria, BC | Victoria, BC |

## TABLE 4 – STREAM 4 - DND HCP WORK LOCATIONS

| | WORK LOCATION | LANG-UAGE E=English F=French B=Both bilingual | GEOGRAPHIC LOCATION | NEAREST POPULATED CENTRES |
|---|---|---|---|---|
| **Atlantic** | CFB GAGETOWN | E | Oromocto, NB | Fredericton, NB |
| **Quebec** | 3 WING BAGOTVILLE | F | Alouette, PQ | Bagotville, Chicoutimi, La Baie, Jonquière, Qc |
| | CFB VALCARTIER | F | Valcartier, Qc | Quebec City, Qc |
| **Ontario** | CF H SVCS GP HQ OTTAWA/NCR | B | Ottawa, ON | Ottawa, ON |
| | CFB TORONTO | E | Toronto, ON | Toronto, ON |
| | CFHSTC / CFB BORDEN | B | Angus, ON | Barrie / Alliston, ON |
| | 8 WING TRENTON | B | Trenton, ON | Belleville, ON |
| **Western** | PORTAGE LA PRAIRIE | E | Portage la Prairie, MB | Winnipeg, MB |

## TABLE 5 – STREAM 5 DND HCP WORK LOCATIONS

| REGION | CADET TRAINING CENTRE WORK LOCATION | LANG-UAGE E=English F=French B=Both Bilingual | GEOGRAPHIC LOCATION | NEAREST POPULATED CENTRES |
|---|---|---|---|---|
| Atlantic | ACADIA | E | Cornwallis, NS | Halifax, NS |
| | GREENWOOD | E | Kingston, NS | Halifax, NS |
| | | | | |
| | ARGONAUGHT, GAGETOWN, NB | B | Oromocto, NB | Fredericton, NB |
| | | | | |
| | GOOSE BAY | E | Goose Bay, NFLD | St John's, NFLD |
| | AVALON | E | St John's, NFLD | St John's, NFLD |
| Ontario | BLACKDOWN | E | Borden, ON | Alliston, Barrie, ON |
| | CONNAUGHT | B | Ottawa, ON | Ottawa, ON |
| | KINGSTON | E | Kingston, ON | Kingston, ON |
| | TRENTON | E | Trenton, ON | Trenton, Belleville, ON |
| Quebec | BAGOTVILLE | B | Saquenay, Qc | Chicoutimi, QC |
| | ST JEAN | F | St-Jean, Qc | Montreal, QC |
| | VALCARTIER | F | Quebec, Qc | Quebec, QC |
| Western | GIMLI | E | Gimli, MB | Gimli, Winnipeg, MB |
| | | | | |
| | COLD LAKE | E | Cold Lake, AB | Cold Lake, Edmonton, AB |
| | ROCKY MOUNTAIN | E | Cochrane, AB | Cochrane, Calgary AB |
| | PENHOLD | E | Penhold AB | Penhold, Edmonton, AB |
| | | | | |
| | ALBERT HEAD | E | Victoria, BC | Victoria, BC |
| | | | | |
| | COMOX | E | Comox, BC | Courtenay, BC |
| | QUADRA | E | Comox, BC | Comox, Courtenay, BC |
| | VERNON | E | Vernon, BC | Vernon, BC |
| | WHITEHORSE | E | Whitehorse, YK | Whitehorse, YK |

Notes: Summer cadet camps operate during the months of mid-June to end-August each year.

**APPENDIX 13 TO ANNEX A1**

**DND HCP REQUIREMENT FORECAST PLAN**

**(Attached)**

**APPENDIX 14 TO ANNEX A1**

**DND DELIVERABLES TABLE**

## DND Deliverables Table

| # | SOW Para # | Deliverable Description | Format H or S | Information (I) Approval (A) | Frequency | Required Delivery Date (RDD) | Delivery To |
|---|---|---|---|---|---|---|---|
| **Electronic (S) for all Deliverables unless otherwise indicated Hard Copy (H)** | | | | | | | |
| 1. | 4.3.6 | Contractor's Central Office Set-up Notification | | I | Once | Within 10 calendar days ACA | CA, DTA, DPA |
| 2. | 4.3.7 and 4.4.1 | The names, titles, roles and, and contact information for each member of the CMT and CCO | | I | Once | At Initial Contract Kick-Off Meeting | CA, DTA, DPA |
| 3. | 4.3.8 and 4.4.2 | Changes made to the CMT or CCO personnel | | I | As changed | Within two (2) calendar days of change | CA, DTA, DPA |
| 4. | 4.5.5 and 4.6.2 | Name and contact information for SDM and DSDM | | I | Once | Within five (5) calendar days ACA | CA, DTA, DPA |
| 5. | 4.5.7 | Notice of the intent to permanently replace the SDM | | I | As required | 30 calendar days | CA, DTA, DPA |
| 6. | 4.6.4 | Notice of the intent to permanently replace the DSDM | | I | As required | 15 calendar days | CA, DTA, DPA |
| 7. | 4.7 | Contractor's Draft Start-Up Plan | | A | Once | Within 14 calendar days ACA | CA, DTA, DPA |
| 8. | 4.7.3 | Final Start-Up Plan | | A | Once | Within 10 calendar days of any receiving DTA feedback | CA, DTA, DPA |
| 9. | 4.8 | Contractor's Draft Recruitment Plan | | A | Once | Within 30 calendar days ACA | CA, DTA, DPA |
| 10. | 4.8.3 | Contractor's Final Recruitment Plan | | A | Once | 20 calendar days after Initial Kick-off Meeting | CA, DTA, DPA |

| # | SOW Para # | Deliverable Description | Format H or S | Information (I) Approval (A) | Frequency | Required Delivery Date (RDD) | Delivery To |
|---|---|---|---|---|---|---|---|
| 11. | 4.8.6 | Contractor's Updated Recruitment Plan | | A | As updated | Within 10 calendar days of any changes | CA, DTA, DPA |
| 12. | 4.9 | Contractor's Draft Risk Management Plan (CRMP) | | A | Once | Within 30 calendar days ACA | CA, DTA, DPA |
| 13. | 4.9.4 | Contractor's Final Risk Management Plan | | A | Once | 20 calendar days after receipt of input | CA, DTA, DPA |
| 14. | 4.9.6 | Contractor's Updated Risk Management Plan | | A | As updated and for each PRM | Within 10 calendar days of any changes and for each PRM | CA, DTA, DPA |
| 15. | 4.9.8 | Advance electronic copies of current the CRMP | | I | As detailed | Five calendar days before each PRM | DTA, DPA |
| 16. | 4.9.9 | Hard Copies of current CRMP for each attendee | H | I | As detailed | Day of PRM | DTA, DPA |
| 17. | 4.9.10 | Report occurrence of substantive risk | | I | As detailed | Within three calendar days of occurrence | DTA |
| 18. | 4.10 | Draft Contractor's Management Plan (CMP) | | A | Once | Within 30 calendar days after ACA | CA, DTA, DPA |
| 19. | 4.10.3 | Final Contractor's Management Plan | | A | Once | 20 calendar days after receipt of input | CA, DTA, DPA |
| 20. | 4.10.6 | Updated Contractor's Management Plan | | A | As updated | Within 10 calendar days of any changes and April of each year | CA, DTA, DPA |
| 21. | 4.11 | Contractor's draft communications for circulation to the public, etc | | A | As each is developed | Within 30 calendar days of ACA | CA, DTA |
| 22. | 4.15 | Start-Up Phase Lessons Learned Document | | I | Once | Within 30 calendar days of SED | DTA |
| 23. | 4.15 | Annual Lessons Learned Report | | I | Annually | June of each year | DTA |

| # | SOW Para # | Deliverable Description | Format H or S | Information (I) Approval (A) | Frequency | Required Delivery Date (RDD) | Delivery To |
|---|---|---|---|---|---|---|---|
| 24. | 4.15 | Transition-Out Phase Lessons Learned Report | | I | Once | Two-months before the Contract expiry date | DTA |
| 25. | 4.16.1<br>4.24 | Timesheet Tool and User Manual | | A | Once | 60 calendar days prior to SED | CA, DTA, DPA |
| 26. | 4.16.3 | Timesheet Tool demonstration for the DAs at a DND | | I | Once | Five (5) calendar days of Timesheet Tool setup notification | DTA, DPA |
| 27. | 4.26 | Contractor TTP Acceptable Delay Justification | | A | As required | Within 25 calendar days before the HCP required start date | DPA |
| 28. | 4.27.7 | Contractor Notification of HCP Licence Change | S | I | By occurrence | Same business day or next business day if following a weekend | DTA |
| 29. | 4.30.1 | Supervisory Agreement between Physician and PA | H | I | As required | For each Physician Assistant and before start date | DTA |
| 30. | 4.31.1 | N-95 Fit Test Certification - Quantitative Fit Testing results | H | A | As required | For each HCP and before start date | DTA, DPA |
| 31. | 4.31.4 | N-95 Fit Test Certification - Quantitative Fit Testing results on Re-tests | H | A | As required | For each HCP every two years | DTA, DPA |
| 32. | 4.32.2 | WHMIS Certification Report | H | A | As required | For each HCP before start date and for each subsequent re-test | DTA, DPA |
| 33. | 4.33.2 | Basic Life Support Certification | H | A | As required | For each HCP before start date and for each subsequent re-qualification | DTA, DPA |

| # | SOW Para # | Deliverable Description | Format H or S | Information (I) Approval (A) | Frequency | Required Delivery Date (RDD) | Delivery To |
|---|---|---|---|---|---|---|---|
| 34. | 4.34.1 | Recurring HCP Task Authorization Confirmation Report | | A | Annually | Within 30 calendar days from receipt of Annual Requirements Plan | DPA |
| 35. | 4.34.2 | Task Authorization Response Package | | A | By Task Authorization | No later than 20 calendar days prior to HCP Start Date | DPA |
| 36. | 4.35.1 | Signed copy of Orientation Package - HCP Acknowledgement Form | H | I | As required | For each HCP | DPA |
| 37. | 4.40.1 | HCP Overtime Authorization | H | A | As required | With each Overtime invoice | DPA |
| 38. | 4.41.5 | HCP On-Call Authorization and Schedule | H | A | As required | With each On-Call invoice | DPA |
| 39. | 4.42.3 | HCP Call-Back Authorization and Schedule | H | A | As required | With each Call-Back invoice | DPA |
| 40. | 4.45.5 | HCP Travel Expenses with original receipts | H | A | As required | With each HCP Travel invoice | DTA, DPA |
| 41. | 4.65.1 | Prepare and Maintain Action Item Log (AIL) | | A | Once | Initial Contract Kick-off Meeting | All meeting participants |
| 42. | 4.65.5 | Update AIL | | A | As required | Ongoing | All meeting participants |
| 43. | 4.67 | Start-up Phase Report | | | Monthly | During Start-up Phase | CA, DTA, DPA |
| 44. | 4.68 | Task Authorization Status Report | | I | Monthly | Within seven (7) calendar days following month end | DTA |

| # | SOW Para # | Deliverable Description | Format H or S | Information (I) Approval (A) | Frequency | Required Delivery Date (RDD) | Delivery To |
|---|---|---|---|---|---|---|---|
| 45. | 4.69 | Initial Credentialing Report | | I | Once | At least 30 days prior to SED | DTA |
| 46. | 4.69 | Semi-annual Credentialing Report | | I | Semi-annual | Within seven (7) calendar days of the end of September, Within seven(7) Calendar days of the end of March | DTA |
| 47. | 4.70 | Monthly HCP Travel Report | | I | Monthly | Within 7 calendar days following month end | DTA |
| 48. | 4.71 | Monthly HCP Labour, Overtime, and On-Call Report | | I | Monthly | Within seven (7) calendar days following month end | DTA |
| 49. | 4.72 | Recurring HCP Task Authorization Confirmation Report | | I | Annually | 30 calendar days from Receipt of Annual HCP Requirement Plan | DTA |
| 50. | 4.73 | HCP Certifications Report | | I | Annually | At SED and annually thereafter | DTA |
| 51. | 4.74 | Draft Out-Going Phase Plan | H | A | Once | At Out-Going Phase Kick-off meeting | All meeting participants |
| 52. | 4.74 & 4.74.2 | Final Out-Going Phase Plan | | A | Once | Within 10 calendar days based on comments or recommendations received from the DTA. | CA, DTA, DPA |

**APPENDIX 15 TO ANNEX A1**

**CF H SVCS GROUP INSTRUCTION 3120-06 - CREDENTIALING OF MEDICAL BRANCH CLINICAL PRACTITIONERS;**

**DND 2523 CREDENTIALING INFORMATION FORM;**

# Credentialing of Medical Branch Clinical Practitioners

**Document Status:** Current
**Document Type:** **Instruction**
**Document Number:** **3120-06**
**Original Source:** MSI CF 3000-005
**Approval:** Surg Gen
**SME:** D H Svcs Del
**OPI:** D H Svcs Del
**Effective Date:** 06 Jul 09
**Last Reviewed:** 28 Jan 10

## Background

### Abbreviations

1. The table below describes the abbreviations used throughout this Instruction.

| Short Form | Long Form |
|---|---|
| CF H Svcs Gp | Canadian Forces Health Services Group |
| CO | Commanding Officer |
| CP | Certified Practitioner |
| D H Svcs Del | Directorate of Health Services Delivery |
| DND | Department of National Defence |
| D Surg Gen | Deputy Surgeon General |
| MCSP | Maintenance of Clinical Skills Program |
| N/A | Non applicable |
| OR Tech | Operating Room Technician |
| OTC | Over-the-counter |
| PMed Tech | Preventive Medicine Technician |
| Prof Tech Net | Professional Technical Network |
| Res F | Reserve Force |
| Reg F | Regular Force |
| RHP | Regulated Health Profession |

### General

2. This Instruction contains direction relating to the mandatory provision of proof of on-going licensure/ certification to practice by CF H Svcs Gp RHPs and CPs.

### Definitions

3. Definitions provided for the purpose of this Instruction are contained in Annex A.

### Application

4. This Instruction applies to all CF personnel, Department of National Defence (DND) Public Servants, contractors and sub-contractors who provide health services to CF members.

**Context**

5. CF H Svcs Gp RHPs and CPs provide health care to CF members; both in-garrison and on deployed operations. RHPs and CPs are members of professions whose licence/ certificate to practice is governed by provincial/ territorial/ national legislation or certification (i.e. Canadian Association of Physician Assistants (CAPA)) established to assure protection of the public.

6. In the civilian health care sector, RHPs/CPs are required to provide proof of on-going licensure/ certification to practice through various organizational credentialing processes. This Instruction establishes a similar process for the CF H Svcs Gp. The CF credentialing process will ensure that RHPs/CPs working in CF settings are appropriately credentialed, in accordance with best practices as outlined in Annex B.

# Direction

7. All RHPs and CPs listed in Annex B are subject to credentialing as specified in Reference B.

# Requirements

8. The CO or authorised delegate will verify the credentials of all new RHPs/ CPs staff prior to their being hired and/or assuming patient care activities by confirming that all RHPs/CPs:

a. Hold a valid licence/ certification with their respective regulatory/ certifying organization;
b. Have no restrictions/ limitations against their licence/ certificate with their respective regulatory/ certifying organization;
c. Have no sanctions/ past findings against their licence/ certificate with their respective regulatory/ certifying organization and
d. Are in good standing with their provincial/ territorial or national regulatory/ certifying organization.

9. Verification of credentials with the respective regulatory/ certifying organization (Annexes D-R) will be done in one of the following manners:

a. Website: Each regulatory/ certifying organization posts important and varying amount of information about their registered members on their website for the employers and the public to review. If the requested information in para 9 is on the website, print and date the relevant page(s) and attached them to the credentialing documents as proof of verification.
b. Telephone: Regulatory/ certifying organizations will provide the required information about a registered member by telephone. A dated and signed note summarizing the results of the phone verification will be attached to the credentialing documents as proof of verification.
c. Letter of Good Standing: A letter is issued by the regulatory/ certifying organization upon request by its registered member. There is a cost incurred to the HCP/ CP and a time delay in obtaining this letter. It is important that the HCP/CP requesting the Letter of Good Standing ensure that all information requested in para 9 be included in the letter.

10. RHPs and CPs will complete the DND 2523 Credentialing Information Form (Annex C):

a. At time of employment/ DND 2058 contract; and
b. On an on-going basis when their credentials are renewed with their provincial/ territorial or national regulatory/ certifying organizations.

11. RHPs and CPs will only be eligible for membership reimbursement after the completed DND 2523 Credentialing Information Form has been submitted and updated on the Unit Credentialing List IAW Reference C and D. COs will ensure that DND 2523 Credentialing Information Form is submitted prior to authorising membership reimbursement on Membership Fees Request Form IAW Reference E.

12. Should issues arise with respect to the credential verification process outlined in para 9, or should disclosures be made on the DND 2523 Credentialing Information Form (Annex C), the CO will consult the medical Prof Tech Net which will review and determine the candidate's suitability to provide health care services. The Prof Tech Net will ensure that all decisions are properly documented.

**Unit Credentialing List**

13. Each unit will maintain a current Unit Credentialing List (Annex S) of all the health care providers working in their unit. This list will have the most current information on all the licensure/ certificates belonging to all the unit's health care professionals. The Unit Credentialing List will be sent to the Credentialing Cell at the CF H Svcs Gp HQ biannually, NLT 31 Mar and 30 Sept. The information submitted will be entered into the national credentialing databases for all health care professions. Any expired licensure information that is forwarded to the Credentialing Cell on the Unit Credentialing List will be accompanied by a brief explanation for submitting expired information.

**The Credentialing Cell**

14. The Credentialing Cell in the D H Svcs Del at CF H Svcs Gp HQ is a resource centre for the local clinics/ units on issues concerning licensure and certification of health care providers. Email enquiries may be sent to +DHSD Credentialing@CMP DHSD@Ottawa-Hull. The cell will maintain and monitor a national database of verified licensure/ certification information and ensure that the RHP/CP is an active member with their relevant regulatory/ certifying organizations.

**Credentialing Responsibilities**

15. The RHP/ CP is responsible for:

a. Completing all sections of the DND 2523 Credentialing Information Form (Annex C). If any section is not applicable, the acronym N/A will be inserted;
b. Including photocopies of all required documentation listed in Annex B;
c. Signing and dating the DND 2523 Credentialing Information Form; and
d. Submitting the completed DND 2523 Credentialing Information Form with attached supporting documentation to the supervisor/manager prior to the licence/certification's expiration/ renewal date(s).

16. The Supervisor/ Manager are responsible for:

a. Reviewing the DND 2523 Credentialing Information Form and verifying that all sections are answered and the supporting documentation is attached;
b. Verifying credentials of new employees and employees on DND 2058 contracts with their respective regulatory organizations as per para 10; and
c. Forwarding the DND 2523 Credentialing Information Form and documentation to the Base/Wing Surgeon for review.

17. The Base/Wing Surgeon is responsible for:

a. Reviewing and approving the required credentials of the RHP/CP presented in the DND 2523 Credentialing Information Form and supporting documentation (i.e. photocopies of licences & verification of licence/ certificate requirements). Pertinent issues arising from supplied licensure information or answers to questions will be forwarded when required, IAW Reference B;
b. Signing and dating the DND 2523 Credentialing Information Form; and
c. Forwarding the DND 2523 Credentialing Information Form and supporting documentation to the CO for final approval.

18. The CO is responsible for:

a. Reviewing and providing final approval for the RHP/ CP's DND 2523 Credentialing Information Form and supporting documentation;
b. Communicating with the Prof Tech Net when issues arise in the credential verification process;
c. Signing and dating the DND 2523 Credentialing Information Form; and
d. Forwarding the DND 2523 Credentialing Information Form to unit clerk for entry/ update onto the local Unit Credentialing List.

19. The unit clerk is responsible for:

a. Entering/ updating/ maintaining current information from Sections 1, 2, & 4 of the DND 2523 Credentialing Information Form onto the Unit Credentialing List within 30 days of licence(s)/ certificate(s) expiry date(s).
b. Filing the DND 2523 Credentialing Information Form and supporting documentation in the employee's Personnel File.
c. Submitting the Unit Credentialing List bi-annually NLT 31 Mar & 30 Sept to the Credentialing Cell in the D H Svcs Del in CF H Svcs Gp HQ by mail or via email to +DHSD Credentialing@CMP DHSD@Ottawa-Hull.

**Credentialing Reports**

20. The Credentialing Cell is responsible to generate quarterly reports using information submitted by the units. Reports will be sent to the D Surg Gen and made available to senior CF leaders.

## References:

A: Health Services Support Contract (HSSC)
B: CF H Svcs Gp Instruction 3120-01, License/Certificate to Practice – CF H Svcs Gp Certified Practitioners and Regulated Health Professionals
C: CF H Svcs Gp Instruction 3120-03, License to Practice Instructions Reg and Res F Medical Branch Clinical Practitioners (cancelled)
D: CF H Svcs Gp Instruction 3120-04, License to Practice Instructions Public Service Medical Branch Clinical Practitioners (in development)
E: MPCO 1001-0 Membership Fees, Annex A

## Annexes:

A: Annex A - Definitions
B: Annex B - Required Professional Credentials for the CF H Svcs Gp
C: Annex C - DND 2523 Credentialing Information Form
D: Annex D - Addiction Counsellor Regulatory Organizations Contact Information
E: Annex E - Clinical Psychologist Regulatory Organizations Contact Information
F: Annex F - Dietitian Regulatory Organizations Contact Information
G: Annex G - Medical Laboratory Technologist Regulatory Organizations Contact Information
H: Annex H - Medical Radiation Technologist Regulatory Organizations Contact Information
I: Annex I - Medical Technician (Paramedic) Regulatory Organizations Contact Information
J: Annex J - Medical Assistant (Licensed/ Registered Practical Nurse (LPN/RPN)) Regulatory Organizations Contact Information
K: Annex K - Nursing Officer/ Registered Nurse/ Nurse Practitioner Regulatory Organizations Contact Information
L: Annex L - Ophthalmic Technician Regulator Organization Contacts Information
M: Annex M - Pharmacist Regulatory Organization Contacts Information
N: Annex N - Physician Regulatory Organization Contacts Information
O: Annex O - Physician Assistant Regulatory Organization Contacts Information
P: Annex P - Physiotherapist Regulatory Organization Contact Information
Q: Annex Q - Physiotherapy Assistant Regulatory Organizations Contact Information
R: Annex R - Social Worker Regulatory Organization Contacts Information
S: Annex S - Unit Credentialing List

**Annex A to CF H Svcs Gp Instruction 3120-06**

# Definitions

| Term | Definitions |
|---|---|
| Clinical Practitioner | Medical RHPs and CPs that:<br>a. Provide direct patient care at a health care facility (e.g. CF H Svcs Clinic, a deployed care setting, or a civilian facility during training or MCSP);<br>b. Supervise individuals providing direct patient care; and/or<br>c. Provide oversight, direction, or development of programs relating to patient care or health protection. |
| Credentialing | The process of verifying a clinical practitioners training, qualifications, and/or licence/certificate to practice on initial employment and on a periodic, on-going basis to ensure providers are appropriately qualified for their positions and currently authorized to practice. It is a due diligence and risk management strategy designed to enhance patient safety. Within the CF H Svcs Gp, management of the credentialing process is the responsibility of D H Svcs Del/Credentialing Cell. |
| Licence/ Certificate To Practice | Provided by an appropriate national, provincial, or territorial regulatory organization to members of a RHP or CP. By attaining and maintaining a licence/certificate to practice, clinical practitioners assure patients and employers that they are authorized and competent to deliver quality health care. |
| Professional Regulatory Organizations | Each RHP has its own professional regulatory organization with provincial statutory authority (Regulated Health Professions Act) that provides the legal framework for the profession to be self-regulating. To practise as a member of a RHP or to use the professional title/ designation controlled by it, individuals must meet the requirements of the professional regulatory organization, which includes obtaining and maintaining the licence/ authority to practice. |
| Certified Practitioners (CP) | Clinical practitioners whose occupation is not a RHP but has a national, provincial, or territorial certification to practice process. CF H Svcs Gp CPs are listed in Annex B. |
| Regulated Health Professions (RHP) | Clinical practitioners whose occupation is a self-regulated profession. In Canada, the regulation of health professions is under provincial/ territorial jurisdiction with each province/territory individually legislating the credentialing requirements for each profession. CF H Svcs Gp RHPs are listed in Annex B. |

**Annex B to CF H Svcs Gp Instruction 3120-06**

## Required Professional Credentials for the CF H Svcs Gp

click here

**Annex C to CF H Svcs Gp Instruction 3120-06**

## Credentialing Information Form

click here

**Annex D to CF H Svcs Gp Instruction 3120-06**

## Addiction Counsellor Regulatory Organizations Contact Information

click here

**Annex E to CF H Svcs Gp Instruction 3120-06**

## Clinical Psychologist Regulatory Organizations Contact Information

click here

**Annex F to CF H Svcs Gp Instruction 3120-06**

## Dietitian Regulatory Organizations Contact Information

click here

**Annex G to CF H Svcs Gp Instruction 3120-06**

## Medical Laboratory Technologist Regulatory Organizations Contact Information

click here

**Annex H to CF H Svcs Gp Instruction 3120-06**

## Medical Radiation Technologist Regulatory Organizations Contact Information

click here

**Annex I to CF H Svcs Gp Instruction 3120-06**

## Medical Technician (Paramedic) Regulatory Organizations Contact Information

click here

**Annex J to CF H Svcs Gp Instruction 3120-06**

## Medical Assistant (Licensed/ Registered Practical Nurse (LPN/RPN)) Regulatory Organizations Contact Information

click here

**Annex K to CF H Svcs Gp Instruction 3120-06**

## Nursing Officer/ Registered Nurse/ Nurse Practitioner Regulatory Organizations Contact Information

click here

**Annex L to CF H Svcs Gp Instruction 3120-06**

## Ophthalmic Technician Regulator Organization Contacts Information

click here

**Annex M to CF H Svcs Gp Instruction 3120-06**

## Pharmacist Regulatory Organization Contacts Information

click here

**Annex N to CF H Svcs Gp Instruction 3120-06**

## Physician Regulatory Organization Contacts Information

click here

**Annex O to CF H Svcs Gp Instruction 3120-06**

## Physician Assistant Regulatory Organization Contacts Information

click here

**Annex P to CF H Svcs Gp Instruction 3120-06**

## Physiotherapist Regulatory Organization Contact Information

click here

**Annex Q to CF H Svcs Gp Instruction 3120-06**

## Physiotherapy Assistant Regulatory Organizations Contact Information

**click here**

**Annex R to CF H Svcs Gp Instruction 3120-06**

## Social Worker Regulatory Organization Contacts Information

**click here**

**Annex S to CF H Svcs Gp Instruction 3120-06**

## Unit Credentialing List

**click here**

Date Modified: 2013-09-12

National Defence / Défense nationale

# WARNING

In accordance with National Defence Security Policy, form **DND 2523 - Credentialing Information** is designated **"Protected B"** information once completed.

Completed "Protected B" forms MUST NOT BE SAVED **UNENCRYTED** on any network and workstation drive or storage media. "Protected B" forms, when completed, MUST BE ENCRYPTED USING THE DND ISSUED PKI SMARTCARD. Failure to respect this requirement will result in a breach of security and sanctions shall be applied in accordance with the policy.

# AVIS

En vertu de la politique de sécurité du Ministère de la Défense nationale, le formulaire **DND 2523 - Renseignements sur les titres et certificats** porte la désignation **« Protégé B »** lorsque complété.

Les formulaires remplis « Protégé B » NE DOIVENT PAS ÊTRE SAUVEGARDÉS **SANS LA PROTECTION DU CHIFFRAGE NUMÉRIQUE** ni sur les lecteurs de réseau ou locaux ni sur les supports de mémoire. Les formulaires « Protégé B », une fois remplis, PEUVENT ÊTRE SAUVEGARDER SEULEMENT PAR LE CHIFFRAGE NUMÉRIQUE AVEC LA CARTE À PUCE DE L'ICP DU MDN. Le non-respect de cette exigence sera considéré une infraction à la sécurité et entraînera des sanctions en vertu de la politique.

National Defence / Défense nationale

# Credentialing Information
# Renseignements sur les titres et certificats

Date of coverage (yyyy-mm-dd):
Date de couverture (aaaa-mm-jj) : _____

## Section 1

| SN (CF member) - NM (Membre des FC)<br>PRI (Public service) - CIDP (Fonction publique) | Surname - Nom de famille | Given name - Prénom |
|---|---|---|
| Languages spoken - Langues parlées | Languages written - Langues écrites | |

| Street address - Numéro de la rue | City - Ville | Province | Postal code - Code postal |
|---|---|---|---|
| Telephone - Téléphone | E-mail - Courriel | Fax - Télécopieur | |

| Unit - Unité | Location - Lieu | |
|---|---|---|
| Telephone - Téléphone<br>Office - Bureau _____<br>Direct line (if applicable)<br>Ligne directe (s'il y a lieu) _____ | Fax - Télécopieur | Cell - Cellulaire |
| | Pager - Téléavertisseur | Work e-mail - Courriel au travail |

Member / Membre

- ☐ Regular Force - Force régulière
- ☐ Reserve Force - Force de la réserve
- ☐ DND 2058 contracts - Contrats DND 2058
- ☐ Public service - Fonction publique
- ☐ Other - Autre _____

Note: If space provided is not sufficient, attach additional pages with information requested.
Nota : Si l'espace fourni est insuffisant, veuillez ajouter des pages supplémentaires.

## Section 2 - Licence/Certification information
## Informations sur les titres et les certificats

| **1.** Profession | Regulatory organization - Organisme réglementation | Province |
|---|---|---|
| Classification of licence - Catégorie du titre | Registration number - Numéro d'enregistrement | Date of expiration (yyyy-mm-dd)<br>Date d'expiration (aaaa-mm-jj) |
| Terms/conditions/restrictions - Termes/conditions/restrictions | | |

| **2.** Profession | Regulatory organization - Organisme réglementation | Province |
|---|---|---|
| Classification of licence - Catégorie du titre | Registration number - Numéro d'enregistrement | Date of expiration (yyyy-mm-dd)<br>Date d'expiration (aaaa-mm-jj) |
| Terms/conditions/restrictions - Termes/conditions/restrictions | | |

**Enclose photocopy of licence(s)/certificate(s)/receipt(s)**
**Joindre une photocopie des licences/certificats/reçus**

## Section 3 - Liability insurance (if applicable)
## Assurance de responsabilité civile (s'il y a lieu)

| Malpractice insurance coverage<br>Assurance couvrant les fautes professionnelles | ☐ **Yes - Oui**<br>☐ **No - Non**<br>☐ **Crown - Couronne** |
|---|---|

| Name of insurer - Nom de l'assureur | | |
|---|---|---|
| Code - Classification | Registration number - Numéro d'enregistrement | Date of expiration (yyyy-mm-dd)<br>Date d'expiration (aaaa-mm-jj) |
| Terms/conditions/restrictions - Termes/conditions/restrictions | | |

**Enclose copy of current malpractice insurance membership**
**(For CMPA photocopy showing code)**
**Joindre une copie de l'adhésion à l'assurance de responsabilité civile**
**(Pour l'ACPM, veuillez vous assurer que le code est visible)**

## Section 4 - This section for physicians only
## Cette section s'applique aux médecins seulement

Date of expiration (yyyy-mm-dd)
Date d'expiration (aaaa-mm-jj)

Royal College of Physicians and Surgeons
Collège Royal des médecins et chirurgiens

Specialty:
Spécialité : _____ ID _____ _____

Date of expiration (yyyy-mm-dd)
Date d'expiration (aaaa-mm-jj)

Specialty:
Spécialité : _____ ID _____ _____

Date (yyyy-mm-dd - aaaa-mm-jj)

College of Family Physicians of Canada
Collège des médecins de famille du Canada _____ _____

Other
Autre _____

## Section 5 - Questions for physicians only
## Cette section s'applique aux médecins seulement

| | No - Non | Yes - Oui |
|---|---|---|
| 1. Have your privileges at any facility ever been limited, suspended, or revoked?<br>Est-ce que vos privilèges, dans toute installation, ont jamais été limités, suspendus ou annulés? | ☐ | ☐ |
| 2. Have you ever voluntarily or involuntarily resigned or limited your privileges in any facility during the course of any investigation into your conduct?<br>Avez-vous volontairement ou involontairement jamais renoncé à vos privilèges ou les avez-vous limités durant une enquête sur votre comportement? | ☐ | ☐ |

## Section 6 - Questions for all health care providers
## Cette section s'applique à tous les professionnels de la santé

| | No - Non | Yes - Oui |
|---|---|---|
| 1. Has your licence/certification to practice ever been suspended, restricted, or terminated?<br>Vos permis et/ou certificats de practique ont-ils déjà été suspendus, restreints ou révoqués? | ☐ | ☐ |
| 2. Are you presently the subject of an inquiry or an investigation that has been filed against you or is pending investigation?<br>Faites-vous présentement l'objet d'une enquête ou êtes-vous en attente d'une enquête? | ☐ | ☐ |
| 3. Have any adverse findings been made against you in any of the following proceedings for which you did not receive a pardon in relation to your professional practice ...<br>Est-ce qu'une reconnaissance d'événements indésirables à été constaté envers vous, dans votre pratique professionnelle, pour laquelle vous n'auriez pas reçu de pardon ... | | |
| a. Professional discipline proceedings?<br>Procédures de discipline professionnelles? | ☐ | ☐ |
| b. Peer review proceedings?<br>Procédure de révision par les pairs? | ☐ | ☐ |
| c. Legal proceedings that were not settled out of court on the basis of no admission or acceptance of liability on your part?<br>Les procédures légales qui n'ont pas réglées à l'amiable sur la base de la non reconnaissance ou de l'acceptation de responsabilité de votre part? | ☐ | ☐ |
| 4. Have you any criminal convictions for which a pardon has not been granted and have you any criminal proceedings or convictions that may impact on your ability to practice?<br>Avez-vous un casier judiciaire pour lequel le pardon n'a pas été accordé et/ou des procédures criminelles pouvant affecter votre pratique? | ☐ | ☐ |

| **If you answered Yes to one or more of the preceeding questions, please provide dates and particulars below.**<br>**Si vous avez répondu Oui à une ou plusieurs ces questions, veuillez fournir des détails ci-dessous.** |
|---|
| |
| |
| |
| |
| |
| |

**The *Privacy Act* Notice - Énoncé concernant la *Loi sur la protection des renseignements personnels***

I understand that the personal information requested on this form is collected under the authority of the *National Defence Act* and the Queen's Regulations and Orders for the Canadian Forces. I understand the information is required to conduct pre-employment credentialing, and periodic credentialing on each licensed/certified health care practitioner. I understand this information is used to support decisions on individuals working or applying to work through appointment, assignment or contract, transfers or promotions. I understand that the collection of this information is mandatory and a refusal to provide the information will lead to a review of whether I am eligible to hold the position or perform the contract that is associated with this assessment. I have the right to request access to my conditions set out in the *Privacy Act*, and I am aware that the information may be used or disclosed within the conditions set out in the *Privacy Act*, and as outlined in the Medical Professional Standards Register (DND PPE 898) which is described in Infosource www.infosource.gc.ca.

Je comprends que les informations recueillies dans ce formulaire sont protégées par la *Loi sur la Défense nationale* et les Ordonnances et règlements royaux applicables aux Forces canadiennes. Je comprends que les informations sont requises à des fins de vérification de pré-embauche ou périodique du statut des licences et des permis de pratique de tous les professionnels de la santé. Je comprends que les informations seront utilisées afin d'appuyer des décisions concernant les employés et/ou les candidats aux emplois d'appoint, d'affectation, sous contrat pour des transferts et/ou promotions. Je comprends que la collecte de ces informations est obligatoire et qu'un refus de divulguer ces informations entraînera un réexamen de la possibilité d'occuper le poste ou d'accomplir le contrat associé avec cette évaluation. J'ai le droit de demander l'accès à mes informations personnelles conformément à *la Loi sur la protection des renseignements personnels* et je suis conscient que les informations peuvent être utilisées ou divulguées tout en respectant les conditions de *la Loi sur la protection des renseignements personnels* et tel que défini dans les Normes professionnelles médicales (MDN PPE 898) tel que décrit dans Infosource www.infosource.gc.ca.

Applicant's signature
Signature du postulant (de la postulante)

Date (yyyy-mm-dd - aaaa-mm-jj)

Base/Wing Surgeon's comments - Commentaires du médecin-chef de la base ou de l'escadre

Base/Wing Surgeon's signature
Signature du médecin-chef de la base ou de l'escadre

Date (yyyy-mm-dd - aaaa-mm-jj)

CO's comments - Commentaires du commandant

CO's signature
Signature du commandant

Date (yyyy-mm-dd - aaaa-mm-jj)

**APPENDIX 15 TO ANNEX A1**

**DIRECTIVE SURGEON GENERAL 02/12 - CREDENTIALING OF HEALTH CARE PERSONNEL FOR CADET CAMPS;**

**DND 2558 CREDENTIALING INFORMATION OF HEALTH CARE PROFESSIONALS FOR CADET CAMPS FORM**

# AIG - DSG 02/12

UNCLAS 6600-8 (NAT CRED MGR)

01 04 271216Z JUN 12 RR UUUU **DSG 02/12**

- CF H SVCS GP HQ//D SURG GEN//
- AIG 13475/BASE AND WING SURG
- ZEN/CF H SVCS GP HQ OT//D MED POL/DFHP//
- ZEN/CF H SVCS GP HQ OT//1 HSG COMD/AREA SURG//
- ZEN/CF H SVCS GP HQ OT//4 HSG COMD/AREA SURG//
- ZEN/CF H SVCS GP HQ OT//CFMSCWO/NPL//
- ZEN/CF H SVCS GP HQ OT//SSO SURG GEN//
- ZEN/NDHQ COMD RCAF OT//COMD RCAF SURG//
- ZEN/NDHQ COMD CDN ARMY OT//CDN ARMY SURG//
- ZEN/NDHQ COMD RCN OT//RCN SURG//

UNCLAS DSG 02/12

SUBJ: **CREDENTIALING OF HEALTH CARE PERSONNEL FOR CADET CAMPS**

REFS:

1. POLICY AND DIRECTION 3120-06 CREDENTIALING OF MEDICAL BRANCH CLINICAL PRACTITIONERS
2. DND 2558 CREDENTIALING INFORMATION OF HEALTH CARE PROFESSIONALS FOR CADET CAMPS

1. HISTORICALLY THE BASE/WING SURGEON HAS DELEGATED THE SIGN OFF FUNCTION OF THE CREDENTIALING PROCESS PERFORMED FOR HEALTH CARE PERSONNEL IN SUPPORT OF CADET CAMP SUMMER SEASON TO THEIR RESPECTIVE REGIONAL CADET MEDICAL LIAISON OFFICERS. THIS PRACTICE DOES NOT PROVIDE THE APPROPRIATE LEVEL OF PROFESSIONAL-TECHNICAL OVERSIGHT TO THIS IMPORTANT ACTIVITY AND DOES NOT MEET THE REQUIREMENTS OF REF A
2. EFFECTIVE IMMEDIATELY, CIVILIAN HEALTH CARE PERSONNEL WORKING AT CADET CAMPS WILL HAVE THEIR CREDENTIALING FORM (REF B) REVIEWED AND APPROVED BY THE BASE/WING SURGEON SUPPORTING THAT CADET CAMP OR THE MEDICAL OFFICER ACTING IN THAT CAPACITY WHERE THE BASE/WING SURGEON IS ABSENT. CREDENTIALING FORMS

NOT SIGNED OFF BY THE PROPER AUTHORITY WILL NO LONGER BE ACCEPTED

3. THE APPROVED FORM WILL BE FORWARDED BY THE BASE/WING SURGEON S OFFICE TO THE NATIONAL CREDENTIALING CELL AT CF H SVCS GP HQ. ANY ISSUES/FINDINGS REVEALED DURING THE REVIEW PROCESS MUST BE COMMUNICATED IMMEDIATELY TO SUZANNE GIROUX, NATIONAL CREDENTIALING MANAGER AT SUZANNE.GIROUX AT FORCES.GC.CA OR 613-945-6600-3819 OR CSN 422-3819
4. SIGNED BY COL J.J.R.S. BERNIER, D SURG GEN

National Defence Défense nationale

# WARNING

In accordance with National Defence Security Policy, form **DND 2558 - Credentialing Information of Health Care Professionals for Cadet Camps** is designated **"Protected B"** information once completed.

Completed "Protected B" forms MUST NOT BE SAVED **UNENCRYTED** on any network and workstation drive or storage media. "Protected B" forms, when completed, MUST BE ENCRYPTED USING THE DND ISSUED PKI SMARTCARD. Failure to respect this requirement will result in a breach of security and sanctions shall be applied in accordance with the policy.

# AVIS

En vertu de la politique de sécurité du Ministère de la Défense nationale, le formulaire **DND 2558 - Information des titres et des certificats des professionnels de la santé pour les Cadets** porte la désignation **« Protégé B »** lorsque complété.

Les formulaires remplis « Protégé B » NE DOIVENT PAS ÊTRE SAUVEGARDÉS **SANS LA PROTECTION DU CHIFFRAGE NUMÉRIQUE** ni sur les lecteurs de réseau ou locaux ni sur les supports de mémoire. Les formulaires « Protégé B », une fois remplis, PEUVENT ÊTRE SAUVEGARDER SEULEMENT PAR LE CHIFFRAGE NUMÉRIQUE AVEC LA CARTE À PUCE DE L'ICP DU MDN. Le non-respect de cette exigence sera considéré une infraction à la sécurité et entraînera des sanctions en vertu de la politique.

National Defence / Défense nationale

**PROTECTED B** (When completed)
**PROTÉGÉ B** (Une fois rempli)

# Credentialing Information of Health Care Professionals for Cadet Camps
# Information des titres et des certificats des professionnels de la santé pour les Cadets

## Section 1

| Surname - Nom de famille | Given name - Prénom |
|---|---|
| | |

## Licence / Certification information - Information sur les titres et les certificats

| Profession | Regulatory organization - Organisation de réglementation | Province |
|---|---|---|
| Classification of licence - Catégorie du titre | Registration number - Numéro d'enregistrement | Expiration date<br>Date d'expiration |
| Terms/conditions/restrictions - Termes/conditions/restrictions | | |

| **CPR - RCP**<br>Level - Niveau | Expiration date<br>Date d'expiration | **First Aid - Premiers soins**<br>Expiration date - Date d'expiration |
|---|---|---|

## Questions

| | **No - Non** | **Yes - Oui** |
|---|---|---|
| 1. Has your licence/certification to practice ever been suspended, restricted, or terminated?<br>Vos permis et/ou certificats de pratique ont-ils déjà été suspendus, restreints ou révoqués? | ☐ | ☐ |
| 2. Are you presently the subject of an inquiry or an investigation that has been filed against you or is pending investigation?<br>Faites-vous présentement l'objet d'une enquête ou êtes-vous en attente d'une enquête? | ☐ | ☐ |
| 3. Have any adverse findings been made against you in any of the following proceedings in relation to your professional practice...<br>Est-ce qu'une reconnaissance d'événements indésirables à été constatée envers vous, dans votre pratique professionnelle... | | |
| a. Professional discipline proceedings?<br>Procédures de discipline professionnelles? | ☐ | ☐ |
| b. Peer review proceedings?<br>Procédure de révision par les pairs? | ☐ | ☐ |
| c. Legal proceedings that were not settled out of court on the basis of no admission or acceptance of liability on your part and for which you did not receive a pardon?<br>Les procédures légales qui n'ont pas réglées à l'amiable sur la base de la non reconnaissance ou de l'acceptation de responsabilité de votre part et pour laquelle vous n'auriez pas reçu de pardon? | ☐ | ☐ |
| 4. Are you aware of any reason that you would fail Police Records Check (PRC) / Vulnerable Sector Screening (VSS)?<br>Êtes-vous au courant de toute raison qui vous ferait échouer dans la Vérification de casier judicaire (VCJ) / Vérification judiciaire du secteur vulnérable (VJSV)? | ☐ | ☐ |

**If you answered Yes to one or more of the above questions, please provide dates and particulars on a separate sheet and attach.**
**Si vous avez répondu oui à une ou plusieurs des questions, veuillez fournir des détails sur une feuille séparée et la joindre.**

## Liability insurance (Physicians only) - Assurance de responsabilité civile (médecin seulement)

| Name of insurer - Nom de l'assureur | Registration number - Numéro d'enregistrement |
|---|---|
| Code - Classification | Expiration date - Date d'expiration |

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I understand that the personal information requested on this form is collected under the authority of the *National Defence Act* and *Queen's Regulations and Orders* for the Canadian Forces. I understand the information is required to conduct pre-employment credentialing, and periodic credentialing on each licensed/certified health care practitioner. I understand this information is used to support decisions on individuals working or applying to work through appointment, assignment or contract, transfers or promotions. I understand that the collection of this information is mandatory and a refusal to provide the information will lead to a review of whether I am eligible to hold the position or perform the contract that is associated with this assessment. I have the right to request access to my conditions set out in the *Privacy Act*, and I am aware that the information may be used or disclosed within the conditions set out in the *Privacy Act*, and as outlined in the Medical Professional Standards Register (DND PPE 898) which is described in Infosource www.infosource.gc.ca.

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Applicant's signature
Signature du postulant (de la postulante)

Date

**Section 2**

**Verification of Credentials - Vérification des permis et certificats**

☐ **Done - Fait** ☐ **To follow - À suivre**

| | | |
|---|---|---|
| 1. Valid licence?<br>Permis de pratique valide? | ☐ Yes - Oui | ☐ No - Non |
| 2. Restrictions / limitations against licence?<br>Restrictions / limitation mise sur le permis? | ☐ Yes - Oui | ☐ No - Non |
| 3. Sanctions / past findings against licence?<br>Renseignements disciplinaires? | ☐ Yes - Oui | ☐ No - Non |
| 4. Good standing with the College?<br>En règle avec le collège? | ☐ Yes - Oui | ☐ No - Non |
| 5. Valid PRC / VSS?<br>Rapport valide de VCJ / VJSV? | ☐ Yes - Oui | ☐ No - Non |
| **If applicable - Si approprié** | | |
| 6. Current CPR certificate?<br>Certificat de RCR valide? | ☐ Yes - Oui | ☐ No - Non |
| 7. Current First Aid Certificate?<br>Certificat de premiers soins valide? | ☐ Yes - Oui | ☐ No - Non |

Signature
RCMLO - OLMRC

Date

Comments - Commentaires

Base / Wing Surg
Signature du Médecin-chef de la base ou de l'escadre

Date

DND 2558 (03-2012)

# APPENDIX 16 TO ANNEX A1

# HCP ORIENTATION PACKAGE

Table of Content

## Section 1 – Introduction

### Purpose of the DND Environment Briefing Package

1. The purpose of this briefing package is to advise the future Health Care Providers (HCPs) on the Department of National Defence (DND) and Canadian Armed Forces (CAF) unique work environment and to assist future HCPs in gaining a better understanding of the Canadian Forces Health Services (CFHS).

## Section 2 – DND and CAF Work environment

2. The Department of National Defence and the Canadian Armed Forces are two distinct entities working together to fulfill the Canadian government's mission to defend Canadian interests and values, and to contribute to international peace and security. They make up two important parts of the overall national security structure of the country. The CAF's mandate is to protect and serve; DND's mandate is to support (as a partner) the activities of CAF.

### Department of National Defence (DND)

3. The DND is part of the Public Service of Canada. DND, under the leadership of the Deputy Minister, carries out the work assigned to the Minister of National Defence. The DND and the Canadian Armed Forces have complementary roles to play in providing advice and support to the Minister of National Defence and in implementing the decisions of the Government on the defence of Canada and of Canadian interests at home and abroad. Although DND employees are civilian, the kind of work DND does means that its culture – its way of doing things – requires DND employees to work effectively with military personnel as an integral part of the Defence Team.

### Canadian Armed Forces (CAF)

4. The CAF are a modern and effective military capable of playing a number of important roles at home and abroad. CAF personnel belong to air, land, sea and special operations components.

5. The mandate of Canadian Armed Forces is:

   a. Protecting Canada and defending our sovereignty.

   b. Defending North America in cooperation with the United States, Canada's closest ally.

   c. Contributing to international peace and security through operations around the world, most often in partnership with allies from other countries.

6. The main functions of the Canadian Armed Forces include:

   a. supplying the forces to carry out military operations;

b. supplying forces for peacekeeping missions throughout the world;

c. responding to natural disasters; and

d. providing civil assistance.

**Section 3 – Relationship**

**Employer/Employee Relationship**

7. The Contractor is the HCP employer and all HCP employment relationship issues must be referred back to the contractor for resolution. Of importance to note is that the Contractor has been contracted by the Crown as the employer who provides the contracted services to CAF/DND Health Care (Medical and Dental) clinics. There is a contractual requirement for the Contractor to maintain responsibilities and liabilities over the HCP therefore the DND Authorities must keep an arm's length relation with the HCP. All HCP's issues, challenges and problems must be reported to the Contractor's representative.

**HCP Identification**

8. HCPs must be identifiable as a Contractor resource. Therefore the HCPs must wear the Contractor's logo or tag at all times while performing the work. HCPs must also include the designation of "Contractor" within their signature block when sending email or writing letters.

**HCP Professional Performance**

9. The HCPs must maintain a level of professional performance in accordance with their respective regulatory or certifying organizations and CF Health Services standards in the areas of clinical competence and professional conduct. Identification, investigation and management of HCP professional conduct and competency issues are a shared responsibility between the Contractor and the DND.

10. The Contractor will be responsible for the remediation of HCP professional performance issues and the determination and execution of any disciplinary measures.

11. The provided HCP must be able to read, communicate orally and in writing in the specified language(s). If language skills do not meet the requirement; DND reserves the right to cancel the DND 626 Task Authorization.

12. A 90 day probation period will apply to all newly contracted HCP. The probation period will begin on the first working day at the CAF clinic. If the Task Manager (TM) is not satisfied with the services of the contracted HCP, the Contractor will have 14 calendar days to remedy the situation. If the situation cannot be resolved to the satisfaction of the TM, the contracted HCP will be removed and replaced at no cost to DND. Payment for HCPs who have performance issues shall cease upon termination of their Work under the contract.

**HCP Professional Misconduct**

13. The DND will be responsible for identifying potential professional performance issues, determining whether the HCP's professional performance meets the applicable standard, imposing conditions or restrictions on the HCP's patient care privileges as necessary, and identifying any requirements for remediation of the HCP's clinical performance or professional conduct.

14. A CF Health Services investigation will be initiated in cases where the HCPs clinical competence or professional conduct is called into question, either through receipt of a complaint or in the course of routine clinical quality assurance activities.

15. The Contractor and HCP are expected to cooperate with the identified CF Health Services investigator by participating in discussions and/or interviews, unless otherwise protected from the requirement to do so by any applicable laws or statutes. Lack of HCP participation in a CF Health Services investigation may negatively affect the results of the investigation and subsequent decisions regarding ongoing patient care privileges and lead to the requirement to replace the HCP.

16. Should the CF Health Services investigator receive evidence that they reasonably believes relates to an allegation of a criminal act, the investigator shall suspend the investigation, the Departmental Technical Authority (DTA) shall be notified, and the matter shall be referred to the nearest Judge Advocate General representative for advice.

17. In matters of HCP professional misconduct or incompetency, the Contractor and/or the DND will make reports to the HCP's licensing body IAW with the statutory requirements of the applicable province or territory. The DND reserves the right to determine if the DND 626 – Task Authorization should be cancelled. If a HCP has his/her license revoked, the DND 626 – Task Authorization will be cancelled immediately.

**Temporary Change to HCP Work Location**

<u>Temporary Change within the Local DND Location</u>

18. HCPs may be required to work at a Temporary Work Location from the Regular Work Location for various reasons such as, HCP shortages, vacancies, absences, temporary clinics, etc. Temporarily is defined as one (1) work day and up to 30 calendar days. For the purpose of the Contract, a local DND Location spans an area of 50 kilometers from the Regular Work Location using the most direct, safe and practical road.

19. When Temporary Change to a HCP Work Locations are required, the TM will provide the HCP with written notification three (3) calendar days in advance of a temporary change to the Regular HCP Work Location. The notice will contain the following information:

a. location name and address of the temporary work location;

b. duration of change of work location and the number of days. (from day/month/year to day/month/year, and total number of days);

c. required schedule if part time (Monday, Wednesday and Friday, or Tuesday and Wednesday, etc.);

d. required hours of work (7:00 am to 3:00 pm or 8:00 am to 4:00 pm, etc.); and

e. Point of Contact (POC) at the temporary work location (name, email address and telephone number).

20. The HCP must provide, to the Contractor, the TM's written Temporary HCP Work Location Change notice. Local travel expenses to and from the temporary work location are not billable as this is considered the work place.

Temporary Change outside Local DND Work Location

21. HCPs may be required to temporarily work outside the Local DND Work Location or province of work. The change in work location will be considered travel. Temporary for this requirement is defined as less than thirty (30) calendar days. All Temporary HCP Work Location outside the Local DND Location or province of work requires the approval of the DTA before the change can occur.

22. When Temporary Changes to HCP Work Locations are required, the TM will provide the HCP with the DTA's written approval seven (7) calendar days in advance.

23. The HCP must provide the Contractor with the DTA's written approval for the Temporary HCP Work Location outside the Local DND Location or province of work. The written approval must contain the following information:

a. location name and address of the temporary work location;

b. Task Authorization number;

c. name of HCP;

d. reason for the work;

e. date(s) and duration of the work;

f. overtime involved - Yes/No; and

g. Point of Contact (POC) at the temporary work location (name, email address and telephone number).

24. Temporary Changes to HCP(s) Work Location(s) outside the Local DND Location or province of work will be considered travel. The HCP Travel Request and Authorization process is detailed under HCP Travel Section below.

25. When the Temporary Change to a HCP work location is outside of the HCPs current province of work, the Contractor must ensure the HCP obtains the required additional licenses and registration. The HCP must submit the original receipts of the additional licenses and registration expenses to the Contractor for reimbursement.

**Patient Site Visit**

26. HCP may be requested to conduct a Patient Site Visit. A HCP Patient Site is defined as outside of the CF H Svcs C and can be at a CAF member's home, barracks, convalescent home, a local clinic, or hospital, etc. Exceptional circumstances are determined on a case-by-case basis.

27. Before a HCP Patient Site Visit occurs, and in accordance with the Base Surgeon (B Surg) or Commanding Officer's (CO) direction, the TM will obtain the written approval from the DTA. After the approval is obtained, the TM will provide the HCP with the DTA's written approval for the Patient Site Visit.

28. The HCP must provide the Contractor with the DTA's written approval for the HCP Patient Site Visit before the Patient Site Visit can occur. The written approval must contain the following information:

a. Clinic name and location;

b. Task Authorization number;

c. name of the HCP who will conduct the Patient Site Visit(s);

d. reason for the Patient Site visit(s);

e. date(s) and time(s) of scheduled Patient Site Visit(s);

f. travel involved - Yes/No; within or outside of the Local DND Location;

g. copies of the written authorizations from the B Surg or CO, if the Patient Site Visit is to be scheduled outside of clinic hours; and

h. overtime involved - Yes/No.

29. If a HCP Patient Site Visit is conducted outside of the CF H Svcs C's hours, or the regular work hours of the HCP, the HCP Overtime Request and Authorization process must be followed as detailed under the HCP Overtime Section below.

30. When a HCP Patient Site Visit involves travel outside the Local DND Location, the HCP Travel Request and Authorization process must be followed as detailed under the HCP Travel Section below.

31. The HCP must submit to the Contractor the complete approval package, travel itinerary, claimable expenses and receipts for reimbursement.

**HCP Travel**

32. HCPs may be required to travel. All travel must be pre-authorized by the DTA. The Task Manager will provide the HCP Travel Request and Authorization Form to the DTA for approval. If travel is approved, the TM will be notified and the HCP Travel Request Form will be provided to the DPA. The DPA will provide the Contractor with a separate DND 626 – Task Authorization for the travel for its acceptance along with the approved Travel Request Form.

33. The HCP must make all travel arrangements with the Contractor and travel must be obtained and conducted in the most economical means available and IAW the Treasury Board Travel Directive (National Joint Council).
http://www.njc-cnm.gc.ca/directive/index.php?did=10&lang=eng

34. Travel arrangements may not be booked until this form has been approved and permission is received from your Contractor's Authority.

35. The HCP must submit the approved Travel Request and Authorization Form with receipts to the Contractor whom in turn must submit the HCP Travel Expenses with the original receipts with their invoice for reimbursement.

**Temporary Closure to work location**

36. Temporary Closures to Work Location may occur over the period of the Contract.

Expected Temporary Closure to work location

37. Expected Temporary Closures to a work location are due to events such as, repairs, scheduled maintenance, renovations, installation of new equipment(s), etc. When a Temporary Closure to a Work Location is expected, the TM will advise the DTA. The DTA will advise the Contractor in writing, a minimum of seven (7) calendar days in advance, of any expected Temporary Closures, including the date(s) and duration of the closure, and the names of the HCPs affected by the temporary closure.

Unexpected Temporary Closure to work location

38. Unexpected Temporary Closures to a work location are defined as outside the control of the DND, such as flood, fire, equipment failure or shut down, power outages or extreme weather conditions, etc. When an unexpected Temporary Closures to a work location occur, the Task Manager will advise the HCPs verbally and follow with the notice to the DTA and the DPA. The DTA or DPA will advise the Contractor by email on the day of the closure.

**HCP Conduct of Work Issues**

39. The HCP is a representative of the Contractor. Issues with the conduct of work may be identified at a number of junctures, and as such the process to resolve issues related to the HCP is situation dependent. In the event that issues are identified while the HCP is on-site at a work location, it will be expected that the TM, or designated Senior Local Authority will be able to

address the issues directly with the HCP with notification to the DTA and DPA following the event.

40. Issues must be dealt with at the lowest possible level and escalated only when resolution cannot be attained. The TM and the Contractor Representative must first attemp to resolve the issue. If the issue cannot be resolve by the TM, the matter will be referred to the DTA and the Contracting Authority (CA) for resolution throught the proper Contract Dispute resolution.

**Harassment Prevention and Resolution**

41. Harassment is any improper conduct by an individual that is directed at and offensive to another person or persons in the workplace, and that the individual knew or ought reasonably to have known would cause offence or harm. It comprises any objectionable act, comment or display that demeans, belittles or causes personal humiliation or embarrassment, and any act of intimidation or threat. It includes harassment within the meaning of the Canadian Human Rights Act (CHRA).

42. All DND employees, CAF members and Contractor's Employees have a responsibility to contribute to a harassment-free workplace. It is the policy of the Canadian Forces to provide a work environment that is supportive of the productivity as well as the personal goals, dignity and self-esteem of all personnel. As any incidence of harassment is inconsistent with this policy, harassment of any kind will not be tolerated or condoned.

43. Harassment will not be tolerated in the Canadian Forces Health Services. Moreover, it is the responsibility of all supervisors to provide a work environment free from harassment IAW (DAOD 5012-0). http://intranet.mil.ca/en/defence-admin-orders-directives/5000/5012-0.page

44. Where harassment involves misuse of the power or authority inherent in an individual's position, it constitutes an abuse of authority. Conduct involving the proper exercise of responsibilities or authority related to the provision of advice, the assignment of work, counseling, performance evaluation, discipline, and other supervisory/leadership functions *does not constitute harassment*. Similarly, the proper exercise of responsibilities or authority related to situations where, by virtue of law, military rank, civilian classification, or appointment, an individual has authority or power over another individual does not constitute harassment.

45. Within the DND environment, HCPs have the following roles to play in support of the overall objective of a harassment-free environment IAW DAOD 5012-0:

a. Refraining from conduct that could constitute harassment;

b. Correcting or reporting to the Contractor Representative or the TM, as appropriate to their position, any possible harassment that they witness;

c. Taking action, by contacting the Contractor Representative or the TM, when they believe they are being subjected to harassment; and

d. Encouraging and supporting others to take action in similar circumstance.

46. All the complaints of harassment in the workplace shall be investigated by the Responsive Officer IAW DAOD 5012-0.

## Section 4 – Canadian Forces Health Services

### General information

47. Since CAF Personnel must be deployable on short notice, the CAF Members are required to maintain a level of medical, dental and physical fitness consistent with their role on deployed operations. In support of this requirement, regular medical and dental examinations and other occupational health and safety assessments are mandated by policy and are an integral part of the delivery of health services in the CAF.

48. Health care provided to CAF members covers a broad range of health services, including health promotion, disease prevention, health maintenance, counselling, patient education, vaccination, diagnosis and treatment of acute and chronic illnesses, as well as facilitating referrals to tertiary care, which denotes the medical treatment provided at a specialist institution.

49. CAF members' access health care services at Canadian Forces Health Services Centres (CF H Svcs Cs) and Canadian Forces Dental Detachments (CF Dent Dets) located within or near major military installations, referred to as CAF Bases. Within each CF H Svcs C and CF Dent Det, the range of health care services varies based upon the department's planned military and civilian resources available.

50. Generally, specialized health care, such as secondary, tertiary, quaternary, and long-term home care, as well as after-hours primary health care, are provided from civilian health care facilities. However, some specialized secondary health care services are provided at some locations through the CF H Svcs C and CF Dent Det. When specialized health care is not provided at CF H Svcs C and CF Dent Det and is required for a CAF member, the attending physician may recommend an outside referral that is subject to approval by the Senior Medical Authority (SMA) before the appointment is scheduled. A SMA is an individual holding professional-technical authority over all aspects of health services.

51. Health care benefits and services available to CAF members are defined and described in the Canadian Forces Spectrum of Care (CF SoC). Inclusions and exclusions apply everywhere in Canada, regardless of what health care services are covered by provincial health plans. The focus is not on equity with the provinces, but rather on operational benefit of having the right CAF member available for operations with the right level of health fitness.

### The CF H Svcs Cs and CF Dent Dets Command and Control

52. The CF H Svcs Cs and CF Dent Dets are commanded by a Commanding Officer and a Dental Detachment Commander respectively. They are responsible for the overall delivery of in-garrison health care services within their designated geographical area, including any satellite clinics. At the CF H Svcs C's, the Base Surgeon is the clinical team lead and the Senior Medical Authority.

53. The Commanding Officers and Dental Detachment Commanders are also responsible for the efficient and effective day-to-day operation of their organization. They are identifying their medical and dental occupational group(s) shortages within their area of responsibility, and initiate the process to obtain additional HCP for approval at the CF Health Service Group Headquarters. Subsequently, if approved, the requirement for a HCP may be staffed through the Health Care Provider Contract (HCPC) to the Contractor via the DND Procurement Authority (DPA).

**Collaborative Practice**

54. The HCPs must operate within a collaborative and interdisciplinary environment that supports continuity of care to the patient. The HCPs must agree and willingly commit to working in a military health system that adheres to a philosophy and doctrine of collaborative practice and interdisciplinary care. The CAF strategy for treating and managing health concerns and/or disorders is in accordance with best practices and requires total commitment to an interdisciplinary team of military, public servants, and contracted HCPs such as family physicians, nurse practitioners, registered nurses, physicians assistants, technicians, technologists, pharmacists, dentists, and other specialist groups such as mental health care providers, medical internists and surgeons etc.

55. The HCPs must participate in activities aimed at promoting collaborative practice amongst care providers and within functional programs such as intra-disciplinary meetings, case conferences, case reviews, and communication of best practices within their respective professional network, e.g. physicians, physiotherapists, dentists etc, through communication means such as email, teleconferences, SharePoint, etc.

**HCP Physician Assistant and Contractor's Clinical Supervision**

56. Physician Assistants HCP (PA HCP) are physician extenders and not independent practitioners. Physician Assistants complement the provision of services within the Canadian Armed Forces (CAF) Health Services Centre and CAF Cadet Camp and are part of the healthcare team. The PA HCP works under the direction of a Contract Physician, as designated by the Contractor, who is providing clinical supervision. When PA HCPs are required by the DND, the Contractor must assign a Physician HCP to perform clinical supervision of the Physician Assistant. A Supervisory Agreement between the PA HCP and the Physician HCP will be signed to formalize the clinical supervision.

57. The Contractor must provide a copy of the signed Supervisory Agreement (See Annex E – HCP PA Supervisory Agreement) between the HCP Physician and the HCP PA to enable the Physician Assistant to practice within the delegated acts related to his Occupational Groups and Categories. Any amendment to the Supervisory Agreement must also be submitted to the DTA via the HCP's Contractor. PA Scope of practice is available at the Canadian Association of Physician Assistants (CAPA) website.
https://capa-acam.ca/wp-content/uploads/2012/12/NCP_en_sept20092.pdf

58. If the Contractor cannot assign a HCP Physician to perform the clinical supervision of a PA, DND may assign an alternate Physician on an exception basis IAW DND policies and

processes.

**Referrals to External Provider (Specialist)**

59. The HCPs may be required to make recommended Referrals to External Providers when the member's required health care is outside of the CF H Svcs C and CF Dent Det's domain.

60. When a HCP makes a recommendation for health care to an external provider, on behalf of a member, their recommended referral must be on the current Federal Health Claims Processing Service (FHCPS) approved Provider List. The FHCPS External Providers List will be provided by the TM to the HCPs who are tasked with recommending referral to External Providers.

61. All recommended referrals to External Providers made by the HCP must be at arm's length and have no perception of a personal nature or benefit. HCPs are to refrain from making recommended referrals to themselves, any relative, entity, organization, business, practice or partner with whom they are associated or affiliated. The Base Surgeon may, on a case-by-case basis, approve a referral, in a remote or an under serviced area that have limited Providers, when the HCP recommends the external referral to themselves.

62. All HCP recommended referrals to External Providers, who are, themselves external providers, must be approved by the Clinic's Senior Medical Authority (SMA) before the appointment is scheduled.

**Patient Safety and Quality Improvement**

63. The HCPs are required to participate in continuous quality improvement IAW current CF H Svcs Group policies, which are currently under revision and will be part of the standard operating procedures (SOPs) provided. HCP participation in continuous quality improvement includes, as required:

a. responding to questionnaires, providing feedback, and participating in committees related to internal audits and external accreditation activities;

b. participation as a member of a working group responsible to identify best practices, reduce waste and errors, and increase effectiveness of health care and service delivery;

c. conducting clinical quality assurance activities such as peer review chart audits, mortality and morbidity rounds or reviews, utilization reviews, etc.;

d. identification of strengths and challenges associated with current processes or practices to share best practices or identify areas of improvement respectively;

e. incorporation and adoption of recommended changes resulting from quality improvement activities into clinical or administrative tasks based on revised policy or procedure, or local direction from the senior administrative and/or senior medical/dental authority; and

f. supporting the collection of metrics through the documentation of data, completion of electronic or paper forms, providing feedback, responding to questionnaires, etc.

**Patient Safety**

64. The HCPs are required to participate in patient safety activities IAW current CF H Svcs Group policies, which are currently under revision and will be part of the standard operating procedures (SOPs) provided. HCP participation in patient safety activities includes, as required:

a. engage in patient safety activities while performing their work;

b. report all patient safety incidents, both actual and potential incidents, to the Patient Safety Representative within the CF H Svcs C or CF Dent Det and IAW the DND processes in place at the time.

c. assistance with the analysis of patient safety incidents to determine what, how, and why an incident occurred;

d. identification and implementation of recommendations to improve existing policies, procedures or processes and prevent the occurrence or recurrence of incidents; and

e. identification of potential risks and open communication with other members of the healthcare team to learn from incidents, continually improves, and supports a strong culture of patient safety.

65. When a HCP is required to participate in Patient Safety Activities the HCP will be given the time to do so and the time will be paid IAW the rate on the HCP's DND 626 – Task Authorization.

**Tele-Health Work requirement**

66. The HCPs working at DND locations may be required to provide Tele-Health work, which is also referred to as Telemedicine, and is defined as the delivery of health services via DND information technologies to CAF members at a distance from the Local DND Location. Tele-Health work may be used for real-time patient-provider consultations and for provider-to-provider discussions. Tele-Health may include the practice of health care delivery, access to care, diagnosis, consultation, treatment, transfer of medical data, and education using DND interactive audio, video, or data communications as a part of their work.

67. If the Tele-Health Work is provided to a CAF member who is outside of the HCPs current province of work, the Contractor must ensure the HCP obtains the required additional licenses and registration IAW the Province or Territory where the service will be received. The HCP must submit the original receipts of the additional licenses and registration expenses to the Contractor for reimbursement.

**Section 5 – Health Record and Information Management**

**Canadian Forces Health Information System (CFHIS)**

68. The Canadian Forces have an integrated electronic health record, referred to as Canadian Forces Health Information System (CFHIS). CFHIS a system which enables over 3500 CAF health care professionals and managers to securely share information and coordinate CAF member care. It is comprised of integrated applications supporting patient registration and scheduling, clinical notes, order entry, and results review, pharmacy, laboratory, diagnostic imaging, and dental treatment.

69. The HCPs must operate and maintain access to CFHIS in order to perform their work under the Contract. HCPs must promptly and accurately complete personal health information concurrent with a patient encounter in CFHIS.

**Safeguard Personal Information/Security Breaches**

70. All HCPs have ethical, professional and legal responsibilities to maintain the confidentiality and privacy of patient health information obtained while providing care. The HCP must conduct their business accordingly to safeguard patient's privacy and health information confidentiality in accordance with the CF H Svcs Gp policies and directives.

71. In the event of suspected breaches involving personal health information, HCPs must immediately notify the Task Manager. Immediately is defined as, "as soon as possible and on the same day".

72. All cases of a suspected breach of personal health information are investigated by the CF Health Services Group IAW CF H Svcs Gp policies and directives.

73. The Contractor and HCP must cooperate with the identified CF Health Services Group Chief Privacy Officer (CPO). If a HCP is requested to participate in discussion or interviews or to provide a written statement, the HCP will be given the time to do so and time will be paid IAW the rate on the HCP's DND 626 – Task Authorization.

74. The HCPs are aware that access to CFHIS is only permitted in respect of an individual with whom the HCP has a HCP-patient relationship for the purpose of providing health care services to that individual or where otherwise specifically authorized as consistent use of the information such as in the performance of peer review chart audit. The HCP is permitted limited access to demographic information of patients with whom the HCP does not have a HCP-patient relationship for the limited purpose of facilitating and verifying the identity of the patient. Any violation shall entitle CFHS to suspend or terminate the HCP's access to CFHIS. The DND reserves the right to determine if the DND 626 – Task Authorization should be cancelled.

**HCP Disclosure of Medical/Social Work Information to Commanding Officers**

75. Within the DND environment, HCPs provide health care to members and advise the chain of command. The HCP's responsibility to the chain of command is to sustain or restore service personnel or cadet members to operational or training effectiveness and deployability. In some circumstances, this will require them to report a service person's Medical Employment Limitations (MELs) or a Cadet member's Participation Limitations (PLs) to the chain of command.

76. The disclosure of information on members' Medical Employment Limitations (MELs) must follow by the DND CANFORGEN 039/08 CMP 018/08 131851Z FEB08 – Disclosure of Medical/Social Work Info to Commanding Officers.
http://vcds.mil.ca/vcds-exec/pubs/default-eng.asp?path=/vcds-exec/**p**ubs/canforgen/2008/039-08_e.asp

**HCP Providing Medical Advice in Support of Administrative or Disciplinary Proceedings**

77. Within the CF military structure, HCPs may be asked by the CAF member or by the member's Commanding Officer (CO) to intervene in career, administrative or disciplinary proceedings. When HCPs are responding to these types of requests, the HCP must act IAW the process outlined in the CF Health Service Group Instruction, 4030-60 - Providing Medical Advice in Support of Administration or Disciplinary Proceedings. http://cmp-cpm.mil.ca/en/health/policies-direction/policies/4030-06.page

**HCP Use of and Access to DND Information Systems**

78. HCPs shall be assigned access to the DND Information Systems that are required to perform their work as a permitted user. HCPs must acknowledge and agree to the specific security, privacy, confidentiality, and usage requirements for each system as outlined below upon initial commencement of performing work and as necessary thereafter.

79. The designation of an HCP as a permitted user may be terminated at any time by written notice given by DND where DND determines that the HCP is no longer eligible to maintain an

account due to failure to comply with Information System regulations or policies, as specified in the respective agreements and/or application forms, and/or lack of completion of required training. In such cases the DND reserves the right to determine if the DND 626 – Task Authorization should be cancelled.

# HCP ACKNOWLEDGEMENT FORM

| 1 - IDENTIFICATION | | | |
|---|---|---|---|
| TA Number – Numéro AT | Name - Nom | First Name - Prénom | Date |
| | | | |

I hereby acknowledge that I have received, read and understood the Orientation Package and the DND work environment and I agree and willingly commit to working to provide health care services in that environment in accordance with CF Health Services Group Instructions and other references.

Signature

Date

**APPENDIX 17 TO ANNEX A1**

**FEDERAL GOVERNMENT HOLIDAYS**

## APPENDIX 17 – FEDERAL GOVERNMENT HOLIDAYS

### DESIGNATED AND OTHER HOLIDAYS

| Serial | Holiday | Date | Comments |
|---|---|---|---|
| 1 | New Year's Day | 1 January | Notes 1,3 |
| 2 | Good Friday | TBD | Notes 3 |
| 3 | Easter Monday | TBD | Notes 3 |
| 4 | Victoria Day/Queen's Birthday | preceding 25 May | Notes 3 |
| 5 | Canada Day | 1 July | Notes 1,3 |
| 6 | Labour Day | First Monday in September | Notes 3 |
| 7 | Thanksgiving Day | Second Monday in October | Notes 3 |
| 8 | Remembrance Day | 11 November | Notes 1,3 |
| 9 | Christmas Day | 25 December | Notes 2,3 |
| 10 | Boxing Day | 26 December | Notes 2,3 |
| 11 | Any day appointed by proclamation by the Governor in Council to be observed as a fast, thanksgiving or holiday. These holidays will be granted on the authority of the Technical Authority | TBD | NA |
| 12 | One provincial or local civic holiday per leave year may be observed at the discretion of the Technical Authority | TBD | NA |

Notes:

1. When 1 January, 1 July or 11 November fall on a Saturday or Sunday, the following Monday will be taken as the designated holiday.
2. When Christmas Day falls on a Saturday or Sunday the following Monday and Tuesday will be taken as the designated Christmas/Boxing Day holidays. When Christmas falls on a Friday, the following Monday will be taken as the designated Boxing Day holiday.
3. Serials 1 to 10 are designated holidays.

Adapted from reference: http://www.forces.gc.ca/en/caf-community-benefits/leave-policy.page

## APPENDIX 18 TO ANNEX A1

## HCP TRAVEL REQUEST AND AUTHORIZATION FORM

# HCP TRAVEL REQUEST AND AUTHORIZATION FORM

## 1 – IDENTIFICATION

| DND/MDN 626 # | Name - Nom | First Name - Prénom | Date | |
|---|---|---|---|---|
| | | | Departure - Départ | Return - Retour |
| | | | | |

| Work Location – Lieu de travail | Destination | Travel requirement on DND 626 – Task Authorization - Exigence de voyage sur le MDN 626 - Autorisation de tâches |
|---|---|---|
| | | ☐ Yes - Oui ☐ No - Non |

## 2 – JUSTIFICATION

| Reason for Travel - Raison du voyage | Point of Contact at Destination - Point de contact à destination |
|---|---|
| | Overtime – Temps supplémentaire ☐ Yes - Oui ☐ No - Non |

## 3 – ESTIMATE D TRAVEL EXPENSE – ESTIMATION DES FRAIS DE VOYAGE

| Transportation - Transport | | Accommodation - Hébergement | |
|---|---|---|---|
| Expected Travel Time (hours) – Durée estimée du Voyage (heures) | | Length of Stay (Days) – Durée du séjour (jours) | |
| Air Fare – Billet d'avion ($) | | Commercial ($) | |
| Train Fare – Billet de train ($) | | Non-Commercial ($) | |
| Car Rental – Location de Voiture ($) | | Other Expenses – Autres dépenses | |
| Taxi/Bus ($) | | Meals - Repas ($) | |
| Personal Vehicle – Véhicule Personnel (Km) | | Registration - Inscription ($) | |

Other Costs - Autres frais

## 4 – REQUESTING AUTHORITY

**Requested by Task Manager - Demandé par le gestionnaire de tâches** ☐ Yes - Oui ☐ No - Non

| Name - Nom | Position |
|---|---|
| Signature | Date |

## 5 – APPROVAL - APPROBATION

| Authorized – Autorisé ☐ Yes - Oui ☐ No - Non | DND 626 Travel Number – Numéro DND 626 de Voyage |
|---|---|
| Technical authority signature – Signature de l'autorité technique | Date |

**APPENDIX 19 TO ANNEX A1**

**GOVERNMENT FURNISHED INFORMATION**

## APPENDIX 19 – GOVERNMENT FURNISHED INFORMATION

| No | SOW Reference | Description | Delivery Date | Delivered To | Delivered By |
|---|---|---|---|---|---|
| 1. | 1.4.3 et 4.20 | DA and TM Names | After Contract Award | Contractor | DTA |
| 2. | 2.1.2 | Amendments, revisions and bulletins to DND Applicable Documents | As required | Contractor | DTA |
| 3. | 3.14.2 | Temporary Change to HCP(s) Work Location(s) Outside Local DND Location(s) or Province of Work | DTA's written approval seven (7) calendar days in advance | Contractor | DTA |
| 4. | 4.16.3 | Location and address for the demonstration of the Timesheet Tool | After Contract Award | Contractor | DTA |
| 5. | 4.25 | Initial HCP Requirements Plan and Associated DND 626s | ACA at Initial Kick-off Meeting | Contractor | DPA/TA |
| 6. | 4.25.2 | New HCP Requirements via DND 626 | As and when required basis | Contractor | DPA |
| 7. | 4.26.1 | Additional 30 Calendar Days Time-To-Provide Notice | When approved | Contractor | DPA |
| 8. | 4.26.1 | Cancellation of a Task Authorization Notice for DND 626 - Task Authorizations | When required | Contractor | DPA |
| 9. | 4.31.2 | Name of the N95 Mask manufacturer(s) | Within 10 days ACA | Contractor | DTA |
| 10. | 4.34 | Annual HCP Requirements Plan | Within the first seven (7) calendar days of December each year | Contractor | DTA |
| 11. | 4.44.1 | HCP Patient Site Visit | When required | Contractor | DTA |
| 12. | 4.45.2 | Travel | When required | Contractor | DTA |
| 13. | 4.62.1 | Initial Contract Kick-Off Meeting date and address | Within 14 calendar days ACA | Contractor | DTA |
| 14. | 4.63.5 | PRM Agendas | 7 calendar days before meeting | Contractor | DTA |

| No | SOW Reference | Description | Delivery Date | Delivered To | Delivered By |
|---|---|---|---|---|---|
| 15. | 4.64.5 | Ad Hoc Invitation and Agenda | As required | Contractor | Party Requesting Meeting |
| 16. | 4.78.4 | FPR Meeting Agenda | Seven (7) calendar days before meeting | Contractor | DTA |

**APPENDIX 20 TO ANNEX A1**

**PA CLINICAL SUPERVISORY AGREEMENT**

# PA CLINICAL SUPERVISORY AGREEMENT

The present agreement is made this _____ day of _____ , by and between

| Name of Physician Assistant | Licence Number | Province |
|---|---|---|
| | | |

**and**

| Name of Physician | Licence Number | Province |
|---|---|---|
| | | |

who will act as supervising physician.

The physician assistant practice in the following locations:

| DND Location |
|---|
| |

WHERE AS, the physician assistant is duly qualified under applicable rules and regulations of the Physician provincial regulatory body, the Canadian Forces Health Services and certified by the Physician Assistant Certification Council of Canada (PACCC), it is hereby agreed that:

1. The physician who signs this agreement will clinically supervise the physician assistant in accordance with the rules and regulations of the Physician provincial regulatory body, the Canadian Forces Health Services policy and directives and the Health Care Provider Contract statement of work. The physician assistant agrees to faithfully and to the best of his/her knowledge and skill, assist the physician in the practice of medicine.

2. By this agreement it is contemplated that the physician will delegate duties to be performed by the physician assistant and a degree of autonomy within its delegated acts and National Competency Profile as specified by CAPA. The physician assistant will perform only those duties and responsibilities that are delegated by the physician. The physician will not delegate to the physician assistant any duty or responsibility for which the physician assistant has not been adequately trained. The physician assistant is the agent of the physician in the performance of all practice-related activities. The physician assistant will provide patient care only in those areas of medical practice where the physician provides patient care.

   During the term of this agreement, the physician assistant shall comply with all proper directions and orders of the physician and shall comply with all rules and regulations of Physician provincial regulatory body and the Canadian Forces Health Service Policy governing physician assistants.

The supervising physician responsibility is to oversee the activities of, and accept the responsibility for, the medical services rendered by the physician assistant. Supervision shall be continuous but shall not be construed as necessarily requiring the physical presence of the supervising physician at the time and place the services are rendered. It is the responsibility of the supervising physician to direct and review the work, records and practice of the physician assistant on a continuous basis to ensure that appropriate and safe treatment is rendered. The supervising physician must be available continuously for contact personally or by telephone or other electronic means as it relates to the Health Care Provider Contract with DND. It is the obligation of each team of physician and physician assistant to ensure that the physician assistant delegated acts are identified; that delegation of medical tasks is appropriate to the physician assistant's level of competence; that the relationship of, and access to, the supervising physician is defined; and that a process for evaluation of the physician assistant's performance is established

The physician agrees to designate a substitute supervising physician in the manner designated by the Canadian Forces Health Service policy and directives and the DND/CF to act under this agreement during any absence or temporary disability of that physician.

The physician assistant, as per the attached Scope of Practice will be permitted to do the following clinical activities within the confines of the DND Location above mentioned:

3. Attach a copy of the agreed delegated acts to this agreement.

The supervising physician and the physician assistant must meet upon initial assignment and no less then every three (3) months to ensure a mutual understanding of the agreed upon scope of practice. The meeting should review, as a minimum, the following criteria:

Clinical Case;
History review;
Physical evaluation review;
Differential diagnosis, treatment plan and disposal;
Recommendations for improvements;
Improvement Plan and Schedule;

This contract may be terminated by either party by giving thirty (30) days' notice of the fact in writing to the other. Copies of said notice must be provided both to the physician assistant, the Contractor's representative, the Base/Wing Surgeon, the DND Technical Authority.

| | |
|---|---|
| Primary Supervising Physician Signature | Physician Assistant Signature |
| Date | Date |

Substitute Supervising Physician Signature

Date

# ANNEX A2

# STATEMENT OF WORK (SOW)

# FOR THE

# ROYAL CANADIAN MOUNTED POLICE

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## 1.0 INTRODUCTION

### 1.1 Purpose

The Royal Canadian Mounted Police (RCMP) has a requirement for a Contractor to provide and manage Health Care Providers (HCPs) needed to supplement their workforce in delivering health evaluations, disability case management and occupational health services to RCMP members, cadets, and applicants at various locations across Canada.

### 1.2 General Information

1.2.1 The RCMP requires a licensed HCP on an as-and-when requested basis to provide health care services to RCMP members. The HCP is required to provide recommendations and/or professional opinions on RCMP member's fitness for duty to perform policing tasks and on health benefits eligibility.

1.2.2 The RCMP provides access to medical and dental treatment programs for Regular Members, Special Constable Members, or Civilian Members who are injured in the performance of his/her duties, to the extent that the treatment is not covered by a publicly funded provincial/territorial health care plan. The RCMP does not provide primary health care; since April 2013 RCMP members access primary care through their respective provincial/territorial health care plans.

1.2.3 Civilian members can apply for their supplemental benefits through the Public Service Health Care Plan; however, when an injury or illness is confirmed work-related, these types of benefits may be approved at RCMP expense under Occupational Health Care benefits.

1.2.4 Under the RCMP's Occupational Health Care Program, the RCMP provides Occupational Health Assessments, Fitness for duty examinations, immunizations and screening for members and applicants.

### 1.3 Background

RCMP health service offices are located in twelve (12) divisions and three (3) national units across Canada. HCPs in these offices are either public service employees or are acquired under various contracts, where public service staffing processes have been unsuccessful due to shortages of personnel in occupational health groups or where due to operational demand, contracting services are required.

1.3.1 The requirements for the provision and management of HCPs within the RCMP will be consolidated under this requirement.

1.4 **Departmental Authorities**

The Department Authorities (DAs) are responsible for the technical Work and contract management activities inside the RCMP and are as follows:

a. Departmental Technical Authority (DTA);

(1) Task Manager (TM); and

b. Departmental Procurement Authority (DPA).

1.4.1 The DTA is the representative of the RCMP, for whom the Work is being carried out under the Contract, and is responsible for all matters concerning the technical content of the Work under the Contract. Technical matters may be discussed with the DTA; however, the DTA has no authority to authorize changes to the scope of the Work. Changes to the scope of the Work can only be made through a Contract amendment issued by the Contracting Authority.

1.4.1.1 The Task Manager (TM) is the manager at the RCMP work location. The TM is responsive to the DTA and the TM is responsible:

a. to manage the Work being carried out under the Task Authorization;

b. to authorize temporary work location changes;

c. to advise HCPs of unexpected temporary closures to work location;

d. to authorize HCP overtime and on-call;

e. to request the RCMP DPA for approval for HCP Travel;

f. to determine the required HCP work hours necessary; and

g. for the scheduling of individual member or applicant Fitness for Duty examinations and assessments.

1.4.2 The RCMP DPA is the representative of the RCMP, responsible for all matters concerning the department's procurement and financial Work under the Contract, and for performing the department's Contract management activities, such as:

a. administering the Task Authorization process;

b. validating the technical requirements against scope of Work and the Contract; and

1.4.3 Contract administrative matters may be discussed with the DPA; however, the DPA has no authority to make changes to the Contract. Changes to the Contractor must be made through a Contract amendment issued by the Contracting Authority.

1.4.4 The RCMP will provide the DAs' names to the Contractor after Contract award.

1.5 **Terminology**

The Glossary of Terminology, which includes abbreviations and definitions, is found at Appendix 1 to Annex A - SOW RCMP.

## 2.0 APPLICABLE DOCUMENTS

For a complete list of applicable RCMP documents, please refer to the Appendices listed in the Table of Contents above which form part of the SOW:

a. Privacy Act, at http://laws-lois.justice.gc.ca/eng/acts/p-21/

2.1 The Contractor, the Contractor's Management Team (CMT), and the Contractor's HCPs must use or apply the applicable documents in the performance or delivery of the Work.

2.2 Many of the applicable documents are subject to change as the RCMP is currently undergoing modernization of its disability management and recruiting programs as well as a review and re-alignment of occupational health care policies.

2.3 The DTA will provide the Contractor with the amendments, revisions and bulletins to the applicable documents. Amendments, revisions and bulletins become effective on the day of notice or the date specified in the notice, whichever comes later.

2.4 Should the RCMP review and revise the applicable documents, updated versions will be provided to the Contractor.

2.5 The Contractor must distribute the amendments, revisions or bulletins to the CMT and HCPs by the end of the day following the day of notice or before the date specified in the notice, whichever comes later.

2.6 The Contractor must ensure that all subsequent Work provided, performed or delivered by the Contractor, the CMT, and HCPs are in accordance with any of the updated and revised amendments, revisions or bulletins.

## 3.0 SCOPE OF CONTRACT

The scope of Work under the Contract includes:

a. the provision of HCPs, which mainly consists of: the recruiting; the verification of credentials and references; hiring; security clearance; and, department introduction, including the orientation package;

b. the management of the HCPs, which mainly consists of: retention; replacing or backfilling HCPs; accounting for hours worked by the HCP using the Timesheet Tool; credentialing; performance management; and issue management when necessary; and

c. the Contract Management activities, which mainly consists of:

(1) the planning, organizing and scheduling work and deliverables to meet the required timelines or schedule; establishing processes or procedures to provide and manage HCPs; administration and management of timesheet tool;
(2) invoicing, preparing and providing various project management plans and reports;
(3) attending meetings; and
(4) establishing and maintaining the Contractor organizational structure and management team to support providing all the Contract requirements and deliverables.

### 3.1 Contract Objectives

The objectives of the HCPC are to ensure that the RCMP obtains the required number of qualified HCPs needed to supplement its existing personnel in delivering occupational health care programs and advice, consultation and screening services, as well as to administer and manage the required HCP resources.

### 3.2 Intended Use of Contract

The RCMP intends to use the HCPC when identified workforce shortages occur because of one or a combination of the following circumstances:

a. When replacement of personnel is required as a result of operational deployments, training, extended leave, etc.;

b. To supply HCPs when the Public Service staffing process has not been successful;

c. To act as a bridging mechanism while awaiting the Public Service staffing process to be completed; and

d. When Urgent HCP requirements arise.

3.3 **Contract Phases**

Under the Contract there are three (3) Contract Phases defined as follows:

a. Start-Up Phase is the period from the date of Contract award to the Service Effective Date (SED), which will be approximately six (6) months. The Start-Up Phase is outside of the initial Contract period. The Contracting Authority (CA) will provide the Contractor with the duration of the phase on the Contract Award Date;

b. In-Service Phase starts on the SED, and includes the initial Contract period (48 months), as well as any of the option periods exercised; and will cease at the start date of the Out-Going Phase; and

c. Out-Going Phase is a period of approximately 12 months before the Contract expiry date. The CA will provide the Contractor with Out-Going Phase notification when the final option is exercised.

3.3.1 During the Start-Up Phase, the Contractor must set-up and prepare for providing all of the requirements and deliverables required in this phase and the subsequent phases. In addition, the Contractor must carry out all provision type activities based on the Initial HCP Requirement Plan and RCMP Task Authorizations for the HCPs that are required at SED.

3.3.2 During the In-Service Phase, the Contractor must provide all requirements and deliverables required in this phase; some may have commenced in the Start-Up Phase but continue throughout this phase and the subsequent phase. In addition, the Contractor must carry out all provision and management activities based on terms and conditions of the Contract and on the Annual HCP Requirement Plan and RCMP Task Authorizations issued for recurring requirements, and for any New HCP Requirements identified thereafter via RCMP Task Authorization.

3.3.3 During the Out-Going Phase, the Contractor must provide all requirements and deliverables required in this phase; some may have commenced in the Start-Up or In-Service Phases but continue throughout this phase. In addition, the Contractor must continue to manage the existing HCPs on RCMP Task Authorizations as well as provide and manage any New HCP requirements identified via RCMP Task Authorization process during this phase, and undertake the Out-Going Phase activities.

3.3.4 Any transition activities required between the previous and new Contract will be organized and coordinated through the CA.

3.3.5 The requirements and deliverables for all the Contract Phases are stated in the article titled Requirements and Deliverables.

## 3.4 HCP Work Streams

The RCMP HCP Work Streams are Streams 1 to 3, and as follows:

a. Stream 1 - RCMP Occupational Health Assessments, Fitness for Duty Examinations, Advice and Consultation, Screening and Immunizations for members and applicants;

b. Stream 2 – RCMP Fitness for Duty Examinations of members and applicants; and

c. Stream 3 – Health Care to Cadets (recruits in training) at Medical Treatment Centre at RCMP Depot (RCMP Training Academy).

3.4.1 Under Stream 1, the Work consists of tasks such as providing occupational health assessments, fitness for duty examinations, advice and consultation, screening and immunizations and associated administrative activities. HCPs under this stream reviews Fitness for Duty Examination or health benefits claims information obtained from external health care providers and services (ie. international travel assistance services). HCPs would provide recommendations and/or professional opinions on RCMP member's health benefits eligibility. HCPs are to provide support to the Occupational Health Care Policy Centre, Work in administrative and consultative capacity to support case file reviews and provide subject matter expertise to management. The HCPs may be required to perform one or more of the above noted functions. This Stream does not provide direct medical care or treatment to RCMP members/applicants. The outline of the Work tasks and deliverables are identified under the specific occupational groups and categories.

3.4.2 Under Stream 2, the Work consists of Physicians and Psychologists performing Fitness for Duty Examinations and occupational health assessments on RCMP members and applicants and providing the results of the examination.

3.4.3 Under Stream 3, the Work consists of occupational health care assessments and, on an as and when required basis, providing medical care to RCMP Cadets until such care can be administered by Emergency Care Responders or through provincial/territorial medical clinics or hospitals.

## 3.5 HCP Occupational Groups and Categories

The HCP Occupational Groups and Categories are presented in Appendix 10 to Annex A - SOW RCMP, and are listed by Streams.

## 3.6 HCP Qualifications and Tasks

The HCP Qualifications and Tasks are found at Appendix 11 to Annex A - SOW RCMP, and include the specific work environment, education and credentials, experience and tasks required for each Category.

3.6.1 As a minimum, all HCPs provided by the Contractor must meet all the mandatory requirements of the Contract, including the education and experience stated in the Qualifications and Task Sheets for the specific Occupational Group and Category.

3.6.2 Any HCPs who do not meet the mandatory requirements for credentials or experience but whom the Contractor believes have equivalent qualifications will be reviewed by the RCMP DTA and may be considered on an exceptional basis based on RCMP operational requirements, policies and processes.

## 3.7 Type of HCP Requests

There are three (3) types of HCP Requests, which are as follows:

a. New;

b. Recurring; and

c. Short-term.

3.7.1 A New HCP Request is defined as HCP shortage identified that was not under a Task Authorization in the current FY.

3.7.2 A Recurring HCP Request is defined as a HCP requirement that were under Task Authorization in the current FY that continue to be required in the upcoming FY.

3.7.3 A Short-term HCP Request is defined as a HCP requirement needed to fill a capability gap that lasts for, pertains to, or involves a short period. For the purposes of the HCPC, the length of a short-term requirement is 180 calendar days or less.

## 3.8 Priority of HCP Requests

There are two (2) types of HCP Request priorities; which are as follow:

a. Routine; and

b. Urgent.

3.8.1 Routine is defined as a HCP Requirement that the priority to fill is a not Urgent.

3.8.2 Urgent is defined as a HCP Requirement that must be staffed as a priority over a Routine HCP Request, and therefore necessitates immediate action and attention.

3.8.3 Routine and Urgent HCP Requests can also be New, Recurring, and Short-term.

3.8.4 The priority of HCP Request can be applied under any of the HCP Work Streams.

**3.9 HCPs Work Locations**

The HCPs Work Locations are found at Appendix 12 to Annex A - SOW RCMP. The work location can be either Regular or Temporary Work Locations.

3.9.1 Regular Work Locations is defined as the single permanent location defined on the RCMP Task Authorization, at or from which the HCP ordinarily performs the Work of the position.

3.9.2 Temporary Work Locations is defined as the single location where the HCP is temporarily assigned to perform the Work of the position.

**3.10 Initial HCP Requirement Plan Definition**

The Initial HCP Requirement Plan is the estimated HCP Requirements that are required to start working at the SED. An example Plan is provided at Appendix 13 to Annex A – SOW RCMP for information purposes only, and does not represent a commitment by the RCMP that the Initial HCP Requirement Plan provided to the Contractor after Contract award will be the same.

3.10.1 Full-time is defined as a 7.5-hour workday, totaling 37.5 hours per week.

3.10.2 Part-time is defined as work less than 37.5 hours per week.

3.10.3 Overtime is defined as authorized time worked by the HCP in excess of 37.5 hours in a working week.

3.10.4 Full-time and Part-time HCP Requirements can be New, Recurring or Short-Term.

**3.11 Annual HCP Requirement Plan Definition**

The Annual HCP Requirement Plan is the HCP Requirements that are required for the following Fiscal Year (FY), which starts on 1 April of every year. The RCMP compiles

the Annual HCP Requirements in the third quarter (September and November) of each FY for organizational planning and budget purposes.

3.11.1 The Annual HCP Requirement Plan will consist of RCMP HCP (Recurring and New) requirements for each RCMP location, HCP category and streams.

**3.12 Time To Provide**

The Time to Provide (TTP) period is defined as the period that starts when the RCMP Task Authorization Form (TA Form) is initially sent to the Contractor and ends on the required Work start date. The Contractor must submit its responses to the DPA no later than 20 calendar days before the end of the TTP. During the Start-up Phase, in order to streamline the processing of the large volume of responses during this period, the Contractor should submit the response packages as they become available.

3.12.1 The end date of TTP in the In-Service and Out-Going Phases are as follows:

a. for New HCP Requests with Routine priority: 60 calendar days from when the RCMP Task Authorization Form is initially sent to the Contractor;

b. for New HCP Requests with Urgent priority: 21 calendar days from when the RCMP Task Authorization Form is initially sent to the Contractor; and

c. for Recurring Annual HCP Requirements: 30 calendar days from when the Annual HCP Requirements Plan is sent to the Contractor.

d. an extension to the TTP may be authorized by the DTA, via the DPA, on a case-by-case basis.

**3.13 Temporary Change to HCP(s) Designated Work Location(s) Within the Designated RCMP Locations**

HCPs may be required to work at a Temporary Work Location from the Regular Work Location for various reasons such as; HCP shortages, vacancies, absences, etc. Temporarily is defined as one (1) workday and up to 30 calendar days. For the purpose of the Contract, a Local RCMP Location spans an area of 50 kilometers from the Regular Work Location using the most direct, safe and practical road.

3.13.1 When Temporary Change to a HCP Designated Work Locations are required, the TM will provide the HCP and the DTA with a written notification three (3) calendar days in advance of a temporary change to the Regular HCP Work Location.

3.13.2 The notice will contain the following information:

a. Task Authorization number;

b. Name of HCP;

c. location name and address of the temporary work location;

d. reason for the change;

e. duration of change and the number of days (from and to dates and total number of days);

f. required hours of work (7:00am to 3:00pm or 8:00am to 4:00pm, etc.);

g. required schedule if part time (Monday, Wednesday and Friday, or Tuesday and Wednesday, etc.);

h. overtime involved – Yes/No; and

i. Point of Contact (POC) at the temporary work location (name, email address and telephone number).

3.13.3 Travel expenses to and from the temporary work location are not billable because it is considered the work place.

3.13.4 The DTA will provide written Temporary HCP Work Location notice, to the Contractor.

3.13.5 The Contractor must submit the Temporary HCP Work Location notice with their invoice, as this establishes the "authorization" for the change.

3.13.6 An amendment to the RCMP Task Authorization will not be issued for Temporary HCP Work Location within the Local RCMP Location.

**3.14 Temporary Change to HCP(s) Work Location(s) Outside Designated RCMP Location (s) or Province of Work**

On occasion, RCMP may require HCPs to temporarily work outside the Designated RCMP Location or Province of Work. The change in work location will be considered travel. Temporary, for this requirement, is defined as less than 30 calendar days. All Temporary HCP Work Locations outside the Designated RCMP Location or Province of Work requires the approval of the RCMP DTA before the change can occur.

3.14 When Temporary Changes to HCP Work Locations are required, the TM will request approval from the RCMP DTA seven (7) calendar days in advance.

3.14.2 The RCMP DTA will provide the Contractor with the written approval for the Temporary HCP Work Location outside the Designated RCMP Location of Province of Work. The written approval must contain the following information:

a Task Authorization number;

b. name of HCP;

c. location name and address of the temporary work location;

d. reason for the change;

e. duration of change and the number of days (from and to dates and total number of days);

f. required hours of work (7:00am to 3:00pm or 8:00am to 4:00pm, etc.);

g. overtime involved - Yes/No; and

h. Point of Contact (POC) at the temporary work location (name, email address and telephone number).

3.14.3 Temporary Changes to HCP(s) Work Location(s) outside the Designated RCMP Location or Province of Work will be considered travel. The HCP Travel Request and Authorization process must be followed and is detailed under the article titled HCP Travel.

3.14.4 When the Temporary Change to a HCP work location is outside of the HCPs current Province of Work, the Contractor must ensure the HCP obtains the additional licenses and registration, when required.

3.14.5 The Contractor must submit the complete approval package, travel itinerary, claimable expenses and receipts with the invoice.

3.14.6 When a HCP is requested to travel and the travel requirement is not stated in the RCMP Task Authorization, the Task Authorization must be amended for the travel requirement before the travel for Temporary Changes to the HCP(s) Work Location(s) outside the Local RCMP Location or Province of Work is conducted.

**3.15 Temporary Closures to Work Location**

Temporary Closures to Work Location(s) may occur over the period of the Contract and closures can be expected or unexpected. Expected is defined as within the Department's

control such as, repairs, scheduled maintenance, renovations, installation of new equipment(s), etc. Unexpected is defined as outside the control of the Department, such as flood, fire, equipment failure or shut down, power outages or extreme weather conditions, etc.

3.15.1 When a Temporary Closure to a Work Location is expected, the TM will advise the DTA and DPA. The DTA and DPA will advise the Contractor in writing, a minimum of seven (7) calendar days in advance, of any expected Temporary Closures, including the date(s) and duration of the closure, and the names of the HCPs affected by the temporary closure.

3.15.2 The Contractor must advise the affected HCPs of any expected Temporary Closures to Work Location(s) accordingly.

3.15.3 If unexpected Temporary Closures to a Work Location occur, the TM will advise the HCPs verbally and follow with the notice to the DTA and DPA. The DTA or DPA will: advise the Contractor by email on the day of the closure; include the name(s) of the HCP(s) affected; and when known, advise the Contractor of the date and time the HCPs' are to return to the work location.

3.15.4 The Contractor must contact its HCPs and advise them of the date and time they are to return to the work location.

3.15.5 The HCPs time during expected or unexpected Temporary Closures to Work Location closures are not billable hours.

**3.16 Permanent Closures to Work Location**

Permanent Closures to Work Location(s) may occur over the period of the Contract.

3.16.1 If a Permanent Closure to a Work Location is expected by the RCMP, the DTA will advise the Contractor in writing, a minimum of 60 calendar days in advance of the Permanent Closure.

3.16.2 The Permanent Closure to Work Location Notice will contain the following information:

a. date of the Notice;

b. work location closure date;

c. a list of the RCMP Task Authorizations affected by the work location closure; and

d. a list of the HCP Requirements that may be needed at other work locations, if applicable, and the anticipated start date(s).

3.16.3 The Contractor must advise the affected HCPs of Permanent Closures to Work Location(s).

3.16.4 If a list of HCP Requirements is provided to the Contractor, the DPA will issue a New RCMP Task Authorization accordingly for the Contractor's acceptance.

3.16.5 If HCPs are affected by a Permanent Closure to a RCMP Work Location, the conditions stipulated in the article titled Cancellation of a RCMP Task Authorization Process will apply.

## 3.17 RCMP Tele-Health Work Requirements

3.17.1 On a case-by-case basis, RCMP Psychologists may be required to provide Tele-health work, which is also referred to as Telemedicine.

3.17.2. For the purposes of this Contract, Tele-health is defined as the delivery of occupational health services via RCMP information technologies to RCMP members at a distance. The RCMP supports this Work requirement on an exceptional basis when a member is located in a remote area where Registered Psychologists are not readily available or accessible to provide services, or if the member requires a specialized treatment that local care providers do not possess the necessary training and experience to provide (e.g. eating disorders, panic disorders, etc).

3.17.3 When Tele-health Work is required by a HCP Psychologist, it will be stated in the RCMP Task Authorization.

3.17.4 If Tele-health Work is not stated in the RCMP Task Authorization, and becomes a requirement, the DPA will issue an amendment to the RCMP Task Authorization accordingly.

3.17.5 The Contractor is responsible in verifying the HCP Psychologists hold a license to offer remote services in the locations where this service is required. The Contractor must check with corresponding Regulatory Bodies where the Psychologist is expected to work in and may provide Tele-health services.

3.17.6 With other RCMP HCPs, such as Physicians and Nurses, Tele-Health is not used as a service modality to RCMP members.

# 4.0 REQUIREMENTS

## Part One – Start-Up Phase

## 4.1 Contractor's Organization

The Contractor must set up its Organizational Structure to manage Work, requirements, deliverables, and Task Authorizations related to all HCP requirements throughout all Phases of the Contract.

4.1.1 The Contractor's Organizational structure, number of team members, roles and responsibilities or function(s), and qualifications of the individual team members are the Contractor's responsibility.

## 4.2 Contractor's Work Location

The Contractor and Contractor's Management Team must work from its own site(s) throughout the duration of the Contract.

## 4.3 Contractor's Central Office

The Contractor must set up and manage a Contractors Central Office (CCO) in Canada throughout the duration of the Contract.

4.3.1 The CCO must be the centralized point of contact for the CA, RCMP DTA and RCMP DPA for all Contract related communications, such as, Task Authorizations, inquiries, issues or clarifications.

4.3.2 The CCO must be equipped to receive the Task Authorizations and general inquiries, via email, fax, and telephone and have the capability to conduct teleconferences, videoconferences and web conferences.

4.3.3 The CCO must be available from Monday to Friday between the hours of 8:00am and 5:00pm, Eastern Standard Time (EST).

4.3.4 The CCO will not be required to be available on Federal Government Holidays or on civic and statutory holidays in which the CCO is located.

4.3.5 The CCO must employ a minimum of one person who is bilingual and capable of providing services to the RCMP in both of Canada's Official Languages (OL) – English and French. Bilingual means that the individual(s) must be able to read and communicate in clear language in oral and writing, using both official languages, without assistance and with minimal errors.

4.3.6 The Contractor must provide a CCO Set-Up Notification with a toll free telephone number, teleconference number, and an email address. Refer to Appendix 14.

4.3.7 The Contractor must provide the name, title, role and responsibility, and email address if different from the general email address, for all personnel employed within the CCO. Refer to Appendix 14.

4.3.8 The Contractor must manage any CCO personnel changes without affecting the services required under the Contract and provide the name, title, role and responsibility, and email address if different from the general email address of any changes made to the CCO personnel within five (5) calendar days. Refer to Appendix 14.

4.3.9 The Contractor must ensure that the CCO personnel have the necessary experience or training required to be able to discharge their responsibilities.

4.3.10 Any associated training costs or travel expenses incurred in support of training their personnel are the Contractor's responsibility.

## 4.4 Contractor's Management Team

The Contractor must establish a Contractor's Management Team (CMT). The team composite may be different for each phase of the Contract.

4.4.1 The name, title, role, summary of responsibilities, location and contact information for each member of the CMT must be confirmed at the initial Contract Kick-Off Meeting and must be based on the team composite described and proposed in the Contractor's bid. Refer to Appendix 14.

4.4.2 The Contractor must provide updated name, title, role and responsibility, and email address if different from the general email address, for any changes made to the CMT personnel, within two (2) working days of the change. Refer to Appendix 14.

4.4.3 The CMT must employ a minimum of one (1) person who is bilingual and capable of providing services to the RCMP in both of Canada's Official Languages (OL) – English and French. Bilingual means that the individual(s) must be able to read and communicate in clear language in oral and writing, using both official languages, without assistance and with minimal errors.

4.4.4 The Contractor must ensure that the CMT personnel have the necessary experience or training required to be able to discharge their responsibilities.

4.4.5 Any associated training costs or travel expenses incurred in support of training their personnel are the Contractor's responsibility.

## 4.5 Contractor's Service Delivery Manager

The Contractor must provide a dedicated Service Delivery Manager (SDM) as Lead for the CMT throughout the duration of the Contract.

4.5.1 The SDM position must be filled at all times, including periods when the SDM is absent for any reason.

4.5.2 The SDM will be the primary point of contact (POC) for the Contracting Authority (CA), the Departmental Technical Authority (DTA) and the Departmental Procurement Authority (DPA).

4.5.3 The SDM must have the authority to plan, organize, coordinate, make decisions, direct, execute, implement, monitor, provide feedback, report, and manage all Work activities undertaken by the CMT in support of the Work associated with the provision and management of the HCPs.

4.5.4 The SDM must respond to any phone calls or emails from the CA, DTA or DPA within two (2) working days.

4.5.5 The SDM's name and contact information must be confirmed within five (5) calendar days after Contract award (ACA). Refer to Appendix 14.

4.5.6 As a minimum, the SDM must have the following qualifications and experience:

a. a University degree or an acceptable combination of education and experience, such as:

(1) a college certificate or college diploma; plus
(2) seven (7) years' experience in a senior management role or position with direct responsibility for managing a multi-million-dollar contract, project or program;

b. Seven (7) years' experience within the last 14 years in Project or Program Management;

c. five (5) years' experience within the last 10 years in managing employees;

d. three (3) years' experience within the last six (6) years in Contract Management; and

e. must be proficient in English.

4.5.7 The Contractor must provide a minimum of 30 calendar days' notice of the intent to permanently replace the SDM. Refer to Appendix 14.

4.5.8 Any proposed replacement SDM must meet the qualifications as outlined above and will be subject to the concurrence of the DTA.

4.6 **Deputy Service Delivery Manager**

The Contractor must provide a Deputy Service Delivery Manager (DSDM) as part of the CMT throughout the duration of the Contract.

4.6.1 The DSDM must replace and be available when the SDM is absent for any reason.

4.6.2 The DSDM's name and contact information must be confirmed five (5) calendar days ACA. Refer to Appendix 14.

4.6.3 As a minimum, the SDM must have the following qualifications and experience:

a. University degree or an acceptable combination of education and experience, such as:

(i) a college certificate or diploma; plus
(ii) five (5) years' experience in a senior management role or position with direct responsibility for managing a multi-million-dollar contract, project or program;

b. five (5) years' experience within the last 14 years in Project or Program Management;

c. four (4) years' experience within the last 10 years in managing employees;

d. two (2) years' experience within the last six (6) years in contract management; and

e. must be proficient in English.

4.6.4 The Contractor must provide a minimum of 15 calendar days' notice of the intent to permanently replace the DSDM. Refer to Appendix 14.

4.6.5 Any proposed replacement DSDM must meet the qualifications as outlined above and will be subject to the concurrence of the DTA.

4.7 **Contractor's Start-Up Plan**

The Contractor must develop and deliver a Draft Start-Up Plan within 14 calendar days ACA and Final Start-Up Plan. Refer to Appendix 14.

4.7.1 The Start-Up Plan can incorporate any Contractor start-up and set-up activities and practices but as a minimum, must include the following:

a. a list and description of Contractor start-up and set-up activities to be completed and the major milestones to be achieved during the Contract Start-Up Phase to allow for orderly and timely set up in order to fully meet all the SOW RCMP requirements before and at SED;

b. a high-level Work Breakdown Structure (WBS) reflective of all the activities and sub-activities, the major milestones and deliverables;

c. a schedule in MS Project which states the proposed timelines or timeframes for all activities and sub-activities, related milestones, all dependencies and the critical path; and

d. the Contractor's Senior Management structure for the Contract Start-Up Phase, including but not limited to: the Contractor's Start-Up Phase Management team; any oversight committees; or working groups established by the Contractor, etc. The structure must indicate where participation is required or may be requested from the RCMP DTA, and what processes and procedures are recommended to ensure quick decision-making within the plan to facilitate the timely delivery of services.

4.7.2 The schedule must form the baseline on which the Contractor's performance will be monitored and measured by the RCMP.

4.7.3 The Contractor must revise and update within 10 calendar days the Draft Start-Up Plan if comments or recommendations are received from the RCMP DTA. Refer to Appendix 14.

4.7.4 Once the Start-Up Plan is approved by the RCMP DTA, it will be deemed the Final Start-Up Plan.

4.7.5 The Contractor must implement and carry out all start-up and set-up activities in accordance with the approved Start-Up Plan during the Start-Up Phase.

4.8 **Contractor's Recruitment Plan**

The Contractor must develop and deliver a Draft Recruitment Plan within 30 calendar days ACA. Refer to Appendix 14.

4.8.1 The Recruitment plan must list and describe all the recruiting activities that will be completed in order to meet the Department's requirements for HCPs at the SED and throughout the duration of the Contract.

4.8.2 The Recruitment Plan, as a minimum, must include the following strategies and approach elements:

a. to recruit the initial HCPs required at SED; and new HCPs requirements after the SED and during the In-Service Phase;

b. to meet short-term HCP requirements;

c. for urgent HCP requirements within the reduced Time To Provide timelines;

d. the recruitment strategies for HCP occupational groups and categories that:

(1) may require an additional 30 calendar days for the TTP;
(2) experience a higher requirement volume, including continuous and on-going advertising activities;

e. the retention strategies to be used to retain HCPs and to minimize HCP turnover;

f. the replacement approach when HCPs are absent for an extended period of time;

g. the recruiting communications strategies for:

(1) promotional material development and distribution;

(2) communication channels, streams, and methodologies; and

(3) advertising plans and strategies; and

(4) Contractor's recruiting innovations.

4.8.3 The Contractor must revise and update within 20 calendar days the Recruitment Plan if comments or recommendations are received from the DTA. Refer to Appendix 14.

4.8.4 Once the Draft Recruitment Plan is approved by the DTA, it will be deemed the Final Recruitment Plan.

4.8.5 The Contractor must implement, and carry out all recruiting activities in accordance with the approved Final Recruitment Plan throughout the duration of the Contract.

4.8.6 If the Contractor's strategies and approach to recruitment change during the Contract period, the Contractor must update the Final Recruitment Plan for DTA approval. Refer to Appendix 14.

4.9 **Contractor's Risk Management Plan**

The Contractor must develop and deliver a Draft Contractor's Risk Management Plan (CRMP) within 30 calendar days ACA. Refer to Appendix 14.

4.9.1 The CRMP must detail and describe the procedures and methods to be used in identifying, analyzing, evaluating, tracking, reporting, and mitigating risk(s) throughout the duration of the Contract.

4.9.2 The CRMP, as a minimum, must describe and detail all the elements listed below:

a. Concept for Management of Risk;

b. Risk Prediction Methodology;

c. Risk Identification (Risk Factors);

d. Risk Analysis (Probabilities and Effects) and Risk Assessment;

e. Risk Response (Avoid, Transfer, Mitigate, and Accept) and associated costs;

f. Issue Review and Lessons Learned (LL) Analysis Methodology; and

g. Issue Report Methodology.

4.9.3 The CRMP must include a section for each phase of the Contract with identification of each of the phase's risks. Each of the sections must include:

a. an initial risk analysis and assessment;

b. identification of risks and if necessary a creation of Risk Breakdown Structure;

c. Qualitative Risk Analysis;

d. Quantitative Risk Analysis;

e. Risk Response Planning;

f. Risk Monitoring and Control; and

g. a feedback and lessons learned process.

4.9.4 The Contractor must revise and update, within 20 calendar days, the draft CRMP based on comments or recommendations received from the DTA. Refer to Appendix 14.

4.9.5 Once the draft CRMP is approved, the CRMP will be deemed to be the Final Contractor's Management Plan (CRMP) and must be used to manage and mitigate the risks throughout the duration of the Contract.

4.9.6 The Contractor must update the Final CRMP for every Program Review Meeting (PRM). The version number and date must be annotated on each CRMP revision or update. Refer to Appendix 14.

4.9.7 The Final CRMP updates must include:

a. the identification of new risks;

b. ongoing risks;

c. any or all risk mitigation actions taken plus the associated costs;

d. all corrective actions taken;

e. outcomes to date;

f. detail(s) of all the potential issues or obstacles affecting the schedule timelines;

g. further recommended or suggested course(s) of action.

4.9.8 The Contractor must provide advance electronic copies of the current CRMP to the CA, the DTA and DPA, five (5) calendar days before each Progress Review Meeting (PRM). Refer to Appendix 14.

4.9.9 The Contractor must provide hard copies of the current CRMP to each attendee at the PRM. Refer to Appendix 14.

4.9.10 If any substantive risk(s) occur before the PRM reporting cycle, the Contractor must advise the DTA in writing within three (3) calendar days and must report these risks in the Monthly Program Report. Refer to Appendix 14.

4.10 **Contractor's Management Plan**

The Contractor must develop and deliver a Draft Contractor's Management Plan (CMP) within 30 calendar days ACA, Final and an Updated CMP. Refer to Appendix 14.

4.10.1 The CMP must consolidate the entire Contractor's administrative and management processes, practices and procedures, and their supporting organizational structure used to manage all the Work, requirements and deliverables required under the Contract. The CMP must be used throughout the duration of the Contract.

4.10.2 The CMP, as a minimum, must describe and detail the Contractor's administrative and management processes, practices and procedures for the:

a. management of Work, requirements and deliverables required under the Contract;

b. schedule control and management during the Contract Start –Up Phase;

c. Contractor's CCO and CMT Performance management and monitoring;

d. HCP management as it relates to recruitment, retention, credentialing, training, discipline and performance evaluation management and monitoring;

e. quality control;

f. risk reporting process;

g. media communications process;

h. Contract Change Management process to implement Improvement or Changes;

i. problem resolution;

j. HCPs time verification process (Timesheet Tool);

k. Invoice processing including verifications and validations to detect errors; and

l. Contractor's internal and external lines of communication.

4.10.3 The Contractor must revise and update within 20 calendar days the CMP if comments or recommendations are received from the DTA. Refer to Appendix 14.

4.10.4 Once the Draft CMP is approved, the CMP will be deemed the Final Contractor's Management Plan (CMP) and must be used throughout the duration of the Contract.

4.10.5 The Contractor must ensure that it's administrative and management processes, practices and procedures are consistently applied across all locations by its personnel and in accordance with the approved Final CMP.

4.10.6 If the Contractor's administrative and management processes, practices and procedures change during the Contract period, the Contractor must update or revise the CMP for DTA approval. The version number and date must be annotated on each CMP revision or update. Refer to Appendix 14.

## 4.11 Contractor's Communication Packages

When the Contractor develops communications for recruitment purposes, for circulation to media organizations, the public, industry, educational institutes, etc., the Contractor must submit the draft communication to the CA and the DTA, before publication for its review and acceptance. Refer to Appendix 14.

4.11.1 When the draft is accepted and approved by the CA and the DTA, the Contractor will receive a confirmation from the DTA.

4.11.3 All communications materials developed for circulation for recruitment purposes by the Contractor must be in English and French.

## 4.12 Issues, Challenges and Problem Resolution Process

Throughout the duration of the Contract, the Contractor or the Contractor's HCPs must, as a preliminary step, contact the appropriate authority listed in SOW RCMP paragraph titled Departmental Authorities (DAs) to resolve any issues, challenges and problems at the lowest possible level.

4.12.1 Should the Contractor or the Contractor's HCP contact a DA that is not the responsible authority for the issue, challenge or problem, the Contractor or the Contractor's HCP will be re-directed to the appropriate authority.

4.12.2 The TM is the lowest level for issues, challenges or problems that are within the scope of TM's authority.

4.12.3 For issues, challenges or problems not resolved at the lowest level, the DTA is the authority for the technical content of the Work, requirements, and deliverables.

4.12.4 If the issue, challenges or problems cannot be resolved at the lowest possible level, the matter will be referred to the DTA and upward for resolution. If the issue cannot be resolved by the DA and CA levels, the matter will be escalated to the Executive Steering Committee.

4.13 **HCPC Lessons Learned**

The Contractor must develop and deliver a HCPC Lessons Learned (HCPC LL) document based on their lessons learned for the Start-Up and Outgoing Phases of the Contract; and on an annual basis for each year of the In-Service Phase of the Contract. Refer to Appendix 14.

4.13.1 The intention is to have all stakeholders benefit and contribute to a formalized Lessons Learned (LL) process by implementing a formal HCPC LL Contract Management Activity process that ensures visibility and accountability using a feedback loop, and which minimizes the repetition of errors, improves service delivery, and result in positive and improved capability or requirements.

4.13.2 The HCPC LL document can incorporate any Contractor's Lessons Learned but as a minimum, must include the following information:

a. section for Observation/Issue, which states what the issue, problem, or difficulty was or the "what" part of the phase, activity, requirement or event. The Observation(s) or Issue(s) must be short, factual descriptions of what has occurred, and are used to describe either a positive or a negative event. Multiple observations of a similar nature may be combined into a single issue;

b. section for Discussion, which includes sufficient details surrounding the observation(s) or issue(s) to provide the reader with an understanding of the phase, activity, requirement or event without being part of the requirement. The details can include "who", "when", "why" and "where" statements;

c. section for Conclusion, which includes details on the overall impact of the observation(s) or issue(s);

d. section for Recommendations, which includes suggestions or recommendations on how the issue, problem or difficulty can be rectified, reduced or eliminated in the future; and

e. section for Point of Contact (POC), which identifies the appropriate office responsible for the matter based on the issue, problem or difficulty. The POC is the RCMP DTA for the technical content of the Work, requirements, and deliverables. The POC is the RCMP DPA for procurement and financial matters, administration of the Task Authorization and process, and departmental contract management activities. The POC for Contract, Contract obligations and requirements, and Contract Administration, including amendments, is the CA.

4.13.3 The RCMP DTA will track all HCPC LLs provided by the Contractor. The HCPC LLs will be provided for review and approval, program governance via senior management stakeholder's committees. Refer to article titled Governance. Any HCPC LL approved for implementation, resulting in a change to the Contract obligations, requirements or

deliverables, will be brought to the attention of the CA. Changes to the Contract can only be made through a contract amendment issued by the CA.

4.14 **Timesheet Tool**

The Contractor must implement a Timesheet Tool (TsT), which is accessible from the Contractor's website through a secure site to authorized users that hold various roles. The TsT is intended as a tool for:

a. HCPs to record their hours worked;

b. the TM to validate and approve the HCP`s recorded hours; and

c. the DAs to validate the labour charges on the Contractor's invoice.

4.14.1 The Contractor must have the TsT ready for use 60 calendar days before the SED, and must provide a notification that the Timesheet Tool is setup and ready. Refer to Appendix 14.

4.14.2 The Contractor's TsT must be available to users as a minimum, from Monday to Friday, and between the hours of 7am and 6pm across all Canadian Time Zones.

4.14.3 Within five (5) calendar days of setup notification of the Timesheet Tool, the Contractor must conduct a TsT demonstration for the DAs at a RCMP location. The location and address will be provided to the Contractor after Contract Award. The demonstration must confirm that the TsT is ready for use and detail how the tool works from a user perspective. Refer to Appendix 14.

4.15 **Timesheet Tool Capabilities and Functionalities**

As a minimum, the Timesheet Tool must have the following capabilities and functionalities:

a. to allow HCPs to record their regular, overtime, on-call, and call-back hours worked;

b. to allow the TMs to review, validate and approve the HCP recorded hours;

c. to have an approval indicator that denotes that the recorded hours have been validated;

d. to set permissions for control what users can see and do;

e. to allow for simultaneous access of users;

f. to allow for the storage of HCP timesheets and data;

g. to secure all data;

h. to enable reports to be generated from the TsT data and to be able to specify report filters to return the specific results wanted;

i. to enable queries to be conducted with the available fields in the TsT;

j. to allow for customization or modifications including: modifications of the field names; setting tasks, such as travel; and linking tasks to the timesheet;

k. have a data back-up feature;

l. to allow the exporting of data; and

m. to have printing capabilities.

4.16 **Timesheet Tool Setup**

As a minimum, the timesheet tool setup must include the following data fields:

a. Task Authorization Number;

b. HCP location;

c. HCP surname;

d. HCP given name;

e. a separate field to be used by the HCP to input hours worked for each day of the week, including Saturday and Sunday, within the billing period;

f. sub-total regular hours worked. This field must reflect the total number of regular hours worked within the billing period;

g. total regular hours worked. This field must reflect the total number of hours worked to date on the RCMP Task Authorization;

h. sub-total overtime hours worked. This field must reflect the total number of overtime hours worked within the billing period;

i. total overtime hours worked. This field must reflect the total overtime hours worked to date on the RCMP Task Authorization;

j. sub-total on-call hours worked. This field must reflect the total number of on-call hours worked within the billing period;

k. total on-call hours worked. This field must reflect the total of on-call hours worked to date on the RCMP Task Authorization;

l. sub-total call-back hours worked. This field must reflect the total number of call-back hours worked within the billing period;

m. total call-back hours worked. This field must reflect the total of call-back hours worked to date on the RCMP Task Authorization;

n. remaining hours on the RCMP Task Authorization. This field must reflect, in hours or days, the Level of Effort (LOE) remaining and in accordance with the RCMP Task Authorization.

o. Travel. This section must reflect the from and to date fields that the HCP is on Travel Status within the billing period; and

p. The approved travel RCMP Task Authorization number; and

q. Approval Indicator. This field would identify for the Contractor: if the timesheet was approved or not approved by the TM; the name of the TM that has approved or not approved the timesheet; and must also have a Comment field for information to be inserted by the TM.

4.17 **HCP Timesheet**

As a minimum, the HCP timesheet must include the following data fields:

a. Task Authorization Number;

b. HCP location;

c. HCP name;

d. HCP given name;

e. A separate field to be used by the HCP to input hours worked for each day of the week, including Saturday and Sunday, within the billing period;

f. sub-total regular hours worked. This field must reflect the total number of regular hours worked within the billing period;

g. sub-total overtime hours worked. This field must reflect the total number of overtime hours worked within billing period;

h. sub-total on-call hours worked. This field must reflect the total number of on-call hours worked within the billing period;

i. sub-total call-back hours worked. This field must reflect the total number of call-back hours worked within the billing period;

j. remaining hours on the RCMP Task Authorization. This field must reflect, in hours or days, the Level of Effort (LOE) remaining and in accordance with the RCMP Task Authorization

k. Travel. This section must reflect the from and to date fields that the HCP is on Travel Status within the billing period;

l. the approved travel RCMP Task Authorization number; and

m. Approval Indicator. This field would identify for the Contractor: if the timesheet was approved or not approved by the TM; the name of the TM that has approved or not approved the timesheet; and must also have a Comment field for information to be inserted by the TM.

**4.18 Timesheet Tool Account Creation Setup**

The Contractor must create user accounts and initial passwords.

a. all accounts for the Contractor`s HCPs must be setup and provided before the HCP start date on the Task Authorization;

b. the Contractor must create a user account for the DAs and TMs before the Timesheet Tool demonstration. The number of DAs is estimated at 17 and the number of TM user accounts is estimated at three (3) positions per location (approximately 65 in total). The Contractor will be provided with the names of the DAs and TMs after Contract award;

c. throughout the Contract the Contractor must create new user accounts within seven (7) calendar days of receipt of the approved User Account Creation and Cancellation Request, provided to the Contractor from the DAs. New user accounts will only be requested and required when the assigned DAs and TMs change; and

d. the Contractor must delete old user accounts within seven (7) calendar days of the user change date that is stated on the User Account Creation and Cancellation Request provided to the Contractor from the DAs.

4.19 **Timesheet Tool Account Permissions**

The Contractor must set up specific TsT access permissions for the DAs and TMs.

a. the DAs must be given full user access: to view any HCP timesheet; to verify if TMs have approved the timesheet; for viewing data; and to generate reports based on the data found in the TsT;

b. the TMs must be given user access restricted to the information related only to HCPs on Task Authorizations at their location; and

c. the Contractor is responsible to ensure that HCPs do not have access to the timesheet approval field on the TsT.

4.20 **Timesheet Tool User Help and Support**

The Contractor must provide a Help and Support functionality for the TsT that, at a minimum, is available to authorized users, from Monday to Friday, between the hours of 7am and 6pm across all Canadian Time Zones, and that it is available by email or telephone.

4.21 **Timesheet Tool Maintenance**

The Contractor must conduct updates and maintenance of the TsT outside the working hours of 7am to 6pm across all Canadian Time Zones.

4.22 **Timesheet Tool User Training and Manual**

The Contractor's TsT must contain a computer-based training component and a User Manual, in both official languages. Refer to Appendix 14.

4.23 **Initial HCP Requirements**

The Contractor will be provided with the Initial HCP Requirement Plan and the associated RCMP Task Authorizations after Contract Award at the Initial Kick-off Meeting.

4.23.1 On receipt of the RCMP Task Authorizations, the Contractor must follow the Task Authorization process detailed in the Contract. The Contractor must provide the RCMP DPA with the Task Authorization Response Packages for all RCMP Task Authorizations issued, no later than 40 calendar days prior to SED, and all HCPs Requirements must start working on the SED.

4.23.2 All HCP Requirements that are identified after the Initial HCP Requirement Plan has been provided to the Contractor, and the HCP Requirement start dates are after the SED, are considered to be New HCP Requirements. The RCMP DPA provides New HCP Requirements to the Contractor, via a RCMP Task Authorization. The Contractor must follow the Task Authorization process detailed in the Contract. The TTP period will apply to all New RCMP Task Authorizations issued.

4.23.3 For the New HCP Requirements identified in the Annual HCP Requirement Plan, the Contractor must follow the Task Authorization process as detailed in the Contract.

**4.24 Acceptable Delay**

When the Contractor is not able to fill a RCMP Task Authorization in any of the Phases, the Contractor must justify the delay in satisfying the requirement, in writing, to the DTA. The DTA will determine if the Contractor will be given an additional 30 calendar day period to fill, or if the Task Authorization will be cancelled. Refer to Appendix 14.

4.24.1 The Contractor will be given a written notice by the DPA for all requests. The Task Authorizations that are not filled will not remain open indefinitely. The DPA will provide the Contractor with the Cancellation of a Task Authorization Notice for Task Authorization, when the issued Task Authorization is cancelled because it was not filled.

4.25 **HCP Credentials**

Throughout the duration of the Contract, the Contractor must verify the HCP credentials before providing HCPs to the RCMP.

4.25.1 The HCP credential verification process is to confirm with their respective regulatory or certifying organization that the HCP:

a. holds a valid license or certification;

b. has no restrictions or limitations against their license or certification and are in good standing; and

c. has no sanctions or past findings against their license or certificate.

4.25.2 If the HCP is the subject of an investigation, is involved in part of an investigation, has restrictions, limitations, sanctions or past findings against their license or certificate, the RCMP reserves the right to refuse the proposed HCP.

4.25.3 Throughout the duration of the Contract, including the Start-up Phase, when the Contractor provides any HCP, the Contractor must provide the RCMP Credential Information Form.

4.25.4 After the initial Credential Information Form is provided by the Contractor, and throughout the duration of the Contract thereafter, the Contractor must conduct and confirm verification of the HCPs' credentials every six (6) months.

4.25.5 Throughout the duration of the Contract, the Contractor must conduct the HCP re-verification process and confirm the status via the Credentialing Report, which is detailed under article titled Credentialing Report.

4.25.6 Throughout the duration of the Contract, if a HCP's credentials change, the Contractor must notify the DTA, within the same business day or next business day if following a weekend, if the HCP has had his/her license revoked for whatever reason, or should a HCP becomes subject of an investigation or involved in part of an investigation. Refer to Appendix 14.

4.25.7 If a HCP has his/her license revoked, the HCP RCMP Task Authorization will be cancelled immediately.

4.25.8 If the HCP becomes the subject of an investigation or is involved in part of an investigation, the RCMP reserves the right to determine if the HCP Task Authorization will be cancelled or if the Contractor will be requested to replace the HCP.

4.26 **HCP Language Requirements**

Throughout the duration of the Contract, the Language requirement for the HCP will be specified in the RCMP Task Authorization as English, French or Bilingual (English and French).

4.26.1 The provided HCP must be able to read, communicate orally and in writing in the specified language(s) without assistance and with minimal errors.

**Part Two - In-Service Phase**

### 4.27 Annual HCP Requirements

The Contractor will be provided with the Annual HCP Requirement Plan and the associated New RCMP Task Authorizations within the first seven (7) days of December each year.

4.27.1 For the Recurring HCP Requirements identified in the Annual HCP Requirement Plan, the Contractor must review the list and confirm via the Recurring HCP Task Authorization Confirmation Report within 30 calendar days from receipt whether the incumbent HCPs will continue to provide the services in the upcoming FY. Refer to Appendix 14.

4.27.2 On receipt of the RCMP Task Authorizations, the Contractor must follow the Task Authorization process detailed in the Contract. The Contractor must provide the Task Authorization Response Package to the DPA no later than 20 calendar days prior to HCP Start Date. Refer to Appendix 14.

4.27.3 During the In-Service Phase and after the Annual HCP Requirement Plan has been provided to the Contractor, any New HCP Requirements identified will be provided to the Contractor by the DPA via the RCMP Task Authorization(s).

### 4.28 HCPs Orientation to the RCMP Work Environment

Throughout the duration of the Contract, the Contractor must provide all HCPs with the Orientation Package on the RCMP work environment. The Orientation Package will be provided at the time of the contract award. Refer to Appendix 16.

4.28.1 As part of the Task Authorization process, the Contractor must provide a signed copy of the Orientation Package – HCP Acknowledgement Form, which is included in the Orientation Package. The Orientation Package – HCP Acknowledgement Form is the confirmation that the HCP has received, read and understood the Orientation Package and the RCMP work environment, and agrees to provide health care services in that environment. Refer to Appendix 14.

4.28.2 The Contractor may request a location site visit, when the HCP would like to see the facility before committing to working in a RCMP Environment. The Contractor must submit all Location Site Visit Requests to the RCMP DTA for approval.

4.29 **HCP Contractor Identification**

Throughout the In-Service and Out-Going Phases, HCPs must be identifiable as a Contractor resource in accordance with the RCMP security policy.

4.29.1 HCPs must include the designation of "Contractor" within their signature block when sending email or writing letters.

4.30 **HCP Hours of Work**

Throughout the In-Service and Out-Going Phases, HCPs must work between the core hours of 6am and 6pm local time, Monday to Friday.

4.30.1 The hours of work required will be stated in the RCMP Task Authorization.

4.30.2 HCPs will not be required to provide services on Federal Government Holidays as listed at Appendix 17 - SOW RCMP.

4.31 **Extended Hours**

Extended hours are paid at the HCP hourly rate.

4.32 **HCP Overtime**

Throughout the duration of the Contract, HCPs may be required to work Overtime. When a HCP is required to work Overtime, it will be stated in the RCMP Task Authorization. Overtime work must be authorized in advance by the Task Manager.

4.32.1 The Contractor must submit the HCP Overtime Authorization with its invoice. Overtime is billable in accordance with the terms and conditions of the Contract. Refer to Appendix 14.

4.33 **HCPs On-Call**

Throughout the In-Service and Out-Going Transition Phases, HCPs may be required to be On-Call. When a HCP is required to be on-call, it will be stated in the RCMP Task Authorization. On-Call is defined as, time scheduled by the TM, to carry a pager or cell phone and respond to calls outside the RCMP hours.

4.33.1 When a HCP is requested to be On-Call and the On-Call requirement is not stated in the RCMP Task Authorization, the Task Authorization must be amended for the On-Call requirement before On-Call is worked.

4.33.2 Only one HCP per category and location at a time can be assigned to on-call duty and only when a public servant is not available to cover the on-call period. The period for on-call duty cannot exceed 16 hours on week days, and 24 hours on weekend and Statutory holidays.

4.33.3 Every occurrence of On-Call must be authorized and provided in writing by the TM to the HCP the On-Call is scheduled.

4.33.4 The HCP must submit to the Contractor the written On-Call Authorization received from the TM, with their timesheet submission.

4.33.5 The Contractor must submit the On-Call Authorization and schedule with its invoice. On-Call is billable in accordance with the Annex B – Basis of Payment RCMP. Refer to Appendix 14.

4.34 **HCP Call-Back**

Throughout the In-Service and Out-Going Transition Phases, HCPs On-Call may be required to be Call-Back. Call-Back is defined as required to return to the RCMP facility to work as a result of the on-call task.

4.34.1 Every occurrence of Call-Back must be verified and approved in writing by the TM. The written approval will be provided to the HCP.

4.34.2 The HCP must submit to the Contractor the written Call-Back Authorization received from the TM, with their timesheet submission.

4.34.3 The Contractor must submit the Call-Back written approval of the HCP Call-Back hours worked with the invoice. Call-Back is billable in accordance with the Annex B – Basis of Payment RCMP. Refer to Appendix 14.

4.35 **HCP Travel**

Throughout the In-Service and Out-Going Phases, HCPs may be required to travel. When a HCP is required to travel, it will be stated in the RCMP Task Authorization.

4.35.1 When a HCP is requested to travel and the travel requirement is not stated in the RCMP Task Authorization, the Task Authorization must be amended for the travel requirement before the travel is conducted.

4.35.2 All travel must be pre-authorized by the DTA. The TM will provide the HCP Travel Request Form to the DTA for approval. If travel is approved, the TM will provide the DTA approval to the RCMP DPA. The DPA will provide the Contractor with a separate RCMP Task Authorization for the travel for its acceptance along with the approved Travel Request Form.

4.35.3 The Contractor must make all travel arrangements and travel must be obtained and conducted in the most economical means available and in accordance with the Treasury Board Travel Directive.

4.35.4 The Contractor must submit the HCP Travel Expenses with the original receipts with their invoice for re-imbursement in accordance with the conditions stated in the Contract. Refer to Appendix 14.

4.35.5 The RCMP Task Authorization for the HCP travel requirement will be closed once the invoice for the HCP Travel has been paid.

4.36 **HCP Qualification Training**

Throughout the duration of the Contract, the Contractor is responsible for any HCP qualification training or training that is necessary for the HCP to maintain its specific qualifications and credentials such as re-training or re-certifications.

4.36.1 The HCPs training costs, travel costs associated with training and time absent are not billable to RCMP.

4.36.2 The Contractor must provide the DTA with a minimum of 14 calendar days advance written notice when a HCP will be absent for training purposes that is for a period not to exceed 14 calendar days. The notice must contain the HCP name, Task Authorization number, name of training, and dates and duration of training.

4.36.3 If the training exceeds 14 calendar days, the conditions under the article titled HCP Long Term Absences article will apply.

4.37 **RCMP Unique Specialization Training**

Throughout the duration of the Contract, the Contractor is responsible for any required HCP training, re-training or certification costs, plus any travel costs associated with the training.

4.37.1 Specialized Training that is unique to the RCMP may not be accessible to the Contractor. On a case-by-case basis and at its discretion, the RCMP may offer, RCMP specialized training or courses to the Contractor for its HCPs.

4.37.2 If Specialized Training that is unique to the RCMP is offered by RCMP to the Contractor, the costs charged to the Contractor will be the same costs per person as would be charged for a public service employee. Travel costs associated with the training and time absent are not to be billable to the RCMP.

## 4.38 HCP Professional Misconduct

Throughout the In-Service and Out-Going Phases, identification, investigation and management of HCP professional conduct and competency issues are a shared responsibility between the Contractor and the RCMP. The Contractor and the RCMP have a responsibility to report HCP Professional Misconduct in accordance with the relevant provincial/territorial statute and/or regulatory body.

4.38.1 HCP professional performance shall be in accordance with standards set by the applicable regulatory authority as well as any additional standards imposed by the RCMP.

4.38.2 The RCMP will be responsible for identifying potential professional performance issues, determining whether the HCP's professional performance meets the applicable RCMP standard, and identifying any requirements for remediation of the HCP's performance or professional conduct.

4.38.3 The Contractor will be responsible for the remediation of HCP professional performance issues and the determination and execution of any disciplinary measures.

4.38.4 In matters of HCP professional misconduct or incompetency, the Contractor and the RCMP will report to the HCP's regulatory authority in accordance with the statutory requirements of the applicable province or territory.

## 4.39 HCP Holidays

Throughout the In-Service and Out-Going Phases, the Contractor must provide the TM with 14 calendar days written notice when a HCP is planning holidays for a period of 14 calendar days or less and 21calendar days written notice when a HCP is planning holidays for a period greater than 14 calendar days. The TM is responsible to ensure that there is adequate staffing available to deliver the health services and may have to rearrange workload to accommodate the holiday period.

## 4.40 HCP Short-Term Absences

Throughout the In-Service and Out-Going Phases, the Contractor must advise the TM in writing or by telephone when any of its HCPs will be absent from the work location for workload management purposes. Short-term absence is defined as 21 calendar days or less.

## 4.41 HCP Long Term Absences

Throughout the In-service and Out-Going Phases, the Contractor must provide the DTA 42 calendar days written notice when a HCP is planning to be absent for a period greater than 21 calendar days. The DTA may request that the Contractor replace the HCP or to deny some or all of the leave should the RCMP not have adequate staffing available to deliver the health services.

4.41.1 If the HCP absence is unplanned and the absence will be for a period greater than 21 calendar days, the Contractor must provide written notice to the DTA when advised by the HCP. The DTA may request that the Contractor temporarily replace the HCP.

4.41.2 When the HCP is replaced temporarily, the RCMP Task Authorization must be amended. The Contractor's replacement HCP must meet all the qualifications for the HCP category; must not be under another RCMP Task Authorization for same hours of work or schedule; and must not be a transferred HCP from another RCMP Task Authorization, creating another unfilled Task Authorization elsewhere, unless accepted by the DTA in some particular circumstances.

4.41.3 If the Contractor cannot provide a replacement HCP temporarily, the RCMP Task Authorization may be cancelled. If the RCMP Task Authorization is cancelled; a new RCMP Task Authorization may be issued to the Contractor by the DPA.

## 4.42 HCP Departure While on a Task Authorization

Throughout the In-Service and Out-Going Phases, the Contractor must provide 14 calendar days written notice to the DTA when a HCP is planning to vacate the position while on a Task Authorization. The Task Authorization will be cancelled and the Contractor may be provided a new RCMP Task Authorization.

## 4.43 RCMP Cancellation of a Task Authorization

Throughout the In-Service and Out-Going Phases, when the services of a HCP are no longer required, the DPA will give the Contractor a minimum of 14 calendar days written notice of a Cancellation of a Task Authorization. The minimum 14 calendar day period is not required when Task Authorization has been cancelled as a result of the Contractor not meeting the timeframe for a replacement of a HCP, or for HCP Short term and Long Term absence.

4.44 **Personal Health Information**

All HCPs have ethical, professional and legal responsibilities to maintain the confidentiality and privacy of patient health information obtained while providing health services. The HCP must conduct their business accordingly with the Government of Canada and the RCMP privacy legislation and policies.

4.44.1 In the event of suspected breaches of personal health information, HCPs must immediately notify the TM. Immediately is defined as "as soon as possible and on the same day".

4.44.2 All cases of a suspected breach of personal health information are investigated by the RCMP in accordance with with GOC and RCMP regulations, legislations and policies.

4.44.3 The Contractor and HCP must cooperate with the RCMP internal process. If a HCP is requested to participate in discussion or interviews or to provide a written statement, the HCP will be given the time to do so and time will be paid in accordance with the rate on the HCP's RCMP Task Authorization.

4.45 **HCPs Disclosure of Medical Information to Supervisors and other stakeholders**

Throughout the duration of the Contract, and within the RCMP environment, any health information collected by HCPs will be protected by medical confidentiality. HCPs will not disclose medical information unless such information is considered crucial and essential to an enquiry and is subpoenaed. HCPs must adhere to RCMP regulations and policies regarding RCMP Member medical confidentiality and medical information.

4.46 **HCPs Providing Medical Advice in Support of Administration or Disciplinary Proceedings**

Throughout the In-Service and Out-Going Phases, HCPs may be asked by the RCMP member or by the RCMP member's Commanding Officer (CO) to intervene in career, administrative or disciplinary proceedings.

4.46.1 When HCPs are responding to these type of requests, the HCP must adhere to RCMP policies and processes for administration or disciplinary proceedings.

4.47 **HCPs Participation in Collaborative Practice Approach**

Throughout the In-Service and Out-Going Phases, HCPs must participate in the Collaborative Practice approach in the delivery of health services.

4.47.1 HCP Participation in collaborative practice activities may include:

a. promoting collaborative practice amongst HCPs and within functional programs; and attending functional program, intra-disciplinary, case conferences, and

b. case reviews, as well as meetings to discuss collaborative practices.

4.48 **HCP Recommended Referrals to External Providers**

Throughout the In-Service and Out-Going Phases, HCPs may be required to make referrals to External Providers.

4.48.1 When a HCP makes a recommendation for External Providers, their recommended referral must be on the currently registered with Federal Health Claims Processing Service (FHCPS). The FHCPS External HCPs List will be provided by the TM to the HCPs who are tasked with recommending referral to external providers. All HCP recommended referrals to external providers, must be approved by the Member's Divisional Occupational Health and Safety Services (OHSS) Office.

4.48.2 All HCP recommended referrals to external providers made by the HCP must be at arm's length and have no perception of a personal nature or benefit. HCPs are to refrain from making recommended referrals to themselves, any relative, entity, organization, business, practice or partner with whom they are associated or affiliated. On a case-by-case basis, when health services are required in a remote or underserviced area with limited access to Providers, approval for a HCP's referral to themselves can be provided by the RCMP Member's Divisional OHSS Office.

4.49 **Meetings**

The Contractor's appropriate CMT or CCO personnel must attend various meetings throughout the duration of the Contract.

4.49.1 The SDM or DSDM must attend all required meetings.

4.49.2 The Contractor must determine who from its CMT or CCO will be required to attend each type of meeting. The Contractor's personnel who are attending should be determined by the Agenda Items to be discussed and the Action Items Log (AIL).

4.49.3 The Contractor will be responsible for making all travel arrangements for their personnel attending meetings.

4.49.4 All Contractor or CMT and CCO personnel travel costs related to attending any of the required meetings will be borne by the Contractor and are not to be invoiced to the RCMP.

4.50 **Initial Kick-Off Meeting**

The Contractor will be required to attend an Initial Contract Kick-Off Meeting in the Start-Up Phase, at a Government of Canada (GoC) facility. As a minimum, the

Contractor's senior representative and SDM must attend this meeting and may include other Contractor's personnel it deems appropriate.

4.50.1 The Initial Contract Kick-off meeting must take place within 14 calendar days After Contract Award (ACA). The DTA will advise the Contractor of the date and address of the meeting.

4.50.2 The duration of the meeting is anticipated to be one (1) to three (3) calendar days.

4.50.3 This meeting will be co-chaired by the Contractor and DTA and will include, as a minimum, the following Agenda items:

a. review of the Contract including SOW;

b. an overview of the Contractor's Management Plan;

c. an overview of the Contractor's Organization;

d. an overview of the Contractor's Start-up Plan and Schedule;

e. an overview of the Contractor's Recruitment Strategy;

f. an overview of the Contractor's Risks and Risk Analysis and the methods or procedures by which the impact of these risks will be mitigated and managed;

g. confirmation of the names, title(s), roles and responsibilities plus contact information for the primary Points Of Contact (POC) for CCO and CMT personnel;

h. confirmation of the CCO and CMT structure; and

i. other items.

4.50.4 The Agenda for the Initial Contract Kick-Off Meeting will be prepared by the DTA and provided to the Contractor by the DTA no less than five (5) calendar days before the meeting.

4.50.5 The minutes of the meetings will be prepared by the Chairs in accordance with the article titled Minutes of the Meetings and provided by the DTA to the Contractor and all attendees within seven (7) calendar days following the date of the meeting.

4.50.6 The minutes will be signed by the Chairs and the Contractor.

4.50.7 Should there be any action items resulting from the Initial Kick-off meeting, the DTA will prepare the Action Item Log (AIL) in accordance with the article titled Action Item Log (AIL). The AIL must be provided with the Minutes.

4.50.8 The DTA will coordinate responses to Action Items from the responsible parties and update the AIL.

4.50.9 All Action Items resulting from the Initial Contract Meeting must be responded to within 10 calendar days following the date of the meeting or by the date agreed upon at the Initial Contract Kick-Off Meeting.

4.50.10 The updated AIL will be distributed by the DTA to all attendees within 15 calendar days from the date of the meeting and will contain all responses for the Action Items assigned to all parties.

4.51 **Progress Review Meetings**

The Contractor must organize and hold Progress Review Meetings (PRMs) in the National Capital Region (NCR) as follows:

a. during the Start-up and Outgoing Phases on a monthly basis within the first 10 days of the month, unless agreed otherwise; and

b. during the In-Service Phase on a quarterly basis within the first 10 calendar days after the end of the quarter, unless agreed otherwise.

4.51.1 If agreed upon by the DTA in advance, the PRM may be held via videoconference or teleconference.

4.51.2 As a minimum, the SDM or DSDM must attend this meeting and may include other Contractor personnel it deems appropriate.

4.51.3 The PRMs will be co-chaired by the DTA and the Contractor.

4.51.4 The PRMs are anticipated to be half-day to two (2) full days (15 hours) in duration. The duration will be based on the Agenda items and Action Items to be discussed.

4.51.5 The Contractor will prepare and distribute the PRM Agendas to all attendees a minimum of seven (7) calendar days before the meeting.

4.51.6 The Agenda will include:

a. the purpose of the meeting;

b. the location;

c. the date and estimated duration of the meeting;

d. the proposed list of topics and sub-topics to be discussed plus the time allocated to each discussion item; and

e. the name of the party and individual responsible for addressing each topic or sub-topic included.

4.51.7 The topics for presentation and discussion at PRMs may include:

a. opening remarks;

b. agenda review;

c. review of previous Minutes (if applicable);

d. current status or changes to the Contractor's Plans;

e. status on Contractor's Work and activities during the PRM period;

f. discussions on Contractor's Reports during the PRM period;

g. discussions review of Contractor's Performance;

h. problem or issue reviews and Lessons Learned (LL);

i. review of closed Action Items during the PRM period;

j. status of current Action Items;

k. new problem or issue areas and corrective measures or action plans;

l. new discussion Items;

m. plans for next reporting period;

n. round table discussion;

o. next meeting date; and

p. closing remarks.

4.51.8 The Contractor must provide its planned action(s) to address all discrepancies identified in the PRM in accordance with the time period and schedule agreed to at the PRM.

4.51.9 The Contractor must prepare the minutes of the PRM in accordance with article titled Minutes of Meetings.

4.51.10 The Contractor must correct any discrepancies noted in the minutes of the PRM within three (3) calendar days of the notification of the discrepancies by the DTA.

4.52 **Ad Hoc Meetings**

Ad Hoc Meetings are meetings that may be conducted when necessary to respond to urgent or unforeseen requirements, technical Work, contract or program management

activities or issues, and contractual obligations. Ad Hoc meetings are to be kept to a minimum and only take place if absolutely necessary.

4.52.1 Ad hoc meetings can be requested by Canada or by the Contractor. The party requesting the Ad hoc meeting may invite representatives as it deems appropriate.

4.52.2 The party requesting an Urgent Ad Hoc Meeting must provide the requested participants with written notice one (1) working day prior to the meeting. The meeting should take place within two (2) working days of said notice.

4.52.3 The party requesting a Non-urgent Ad Hoc Meeting must provide the requested participants a minimum of five (5) working days written notice and the meeting will take place at a time agreed to by the parties.

4.52.4 Ad Hoc meetings must be held at a location that is mutually acceptable to the parties or by teleconference, videoconference or Web conference, if acceptable by all the parties.

4.52.5 The party requesting the Ad Hoc meeting must organize and chair the meeting as well as prepare and provide the Agenda. As a minimum, the Agenda must include:

a. the purpose of the meeting;

b. the location;

c. the date and estimated duration of the meeting;

d. the proposed list of topics and sub-topics to be discussed plus the time allocated to each discussion item; and

e. the name of the party and individual responsible for addressing each topic or sub-topic included.

4.52.6 The party who requested the Ad Hoc meeting will be responsible for the preparation and distribution of the Minutes in accordance with the article titled Minutes of Meetings, and the resulting Action Items Log and follow up actions in accordance with the article titled Action Item Log (AIL).

4.52.7 The costs associated with hosting the Ad Hoc Meetings will be borne by the party requesting the meeting.

4.52.8 All costs incurred in the attendance of Ad Hoc Meetings such as preparations and travel will be the responsibility of each of the parties required to participate in the meeting.

**4.53 Minutes of the Meetings**

Minutes of the Meetings will be required, throughout the duration of the Contract, for each meeting or review held, and must include and document all information required to provide an accurate record of the content of the meeting or review.

4.53.1 The minutes are prepared by the party indicated in the meeting paragraphs above. All parties are to indicate their required changes. Once approved by the parties, the responsible party will distribute copies of the minutes to all the participants within seven (7) calendar days.

4.53.2 The minutes must include, as a minimum, the following sections:

a. a title page containing the title or purpose of the meeting, meeting number, date and location;

b. identification of the Contract number;

c. list of invitees' names, titles, and contact particulars (telephone and email addresses);

d. copy of the Agenda;

e. sections for: the Opening Remarks, Agenda Review, Review of Previous Minutes (if applicable), Open Discussion Items, New Discussion Items, and Review of Previous and New Action Items, Next Meeting, and Closing remarks;

f. a detailed summary of the proceedings, discussions, agreements or decisions reached or taken and by whom;

g. the AIL must be attached and include any responses provided from any of the attendees at the meeting; and

h. a signature page with spaces for the Contractor, the CA and the DTA, as applicable.

4.53.3 All Minutes prepared must be approved and signed, before distribution by the Contractor and the CA or the DTA as applicable.

**4.54 Action Item Log (AIL)**

The AIL is the living document that details all Action Items related to all aspects of the Contract. The AIL is a follow-on document from the Initial Contract Kick-Off Meeting and runs for the life of the contract.

4.54.1 The Contractor must prepare and maintain the AIL commencing with receipt of the AIL from the CA after the Initial Kick-off Meeting. Refer to Appendix 14.

4.54.2 The AIL must provide a consolidated list of all actions to be taken and by each party.

4.54.3 The AIL must include, as a minimum, the following sections:

a. serial number;

b. item;

c. description of the action to be taken;

d. cross-reference to the minutes;

e. indication of the person who is responsible for action;

f. estimated target date for completion of action; and

g. Status Indicator on whether the Action Item is open or closed.

4.54.4 All Action items will remain open until there is a decision recorded in Minutes of Meetings to close the item.

4.54.5 The updated version of the AIL must be distributed by the Contractor with meeting minutes to all participants. Refer to Appendix 14.

## 4.55 Reports

The Contractor must prepare and provide various reports throughout the duration of the Contract.

## 4.56 Start-Up Phase Report

During the Start-Up Phase of the Contract, the Contractor must prepare and deliver monthly Start-Up Phase Status Reports. Refer to Appendix 14.

4.56.1 The report must show all Work undertaken, including work in progress, against the Start-Up schedule and must:

a. present an overview of all activities that have taken place in the reported period, those planned but that have not taken place in the reported period, and those that are planned for the following period; and

b. address the activities including all scheduled events or milestones, conducted activities, major accomplishment, non-conducted planned activities and missed schedule activities, including delay reasons, current status of problems, action items taken or planned to resolve, impacts, impacts to the schedule, forecasted problems, recommendations or solutions to any issues or problems, and planned activities for the following period.

## 4.57 Task Authorization Status Report

The Contractor must prepare and deliver a Task Authorization Status Report monthly, during the start-up phase for the duration of the Contract. Refer to Appendix 14.

4.57.1 The reporting requirement details are specified in the Contract article titled Task Authorization Status Report – Contracts with Task Authorizations of the Contract.

4.58 **HCP Credentialing Report**

The Contractor must prepare and deliver an Initial Credentialing Report prior to the SED and for each six (6) months thereafter for the duration of the Contract. Refer to Appendix 14.

4.58.1. The report, as a minimum, must include the following information for each HCP:

a. the Task Authorization number;

b. the location;

c. the occupation category;

d. the HCP name;

e. the Credential type (e.g. licence, insurance, registration, certification, education, etc.);

f. the credential description (e.g., name, regulatory body, level of education, etc.)

g. status (e.g. confirmed, pending, expired, etc.); and

h. expiry date.

4.59 **HCP Travel Report**

Throughout the duration of the Contract, the Contractor must prepare and deliver a monthly HCP Travel Report. Refer to Appendix 14.

4.59.1. The report is to be provided with the invoice. The report, as a minimum, must list:

a. every HCP authorized to travel under the Contract; and

b. include for each HCP the following distinct data elements:

(1) RCMP Task Authorization number;
(2) province;

(3) location;
(4) occupation and category;
(5) HCP surname;
(6) HCP given name;
(7) HCP start date;
(8) Task Authorization period (period of travel);
(9) status (fulltime or part-time);
(10) total RCMP Task authorization travel amount;
(11) total travel costs expended during the reporting period; and,
(12) total accumulated travel costs incurred to date.

4.60 **HCP Labour, Overtime, On-Call and Call-Back Report**

Throughout the duration of the Contract, the Contractor must prepare and deliver a monthly HCP Labour, Overtime, On-Call and Call-Back Report. Refer to Appendix 14.

4.60.1. The report is to be provided with the invoice but should be able to be generated through the Timesheet Tool. The report, as a minimum, must include:

a. every HCP authorized to perform Work under the Contract;

b. RCMP Task Authorization number;

c. location;

d. occupation and category;

e. level of education (when applicable);

f. HCP surname;

g. HCP given name;

h. HCP start date;

i. RCMP Task Authorization end date;

j. Level of Effort (LOE), which is authorized hours worked per week, for each of "regular hours and overtime worked during the current month;

k. average LOE per HCP;

l. On-Call Hours worked during the period;

m. Call-Back hours worked during the period;

n. total cost for current month;

o. total cost incurred over duration of Contract; and

p. total Task Authorization authorized value.

4.61 **Recurring HCP Task Authorization Confirmation Report**

Throughout the duration of the Contract, the Contractor must prepare and deliver an Annual Recurring HCP Task Authorization Confirmation Report. Refer to Appendix 14.

4.61.1. The report, as a minimum, must include:

a. all HCPs who have committed to continuing on the recurring Task Authorization;

b. RCMP Task Authorization number;

c. location;

d. occupation and category;

e. HCP surname;

g. HCP given name;

h. HCP start date;

i. RCMP Task Authorization end date; and

j. Level of Effort (LOE), which is authorized hours worked per week, for each of regular and overtime worked during the current month.

4.62 **HCPs Certifications Report**

Throughout the duration of the Contract, the Contractor must prepare and deliver an annual N95 Mask Fit Test; WHMIS Certification; and BLS Certification Report. Refer to Appendix 14.

4.62.1 The report, as a minimum, must include the following information:

a. RCMP Task Authorization number;

b. location;

c. occupation category;

d. HCP name;

e. HCP given name;

f. HCP start date;

g. Quantitative Fit Test Results;

h. Quantitative Fit Test Results effective date;

i. Quantitative Fit Test Results expiry date;

j. HCP WHMIS Certification date;

k. HCP WHMIS Certification expiry date;

l. HCP BLS Certification date; and

m. HCP BLS Certification expiry date.

**Phase Three – Out-Going Phase**

4.63 **Out-Going Phase Plan**

The Contractor must develop and deliver a Draft Out-Going Phase Plan at the Out-Going phase kick-off meeting and Final Out-Going Phase Plan that will outline out-going activities and will propose timings for the range of Deliverables listed below. Refer to Appendix 14.

4.63.1 The Out-Going Phase Plan can incorporate any out-going activities and practices but as a minimum, must include the following:

a. a list and description of Contractor out-going activities to be completed and the major milestones to be achieved during the Out-Going Phase to allow for orderly and timely transition and fully meet all the SOW RCMP requirements;

b. a schedule, which states the proposed timelines or timeframes for all activities and sub-activities related milestones, all dependencies, and the critical path; and

c. the Contractor's Senior Management structure for the Contract Out-Going Phase, including but not limited to: the Contractor's Out-Going Phase Management Team. The structure must indicate where participation is required or may be requested from the DTA, and what processes and procedures are recommended to ensure quick decision-making within the plan to facilitate the timely delivery of services.

4.63.2 The Contractor must revise and update within 10 calendar days the Draft Out-Going Phase Plan if comments or recommendations are received from the DTA.

4.63.3 Once the Out-Going Phase Plan is approved by the DTA, it will be deemed the Final Out-Going Phase Plan. Refer to Appendix 14.

4.63.4 The Contractor must implement and carry out all out-going activities in accordance with the approved Out-Going Phase Plan during the Out-Going Phase.

## 4.64 **Out-Going Phase Kick-Off Meeting**

The Contractor will be required to attend an Out-Going Phase Kick-Off Meeting in the Out-Going Phase, at a Government of Canada (GoC) facility. As a minimum, the Contractor's senior representative and SDM must attend this meeting and may include other Contractor's personnel it deems appropriate.

4.64.1 The Out-Going Phase Kick-Off Meeting must take place within 30 calendar days after the Contractor has been officially notified of the commencement of the Out-Going Phase by the CA. The DTA will advise the Contractor of the date and address of the meeting.

4.64.2 The duration of the meeting is anticipated to be one (1) to two (2) calendar days

4.64.3 This meeting will be co-chaired by the Contractor and DTA and will include, as a minimum, the following Agenda items:

a. an review of the Contractor's Out-Going Plan and Schedule;

b. an review of the Contractor's Risks and Risk Analysis and the methods or procedures by which the impact of these risks were mitigated and managed;

c. confirm at the Out-Going Phase Kick-Off Meeting, the CCO and CMT structure; and

d. other items.

4.64.4 The Agenda for the Out-Going Phase Kick-Off Meeting will be prepared by the DTA and provided to the Contractor by the DTA no less than five (5) calendar days before the meeting.

4.64.5 The minutes of the meetings will be prepared by the Chairs in accordance with the article titled Minutes of the Meetings and provided by the DTA to the Contractor and all attendees within seven (7) calendar days following the date of the meeting.

4.64.6 The minutes will be signed by the Chairs.

4.64.7 Should there be any action items resulting from the Out-Going Phase Kick-Off Meeting, the DTA will prepare the Action Item Log (AIL) in accordance with the article titled Action Item Log (AIL). The AIL must be provided with the Minutes.

4.64.8 The Contractor will coordinate responses to Action Items from the responsible parties and update the AIL.

4.64.9 All Action Items resulting from the Out-Going Phase Kick-Off Meeting must be responded to within 10 calendar days following the date of the meeting or by the date agreed upon at the Out-Going Phase Kick-Off Meeting.

4.64.10 The updated AIL will be distributed by the Contractor to all attendees within 15 calendar days from the date of the meeting and will contain all responses for the Action Items assigned to all parties

4.65 **Out-Going Phase Contract Summary Reports**

During the Out-Going Phase, the Contractor may be requested to:

a. provide Contract summary reports such as but not limited to:

(1) reports generated through the Timesheet Tool;

(2) Final HCP Certifications Report;

(3) Final HCP Labour, Overtime, On-Call and Call-Back Report;

(4) Final HCP Travel Report; and

(5) Final HCP Credentialing Report;

b. export data electronically from the Timesheet Tool for accounting purposes, retention and audit requirements; and

c. provide Final Lessons Learned documents.

4.66 **Final Progress Review Meeting**

During the Out-Going Phase, the Contractor and its appropriate personnel must attend a Final Progress Review (FPR) meeting at a Government of Canada facility. The purpose of the FPR will be to perform a complete review of all of the contractual and RCMP SOWS requirements, deliverables, remaining or outstanding PRM Action Items, and to discuss the Contractor's final invoice, to ensure all contractual obligations are completed and the Contract can be closed.

4.66.1 The FPR meeting will take place no more than 30 and no less than 20 calendar days before the Contract expiry date. The CA will advise the Contractor of the date and address of the meeting. As a minimum, the Contractor's senior representative and SDM must attend this meeting and may include other Contractor personnel, as it deems appropriate.

4.66.2 The meeting duration is anticipated to be approximately three (3) to five (5) calendar days.

4.66.3 This meeting will be co-chaired by the CA and DTA and will include, as a minimum, the following Agenda items for review and discussion:

a. contractual and RCMP SOW requirements and deliverables;

b. remaining or outstanding PRM Action Items;

c. Contractor's Out-Going Phase activities;

d. Contractor's final invoice; and

e. other items.

4.66.4 The Agenda for the FPR Meeting will be prepared and provided by the DTA to the Contractor, no less than seven (7) calendar days before the meeting.

4.66.5 The minutes of the meeting will be prepared by the Chairs in accordance with the article titled Minutes of Meetings and provided by the DTA to the Contractor and all attendees within seven (7) calendar days following the date of the meeting.

4.66.6 The minutes will be signed by the Chairs and the Contractor.

4.66.7 Should there be any action items resulting from the FPRM, the DTA will prepare the Action Item Log (AIL) in accordance with the article titled Action Item Log (AIL). The AIL must be provided with the minutes.

4.65.8 The DTA will coordinate responses to Action Items from the responsible parties and update the AIL.

4.66.9 All Action Items resulting from the FPR Meeting must be responded to and closed before the Contract expiry date.

## 5.0 DELIVERABLES

The Contractor must prepare and provide all Deliverables in the consolidated table, found in Appendix 14 to Annex A – SOW RCMP.

5.1 The Table specifies:

a. the deliverable number;

b. the SOW RCMP reference paragraph;

c. the required delivery date;

d. the delivery format (electronic or paper); and

e. to whom the deliverables are to be provided.

5.1.1 All deliverables are to be in English only.

5.2 The Contractor must ensure that all Deliverables have a cover page and that the cover page indicates the Deliverable number, Deliverable name, whether it is an original

submission or re-submission, draft or final version (if applicable), and date in the format of DD-MM-YYYY.

5.3 All Deliverables must:

a. be formatted to fit on Letter size paper (8.5 x 11) unless doing so makes the content illegible, in which case, larger size paper may be used;

b. be provided in Microsoft Office format;

c. be legible and suitable for reproduction;

d. not be password protected; and

e. have pages numbered sequentially.

5.4 The process for approval of deliverables is as follows:

a. the DTA will acknowledge receipt of all Deliverables within five (5) calendar days after receipt;

b. within 20 calendar days of receipt, the DTA will review all Deliverables;

c. the DTA will advise the Contractor, via e-mail, if the Deliverable has been approved or rejected;

d. if the Deliverable is rejected by the DTA, a notice of the deficiency(ies) will be provided;

e. the Contractor must address the deficiency(ies) noted and resubmit the corrected deliverable within 10 calendar days from the date of notification; and

f. the DTA will have an additional 14 calendar days to review and approve or reject the resubmitted Deliverable.

## 6.0 GOVERNMENT FURNISHED RESOURCES

Government Furnished Resources (GFR) are Canada-owned Government Furnished Equipment (GFE), Government Supplied Material (GSM), and Government Furnished Information (GFI) that the RCMP will make available for use by the Contractor or Contractor's HCPs.

6.1 All GFE, GSM, and GFI provided to the Contractor or to the Contractor's HCPs in support of performing the Work under the Contract, will be provided to the Contractor, free of charge.

6.2 The Contractor's HCPs must ensure that any GFE or GSM provided are returned in satisfactory condition, subject to normal wear and tear, to the RCMP upon completion of the Work under the RCMP Task Authorization.

6.3 Cost recovery action will be taken in accordance with the Contract for any GFE or GSM lost or damaged, subject to normal wear and tear.

6.4 The RCMP will provide each HCP with the following GFE:

a. all office related equipment necessary to support HCP tasks such as office space, desk, chair, telephone with unlimited access for health care related business purposes only, computer with DWAN and CFHIS access, printer access, access to filing cabinet with locking capability (if required), etc.; and

b. all medical equipment required to perform HCP tasks related to occupational health care assessments.

6.5 The RCMP will provide the following GSM for each HCP, where applicable:

a. all office related supplies required to perform HCP tasks such as pens, paper, forms, prescription pads, etc.; and

b. all medical or dental consumables used in the completion of HCP tasks such as bandages, needles, sharps containers, dressings, braces, splints, orthotics, masks, etc.

6.6 Any HCP ergonomic equipment, specialized equipment or material requested, are the responsibility of the Contractor

6.7 GFI provided to the Contractor or to the Contractor's HCPs will be as per Appendix 19 to Annex A2 – SOW RCMP.

## APPENDIX 1 TO ANNEX A2

## GLOSSARY OF TERMINOLOGY

# APPENDIX 1 – GLOSSARY OF TERMINOLOGY

| PART 1 - ACRONYMS | |
|---|---|
| ACA | After Contract Award |
| AIL | Action Items Log |
| CA | Contracting Authority (PSPC) |
| CCO | Contractor`s Central Office |
| CMP | Contractor's Management Plan |
| CMT | Contractor Management Team |
| CO | Commanding Officer |
| CRMP | Contractor's Risk Management Plan |
| DA | Departmental Authorities |
| DSDM | Deputy Service Delivery Manager |
| DPA | Departmental Procurement Authority |
| DTA | Departmental Technical Authority |
| FHCPS | Federal Health Claims Processing Service |
| FPR | Final Progress Review |
| GFE | Government Furnished Equipment |
| GFI | Government Furnished Information |
| GFR | Government Furnished Resources |
| GSM | Government Supplied Material |
| HCP | Health Care Provider |
| IAW | In accordance with |
| LL | Lessons Learned |
| MEL | Medical Employment Limitations |
| MS | Microsoft |
| NJC | National Joint Council |
| OHC | Occupational Health Care |
| OHSS | Occupational Health and Safety Services |
| OHSB | Occupational Health and Safety Branch |
| OL | Official Languages |
| PHA | Periodic Health Assessment |
| PKI | Public Key Infrastructure |
| POC | Point of Contact |
| PRM | Progress Review Meeting |
| PRMs | Program Review Meetings |
| PS | Public Service |
| QMP | Quality Management Plan |
| QR&Os | Queen's Regulations and Orders |
| RCMP | Royal Canadian Mounted Police |
| RDD | Required Delivery Date |
| RFP | Request for Proposal |
| RMP | Risk Management Plan |
| SDM | Service Delivery Manager |
| SED | Service Effective Date |
| SOW | Statement of Work |
| TM | Task Manager |
| TOC | Table of Contents |
| WBS | Work Breakdown Structure |

| PART 2 - DEFINITIONS | |
|---|---|
| Certified Practitioner | Clinical practitioners whose occupation is not a regulated health profession, but has a national, provincial, or territorial certification to practice process. |
| Full-time | A 7.5-hour workday, totaling 37.5 hours per week. |
| Lessons Learned | Lessons learned means the adding of value to an existing body of knowledge, or seeking to correct deficiencies in areas of concepts, process, policy, doctrine, training, equipment, requirements, deliverables, or organizations, by providing feedback and follow-on action. |
| New HCP Request | A new HCP shortage identified that is not currently under a Task Authorization. It will also be either Recurring or Short-term. |
| Part-time | Work up to a maximum total of 30 hours per week. Part-time hours could be half days, full days, or a combination, and the schedule could be any days during Monday to Friday. |
| Personal Health Information | Medical, dental or psychosocial information about an identifiable individual that is recorded in any form. |
| Personal information | Personal information is defined by section 3 of the Privacy Act, and includes personal health information. |
| Recurring Requirement Plan | HCP requirement that is already under Task Authorization and are planned to be further extended for a defined period of time. |
| Recurring HCP Request | A HCP requirement needed to fill a capability gap that lasts for, pertains to, or involves a period longer than 180 calendar days. |
| Regular Work Locations | The single permanent location defined on the RCMP Task Authorization, at or from which the HCP ordinarily performs the work of the position. |
| Regulated Health Professions | Clinical practitioners whose occupation is a health regulated profession. In Canada, the regulation of health professions is under provincial/ territorial jurisdiction with each province/territory individually legislating the credentialing requirements for each profession. |
| Routine HCP Request | A HCP Requirement that the priority to fill is a not Urgent. Can also be new, recurring and short-term. |
| Secondary care | Secondary care is the health care services provided by medical specialists and other health professionals who generally do not have first contact with patients, for example, cardiologists, urologists and dermatologists. |
| Short-term HCP Request | A HCP requirement needed to fill a capability gap that lasts for, pertains to, or involves a short period. The length of a short-term requirement is 180 calendar days or less. |
| Task Authorization | Authorization to the Contractor to provide HCP and details task requirements. |
| Temporary Work Locations | The single location where the HCP is temporarily assigned to perform the work of the position. |
| Time to Provide Period | The period of time allotted to the Contractor to recruit and provide one or multiple HCPs in response to RCMP Task Authorizations. TTP period are stated on RCMP Task Authorization and are effective from the day of issuance of the RCMP Task Authorization and are effective from the day of issuance. |

| | |
|---|---|
| Urgent HCP Request | A HCP requirement that must be staffed as a priority over a Routine HCP Request, and therefore necessitates immediate action and attention. Can also be new, recurring and short-term. |

**APPENDIX 2 TO 8 OF ANNEX A2**

**NOT APPLICABLE TO RCMP**

## APPENDIX 9 TO ANNEX A2

## RCMP ACCEPTABLE USER PRACTICES FOR RCMP INFORMATION TECHNOLOGY

# RCMP ACCEPTABLE USER PRACTICES FOR RCMP INFORMATION TECHNOLOGY

## 1. Definitions

1. **Monitor** means any action that involves the viewing, recording, subsequent analysis of, and preparation of reports on Authorized User activity on, or use of, the RCMP's IM/IT systems. Examples include recording user accounts, user activities, volume of usage, sites visited, information downloaded and computer resources used to perform a routine analysis of traffic flow on networks, use patterns and sites that certain work groups or individuals have visited or responding to a subpoena or other court process. The information recorded and subject to analysis does not normally involve the contents of individual electronic mail, files, and transmissions but it may require collecting personal information on specific employee use and preparing reports on this use which include personal information to determine whether there has been unacceptable or unlawful activity.

2. **Information Systems Security Field Compliance Reviews** means the RCMP Information Systems Security Field Compliance Review Program. The program ensures that RCMP employees follow RCMP policy, Treasury Board of Canada Secretariat, Management of Information Technology Security and security practices regarding the protection of sensitive information. Reviews include randomly inspecting servers or employee workstation hard-drive information content. Reviews allow the RCMP to assess IT security and remedy deficiencies.

## 2. General

1. RCMP Information Management (IM) and Information Technology (IT) hardware, software and systems, e.g. laptops, desktops, mainframe, networks, e-mail, exist to support RCMP administrative and operational functions and official National Police Services (NPS) matters.

2. Use of RCMP IM/IT systems is restricted to RCMP employees, authorized organizations and their agents working on behalf of the RCMP, and authorized organizations and their agents working under the NPS network.

3. Access to RCMP IM/IT systems is limited to official RCMP and NPS administrative and operational business, and the functions specifically designated for those systems and facilities.

4. Use of RCMP IM/IT systems for personal profit, personal recreation or illegal purposes or storage of non-work related information is prohibited.

5. External organizations using RCMP IM/IT systems are responsible for the actions of their employee and any other persons acting on their behalf.

6. The RCMP will monitor the use of RCMP IM/IT systems and conduct field compliance reviews to ensure government security and RCMP directives are being followed, appropriately

used, and system integrity is maintained. The RCMP will randomly monitor routine use of networks and specific employee use.

7. All software and hardware used or connected to RCMP IM/IT systems must be authorized by the Regional Informatics Officer (RIO)/delegate. Software may only be downloaded from the Internet by authorized personnel when it is work related and been approved by the RIO/delegate. All hardware and software will be configured to national RCMP standards.

8. Before being used on an RCMP IM/IT system, all files contained on any external storage media, e.g. diskette, CD, USB memory stick, must be scanned by a current virus scanner approved by the Departmental Security Officer (DSO) to ensure they are virus free.

9. Laptop computer users must ensure there is adequate IT and physical security for the laptops and any data contained in them. Users traveling outside North America must encrypt their laptops' hard drives using encryption software approved by the DSO.

10. USB tokens that contain user's encryption keys must not be left unattended with the workstation. When the token is no longer being used, it must be locked in an approved container or kept on the employee's person. Contact Physical Security Sec., DSB for container specifications. Contact the Help Desk immediately if a token is lost or stolen.

3. **RCMP/NPS Systems**

1. Only desktop and laptop workstations approved by the RIO/delegate may be connected to RCMP IM/IT systems.

1. Once a desktop workstation is connected to the network, it must not be moved to a different location. All requests for relocations will be made through the LAN Administrator or Help Desk.

2. The user will not alter a workstation's configuration. All requests for different configurations will be made through the LAN Administrator or Help Desk.

2. Installation of software on RCMP IM/IT systems will be performed by the LAN Administrator or an employee who has approval from the RIO/delegate.

3. Standard configuration of RCMP IM/IT systems provides for the storage and transmission of data up to and including the security designation of Protected-A. Approved encryption must be used to store or transmit Protected-B information. Higher levels of information must be processed using an approved IM/IT security solution.

4. The data saved on removable media, e.g. floppy diskette, removable hard disk, optical drive, USB memory stick, must be protected in accordance with the highest level of sensitivity of the information. The employee is responsible for using approved encryption or physical security or both. Storage media must be labeled in accordance with the highest level of information it contains.

5. Software on the RCMP IM/IT systems is covered by RCMP license agreement. Unauthorized copying of software programs may lead to prosecution under the *Copyright Act*. Unlicensed software is prohibited on RCMP IM/IT systems.

6. Creating backup copies of the data stored on the user's local workstation is the responsibility of the user. Use of a removable device for backup storage is appropriate.

7. The ROSS system cannot be used to replace the RCMP records system. All data which meet the criteria of a **record** as defined in IM IV.1. must be stored in an official RCMP file. Users are responsible for the cleanup of old data from their ROSS home and shared drives.

8. The RCMP e-mail system (GroupWise) is a delivery system only. E-mail messages which meet the criteria of a record as defined in IM IV.1. must be stored in an official RCMP file. Mail messages will be retained on the system for a maximum of 90 days. If a user wants to retain a message more than 90 days, the user may store (archive) it to his/her local hard disk subject to sec. 3.6.

9. When using E-mail on the RCMP IM/IT systems:

1. If you will be absent for up to three months, appoint a proxy to read and respond to your mail or forward it to another user for action.

2. If you will be absent for more than three months, create a rule to have an automated reply to e-mail messages and appoint a proxy to read and respond to your mail or forward it to another user for action.

3. Use caution when using automated reply messages (rules). An improperly created rule can cripple a local post office. Contact the Help Desk for assistance to create a rule.

4. Large file attachments (greater than 100 KB), should only be sent during quiet hours, after 15:00 hours local time. These messages, including attachments, must not exceed 5 MB.

10. Out-of-office messages:

1. must be in both official languages when required by position language profile as indicated in the Directive on the Use of Official Languages in Electronic Communications;

2. will contain very little detail of circumstances and job title;

3. will provide an alternative centralized contact within the organization to deal with enquiries; and

4. will not contain the original message, any sensitive information and any attachments.

11. To protect system security when you are away from your workstation for less than four

hours:

1. Lock the workstation, i.e. Ctrl + Alt + Delete, followed by the Enter key.

2. Set the workstation screen saver, including the password option, which activates after 10 minutes of inactivity.

12. Logout from the RCMP IM/IT systems if you are going to be away from your workstation for more than four hours.

4. **External E-mail (Internet)**

1. Do not send any protected information without using encryption systems approved by the DSO. Sending classified or Protected-C information by external e-mail is prohibited.

2. Messages with attachments sent over the Internet will be limited to 5 MB.

3. Do not act on any official request without explicitly verifying the originator's identify and validity of the request.

4. Access to Internet mail sites, e.g. Hot Mail, Instant messenger, from RCMP IM/IT systems is prohibited. Use your GroupWise account for all internal and external E-mail.

5. To reduce the risk of receiving unsolicited advertising (SPAM), be cautious when divulging your E-mail address.

5. **Use of Virtual Private Networks (VPN)**

1. Use CIO-approved configuration.

2. Within RCMP buildings (Operations Zone or higher), terminate the VPN session if you plan to leave the workstation unattended for more than one hour.

3. For all other locations, e.g. home, hotel room, terminate the VPN session immediately when unattended.

4. Be aware that your workstation is live and vulnerable on the Internet until you start your VPN session and immediately after terminating your VPN session. Physically disconnect your workstation from the Internet when not in use.

6. **Internet Access (Non E-mail)**

1. Access to Internet services is only permitted using:

1. standalone workstations through an internet service provider,

2. DSO-approved private networks which are not inter-connected with any other RCMP network,

3. approved removable hard-disk workstations where one hard disk is used exclusively for Internet access and non-sensitive information, or

4. RCMP-configured workstations using the RCMP Intranet (InfoWeb).

2. Release of official RCMP information, including photographs, on any Internet website will be approved by the level of management specified in the RCMP Manuals, or where no policy exists, by the level of management responsible for the creation of that information. RCMP-related information cannot be shared on-line in places such as chat rooms and blogs (web logs).

3. Only non-sensitive information may be transmitted in clear text over the Internet.Protected or Classified information must only be transmitted using encryption systems approved by the DSO.

**Acknowledgement of Responsibility**

I have read and agree to comply with the provisions of the Acceptable User Practices for RCMP Information Technology.

| | | | |
|---|---|---|---|
| Employee: | | Witness (Supervisor/Manager): | |
| Signature: | _____ | Signature: | _____ |
| Print Name: | _____ | Print Name: | _____ |
| Date: | _____ | Date: | _____ |
| | YYYY-MM-DD | | YYYY-MM-DD |

(when signed, file with form 2871)

Amended 2011-11-15

## APPENDIX 10 TO ANNEX A2

## RCMP HEALTH CARE PROVIDER OCCUPATIONAL GROUPS AND CATEGORIES

## RCMP HEALTH CARE PROVIDER OCCUPATIONAL GROUPS & CATEGORIES

| NUMBER | CATEGORY | STREAMS |
|---|---|---|
| 1. | Physician | 6, 7, 8 |
| 2. | Psychologist | 6, 7, 8 |
| 3. | Occupational Health Nurse | 6, 7, 8 |

# APPENDIX 11 TO ANNEX A2

# RCMP HCP QUALIFICATIONS AND TASKS

**RCMP HCP WORK LOCATIONS**

**OCCUPATIONAL HEALTH CATEGORY: Health Services Officer (HSO)**

HSOs are occupational health physicians with knowledge of medicine, workplace and stakeholder interest, ergonomics, human factors, industrial hygiene, toxicology and disability management. Their scope includes the effect of work on human health and effects of health on an employee's ability to work.

**WORK AND ENVIRONMENT:**

The HSO is a member of the Occupational Health and Safety Services team and provides on-site periodic health assessments (PHA) to RCMP members/applicants; assists with disability case management; acts as a medical advisor for the determination of eligibility and approval of benefits under the RCMP's Supplemental and Occupational Health Care (SHC and OHC) programs; and performs administrative/organizational tasks as required. The HSO reports directly to the Officer in Charge of Occupational Health and Safety Services.

**EDUCATION AND CREDENTIALS:**

HSOs shall possess, as a minimum:

A licence from the provincial or territorial regulatory organization in the province or territory of practice.

Five (5) years within the last ten (10) years of clinical experience.

**TASKS:**

**The required tasks may include, but are not limited to the following:**

**Periodic Health Assessments (PHA):**

- Performs member PHAs, reviews results and assigns a medical profile to members based upon objective determinations of fitness for duty in accordance with occupational health standards and RCMP policies. It includes the assessment of the member's following key abilities: performance of maximal physical exertion, use of a duty firearm, emergency vehicle driving, making an arrest and acting as a witness in the context of police work and in accordance with RCMP policies.

- Performs applicant PHAs, reviews results of PHAs, psychological reports and assigns medical profile in accordance with the RCMP applicant standards. Responsible for coordinating any further follow-up or evaluative assessments when any area of the assessment shows concern; and to follow RCMP policies and procedure, which may

include the requirement to respond to requests for information.

- Performs return to work evaluations after absence, illness or injury. Other duties include performing Special Assignment Examinations, Special Assignment Examinations, and Special Medical Evaluations, when there is a reason to suspect an underlying health issue.

- Determines occupational suitability of members and their families for overseas, isolated and liaison officer postings.

**Medical Disability Case Management:**

- Reviews medical information to substantiate medical leave requests and provides occupational health recommendations, including review of treatment plans, return to work capabilities, permanent or temporary limitations and restrictions.

- May recommend and arrange an employer mandated medical assessments (a.k.a. independent medical exams).

- Provides recommendation to the Integrated Services Committee (ISC) regarding a member's suitability to return to work.

- May be required, on occasion, to make recommendation toward administrative discharge in the event that a member is no longer capable, due to medical illness or condition, of performing work for the RCMP.

**Medical Advisor:**

- Reviews individual requests for extensions of ongoing benefits/treatment modalities and medical investigations and /or treatments that have been provided or recommended by the member’s health care provider for coverage under the RCMP’s OHC and SHC program.

- Advises management and employees with regard to health problems and work environment, including health hazards and statutory requirements.

- Provides health hazard identification, assessments, investigation and related medical surveillance.

- Counsels and educates members occupying high-risk positions in relation to medical advice.

- Liaises with external healthcare providers.

- Establishes prevention and immunization programs.

**Administrative/Organizational Requirements:**

- Provides direction and guidance to the health services team, including nurses, psychologists and administrative staff.

- Reviews medical records for ATIP requests and provides recommendation regarding medical information exemption under Sec. 28 of the Privacy Act.

- May perform environmental scans of police universe to identify potential health risks and safety impacts and reports recommendations for remedial actions accordingly.

- Participates in multi-disciplinary team meetings.

- Maintains an expert and extensive knowledge of developments of current best practices in occupational health through continued medical education.

- Provides medical expertise, including advice on standards, policy and program evaluation, surveillance methods, peer review of publications, monographs, research results, etc.; may be required to prepare briefings and media materials and respond to external requests for information.

**OCCUPATIONAL HEALTH CATEGORY: Psychologist**

**WORK AND ENVIRONMENT:**

The Clinical Psychologist is a member of the Occupational Health and Safety Services team. They provide professional services relating to the diagnosis, assessment, evaluation, treatment and prevention of psychological, emotional, psycho-physiological and behavioural disorders with the adult population. Clinical Psychologists focus on promotion of physical, intellectual, emotional, interpersonal and social well-being. Clinical Psychologists receive patients through referrals from other health care providers.

**EDUCATION AND CREDENTIALS:**

All Clinical Psychologists must possess, as a minimum

A Master's or Doctoral Degree in Adult Clinical Psychology from a recognized university or equivalent (equivalence in training is determined by the provincial licensing body); and

Registration for autonomous practice of psychology by a provincial or a territorial registering or licensing body in the province of practice.

**EXPERIENCE LEVELS:**

Three Levels of Experience have been defined for the Clinical Psychologist Category:

**Level 1:**

The Clinical Psychologist shall possess a minimum of 2 years' experience in psycho-diagnostic assessment services provided to adults including differential diagnosis and providing cognitive behavioural therapy;

**Level 2:**

The Clinical Psychologist shall possess a minimum of 5 years' experience in psycho-diagnostic assessment services provided to adults including differential diagnosis and providing cognitive behavioural therapy;

**Level 3:**

The Clinical Psychologist shall possess a minimum of 10 years' experience in psycho-diagnostic assessment services provided to adults including differential diagnosis and providing cognitive behavioural therapy;

**TASKS:**

**The required tasks may include, but are not limited to the following:**

**Critical Incident Stress Management (CISM)**

- Provides consultation within the CISM program services including individual and group debriefings when required.

- Attends sites on short notice when requested in order to conduct immediate fitness for duty assessments.

- Participates in the delivery of psychological services with Health Services, Peer to Peer program, Employee and Management Relations Officer, Human Resources and Senior Management.

- Makes referrals to various health care professionals where required.

**Cadet Screening**

- Administers a full range of diagnostic tests for psychometric assessment, interpret results, and prepare psychological evaluations.

- If deemed necessary, schedules and completes a follow-up interview with applicants in order to arrive at a definitive recommendation.

- Completes and provides the HSO with a definitive written recommendation of psychological suitability for all cadet applicants who complete the required RCMP Nationally approved psychological screening tests.

- Responds to applicant, Access to Information Program (ATIP) and Human Rights Commission requests for information about deferral/rejections decisions.

- Consults with divisional HSO and Recruiting Units as required in order to resolve specific cases or to address required changes to the cadet screening process.

**Specialized Psychological Assessments**

- Conducts mandatory psychological assessments and debriefings with members being posted to specialized Units and Isolated Posts. These assessments are for the purpose of

screening in/out of section and monitoring the mental health and fitness for specialized duty of members.

- Conducts / coordinates group debriefings as needed and requested.

- Provides the HSO with a written recommendation of the psychological suitability of each applicant employee.

- Conducts member involved firearm shooting interviews for fitness for duty assessments / recommendations

**Occupational Health**

- Provide a specialized clinical psychological assessments and diagnostic consultations for Members and Civilian Members upon referral.

- Responds to requests for services and screen referrals to determine need for assessment and/or intervention, considering referral to and liaison with other physicians/psychologists where appropriate.

- Assesses and determines steps to be taken when a member is a danger to him/herself or others, coordinating with Divisional HSO and other professionals on such matters.

- Participates in multi-disciplinary team consultations with the Divisional HSO, Occupational Health Nurse, Divisional Integrated Services Committee and external specialists to determine fitness for duty, return to work and long term disability planning for members with psychological conditions.

- Conducts fitness for duty assessments at the request of the Divisional HSO.

- Conducts assessments and consultation for performance enhancement situations.

- Reviews and comments on analysis and decisions made by other health professionals.

- Provides recommendation on fitness for duty for members returning to work after a mental health related sick leave period

**Administrative/Organizational Requirements:**

- Provides professional consultation and advice to RCMP Management, Divisional Health Services Officer (HSO), members, Peer to Peer program, and the organization about mental health crises and the delivery of psychological services within the Division.

- Completes all tasks and reports in accordance with the established RCMP occupational health policies, guidelines and procedures.

- Leads or participates in patient counselling group sessions for specific mental illnesses such as anxiety, PTSD, depression, and stress management.

**OCCUPATIONAL CATEGORY: Occupational Health Nurse (OHN)**

**WORK AND ENVIRONMENT:**

The Occupational Health Nurse (OHN) is responsible for providing occupational health services to RCMP members to promote and optimize the health and well-being of members. The OHN's work within a multidisciplinary team environment for the delivery of occupational health nursing services and programs to members.

**EDUCATION AND CREDENTIALS:**

All Occupational Health Nurses must possess, as a minimum:

A Baccalaureate Degree in Nursing from a recognized university; and

Occupational Health Nurse Certificate; and

A current license to practice from a provincial or territorial College of Nurses

**EXPERIENCE:**

The OHN shall possess a minimum of 3 years' experience within the last 5 years in an occupational health environment.

**TASKS:**

**The tasks may include but are not limited to the following:**

**Occupational Health:**

- Performs Standards of Practice in accordance with the provincial/territorial nursing regulatory body.

- Assists RCMP health services officer (physicians) to perform pre-employment and periodic examinations according to guidelines found within the RCMP health services manual.

- Plans, organizes and performs screening tests such as but not limited to; audiograms, vision testing, pulmonary function testing, electrocardiograms, and blood pressure reading.

- Coordinates and implements the immunization program.

- Arranges and coordinates with community provider's periodic and special health assessments.

- Collection and interpretation of pertinent data for statistical reporting requirements.

- Participates in multidisciplinary team meetings and working groups, as a member of the RCMP health services team.

- Maintains a comprehensive understanding of the interaction between members, the work and the environment in which their duties are performed.

- Develops and maintains a network of partnerships with internal and external community organizations within the OHN's geographical area.

- Conducts quarterly presentations to units, internal and external agencies to promote occupational health nursing services.

- Promotes and enhances peer development by sharing individual skills and knowledge through mentorship.

**Medical Disability Case Management:**

- Participates in multidisciplinary team meetings and working groups, as a member of the RCMP health services team.

- Gathers member's functional abilities, limitations and restrictions to support a timely, safe return to work program in conjunction with other stakeholders, the member and the member's care provider.

- Reviews all information gathered from consultation with the member and determines if all available information supports the member's absence from work and for what time frame.

- Reviews functional abilities, limitations, and restrictions as recommended by the physician, confirms if temporary or permanent, and communicates to stakeholders.

- Educates members about their health condition(s) and provides them with information and eligibility criteria on benefits and entitlements.

- Provides current health and services information to members in order for them to make informed decisions and to access a broad range of community, provincial, and federal

services. The services include, Veterans Affairs Canada (VAC), Public Service Health Care Plan or Public Service Dental Plan (PSHCP or PSDP), provincial health-care card and so on.

- Provides the medical case management perspective at various meetings such as case conference.

- Conducts quarterly presentations to units, internal and external agencies to promote the Case Management program.

**APPENDIX 12 TO ANNEX A2**

**RCMP HCP WORK LOCATIONS**

**RCMP HCP WORK LOCATIONS**

The RCMP may request resources for any of the identified location.

| DIVISION | LANGUAGE<br>E=English;<br>F=French;<br>B=Both<br>(bilingual) | RCMP HEALTH SERVICES OFFICES<br>ADDRESS |
|---|---|---|
| "N" & "S" | B | 73. Leikin Dr.<br>M5, 1st floor –Mailstop #34<br>Ottawa, ON K1A 0R2 |
| "B" | E | PO Box 9700<br>St. John's, NL<br>A1A 3T5 |
| "H" | E | Mailstop #H-062<br>80 Garland Avenue<br>Dartmouth, NS B3B 0J8 |
| "J" | B | Regent St.<br>PO Box 3900<br>Fredericton, NB E3B 4Z8 |
| "C" | B | 4225 Dorchester Blvd. W<br>Westmount, QC H3Z 1V5 |
| "O" | B | 345 Harry Walker Parkway South<br>Room 211B<br>Newmarket, ON L3Y 8P6 |
| "D" | E | PO Box 5650<br>Winnipeg, MB R3C 3K2 |
| "F" & "DEPOT" | E | 5600 – 11th Ave<br>PO Box 6500<br>Regina, SK S4P 3J7 |
| "K" | E | 11140 – 109 St.<br>Edmonton, AB T5G 2T4 |
| "E" | E | Mailstop #1208<br>14200 Green Timbers Way<br>Surrey, BC V3T 6P3 |
| OHSB | B | 73 Leikin Dr. |

| DIVISION | LANGUAGE<br>E=English;<br>F=French;<br>B=Both<br>(bilingual) | RCMP HEALTH SERVICES OFFICES<br>ADDRESS |
|---|---|---|
| | | M5, 3rd floor Mailstop #40<br>Ottawa, ON, K1A 0R2 |
| IHPW | B | 73 Leikin Dr.<br>M2, Mailstop #70<br>Ottawa, ON, K1A 0R2 |
| Recruiting | B | 73 Leikin Dr.<br>M5, 4th floor<br>Ottawa, ON, K1A 0R2 |

Notes:
1. The language column is meant to indicate the general language of work at the work location and is presented for information purposes only. The HCP language requirement shall be specified on the Task Authorization.
2. Language profiles for each all location will be verified; thus this information will be subject to change at next SOW release.

**APPENDIX 13 OF ANNEX A2**

**RCMP HCP REQUIREMENTS PLAN SAMPLE**

**(ATTACHED)**

**APPENDIX 14 TO ANNEX A2**

**RCMP DELIVERABLES TABLE**

## RCMP Deliverables Table

| D # | SOW Para # | Deliverable Description | Format H: Hard Copy S: Electronic | Information (I) Approval (A) | Frequency | Required Delivery Date | Delivery To |
|---|---|---|---|---|---|---|---|
| **Electronic for all deliverables unless otherwise indicated** | | | | | | | |
| 1. | 4.3.6 | Contractor's Central Office Set-up Notification with a toll free telephone number, teleconference number, and an email address | | I | Once | Within 10 calendar days of ACA | CA<br>DTA DPA |
| 2. | 4.3.7 and 4.4.1 | The names, titles, roles and responsibility, and contact information for each personnel employed within the CCO and CMT. | | I | Once | At Initial Contract Kick-Off Meeting (4.4.1.) | CA<br>DTA<br>DPA |
| 3. | 4.3.8 and 4.4.2 | Changes made to the CCO and CMT personnel | | I | As required | Within five (5) calendar days of change (4.3.8)<br>Within two (2) calendar days of the change (4.4.2) | CA<br>DTA<br>DPA |
| 4. | 4.5.5 and 4.6.2 | Name and contact information for SDM and DSDM | | I | As required | Within five (5) calendar days ACA | CA<br>DTA<br>DPA |

| D # | SOW Para # | Deliverable Description | Format H: Hard Copy S: Electronic | Information (I) Approval (A) | Frequency | Required Delivery Date | Delivery To |
|---|---|---|---|---|---|---|---|
| 5. | 4.5.8 and 4.6.4 | Notice of intent to permanently replace the SDM and DSDM | | I | As required | Minimum of 30 calendar days for SDM; Minimum of 15 calendar days for DSDM | CA<br>DTA<br>DPA |
| 6. | 4.7 | Contractor's Draft Start-Up Plan and Final Start-Up Plan | | A | Once | Within 14 calendar days of ACA | CA<br>DTA<br>DPA |
| 7. | 4.7.3 | Revised and update Start-Up Plan | | A | Once | Within 10 calendar days of receiving DTA feedback | CA<br>DTA<br>DPA |
| 8. | 4.8 | Contractor's Draft Recruitment Plan | | A | Once | Within 30 calendar days ACA | CA<br>DTA<br>DPA |
| 9. | 4.8.3 | Contractor's Final Recruitment Plan | | A | Once | Within 20 calendar days of receiving DTA feedback | CA<br>DTA<br>DPA |
| 10. | 4.8.6 | Contractor's Updated or revised Recruitment Plan | | A | As required and annually | Within 10 calendar days of any changes | CA<br>DTA<br>DPA |
| 11. | 4.9 | Contractor's Risk Management Plan (CRMP) | | A | Once | Within 30 calendar days of ACA | CA<br>DTA<br>DPA |
| 12. | 4.9.4 | Contractor's Final Risk Management Plan | | A | Once | 20 calendar days after receipt of input | CA<br>DTA |

| D # | SOW Para # | Deliverable Description | Format H: Hard Copy S: Electronic | Information (I) Approval (A) | Frequency | Required Delivery Date | Delivery To |
|---|---|---|---|---|---|---|---|
| | | | | | | | DPA |
| 13. | 4.9.6 | Contractor's Updated Risk Management Plan | | A | As updated and for each PRM | Within 10 calendar days of any changes and for each PRM | CA<br>DTA<br>DPA |
| 14. | 4.9.8 | Advance electronic copies of updated CRMP | | I | As detailed | Five (5) calendar days before each PRM | CA<br>DTA<br>DPA |
| 15. | 4.9.9 | Hard Copies of current CRMP to each attendee | H | I | As detailed | Day of PRM | To each attendee at the PRM |
| 16. | 4.9.10 | Report occurrence of substantive risk | | I | As detailed | Within three (3) calendar days of occurrence | DTA |
| 17. | 4.10 | Draft Contractor's Management Plan (CMP) | | A | Once | Within 30 calendar days ACA | CA<br>DTA<br>DPA |
| 18. | 4.10.3 | Final Contractor's Management Plan | | A | Once | Within 20 calendar days after receipt of input | CA<br>DTA<br>DPA |
| 19. | 4.10.6 | Updated Contractor's Management Plan | | A | As updated | Within 10 calendar days of any changes and April of each year | DTA |

| D # | SOW Para # | Deliverable Description | Format H: Hard Copy S: Electronic | Information (I) Approval (A) | Frequency | Required Delivery Date | Delivery To |
|---|---|---|---|---|---|---|---|
| 20. | 4.11 | Contractor's draft communications for circulation to the public, etc | | A | As - each is developed | Within 30 calendar days when draft is accepted and approved | CA<br>DTA |
| 21. | 4.13 | Start-Up Phase Lessons Learned Document | | I | Once | Within 30 calendar days of SED | DTA |
| 22. | 4.13 | In-Service Phase Annual Lessons Learned Report | | I | Annually | June of each year | DTA |
| 23. | 4.13 | Outgoing Phase Lessons Learned Report | | I | Once | Two-months before the Contract expiry date | DTA |
| 24. | 4.14.1<br>4.22 | Timesheet Tool and User Manual | | A | Once | Ready for use 60 calendar days before the SED | CA<br>DTA<br>DPA |
| 25. | 4.14.13 | Timesheet Tool demonstration for the DA at RCMP | | I | Once | Five (5) calendar days of Timesheet Tool setup notification | DTA<br>DPA |
| 26. | 4.24 | Contractor TTP Acceptable Delay Justification | | A | As required | Within 30 calendar days before the HCP required start date | DTA |
| 27. | 4.25.6 | Contractor Notification of HCP Licence Change | S | I | By occurrence | Same business day or next business day if following a weekend | |

| D # | SOW Para # | Deliverable Description | Format H: Hard Copy S: Electronic | Information (I) Approval (A) | Frequency | Required Delivery Date | Delivery To |
|---|---|---|---|---|---|---|---|
| 28. | 4.27.1 and 5.6 | Recurring HCP Task Authorization Confirmation Report | | A | Annually | 30 calendar days from Receipt of Annual HCP Requirement Plan | DTA DPA |
| 29. | 4.27.2 | Task Authorization Response Package | | A | By task authorization | No later than 20 calendar days prior to HCP Start Date | DPA |
| 30. | 4.28.1 | Orientation Package – HCP Acknowledgement Form | | I | As required | For each HCP | DTA DPA |
| 31. | 4.32.1 | HCP Overtime Authorization | | A | As required | With each overtime invoice | DPA |
| 32. | 4.33.5 | HCP On-Call Authorization and Schedule in accordance with Annex B – Basis of Payment RCMP | | A | As required | With each On-call invoice | DTA DPA |
| 33. | 4.34.3 | HCP Call-Back Approval and Schedule in accordance with Annex B – Basis of Payment RCMP | | A | As required | With each Call-Back invoice | DTA DPA |
| 34. | 4.35.4 | HCP Travel Expenses with original receipts | | A | As required | With each HCP Travel invoice | DTA DPA |
| 35. | 4.54.1 | Prepare and Maintain Action Item Log (AIL) | | A | Once | Initial Contract Kick-off Meeting | All meeting participants |

| D # | SOW Para # | Deliverable Description | Format H: Hard Copy S: Electronic | Information (I) Approval (A) | Frequency | Required Delivery Date | Delivery To |
|---|---|---|---|---|---|---|---|
| 36. | 4.54.5 | Update AIL | | A | As required | Ongoing | All meeting participants |
| 37. | 4.56 | Start-up Phase Status Report | | I | Monthly | During Start-up Phase | CA<br>DTA<br>DPA |
| 38. | 4.57 | Task Authorization Status Report | | I | Monthly | Within seven (7) calendar days following month end | DTA |
| 39. | 4.58 | Initial Credentialing Report | | I | Once | At least 30 days prior to SED | DTA |
| 40. | 4.58 | Semi-annual Credentialing Report | | I | Semi-annual | Within seven (7) calendar days of the end of September, Within seven (7) calendar days of the end of March | DTA |
| 41. | 4.59 | Monthly HCP Travel Report | | I | Monthly | Within seven (7) calendar days following month end | DTA |
| 42. | 4.60 | Monthly HCP Labour, Overtime, and On-Call and Call-Back Report | | I | Monthly | Within seven (7) calendar days following month end | DTA |
| 43. | 4.61 | HCPs Certification Reports | | I | Annually | At SED and annually thereafter and for each re-test | DTA |

| D # | SOW Para # | Deliverable Description | Format H: Hard Copy S: Electronic | Information (I) Approval (A) | Frequency | Required Delivery Date | Delivery To |
|---|---|---|---|---|---|---|---|
| 44. | 4.62 | Draft Out-Going Phase Plan | | A | Once | At Out-Going Phase Kick-off meeting | All meeting participants |
| 45. | 4.63 and 4.63.3 | Final Out-Going Phase Plan | | A | Once | Within 10 calendar days from receipt of DTA comments | CA, DTA, DPA |
| 46. | 5.0 | Consolidated table for all deliverables | | A | As detailed | In accordance to approval process | DTA |

**APPENDIX 15 TO ANNEX A2**

**NOT APPLICABLE TO RCMP**

**APPENDIX 16 TO ANNEX A2**

**RCMP WORK ENVIRONMENT ORIENTATION PACKAGE**
**(to be provided at time of Contract Award)**

# APPENDIX 17 TO ANNEX A2

# LIST OF FEDERAL GOVERNMENT HOLIDAYS

# List of Federal Government Holidays

## Designated and Other Holidays

| Serial | Holiday | Date | Comments |
|---|---|---|---|
| 1 | New Year's Day | 1 January | Notes 1,3 |
| 2 | Good Friday | TBD | Notes 3 |
| 3 | Easter Monday | TBD | Notes 3 |
| 4 | Victoria Day/Queen's Birthday | preceding 25 May | Notes 3 |
| 5 | Canada Day | 1 July | Notes 1,3 |
| 6 | Labour Day | First Monday in September | Notes 3 |
| 7 | Thanksgiving Day | Second Monday in October | Notes 3 |
| 8 | Remembrance Day | 11 November | Notes 1,3 |
| 9 | Christmas Day | 25 December | Notes 2,3 |
| 10 | Boxing Day | 26 December | Notes 2,3 |
| 11 | Any day appointed by proclamation by the Governor in Council to be observed as a fast, thanksgiving or holiday. These holidays will be granted on the authority of the Technical Authority | TBD | n/a |
| 12 | One provincial or local civic holiday per leave year may be observed at the discretion of the Technical Authority | TBD | n/a |

Notes:

1. When 1 January, 1 July or 11 November fall on a Saturday or Sunday, the following Monday will be taken as the designated holiday.
2. When Christmas Day falls on a Saturday or Sunday the following Monday and Tuesday will be taken as the designated Christmas/Boxing Day holidays. When Christmas falls on a Friday, the following Monday will be taken as the designated Boxing Day holiday.
3. Serials 1 to 10 are designated holidays.

**APPENDIX 18 TO ANNEX A2**

**NOT APPLICABLE TO RCMP**

**APPENDIX 19 TO ANNEX A2**

**LIST OF GOVERNMENT FURNISHED INFORMATION**

## APPENDIX 19 – LIST OF GOVERNMENT FURNISHED INFORMATION

| No | SOW Reference | Description | Delivery Date | Delivered To | Delivered By |
|---|---|---|---|---|---|
| 1. | 1.4.4 | DA and TM Names | After Contract Award | Contractor | DTA |
| 2. | 2.2 | Amendments, revisions and bulletins to RCMP Applicable Documents | As required | Contractor | DTA |
| 3. | 3.13 | Temporary Change to HCP(s) Work Location(s) Outside Designated RCMP Location(s) or Province of Work | DTA's written approval seven (7) calendar days in advance | Contractor | DTA |
| 4. | 4.14.3 | Location and address for the demonstration of the Timesheet Tool | After Contract Award | Contractor | DTA |
| 5. | 4.23 | Initial HCP Requirements Plan and Associated RCMP Task Authorization | ACA at Initial Kick-off Meeting | Contractor | DPA/TA |
| 6. | 4.25.2 | New HCP Requirements via RCMP Task Authorization | As and when required basis | Contractor | DPA |
| 7. | 3.12 | Additional 20 Calendar Days Time-To-Provide Notice | When approved | Contractor | DPA |
| 8. | 4.43 | Cancellation of a Task Authorization Notice for RCMP Task Authorizations | When required | Contractor | DPA |
| 9. | 4.62 | Name of the N95 Mask manufacturer(s) | Within 10 days ACA | Contractor | DTA |
| 10. | 4.27 | Annual HCP Requirements Plan | Within the first seven (7) calendar days of December each year | Contractor | DTA |
| 11. | 4.35 | Travel | When required | Contractor | DTA |
| 12. | 4.50 | Initial Contract Kick-Off Meeting date and address | Within 14 calendar days ACA | Contractor | DTA |
| 13. | 4.51.5 | PRM Agendas | 7 calendar days before meeting | Contractor | DTA |
| 14. | 4.52.5 | Ad Hoc Invitation and Agenda | As required | Contractor | Party Requesting Meeting |
| 15. | 4.66.4 | FPR Meeting Agenda | Seven (7) calendar days before meeting | Contractor | DTA |

## APPENDIX 20 TO ANNEX A2

## ROLES AND RESPONSIBILITIES OF RCMP HEALTH SERVICES

RCMP
ROYAL CANADIAN MOUNTED POLICE

# Occupational Health and Safety Branch (OHSB) Roles and Responsibilities

## National Occupational Health Services Workshop

HH1

**November 2015**

Royal Canadian Mounted Police / Gendarmerie royale du Canada

Canada

**Slide 1**

**HH1** Is this the date that the event occurred or are you providing a current day update on the workshop?

Hamilton, Heather, 15/12/2016

RCMP
ROYAL CANADIAN MOUNTED POLICE

# OHSB Roles and Responsibilities

Centre of Expertise, with SMEs to:

1. Provide advice, guidance and support to divisions
2. Oversee policy and program development
3. Develop guidelines and tools
4. Ensure quality assurance
5. Coordinate national response to media, ministerial requests, and reports
6. Provide strategic advice to senior management

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# Occupational Health Program Mandate

The Occupational Health Program and Control (OHPC) team supports front line policing operations by establishing and overseeing programs and policies to:

- assess a member's fitness to safely perform their duties;
- coordinate services or assessments in support of an ill or injured member's recovery; and
- provide a consistent member-centered return to work and accommodation approach through which an ill or injured member's connection to the workplace is maintained during recovery.

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# Health Service Officers (HSO) Roles and Responsibilities

## National Occupational Health Services Workshop

**November 2015**

RCMP
ROYAL CANADIAN MOUNTED POLICE

# HSO Roles and Responsibilities

1. Health Evaluations
   - Applicant / Periodic Health Assessment / Special Assessment
2. Medical Disability Case Management
   - Sick leave / Gradual Return to Work / Evaluation of Treatment Plans / Workplace Accommodation
3. Occupational Health Subject Matter Expert (SME)
   - Advice and consultation to OHSS team / Advisory role to CO
4. Immunization and Travel Medicine
5. Work Related Accidents and Incidents
6. Medical Oversight of Health Professionals
7. Medical Records Management

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# 1. Health Evaluations

- Conduct and/or review of health evaluations of applicants and members.
- Review laboratory result**s**, medical reports and medical information.
- Request medical information.
- Health assessment for the determination of medical fitness.
- Provide medical recommendation**s** pertaining to functional ability, limitations and restrictions.
- Professional oversight of delegated medical acts.
- Point of contact for designate physician and external providers.
- Provide emergency treatment if appropriate and refer if necessary.

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# 2. Medical Disability Case Management

- Request and review medical information, assessments and treatment plans to ensure member is receiving appropriate and timely treatment.
- Provide recommendations to CO, supervisor and other players in respect to health issues affecting sick leave, return to work and accommodation.
- Provides medical interpretation and assessment of individual requests for determination of benefit entitlement.
- Assessment for the determination of functional abilities, restrictions and limitations and abilities of the member; and update the medical profile accordingly.
- Review and discuss medical information with the member.
- Liaison with external health professional.
- Assistance with medical referrals, investigations and treatments when necessary, as per applicable policy.

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# 3. Occupational Health SME

- Advice and consultation to Occupational Health team.
- Advice and consultation to CO and delegates (e.g. EMRO, OIC of Health) on occupational health issues affecting membership.
- Review of scientific literature and best practices.
- Representation of divisional OHSS unit where occupational health expertise is required.

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# 4. Immunization and Travel Medicine

- Ensure that all RMs receive the work related immunizations and screening tests.
- Activities may be delegated to a competent health professional.

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# 5. Work Related Accident and Incidents

- Enter in the medical file, reports of occupational and non occupational incidents, injuries and illnesses.
- Assist with the determination process as per guidelines.

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# 6. Oversight of Health Professionals

- For delegated activities, ensure procedures are in place.
- Leadership role within the interdisciplinary team, including training and orientation.
- Guiding role for external health professionals and designated practitioners.

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# 7. Medical File Management

- Maintain the integrity of health records and medical documentation of members in accordance with professional standards and applicable legislation. This is a shared organizational responsibility.
- Maintain and safeguard the confidentiality of medical records in accordance with Privacy legislation.

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# Occupational Health Nurses Roles and Responsibilities

## National Occupational Health Services Workshop

**November 2015**

RCMP
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# Nurses' Role and Responsibilities

1. Health Evaluations
   - Applicant / Periodic Health Assessment / Special Assessment
2. Medical Disability Case Management
   - Sick leave / Gradual Return to Work / Benefits / Workplace Accommodation
3. Occupational Health Subject Matter Expert (SME)
   - Advice and consultation to OHSS team and membership
4. Immunization and Travel Medicine
5. Work Related Accidents and Incidents
6. Medical Records Management

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# 1. Health Evaluations

- Plan, coordinate and monitor the PHA process.
- Conduct or arrange for hearing, vision, urine, blood, tuberculin testing and others.
- Prepare or arrange for RCMP Members (and others) for UN Missions and general foreign travel (i.e. missions).
- Review of immunization records, establish a schedule of required vaccines.
- Ensure that all test results are returned and reviewed prior to the HSO assigning medical profile.
- Prepare reports and statistical information.
- Ensure that standing orders are reviewed and signed by HSO.
- Provide emergency treatment if appropriate and refer  if necessary.

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# 2. Medical Disability Case Management

- Coordinate, monitor and track medical case management activities in Health Services and promote a collaborative approach.
- Under the direction of the health services officer:
  - Clarify the period of sick leave required for recovery.
  - Gather medical and functional abilities information and seek clarification when required.
  - Review all information gathered from consultation with the member and determine if all available information supports the member's absence from work and for what time frame.
  - Review functional abilities, limitations, and restrictions as recommended by the HSO and confirm if temporary or permanent and communicate to stakeholders.
  - Advise appropriate stakeholders of a member's expected return to work date.
  - Monitor the member's medical progress and identify barriers.

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# 3. Occupational Health SME

- Advice and consultation to Occupational Health team.
- Advice and consultation to membership on occupational health.
- Representation of divisional OHSS unit where occupational health expertise is required.

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# 4. Immunization and Travel Medicine

- Review, administer or arrange immunizations for prevention and travel protection and document.
- Record in “yellow immunization book” given immunizations.
- Perform tuberculin testing and reading.
- Update immunization record (form 3866) and put in member’s file.
- Send reviewed immunization record (form 3866) to delegated physician.

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# 5. Work Related Accident and Incidents

- Enter in the medical file, reports of occupational and non occupational incidents, injuries and illnesses
- Assist with the determination process as per guidelines

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# 6. Medical Record Management

- Maintain the integrity of health records and medical documentation of the members in accordance with professional standards and applicable legislation. This is a shared organizational responsibility.
- Maintain and safeguard the confidentiality of medical records in accordance with RCMP Policy and Privacy legislation.
- Disclosure of information from RCMP health record as per policy and consult policy center when in doubt.

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# RCMP Psychologists
# Roles and Responsibilities

## National Occupational Health Services Workshop

**November 2015**

RCMP
ROYAL CANADIAN MOUNTED POLICE

# Psychologists' Roles and Responsibilities

1. Applicant psychological screening.
2. High risk duties psychological assessments.
3. Referral to external providers and follow-up on treatment plans.
4. Special psychological assessments.
5. EMPA and disability management.
6. Crisis intervention and debriefing.
7. Interdisciplinary approach to DCM.

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# Psychologists' Roles and Responsibilities

8. Suspended and/or Code of Conduct
9. Records management
10. Post-mortem assessment
11. SME mental health strategy initiative – mental health week
12. Psycho-education presentations to managers and employees
13. Determination process

# ANNEX A3

# STATEMENT OF WORK (SOW)

# FOR

# VETERANS AFFAIRS CANADA

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## APPENDICES

Appendix 1- Glossary of Terminology

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Appendix 3 – Not applicable to VAC

Appendix 4 - Not applicable to VAC

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Appendix 6 – Not applicable to VAC

Appendix 7 – No applicable to VAC

Appendix 8 – Not applicable to VAC

Appendix 9 – Not applicable to VAC

Appendix 10 – VAC HCP Occupational Groups and Categories (small list)

Appendix 11 – VAC HCP Qualifications and Tasks

Appendix 12 – VAC - HCP Work Locations

Appendix 13 – VAC - Initial HCP Requirement Plan

Appendix 14 - VAC Deliverables Table

Appendix 15 – Not applicable to VAC

Appendix 16 - Not applicable to VAC

Appendix 17 – List of Federal Government Holidays

Appendix 18 – Not applicable to VAC

Appendix 19 - Not applicable to VAC

Appendix 20 - Not applicable to VAC

## 1.0 INTRODUCTION

### 1.1 Purpose

Veterans Affairs Canada (VAC) has a requirement for a Contractor to provide and manage Health Care Providers (HCPs) needed to supplement its workforce in providing health care support services at various locations across Canada.

### 1.2 General Information

Health professionals working at VAC provide professional health advice, consultation, assessments and decisions, as well as advice on legislation and policies, in support of VAC's mission to provide client-centered services and benefits that respond to the needs of clients. Health professionals working at VAC do not provide primary care to clients.

### 1.3 Background

VAC employs health professionals to provide services to the various offices across Canada. This workforce is supplemented with health professionals under contract, where necessary due to operational demand. In some cases, there is a recurring contractual need for health professional providers, which is supplied through various contractual arrangements.

### 1.4 Departmental Authorities

VAC Department Authorities (DAs) are responsible for the technical Work and contract management activities inside the Department and are as follows:

a. Departmental Technical Authority (DTA);

b. Departmental Procurement Authority (DPA) and

c. Task Manager (TM).

1.4.1 The DTA is the representative from VAC, for whom the Work is carried out under the Contract, and is responsible for all matters concerning the technical content of the Work under the Contract.

The DTA is responsible to:

a. administer the Task Authorization process; and,

b. verify and process the invoices for payment.

1.4.1.1 The Task Manager (TM) is responsive to the DTA and is the manager of the HCP. The TM is responsible to:

a. manage the Work being carried out under Task Authorization;

b. authorize temporary work location changes;

c. advise HCPs of unexpected temporary closures to work location;

d. authorize HCP overtime;

e. authorize HCP travel and Site Visits; and,

f. schedule hours of work.

1.4.2 The DPA is the representative of the VAC, responsible for all matters concerning the department's procurement work under Contract. The DPA is responsible for validating the technical requirements against scope of the Work and the Contract.

1.4.3 VAC will provide the DA names to the Contractor after Contract award.

1.5 **Terminology**

The glossary of Terminology, which includes abbreviations, is found at Appendix 1 to Annex A – SOW VAC.

## 2.0 APPLICABLE DOCUMENTS

For a complete list of applicable VAC documents, please refer to the Appendices listed in the Table of Contents above which form part of Annex A - SOW VAC:

a. Privacy Act, at http://laws-lois.justice.gc.ca/eng/acts/p-21/;

2.1 The Contractor or Contractor's Management Team (CMT) or Contractor's HCPs must use and apply the applicable documents in the performance and delivery of the Work.

## 3.0 SCOPE OF CONTRACT

The scope of Work under the Contract includes:

a. the provision of HCPs, which mainly consists of: recruiting; verification of credentials and references; hiring; obtaining HCP security clearances; and department introduction including the orientation package when applicable;

b. the management of the HCPs, which mainly consists of: retention; replacing or backfilling HCPs; accounting for hours worked by the HCP using the Timesheet Tool; credentialing; performance management and issue management when necessary, and

c. the contract management activities, which mainly consists of:

(1) planning, organizing and scheduling work and deliverables to meet the required timelines or schedule; establishing processes or procedures to provide and manage HCPs; administration and management of the Timesheet Tool;

(2) invoicing; preparing and providing various project management plans and reports;

(3) attending meetings; and

(4) establishing and maintaining the Contractor organizational structure and management team to support providing all the Contract requirements and deliverables.

## 3.1 Contract Objectives

The objectives of the Health Care Provider Contract (HCPC) are to ensure that VAC obtains the required number of qualified HCPs needed to supplement its existing workforce in providing services to support the delivery of work, as well as to administer and manage the required HCP resources.

## 3.2 Intended Use of Contract

VAC intends to use the HCPC when identified work force shortages occur. Examples of circumstances of when this Contract may be used, include, but are not limited to, any one of the following:

a. to offset shortages caused by difficulties in recruiting and retaining public service employees in health occupational groups;

b. when replacement of personnel is required as a result of training, leave, etc.;

c. to supply HCPs when a Public Service staffing process has not been successful;

d. to act as a bridging mechanism while awaiting a Public Service staffing process to be completed;

e. to adjust to the needs of a changing demographic; or

f. when HCP requirements arise.

**3.3 Contract Phases**

Under the Contract, there are three (3) Contract Phases defined as follows:

a. **Start-Up Phase** is the period from the date of Contract award to the Service Effective Date (SED), which will be approximately six (6) months. The Start-Up Phase is outside of the initial Contract period. The Contracting Authority (CA) will provide the Contractor with the duration of the phase on the Contract Award Date;

b. **In-Service Phase** starts on the SED and includes the initial Contract period (48 months), as well as any of the option periods exercised, and will cease at the start date of the Out-Going Phase and;

c. **Out-Going Phase** is a period of approximately twelve (12) months before the Contract expiry date. The CA will provide the Contractor with the Out-Going Phase notification.

3.3.1 During the Start-Up Phase, the Contractor must set-up and prepare for providing all requirements and deliverables required in this phase and the subsequent phases. In addition, the Contractor must undertake any transition activities needed from previous Contracts as well as carry out all provision type activities based on the Initial HCPs Requirement Plan and VAC Task Authorizations for the HCPs that are required at SED.

3.3.2 During the In-Service Phase, the Contractor must provide all requirements and deliverables required in this phase; some may have commenced in the Start-Up Phase but continue throughout this phase and the subsequent phase. In addition, the Contractor must carry out all provision and management activities based on terms and conditions of the Contract and on the Annual HCP Requirement Plan and VAC Task Authorizations issued for recurring requirements, and for any new HCP requirements identified thereafter via VAC Task Authorization.

3.3.3 During the Out-Going Phase, the Contractor must provide all requirements and deliverables required in this phase; some may have commenced in the Start-Up or In-Service phases but continue throughout this phase. In addition, the Contractor must continue to manage the existing HCPs on VAC Task Authorizations, as well as provide

and manage any new HCP requirements identified via the VAC Task Authorization process during this phase, and undertake the Out-Going Phase activities.

3.3.4 Any transition activities required between the previous and new Contract will be organized and coordinated through the CA.

## 3.4 HCP Work Streams

The VAC HCP Work Streams are as follows:

a. VAC Stream 1 – Field Nursing Services Officer;

b. VAC Stream 1 – Field Occupational Therapist Services Officer;

c. VAC Stream 1 – Medical Advisor;

d. VAC Stream 1 – Dental Consultant;

e. VAC Stream 1 – Audiologist Advisor;

f. VAC Stream 1 – Registered Respiratory Therapist; and

g. VAC Stream 2 – Senior Area Medical Officer;

3.4.1 The Work under Stream 1 consists mainly of providing expert advice, assessments, consultations, screening activities, recommendations and decisions. This Stream does not provide direct medical or dental care to clients. The outline of the tasks and deliverables are identified under the specific occupational groups and categories. The VAC Task Authorization will include the detailed information on the specific tasks, deliverables and timelines or schedule.

3.4.2 The Work under Stream 2 consists of conducting Pension Medical Examinations as well providing expert advice, assessments, consultations, screening activities and recommendations. This Stream does not provide primary care to clients. The outline of the tasks and deliverables are identified under the specific occupational groups and categories. The VAC Task Authorization will include the detailed information on the specific tasks, deliverables and timelines or schedule.

## 3.5 HCP Occupational Groups and Categories

The HCP Occupational Groups and Categories are found at Appendix 10 to Annex A - SOW VAC, and are listed by the Streams.

3.6 **HCP Qualifications and Tasks**

The HCP Qualifications and Tasks are presented in Appendix 11 to Annex A - SOW VAC, and include the specific work environment, education, experience and tasks required for each Category.

3.6.1 As a minimum, all HCPs provided by the Contractor must meet all the mandatory requirements of the Contract, including the education and experience stated in the Qualifications and Task Sheets for the specific Occupational Group and Category.

**3.7 Type of HCP Requests**

There are three (3) types of HCP Requests, as follows:

a. New;

b. Recurring; and

c. Short Term.

3.7.1 A New HCP Request is defined as HCP shortage identified that was not under a Task Authorization in the current FY.

3.7.2 A Recurring HCP Request is defined as a HCP requirement that was under a Task Authorization in the current FY that continues to be required in the upcoming FY.

3.7.3 A Short-term HCP Request is defined as a HCP requirement needed to fill a capability gap that lasts for, pertains to, or involves a short period. For the purposes of the HCPC, the length of a short-term requirement is 180 calendar days or less.

3.8 **Priority of HCP Requests**

There are two (2) types of HCP Request priorities, which are as follows:

a. Routine: and

b. Urgent.

3.8.1 Routine is defined as a HCP Requirement that the priority to fill is not urgent.

3.8.2 Urgent is defined as a HCP Requirement that must be staffed as a priority over a Routine HCP Request, and therefore necessities immediate action and attention.

3.8.3 Routine and Urgent HPC Requests can also be New, Recurring and Short-term.

3.8.4 The priority of HCP Requests can be applied under any of the HCP Work Streams.

**3.9 HCPs Work Locations**

The HCPs Work Locations are found at Appendix 12 to Annex A – SOW VAC, and listed by the Streams. For this Contract the work location can be either Regular or Temporary Work Locations.

3.9.1 Regular Work Location is defined as the single permanent location defined on the VAC Task Authorization, from which the HCP ordinarily performs the Work.

3.9.2 Temporary Work Location is defined as the single location where the HCP is temporarily assigned to perform the Work.

3.10 **Initial HCP Requirement Plan Definition**

The Initial HCP Requirement Plan is the estimated HCP Requirements that are required to start working at the SED. An example Plan is provided in Appendix 13 to Annex A – SOW VAC for information purposes only and does not represent a commitment by VAC that the Initial HCP Requirement Plan provided to the Contractor after Contract award will be the same.

3.10.1 The Initial HCP Requirement Plan starts with the Summary Page. The Summary Page lists categories down one side and locations across the top for all Streams. It identifies the number of Full Time and Part Time positions, with the weekly hours per position.

3.10.2 Following the Summary Page, the same information is presented but in total hours per year. The two tables are not to be added together.

3.10.3 Full time is defined as a 7.5-hour work day; total of 37.5 hours per week; and from Monday to Friday.

3.10.4 Part time is defined as Work less than 37.5 hours per week. Part time hours are determined by the TM and the required hours and schedule will be stated on the Task Authorization.

3.10.5 Overtime is defined as authorized time worked by the HCP in excess of 37.5 hours in a working week.

3.10.6 Full Time and Part Time HCP Requirements can be New, Recurring or Short Term.

3.11 **Annual HCP Requirement Plan Definition**

The Annual HCP Requirement Plan is the HCP Requirements that are required for the upcoming Fiscal Year (FY), which starts on April 1 of every year. The Annual HCP Requirements Plan will replace the Initial HCP Requirement Plan. VAC will compile the Annual HCP Requirement Plan in the third quarter of each FY for organizational planning and budget purposes.

3.11.1 The Annual HCP Requirements Plan will consist of VAC HCP (Recurring and New) requirements for each VAC location, category and stream.

3.12 **Time To Provide**

The Time to Provide (TTP) is defined as the period that starts when the VAC – Task Authorization Form (TA Form) is initially sent to the Contractor and ends on the required Work start date. The Contractor must submit its response to the DPA no later than 20 calendar days before the end of the TTP for the In-Service and Out-Going Phases. During the Start-Up Phase the Contractor must submit its response to the DPA no later than 40 calendar days before SED. The Contractor is encouraged to submit response packages as they become available in order to streamline processing of the large volume of responses during the Start-Up Phase.

3.12.1 The end date of the TTP in the In-Service and Out-Going Phases are as follows:

a. for New HCP Requests with Routine priority: 60 calendar days from when the VAC TA Form is initially sent to the Contractor;

b. for New HCP Requests with Urgent priority: 21 calendar days from when the VAC TA Form is initially sent to the Contractor; and

c. for Recurring Annual HCP Requirements: 30 calendar days from when the Annual HCP Requirements Plan is sent to the Contractor.

d. an extension to the TTP may be authorized by the DTA, on a case-by-case basis.

3.13 **Temporary Change to HCP(s) Regular Work Location(s) Within the Designated VAC Locations**

HCPs may be required to work at a Temporary Work Location from the Regular Work Location, for various reasons such as, HCP shortages, vacancies, absences, etc. Temporarily is defined as one (1) work day and up to 30 calendar days. For the purpose of this Contract, a Designated VAC Work Location spans an area of 50 kilometers from the Regular Work Location using the most direct, safe and practical road.

3.13.1 When a Temporary Change to a HCP Designated Work Location is required, the Contractor will be provided with written notification three (3) calendar days in advance of a temporary change to the Regular HCP Work Location.

3.13.2 The notice will contain the following information:

a. Task Authorization number;

b. name of HCP;

c. location name and address of the temporary work location;

d. reason for the change;

e. duration of change and the number of days; (from and to dates and total number of days);

f. required hours of work (7:00 am to 3:00 pm or 8:00 am to 4:00 pm, etc.);

g. required schedule, if part time (Monday, Wednesday and Friday, or Tuesday and Wednesday, etc.);

h. overtime involved - Yes/No; and

i. Point of Contact (POC) at the temporary work location (name, email address and telephone number).

3.13.3 Travel expenses to and from the temporary work location are not billable, as this is considered the work place.

3.13.4 The VAC TA will provide a written Temporary HCP Work Location notice to the Contractor.

3.13.5 The Contractor must submit the Temporary HCP Work Location notice with their invoice, as this establishes the authorization for the change.

3.13.6 An amendment to the VAC Task Authorization will not be issued for a Temporary Work Location.

3.14 **Temporary Change to HCP(s) Work Location(s) Outside Designated VAC Location(s)**

On occasion, VAC may require HCPs to temporarily work outside the Designated VAC Location or province of work. This change in work location will be considered travel. Temporary for this requirement is defined as less than thirty (30) calendar days. All Temporary Work Locations outside the Designated VAC Location or province of work requires the approval of the DTA before the change can occur.

3.14.1 The DTA will provide the Contractor with the written approval for the Temporary Work Location outside the Designated VAC Location or province of work.

3.14.2 The written approval must contain the following information:

a. Task Authorization number;

b. location name and address of the temporary work location;

c. name of HCP;

d. reason for the change;

e. date(s) and duration of the change;

f. required hours of work; and

g. Point of Contact (POC) at the temporary work location (name, email address and telephone number).

3.14.3 Temporary Changes to Work Location(s) outside the Designated VAC Location or province of work will be considered travel. The HCP Travel Request and Authorization process must be followed and is detailed under Annex A- SOW VAC article titled HCP Travel.

3.14.4 When the Temporary Change to a HCP work location is outside of the HCPs current province of work, the Contractor must ensure the HCP obtains the required additional licenses and registration, when required.

3.14.5 The Contractor must submit the complete approval package, travel itinerary, claimable expenses and receipts with the invoice.

3.14.6 When a HCP is requested to travel and the travel requirement is not stated in the Task Authorization, the Task Authorization must be amended for the travel requirement before the travel for Temporary Changes to the Work Location(s) outside the Designated VAC Location or province of work is conducted.

### 3.15 Temporary Closures to Work Location

Temporary closures to work location(s) may occur over the period of the Contract and closures can be expected or unexpected. Expected is defined as within the Department's control and cover repairs, scheduled maintenance, renovations, installations of new equipment(s), etc. Unexpected is defined as outside the control of the Department, such as flood or fire, equipment failure or shut down, power outages or extreme weather conditions, etc.

3.15.1 When a temporary closure to a Work Location is expected, the TM will advise the Contractor in writing, a minimum of seven (7) calendar days in advance of the temporary closures. The notice will include the date(s) and duration (if known) of the closure, and the name(s) of the HCP(s) affected by the temporary closure.

3.15.2 The Contractor must advise the affected HCP(s) of any expected temporary closures to Work Location(s) accordingly.

3.15.3 If unexpected temporary closures to a Work Location occurs, the VAC location manager will advise the HCP(s) verbally. The VAC location manager is a manager who physically works from that specific location, but may not report to the Health Professional Division. The DTA will then advise the Contractor. The notice will include the name(s) of the HCP(s) affected, and when known, advise the Contractor of the date and time the HCPs are to return to the work location.

3.15.4 The Contractor must contact the HCP(s) and advise them of the date and time they are to return to the work location.

3.15.5 The HCP's time during expected or unexpected temporary closures to Work Location closures is not billable.

### 3.16 Permanent Closures to Work Location

Permanent closures to work location(s) may occur over the period of the Contract.

3.16.1 If a permanent closure to a work location is expected by VAC, the DTA will advise the Contractor in writing, a minimum of 30 calendar days' in advance of the permanent Closure date.

3.16.2 The permanent closure to work location notice will contain the following information:

a. date of the notice;

a. work location closure date; and

b. a list of VAC Task Authorizations affected by the work location closure.

3.16.3 The Contractor must advise the affected HCP(s) of permanent closures to work location(s).

3.16.4 If HCPs are affected by a permanent closure to a work location, the conditions stipulated in the Annex A - SOW VAC article titled VAC Cancellation of a Task Authorization will apply.

### 3.17 HCP Tele-Health Work

Tele-Health is defined as the delivery of health services via information technology. Currently Tele-Health is not used at VAC. Over the life of the contract, there may be a requirement to provide Tele-Health Work.

### 3.18 Site Visits

An HCP may be requested to conduct client assessments in the client's residence, which could include seniors residence, hospital, etc. These instances are infrequent.

## 4.0 REQUIREMENTS

**Part One – Start-Up Phase**

### 4.1 Contractor's Organization

The Contractor must set up its organizational structure to manage Work, requirements, deliverables and Task Authorizations related to all HCP requirements throughout all Phases of the Contract.

4.1.1 The Contractor's organizational structure, number of team members, roles and responsibilities or function(s) and qualifications of the individual team members are the Contractor's responsibility.

### 4.2 Contractor's Work Location

The Contractor and Contractor's Management Team must work from their own site(s) throughout the duration of the contract.

4.3 **Contractor's Central Office**

The Contractor must set up and manage a Contractor's Central Office (CCO) in Canada throughout the duration of the Contract.

4.3.1 The CCO must be the centralized point of contact for the CA, DTA and DPA for all contract related communications such as Task Authorizations, inquiries, issues or clarifications.

4.3.2 The CCO must be equipped to receive the Task Authorizations and general inquiries, via email, fax, and telephone and have the capability to conduct teleconferences, videoconferences and web conferences.

4.3.3 The CCO must be available from Monday to Friday between the hours of 8:00 am and 5:00 pm, Eastern Standard Time.

4.3.4 The CCO will not be required to be available of Federal Government Holidays or on civic and statutory holidays designated by the province in which the CCO is located.

4.3.5 The CCO must employ a minimum of one person who is bilingual and capable of providing services to VAC in both of Canada's Official Languages (OL) – English and French. Bilingual means that the individual(s) must be able to read, comprehend and communicate in clear language, both orally and in writing, using both official languages, without assistance and with minimal errors.

4.3.6 The Contractor must have a toll free telephone number, teleconference number, and an email address for use in working with VAC. Refer to Appendix 14 - Deliverable 1.

4.3.7 The Contractor must provide the name, title, role and responsibility, and email address if different from the general email address, for point of contact personnel employed within the CCO. Refer to Appendix 14, Deliverable 2

4.3.8 The Contractor must manage any CCO personnel changes without affecting the services required under the Contract and provide the name, title, role and responsibility, and email address if different from the general email address of any changes made to the CCO personnel within five (5) working days. Refer to Appendix 14, Deliverable 3.

4.3.9 The Contractor must ensure that the CCO personnel have the necessary experience and training required to be able to discharge their responsibilities.

4.3.10 Any associated training costs or travel expenses incurred in support of training are the Contractor's responsibility.

## 4.4 Contractor's Management Team

The Contractor must establish a Contractor's Management Team (CMT). The team composite may be different for each phase of the Contract.

4.4.1 The name, title, role, summary of responsibilities, location and contact information for each member of the CMT must be confirmed at the initial Contract Kick-Off Meeting and must be based on the team composite described and proposed in the Contractor's bid. Refer to Appendix 14, Deliverable 2.

4.4.2 The Contractor must provide updated name, title, role and responsibility, and email address if different from the general email address, for any changes made to the CMT personnel, within two (2) working days of the change. Refer to Appendix 14, Deliverable 3.

4.4.3 The CMT must employ a minimum of one (1) person who is bilingual and capable of providing services to VAC in both of Canada's Official Languages (OL) – English and French. Bilingual means that the individual(s) must be able to read, comprehend and communicate in clear language, both orally and in writing, using both official languages, without assistance and with minimal errors.

4.4.4 The Contractor must ensure that the CMT personnel have the necessary experience and training required to be able to discharge its responsibilities.

4.4.5 Any associated training costs or travel expenses incurred in support of training their personnel are the Contractor's responsibility.

## 4.5 Contractor's Service Delivery Manager

The Contractor must provide a dedicated Service Delivery Manager (SDM) as Lead for the CMT throughout the duration of the Contract.

4.5.1 The SDM position must be filled at all times, including periods when the SDM is absent for any reason.

4.5.2 The SDM will be the primary point of contact (POC) for the CA, the DTA and DPA.

4.5.3 The SDM must have the authority to plan, organize, coordinate, make decisions, direct, execute, implement, monitor, provide feedback, report, and manage all Work activities undertaken by the CMT in support of the Work associated with the provision and management of the HCPs.

4.5.4 The SDM must respond to any phone calls or emails from the CA, DTA or DPA within two (2) working days.

4.5.5 The SDM's name and contact information must be confirmed within 5 (five) calendar days after Contract award. Refer to Appendix 14, deliverable 4.

4.5.6 As a minimum, the SDM must have the following qualifications and experience:

a. a University degree, or an acceptable combination of education and experience, such as:

(1) a college certificate or college diploma; plus

(2) seven (7) years' experience in a senior management role or position with direct responsibility for managing a multi-million-dollar contract, project or program;

b. seven (7) years' experience within the last 14 years in project or program management;

c. five (5) years' experience within the last 10 years in managing employees;

d. three (3) years' experience within the last six (6) years in contract management; and

e. must be proficient in English.

4.5.7 The Contractor must provide a minimum of 30 calendar days' notice of the intent to permanently replace the SDM. Refer to Appendix 14, deliverable 5.

4.5.8 Any proposed replacement SDM must meet the qualifications as outlined above and will be subject to the concurrence of the DTA.

4.6 **Deputy Service Delivery Manager**

The Contractor must provide a Deputy Service Delivery Manager (DSDM) as part of the CMT throughout the duration of the Contract.

4.6.1 The DSDM must replace and be available when the SDM is absent for any reason.

4.6.2 The DSDM's name and contact information must be confirmed five (5) calendar days after Contract award. Refer to Appendix 14, deliverable 4.

4.6.3 As a minimum, the SDM must have the following qualifications and experience:

a. University degree or an acceptable combination of education and experience, such as:

(1) college certificate or college diploma; plus

(2) five (5) years' experience in a senior management role or position with direct responsibility for managing a multi-million-dollar contract, project or program;

b. five (5) years' experience within the last 14 years in project or program management;

c. four (4) years' experience within the last 10 years in managing employees;

d. two (2) years' experience within the last six (6) years in contract management; and

e. must be proficient in English.

4.6.4 The Contractor must provide a minimum of 15 calendar days notice of the intent to permanently replace the DSDM. Refer to Appendix 14, deliverable 6.

4.6.5 Any proposed replacement DSDM must meet the qualifications as outlined above and will be subject to the concurrence of the DTA.

4.7 **Contractor's Start-Up Plan**

The Contractor must develop and deliver a draft and final Start-Up plan. The draft Start-Up plan must be delivered within 14 calendar days after Contract award. Refer to Appendix 14, Deliverable 7.

4.7.1 The Start-Up Plan can incorporate any Contractor start-up and set-up activities and practices but as a minimum, must include the following:

a. a list and description of Contractor start-up and set-up activities to be completed and the major milestones to be achieved during the Contract Start-Up Phase to allow for orderly and timely set up that will fully meet all the Annex A - SOW VAC requirements before and at SED;

b. a high-level Work Breakdown Structure reflective of all the activities and sub-activities, the major milestones and deliverables;

c. a schedule in MS Project which states the proposed timelines or timeframes for all activities and sub-activities, related milestones, all dependencies and the critical path; and

d. the Contractor's Senior Management structure for the Contract Start-Up Phase, including but not limited to the Contractor's Start-Up Phase management team, any oversight committees, or working groups established by the Contractor, etc. The structure must indicate where participation is required or may be requested from the DTA, and what processes and procedures are recommended to ensure quick decision-making within the plan to facilitate the timely delivery of services.

4.7.2 The schedule will form the baseline in which the Contractor's performance will be monitored and measured by VAC.

4.7.3 The Contractor must revise and update the Start-Up Plan within ten (10) calendar days if comments or recommendations are received from the DTA. Refer to Appendix 14, deliverable 8.

4.7.4 Once the Start-Up Plan is approved by the DTA, it will be deemed the final Start-Up Plan.

4.7.5 The Contractor must implement and carry out all start-up and set-up activities in accordance with approved Start-Up Plan during the Start-Up Phase.

4.8 **Contractor's Recruitment Plan**

The Contractor must develop and deliver a draft and final Recruitment Plan. The draft Recruitment Plan is due within 30 calendar days after Contract award. Refer to Appendix 14, Deliverables 9.

4.8.1 The Recruitment Plan must list and describe all the recruiting activities that will be completed in order to meet the VAC's requirements for HCPs at the SED and throughout the duration of the Contract.

4.8.2 The Recruitment Plan, as a minimum, must include the following strategies and approach elements:

a. to recruit the initial HCPs required at SED; and new HCPs requirements after the SED and during the In-Service Phase;

b. to meet short-term HCP requirements;

c. for urgent HCP requirements within the reduced Time To Provide timelines;

d. the retention strategies to be used to retain HCPs and to minimize HCP turnover;

e. the replacement approach when HCPs are absent for an extended period of time; and,

f. the recruiting communications strategies for:

(1) promotional material development and distribution;

(2) communication channels, streams, and methodologies;

(3) advertising plans and marketing strategies; and

(4) Contractor's recruiting innovations.

4.8.3 The Contractor must revise and update the Recruitment Plan within 20 calendar days, if comments or recommendations are received from the DTA. Refer to Appendix 14, Deliverable 10 .

4.8.4 Once the draft Recruitment Plan is approved by the DTA, it will be deemed the final Recruitment Plan.

4.8.5 The Contractor must implement, and carry out all recruiting activities in accordance with the approved final Recruitment Plan throughout the duration of the Contract.

4.8.6 If the Contractor's strategies and approach to recruitment change during the Contract period, or if VAC requests a change to the Recruitment Plan, the Contractor must update or revise the final Recruitment Plan to reflect the requested changes and send to the DTA for approval. Refer to Appendix 14, Deliverable 11.

## 4.9 Contractor's Risk Management Plan

The Contractor must develop and deliver a draft and final Contractor's Risk Management Plan (CRMP). The draft CRMP is due within 30 calendar days of Contract award. Refer to Appendix 14, Deliverable 12.

4.9.1 The CRMP must detail and describe the procedures and methods to be used in identifying, analyzing, evaluating, tracking, reporting, and mitigating risk(s) throughout the duration of the Contract.

4.9.2 The CRMP, as a minimum, must describe and detail all the elements listed below:

a. Concept for Management of Risk;

b. Risk Prediction Methodology;

c. Risk Identification (Risk Factors);

d. Risk Analysis (Probabilities and Effects) and Risk Assessment;

e. Risk Response (Avoid, Transfer, Mitigate, and Accept) and associated costs;

f. Issue Review and Lessons Learned (LL) Analysis Methodology; and

g. Issue Report Methodology.

4.9.3 The CRMP must include a section for each phase of the Contract with identification of each of the phase's risks. Each of the sections must include:

a. an initial risk analysis and assessment;

b. identification of risks and if necessary a creation of Risk Breakdown Structure;

c. Qualitative Risk Analysis;

d. Quantitative Risk Analysis;

e. Risk Response Planning;

f. Risk Monitoring and Control; and

g. a feedback and lessons learned process.

4.9.4 The Contractor must revise and update, within 20 calendar days, the draft CRMP based on comments or recommendations received from the DTA. Refer to Appendix 14, Deliverable 13.

4.9.5 Once the draft CRMP is approved, the CRMP will be deemed the final CRMP and must be used to manage and mitigate the risks throughout the duration of the Contract. If VAC requests changes throughout the Contract period, changes must be implemented by the Contractor within 10 calendar days of receipt.

4.9.6 The Contractor must update or revise the final CRMP for every Program Review Meeting (PRM). The version number and date must be annotated on each CRMP revision or update. Refer to Appendix 14, Deliverable 14.

4.9.7 The final CRMP updates must include:

a. the identification of new risks;

b. ongoing risks;

c. any or all risk mitigation actions taken plus the associated costs;

d. all corrective actions taken;

e. outcomes to date;

f. detail(s) of all the potential issues or obstacles affecting the schedule timelines; and,

g. further recommended or suggested course of action(s).

4.9.8 The Contractor must provide advance electronic copies of the current CRMP to the CA, DTA and the DPA five (5) calendar days before each Progress Review Meeting (PRM). Refer to Appendix 14, Deliverable 15.

4.9.9 The Contractor must provide hard copies of the current CRMP to each attendee at the PRM. Refer to Appendix 14, Deliverable 16.

4.9.10 If any substantive risk(s) occur before the PRM reporting cycle, the Contractor must advise the DTA in writing within three (3) calendar days and must report these risks in the Monthly Program Report. Refer to Appendix 14, Deliverable 17.

4.10 **Contractor's Management Plan**

The Contractor must develop and deliver a draft and final Contractor's Management Plan (CMP). The draft CMP is due within 30 calendar days after Contract award. Refer to Appendix 14, Deliverable 18.

4.10.1 The CMP must consolidate the entire Contractor's administrative and management processes, practices and procedures, and its supporting organizational structure used to manage all the Work, requirements and deliverables required under the Contract. The CMP must be used throughout the duration of the Contract.

4.10.2 The CMP, as a minimum, must describe and detail the Contractor's administrative and management processes, practices and procedures for the:

a. management of Work, requirements and deliverables required under the Contract;

b. schedule control and management during the Contract Start –Up Phase;

c. contractor's CCO and CMT Performance management and monitoring;

d. HCP management as it relates to recruitment, retention, credentialing, training and performance evaluation management and monitoring;

e. quality control;

f. risk reporting process;

g. media communications process;

h. Contract Change Management process to implement improvement or changes;

i. problem resolution;

j. HCPs time verification process;

k. invoice processing including verifications and validations to detect errors;

l. contractor's internal and external line of communication; and

m. Compliance with VAC security requirements. The Contractor must use Public Works and Government Services Canada's Online Industrial Security System (OLISS) to submit security clearance requests unless there is an acceptable reason to submit in an alternative format (VAC will provide approval if the situation warrants use of an alternative submission format).

4.10.3 The Contractor must revise and update the CMP within 20 calendar days if comments or recommendations are received from the DTA. Refer to Appendix 14, deliverable 19.

4.10.4 Once the draft CMP is approved, it will be deemed the final CMP and must be used throughout the duration of the Contract.

4.10.5 The Contractor must ensure that its administrative and management processes, practices and procedures are consistently applied across all locations by its personnel and in accordance with the approved final CMP.

4.10.6 If the Contractor's administrative and management processes, practices and procedures change during the Contract period, or if VAC requests changes, the Contractor must update or revise the final CMP for DTA approval. The version number and date must be annotated on each final CMP revision or update. Refer to Appendix 14, Deliverable 20.

### 4.11 Contractor's Communication Packages

When the Contractor develops communications for recruitment purposes and for circulation to media organizations, the public, industry, educational institutes, etc,; the Contractor must submit the draft communication to the CA and the DTA for review and acceptance before publication. Refer to Appendix 14, Deliverable 21.

4.11.1 When the draft is accepted, and approved by the CA and the DTA, the Contractor will receive a confirmation from the DTA.

4.11.2 All communications materials developed for circulation for recruitment purposes by the Contractor must be in English and French.

4.12 **Probation**

A 90 day probation period will apply to all newly contracted HCPs. The probation period will begin on the first work. If the TM is not satisfied with the services of the contracted HCP, the Contractor has 14 calendar days to remedy the situation. If the situation cannot be resolved to the satisfaction of the TM, the contracted HCP will be replaced at no cost to VAC. Payment for HCPs whom have performance issues shall cease upon termination of their Work under the contract. If a replacement HCP cannot be found by the Contractor, VAC reserves the right to cancel the VAC Task Authorization and VAC will not be held to the cancellation conditions in the Contract.

4.13 **HCP Professional Misconduct**

Throughout the In-Service and Out-Going Phases, identification, investigation and management of HCP professional conduct and competency issues are a shared responsibility between the Contractor and VAC. The Contractor and VAC have a responsibility to report HCP Professional Misconduct in accordance with the relevant provincial/territorial statute.

4.13.1 HCP professional performance shall be in accordance with standards set by the applicable licensing body as well as any additional standards imposed by VAC.

4.13.2 The Contractor will be responsible for the remediation of HCP professional performance issues and the determination and execution of any disciplinary measures. VAC reserves the right to determine if the VAC – Task Authorization should be cancelled. If a HCP has his/her license revoked, the contracted HCP will be removed and replaced at no cost to VAC. Payment for HCPs who have misconduct issues shall cease upon termination of their Work under the contract

4.14 **Issues, Challenges and Problem Resolution Process**

Throughout the duration of the Contract, the Contractor or the Contractor's HCPs must, as a preliminary step, contact the appropriate authority listed in the Annex A - SOW VAC article titled "Departmental Authorities (DA)" to resolve any issues, challenges and problems at the lowest possible level.

4.14.1 Should the Contractor or the Contractor's HCP contact a DA that is not the responsible authority for the issue, challenge or problem, the Contractor or the Contractor's HCP will be re-directed to the appropriate authority.

4.14.2 The TM is the lowest level for issues, challenges or problems that are within the scope of the TM's authority.

4.14.3 For issues not resolved at the lowest level, the DTA is the authority for issues, challenges or problems regarding the technical content of the Work, requirements and deliverables.

4.14.4 For issues that cannot be resolved at the lowest level, the matter will be referred to the DTA and upward for resolution.

4.15 **HCPC Lessons Learned**

The Contractor must develop and deliver a HCPC Lessons Learned (HCPC LL) document based on their lessons learned for the Start-up and Out-Going phases of the Contract; and on an annual basis for each year of the In-Service Phase of the Contract. Refer to Appendix 14, deliverable 22 for the Start-up Phase, deliverable 23 for the Annual, and deliverable 24 for the Out-Going Phase HCPC LL documents.

4.15.1 The intention is to have all stakeholders benefit and contribute to a formalized Lessons Learned process by implementing a formal HCPC LL process that ensures visibility and accountability using a feedback loop, and which minimizes the repetition of errors, improves service delivery, and results in positive and improved capability or requirements.

4.15.2 The HCPC LL document can incorporate any Contractor's lessons learned but as a minimum, must include the following information:

a. section for Observation/Issue, which states what the issue, problem, or difficulty was or the "what" part of the phase, activity, requirement or event. The Observation(s) or Issue(s) must be short, factual descriptions of what has occurred, and is used to describe either a positive or a negative event. Multiple observations of a similar nature may be combined into a single issue;

b. section for Discussion, which includes sufficient details surrounding the observation(s) or issue(s) to provide the reader with an understanding of the phase, activity, requirement or event without being part of the requirement. The details can include "who", "when", "why" and "where" statements;

c. section for Conclusion, which includes details the overall impact of the observation(s) or issue(s);

d. section for Recommendations, which includes suggestions or recommendations on how the issue, problem or difficulty can be rectified, reduced or eliminated in the future; and

e. section for "Point of Contact" (POC) which identifies the appropriate office responsible for the matter based on the issue, problem or difficulty.

4.15.3 The HCPC LL will be provided to the DTA.

4.16 **Timesheet Tool**

The Contractor must have in operation, a Timesheet Tool (TsT), which is accessible from the Contractor's website through a secure site to authorized users that hold various roles. The TsT is intended as a tool for:

a. HCPs to record their hours worked;

b. VAC employees to verify and approve the HCP`s recorded hours; and

c. the DAs to validate the labour charges on the Contractor's invoice.

4.16.1 The TsT must be accessible through a web portal that requires an encrypted session and is accessible from the following platforms without the installation of additional software:

a. Microsoft Windows 7 32-bit and 64-bit;

b. Microsoft Windows 8.1 32-bit and 64-bit;

c. Microsoft Windows 10 32-bit and 64-bit; and,

d. macOS.

The Communications Security Establishment guidelines that must be followed are in the following link:

https://www.cse-cst.gc.ca/en/node/1831/html/26515

4.16.2 The Contractor must have the TsT ready for use 60 calendar days before the SED, and must provide the DTA with notification that the HCP TsT is setup and ready. Refer to Appendix 14, deliverable 25.

4.16.3 The Contractor's TsT must be available to users, from Monday to Friday, and between the hours of 7am and 6pm across all Canadian Time Zones.

4.16.4 Within five (5) calendar days of setup notification of the TsT, the Contractor must conduct a TsT demonstration for the DAs at a VAC location. The location and address will be provided to the Contractor after Contract award. The demonstration must confirm that the TsT is ready for use and detail how the tool works from a user's perspective. Refer to Appendix 14, deliverable 26.

## 4.17 Timesheet Tool Capabilities and Functionalities

As a minimum, the Timesheet Tool must have the following capabilities and functionalities:

a. to allow HCPs to record their regular, (and overtime if applicable) hours worked

b. to allow the TMs to review, validate and approve the HCP recorded hours;

c. to have an approval indicator that denotes that the recorded hours have been validated;

d. to set permissions for control over what users can see and do;

e. to allow for simultaneous access of users;

f. to allow for storage of HCP timesheets and data;

g. to secure all data;

h. to enable reports to be generated from the TsT data and to be able to specify report filters to return the specific results wanted;

i. to enable queries to be conducted with the available fields in the TsT; to allow for customization or modifications including: modifications of the field names; setting tasks, such as travel; and linking tasks to the timesheet;

j. to have a data back-up feature;

k. to allow the exporting of data;

l. to have printing capabilities; and

m. must include a User Account Creation Request and Cancellation Form.

## 4.18 Timesheet Tool Setup

As a minimum, the Timesheet Tool must include the following data fields:

a. Task Authorization number;

b. HCP location;

c. HCP surname;

d. HCP given name;

e. A separate field to be used by HCP to input hours worked for each day of the week, within the billing period;

f. sub-total regular hours worked. This field must reflect the total number of regular hours worked within the billing period;

g. total regular hours worked. This field must reflect the total number of hours worked to date;

h. sub-total overtime hours worked. This field must reflect the total number of overtime hours worked within billing period;

i. total overtime hours worked. This field must reflect the total overtime hours worked to date on the VAC Task Authorization;

j. remaining hours on the VAC Task Authorization. This field must reflect, in hours or days, the Level of Effort (LOE) remaining and in accordance with the VAC Task Authorization;

k. Travel. This section must reflect the from and to date fields that the HCP is on Travel Status within the billing period;

l. the approved travel in accordance with the VAC Task Authorization; and

m. Approval Indicator. This field would identify for the Contractor: if the timesheet was approved or not approved by VAC; the name of the individual who has approved or not approved the timesheet; and must also have a Comment field for information to be inserted by VAC.

4.19 **HCP Timesheet**

As a minimum, the HCP Timesheet must include the following data fields:

a. Task Authorization number;

b. HCP location;

c. HCP surname;

d. HCP given name;

e. A separate field to be used by HCP to input hours worked for each day of the week, within the billing period;

f. sub-total regular hours worked. This field must reflect the total number of regular hours worked within the billing period;

g. total regular hours worked. This field must reflect the total number of hours worked to date;

h. sub-total overtime hours worked. This field must reflect the total number of overtime hours worked within billing period;

i. total overtime hours worked. This field must reflect the total overtime hours worked to date on the VAC Task Authorization;

j. remaining hours on the VAC Task Authorization. This field must reflect, in hours or days, the Level of Effort (LOE) remaining and in accordance with the VAC Task Authorization;

k. Travel. This section must reflect the from and to date fields that the HCP is on Travel Status within the billing period;

l. the approved travel in accordance with the VAC Task Authorization; and

m. Approval Indicator. This field would identify for the Contractor: if the timesheet was approved or not approved by VAC; the name of the individual who has approved or not approved the timesheet; and must also have a Comment field for information to be inserted by VAC.

4.20 **Timesheet Tool Account Creation Setup**

The Contractor must create user accounts and initial passwords.

a. all accounts for the Contractor's HCP must be setup and provided before the HCP start date on the Task Authorization;

b. the Contractor must create a user account for the DTA and VAC local representatives before the TsT demonstration. A VAC local representative is a VAC employee who works at that location. The number of VAC local representative user accounts is estimated as two positions per location with 36 locations totaling approximately 72 accounts for field operations. Six (6) head office accounts will be required in addition to the field operations. The number of

user accounts is subject to change and is based on VAC's requirements. The Contractor will be provided with the names of the DTA and VAC local representatives after Contract Award;

c. throughout the Contract, the Contractor must create new user accounts within seven (7) days of receipt of the approved User Account Creation Request and Cancellation Form; and

d. the Contractor must delete old user accounts within seven (7) days of the date stated on the User Account Request and Cancellation Form.

4.21 **Timesheet Tool Account Permissions**

The Contractor must set up specific permission for the DAs and VAC local representatives:

a. the DAs must be given full user access: to view any HCP timesheet; to verify time sheet approvals; to manipulate data; for viewing data; and for generating reports;

b. the VAC local representatives must be given limited access that allows them to view the information related only to HCPs on Task Authorization at their location; and

c. the Contractor is responsible to ensure that HCPs do not have access to the timesheet approval field on the TsT.

4.22 **Timesheet Tool User Help and Support**

The Contractor must provide help and support functionality for the TsT which, at a minimum, is available to authorized users, from Monday to Friday, and between the hours of 7am and 6pm across all Canadian Time Zones. This functionality must be available by email or telephone.

4.23 **Timesheet Tool Maintenance**

The Contractor must conduct updates and maintenance of the TsT outside the working hours of 7am to 6pm across all Canadian Time Zones.

4.24 **Timesheet Tool User Training and Manual**

The Contractor must provide TsT training which, at a minimum, contains a computer-based training component and a User Manual, available in both official languages. Refer to Appendix 14, deliverable 25.

4.25 **Initial HCP Requirements**

The Contractor will be provided with the Initial HCP Requirement Plan and the associated VAC Task Authorizations after Contract award at the initial Kick-Off meeting.

4.25.1 On receipt of the VAC Task Authorizations, the Contractor must follow the task authorization process detailed in the Contract. The Contractor must provide the DTA with the Task Authorization response package for all Task Authorizations issued no later than **40 calendar days** prior to a SED, and all HCPs requirements must start working on SED.

4.25.2 All HCP requirements that are identified after the Initial HCP Requirement Plan has been provided to the Contractor, and that have the HCP requirement start date after SED, are considered New HCP requirements. VAC provides New HCP requirements to the Contractor via a VAC Task Authorization. The Contractor must follow the task authorization process detailed in the Contract. The Time To Provide period will apply to all new VAC Task Authorizations.

4.25.3 For the New HCP requirements identified in the Annual HCP Requirement Plan, the Contractor must follow the Task Authorization process as detailed in the Contract.

4.26 **Acceptable delay**

When the Contractor is not able to fill a VAC Task Authorization in any of the Contract phases, the Contractor must justify the delay, in writing, to the DTA. The DTA will determine if the Contractor will be given an additional 30 calendar day period to fill the Task Authorization, or if the Task Authorization will be cancelled. Refer to Appendix 14, deliverable 27.

4.26.1 The Contractor will be given a written notice by the DTA for all approved requests. The VAC Task Authorizations that are not filled will not remain open indefinitely. The DTA will provide the Contractor with the Cancellation of a Task Authorization Notice for the VAC Task Authorization, when the issued Task Authorization is cancelled because it was not filled.

4.27 **HCP Credentials**

Throughout the duration of the Contract, the Contractor must verify the HCP credentials before providing HCPs to VAC.

4.27.1 The HCP credential verification process is to confirm with their respective regulatory or certifying organization that the HCP:

a. holds a valid license or certification;

b. has no restrictions or limitations against their license or certification and are in good standing; and

c. has no sanctions or past findings against their license or certificate.

4.27.2 If the HCP is subject of an investigation, is involved in part of an investigation, has restrictions, limitations, sanctions or past findings against their license or certificate, VAC reserves the right to refuse to the proposed HCP.

4.27.3 Throughout the duration of the Contract, including the Start-up Phase, when the Contractor provides any HCP, the Contractor must provide a VAC Credential Information Form for that HCP.

4.27.4 After the initial Credential Information Form is provided by the Contractor, and throughout the duration of the Contract thereafter, the Contractor must conduct and confirm verification of the HCPs credentials every six (6) months.

4.27.5 Throughout the duration of the Contract, the Contractor must conduct the HCP re-verification process and confirm the status via the HCP Credentialing Report, which is detailed under Annex A- SOW VAC article titled "HCP Credentialing Report".

4.27.6 Throughout the duration of the Contract, if an HCP credential changes, the Contractor must notify the DTA within the same business day or next business day if following a weekend, if the HCP has had his/her license revoked for whatever reason, or should an HCP become subject of an investigation or involved in part of an investigation. Refer to Appendix 14 Deliverable 28.

4.27.7 If an HCP has his/her license revoked, the VAC Task Authorization will be cancelled immediately and VAC will not be held to the cancellation conditions in the Contract.

4.27.8 If the HCP becomes the subject of an investigation or is involved in part of an investigation, VAC reserves the right to determine if the VAC Task Authorization should be cancelled or if the Contractor will be requested to replace the HCP.

**4.28 HCP Language Requirements**

Throughout the duration of the Contract, the language requirement for the HCP will be specified in VAC Task Authorization as English, French or Bilingual (English and French).

4.28.1 The provided HCP must be able to read, comprehend and communicate orally and in writing in the specified language(s).

4.28.2 If the HCP's language skills do not meet the requirement as stated on the VAC Task Authorization, VAC reserves the right to cancel the Task Authorization.

## Part Two – In-Service Phase

### 4.29 Annual HCP Requirements

The Contractor will be provided with the Annual HCP Requirement Plan and the associated New VAC Task Authorizations within the first seven (7) days of December each year.

4.29.1 For the Recurring HCP Requirements identified in the Annual HCP Requirement Plan, the Contractor must review the list and confirm via the Recurring HCP Task Authorization Confirmation Report within 30 calendar days from receipt whether the incumbent HCPs will continue to provide the services in the upcoming fiscal year. Refer to Appendix 14, deliverable 29.

4.29.2 On receipt of the VAC Task Authorizations, the Contractor must follow the Task Authorization process detailed in the Contract. The Contractor must provide the Task Authorization Response Package to the DTA no later than 20 calendar days prior to HCP Start Date. Refer to Appendix 14, deliverable 30.

4.29.3 During the In-Service Phase, and after the Annual HCP Requirement Plan has been provided to the Contractor, any New HCP Requirements identified will be provided to the Contractor by the DTA via the VAC Task Authorization(s).

### 4.30 HCPs Orientation to VAC Work Environment

Upon VAC's request, the Contractor will prepare and deliver an orientation package to new HCPs. In some cases, VAC may provide the orientation to the new HCP. The estimated number of days of training is seven. All orientation and training must be completed within a two-week period of the HCP commencing work.

4.30.1 When applicable, the Contractor must provide a signed copy of the Orientation Package – HCP Acknowledgement Form, which is included in the Orientation Package. The Orientation Package – HCP Acknowledgement Form is the confirmation that the HCP has received, read and understood the Orientation Package and the VAC work environment, and agrees to provide services in that environment. Refer to Appendix 14, deliverable 31.

### 4.31 HCP Incoming Clearance Activities

Throughout the duration of the Contract, all HCPs must undertake Incoming Clearance Activities. Incoming clearance activities are completed by the HCP within the first week of their start date. These activities consist of:

a. obtaining a VAC building pass;

b. obtaining various VAC accounts and undertaking associated training. The TM will provide the specific accounts, required forms, associated training links and the organizations responsible for providing these accounts to each HCP. The HCP must fill out and process the account requests. HCPs must comply with all VAC policies and procedures. Failure to comply with policies may result in the cancellation of the Task Authorization.

c. All Work will done on site with the exceptions of client visits when required.

4.32 **HCP Contractor Identification**

Throughout the In-Service and Out-Going Transition phases, HCPs must be identifiable as a Contractor resource.

4.32.1 HCPs must include the designation of "Contractor" within their signature block when sending email or writing letters.

4.33 **HCP Hours of Work**

Throughout the In-Service and Out-Going Transition Phases, HCPs will be required to work between the core hours of 8am and 5pm local time, Monday to Friday.

4.33.1 The hours of work required will be stated in VAC Task Authorization.

4.33.2 HCPs will not be required to provide services on Federal Government Holidays as listed at Appendix 17 to Annex A- SOW VAC.

4.34 **HCP Overtime**

Throughout the duration of the Contract, HCPs may be required to work overtime. When an HCP is required to work overtime, it will be stated in VAC Task Authorization. Overtime must be authorized in advance by the Task Manager.

4.34.1 The Contractor must submit the HCP Overtime Authorization with its invoice. Overtime is billable in accordance with the terms and conditions of the Contract. Refer to Appendix 14, deliverable 32.

4.35 **HCP Tele-Health Requirements**

Currently Tele-Health is not used at VAC. Over the life of the contract, there may be a requirement to provide Tele-Health Work.

4.35.1 Tele-Health is defined as the delivery of health services via information technologies.

4.35.2 The HCP may be requested to use VAC video conferencing facilities to have consultations and discussions.

4.35.3 When Tele-Health Work is required, it will be stated in the VAC Task Authorization.

4.35.4 If Tele-Health Work is not stated on the VAC Task Authorization, and becomes a requirement, the DTA will issue an amendment to the VAC Task Authorization for the Contractor's acceptance.

4.36 **Site Visit Requirements**

On occasion a HCP may be requested to conduct a Site Visit.

4.36.1 The HCP or Contractor must request written approval from the TM by email with a copy to the DTA.

4.36.2 The written approval must contain the following information:

a. Task Authorization number;

b. Client file number;

c. name of the HCP who will conduct the Site Visit(s);

d. reason for the Site visit(s);

e. date(s) and time(s) of scheduled Site Visit(s); and,

f. travel involved with estimated expenses;

4.36.3 The Site Visit is to be conducted during regular work hours but if there is an exceptional need for overtime, the Overtime Request and Authorization process must be followed as detailed under Annex A - SOW VAC article titled "HCP Overtime".

4.36.4 When a Site Visit involves travel outside the designated VAC Location, the HCP Travel Request and Authorization process must be followed as detailed under Annex A - SOW VAC article titled "HCP Travel".

4.36.5 The Contractor must submit the complete approval package, travel itinerary, claimable expenses and receipts with the invoice. Refer to Appendix 14, deliverable 33.

4.37 **HCPs Travel**

Throughout the In-Service and Out-Going phases, HCPs may be required to travel. When an HCP is required to travel, it will be pre-approved via the VAC Task Authorization.

4.37.1 When an HCP is requested to travel and the travel requirement is not stated in VAC Task Authorization, the HCP must receive written approval, via email, from the TM before the travel is conducted.

4.37.2 The Contractor or Contractor's HCP will provide the Travel Request Form to the TM by email, (copying the DTA), for approval.

4.37.3 The Contractor must make all travel arrangements. Travel must be conducted in the most economical means available and in accordance with the Treasury Board Travel Directive.

4.37.4 The Contractor must submit the HCP Travel expenses with the original receipts with their invoice for re-imbursement in accordance with the terms and conditions of the Contract. Refer to Appendix 14, deliverable 34.

4.38 **HCP Qualification Training**

Throughout the duration of the Contract, the Contractor is responsible for any HCP qualification training or training that is necessary for the HCP to maintain their specific qualifications and credentials such as re-training or re-certifications.

4.38.1 HCP training costs, travel costs associated with training, and time absence are not billable to VAC.

4.38.2 The Contractor must provide the DTA with a minimum of 14 calendar days advance written notice when an HCP will be absent for training purposes. The training period must not exceed 14 calendar days. The notice must contain the HCP name, Task Authorization number, name of training, and dates and duration of training.

4.38.3 If the training exceeds 14 calendar days, the conditions under Annex A- SOW VAC article entitled "HCP Long Term Absences" article will apply.

4.39 **VAC Unique Specialization Training**

Throughout the duration of the Contract, the Contractor is responsible for any required HCP training, re-training or certification costs, plus any travel costs associated with the training.

4.39.1 Specialized Training that is unique to VAC may not be accessible to the Contractor. On a case-by-case basis and at its discretion, VAC may offer, VAC specialized training to the Contractor for its HCPs.

4.39.2 If Specialized Training that is unique to VAC is offered by VAC to the Contractor, the costs charged to the Contractor will be the same costs per person as would be charged for a VAC public service employee. Travel costs associated with the training and time absent are not to be billable to the VAC. If VAC requires the HCP to take the specialized training, VAC will cover the cost.

4.40 **HCP Holidays**

Throughout the In-Service and Out-Going Phases of the Contract, the Contractor must provide the DTA with 14 calendar days written notice when an HCP is planning holidays for a period of 14 calendar days or less. Written notice of 21 calendar days must be provided when an HCP is planning holidays for a period greater than 14 calendar days.

4.41 **HCP Short-Term Absences**

Throughout the In-Service and Out-Going Phases of the Contract, the Contractor must advise the DTA and TM in writing by email, when any of its HCPs will be absent from the work location. Short-term absence is defined as 21 calendar days or less.

4.42 **HCP Long Term Absences**

Throughout the In-Service and Out-Going Phases of the Contract, the Contractor must provide the TM and TA with 42 calendar days written notice when an HCP is planning to be absent for a period greater than 21 calendar days. The DTA may request that the Contractor replace the HCP or deny some or all of the leave should VAC not have adequate staffing available to deliver the services.

4.42.1 If the HCP absence is unplanned and the HCP will be absent for a period greater than 21 calendar days, the Contractor must provide written notice to the TM and DTA when it is advised by the HCP. The DTA may request that the Contractor replace the HCP, temporarily.

4.42.2 When the HCP is replaced temporarily, VAC Task Authorization must be amended. The Contractor's replacement HCP must meet all the qualifications for the HCP category; must not be under another VAC Task Authorization for same hours of work or schedule; and must not be a transferred HCP from another VAC Task Authorization, creating another unfilled Task Authorization elsewhere, unless accepted by VAC in some particular circumstances.

4.42.3 If the Contractor cannot provide a replacement HCP temporarily, the VAC Task Authorization may be cancelled. If the VAC Task Authorization is cancelled; a new VAC Task Authorization may be issued to the Contractor by VAC, the Time To Provide section of the Contract applies.

4.43 **HCP Departures while on a Task Authorization**

Throughout the In-Service and Out-Going Phases of the Contract, the Contractor must provide 14 calendar days written notice to the TM and TA when an HCP is planning to depart while on a Task Authorization. The Task Authorization will be cancelled and the Contractor may be provided a new VAC Task Authorization.

4.44 **VAC Cancellation of a Task Authorization**

Throughout the In-Service and Out-Going Phases of the Contract, when the services of an HCP are no longer required, VAC will give the Contractor a minimum of 14 calendar days notice of a Cancellation of a Task Authorization. The minimum of 14 calendar day period is not required when a Task Authorization is cancelled as a result of the Contractor not meeting the timeframe for the replacement of an HCP, or for HCP Short Term and Long Term absence.

4.45 **HCP Providing Advice in Support of Legal or Administration Proceedings**

Throughout the In-Service and Out-Going Phases, HCPs may be asked to attend administrative or legal proceedings.

4.45.1 When HCPs are requested to participate in administrative or legal proceedings, the HCP will be given the time to do so and the time will be paid in accordance with the rate on the HCP's VAC - Task Authorization.

4.45.2 When a HCP participation in administrative or legal proceedings involves travel outside the Designated VAC Location, the HCP Travel Request and Authorization process must be followed as detailed under the Annex A - SOW VAC article titled "HCP Travel".

4.45.3 The Contractor must submit the complete approval package, travel itinerary, claimable expenses and receipts with the invoice.

4.45.4 If the request for a HCP participation in administrative or legal proceedings necessitates changes and updates to the original VAC - Task Authorization, the Contractor's HCP cannot conduct the HCP participation in administrative or legal proceedings until the Contractor receives an approved VAC - Task Authorization amendment.

4.46 **Meetings**

The Contractor's appropriate CMT or CCO personnel must attend various meetings throughout the duration of the Contract.

4.46.1 The SDM or DSDM must attend all required meetings.

4.46.2 The Contractor must determine who from its CMT or CCO will be required to attend each type of meeting. The Contractor's personnel who are attending should be determined by the agenda items to be discussed and the Action Items Log (AIL).

4.46.3 The Contractor will be responsible for making all travel arrangements for their personnel attending meetings.

4.46.4 All Contractor or CMT and CCO personnel travel costs related to attending any of the required meetings will be borne by the Contractor and are not to be invoiced to VAC.

4.47 **Initial Kick-Off Meeting**

The Contractor will be required to attend an Initial Contract Kick-Off Meeting in the Start-Up Phase. As a minimum, the Contractor's senior representative and SDM must attend this meeting and may include other Contractor personnel it deems appropriate.

4.47.1 The Initial Contract Kick-off meeting must take place within fourteen (14) calendar days after contract award. The DTA will advise the Contractor of the date and address of the meeting.

4.47.2 The duration of the meeting is anticipated to be three (3) to five (5) calendar days.

4.47.3 This meeting will be co-chaired by the Contractor and the DTA and will include, as a minimum, the following Agenda items:

a. review of the Contract including the SOW;

b. an overview of the Contractor's Management Plan;

c. an overview of the Contractor's Organization;

d. an overview of the Contractor's Start-up Plan and Schedule;

e. an overview of the Contractor's Recruitment Strategy;

f. an overview of the Contractor's Risks and Risk Analysis and the methods or procedures by which the impact of these risks will be mitigated and managed;

g. confirmation of the names, title(s), roles and responsibilities plus contact information for the primary Points Of Contact (POC) for CCO and CMT personnel;
h. confirmation of the CCO and CMT structure; and

i. other items, as required.

4.47.4 The Agenda for the Initial Contract Kick-Off Meeting will be prepared by the DTA.

4.47.5 The DTA will distribute the Agenda to all meeting participants.

4.47.6 The minutes of the meetings will be prepared by the Contractor in accordance with the Annex A - SOW VAC article titled "Minutes of the Meetings" and provided by the Contractor to the DTA and all attendees within seven (7) calendar days following the date of the meeting. Refer to Appendix 14, deliverable 35.

4.47.7 The minutes will be signed by the Chairs.

4.47.8 Should there be any action items resulting from the Initial Kick-off meeting, the Contractor will prepare the Action Item Log (AIL) in accordance with the Annex A - SOW VAC article titled "Action Item Log (AIL)". The AIL must be provided with the Minutes. Refer to Appendix 14, deliverable 36.

4.47.9 The Contractor will coordinate responses to Action Items from the responsible parties and update the AIL.

4.47.10 All Action Items resulting from the Initial Contract Meeting must be responded to within 10 calendar days following the date of the meeting or by the date(s) agreed to at the Initial Contract Kick-Off Meeting.

4.47.11 The updated AIL will be distributed by the Contractor to all attendees within 15 calendar days from the date of the meeting and will contain all responses for the Action Items assigned to all parties. Refer to Appendix 14, deliverable 37.

4.48 **Progress Review Meetings**

The Contractor must organize and hold Progress Review Meetings (PRM) in the National Capital Region or in Charlottetown, PEI, or by teleconference. The DTA will determine where and how the meeting will take place. The meetings will have the following frequency:

a. during the Start-up and Out-going Phases, as frequently as determined necessary by the DTA but no more than once per month; and

b. during the In-Service Phase, on a semi-annual basis within the first 10 days after the end of the September and March, unless agreed otherwise.

4.48.1 If agreed by the DTA in advance, the PRM may be held via videoconference or teleconference.

4.48.2 As a minimum, the SDM or ASDM must attend this meeting and may include other Contractor personnel it deems appropriate.

4.48.3 The PRMs will be co-chaired by the DTA and the Contractor.

4.48.4 The PRMs are anticipated to range from a half-day (1/2) up to, two (2) full days (15 hours) in duration. Duration will be based on the Agenda and Action Items to be discussed.

4.48.5 The Contractor will prepare the PRM Agenda and provide to the DTA for approval a minimum of ten (10) calendar days before PRM meeting. Refer to Appendix 14, deliverable 38.

4.48.6 Once the PRM Agenda is approved, the Contractor will distribute it to all meeting attendees a minimum of five (5) calendar days before the meeting. Refer to Appendix 14, deliverable 39.

4.48.7 The Agenda will include:

a. the purpose of the meeting;

b. the location;

c. the date and estimated duration of the meeting;

d. the proposed list of topics and sub-topics to be discussed plus the time allocated to each discussion item; and

e. the name of the party and individual responsible for addressing each topic or sub-topic included.

4.48.8 The topics for presentation and discussion at PRMs may include:

a. opening remarks;

b. agenda review;

c. review of previous Minutes (if applicable);

d. current status or changes to the Contractor’s Plans;

e. status of Contractor’s Work and activities during the PRM period;

f. discussions on Contractor’s Reports during the PRM period;

g. review of Contractor's performance;

h. problem or issue reviews and Lessons Learned (LL);

i. review of closed Action Items during the PRM period;

j. status of current Action Items;

k. new problem or issue areas and corrective measures or action plans;

l. new discussion items;

m. plans for next reporting period;

n. round table discussion;

o. next meeting date; and

p. closing remarks.

4.48.9 The Contractor must provide its planned action(s) to address all discrepancies identified in the PRM in accordance with the time period and schedule agreed to at the PRM.

4.48.10 The Contractor must prepare the minutes of the PRM in accordance with the Annex A - SOW VAC article titled "Minutes of the Meetings" and provide to the DTA for approval ten (10) calendar days after the PRM. Refer to Appendix 14, deliverable 40.

4.48.11 The Contractor must correct any discrepancies noted in the minutes of the PRM within three (3) calendar days of notification by the DTA and subsequently distribute to all meeting attendees within seven (7) calendar days of the meeting.

4.49 **Ad Hoc Meetings**

Ad Hoc Meetings are meetings that may be conducted when necessary to respond to urgent or unforeseen requirements, technical Work, contract or program management activities or issues, and contractual obligations. Ad Hoc meetings are to be kept to a minimum and only take place if necessary.

4.49.1 Ad hoc meetings can be requested by either Canada or the Contractor. The party requesting the Ad hoc meeting may invite representatives it deems appropriate.

4.49.2 The party requesting an urgent Ad Hoc Meeting must provide the requested participants with a written notice at least one (1) working day prior to the meeting. The meeting should take place within two (2) working days of said notice.

4.49.3 The party requesting a non-urgent Ad Hoc Meeting must provide the requested participants a minimum of five (5) working days written notice and the meeting will take place at a time agreed to by the parties.

4.49.4 Ad Hoc meetings must be held at a location that is mutually acceptable to all parties or by teleconference, videoconference or Web conference if acceptable by all parties.

4.49.5 The party requesting the Ad Hoc meeting must organize and chair the meeting as well as prepare and provide the Agenda. As a minimum, the Agenda must include:

a. the purpose of the meeting;

b. the location;

c. the date and estimated duration of the meeting;

d. the proposed list of topics and sub-topics to be discussed plus the time allocated to each discussion item; and

e. the name of the party and individual responsible for addressing each topic or sub-topic included.

4.49.6 The Contractor must prepare and distribute the Minutes of the Ad Hoc meeting in accordance with the Annex A - SOW VAC article titled "Minutes of the Meeting", and the resulting Action Items Log and follow up actions in accordance with the Annex A - SOW VAC article titled "Action Item Log".

4.49.7 The costs associated with hosting the Ad Hoc Meetings will be borne by the party requesting the meeting.

4.49.8 All costs incurred in the attendance of Ad Hoc Meetings such as preparation, facility cost, and travel will be the responsibility of each of the parties required to participate in the meeting.

4.50 **Minutes of the Meetings**

Minutes of the meetings will be required, throughout the duration of the Contract, for each meeting or review held and must include and document all information required to provide an accurate record of the content of the meeting or review.

4.50.1 The minutes are prepared and distributed by the Contractor. All parties who receive copies of the minutes are responsible to indicate required changes within three (3) calendar days of receiving the minutes. Once approved by the parties, the Contractor will distribute copies of the minutes to all the participants within seven (7) calendar days.

4.50.2 The minutes must include, as a minimum, the following sections:

a. a title page containing the title or purpose of the meeting, meeting number, date and location;

b. identification of the Contract number;

c. list of invitees' names, titles, and contact particulars (telephone and email addresses);

d. copy of the Agenda;

e. sections for: the Opening Remarks, Agenda Review, Review of Previous Minutes (if applicable), Open Discussion Items, New Discussion Items, and Review of Previous and New Action Items, Next Meeting, and Closing remarks;

f. a detailed summary of the proceedings, discussions, agreements or decisions reached or taken and by whom;

g. the Action Item Log must be attached and include any responses provided from any of the attendees at the meeting; and

h. signature page with spaces for the Contractor, and the CA or the DTA as applicable.

4.50.3 All Minutes prepared must be approved and signed by the applicable DA before distribution.

4.51 **Action Item Log**

The Action Item Log (AIL) is a living document that details all Action Items related to all aspects of the Contract. The AIL is a follow-on document from the Initial Contract Kick-Off Meeting and runs for the duration of the contract.

4.51.1 The Contractor must prepare and maintain the AIL. Refer to Appendix 14, Deliverable 36.

4.51.2 The AIL must provide a consolidated list of all actions to be taken by each party.

4.51.3 The AIL must include, as a minimum, the following sections:

a. serial number;

b. item;

c. description of the action to be taken;

d. cross-reference to the minutes;

e. indication of the person who is responsible for action;

f. estimated target date for completion of action; and

g. status indicator on whether the Action Item is open or closed.

4.51.4 All Action items will remain open until there is a decision recorded in minutes of meetings to close the item.

4.51.5 The updated version of the AIL must be distributed by the Contractor with meeting minutes to all participants. Refer to Appendix 14, Deliverable 37.

4.52 **REPORTS**

The Contractor must prepare and provide various reports throughout the duration of the Contract.

4.53 **Start-Up Phase Reports**

During the Start-Up Phase of the Contract, the Contractor must prepare and deliver monthly Start-Up Phase Status Reports. Refer to Appendix 14, Deliverable 42.

4.53.1 The report must show all Work undertaken, including Work in progress against the Start-Up schedule and must:

a. present an overview of all activities that have taken place in the reported period, those planned but that have not taken place in the reported period, and those that are planned for the following period; and

b. address the activities including all scheduled events or milestones, conducted activities, major accomplishment, non-conducted planned activities and missed schedule activities, including delay reasons, current status of problems, action items taken or planned to resolve, impacts, impacts to the schedule, forecasted problems, recommendations or solutions to any issues or problems, and planned activities for the following period.

4.54 **Task Authorization Status Report**

The Contractor must prepare and deliver a Task Authorization Status Report monthly, commencing after the Initial Kick-Off Meeting, for the duration of the Contract. Refer to Appendix 14, Deliverable 43.

4.55 **HCP Credentialing Report**

The Contractor must prepare and deliver a HCP Credentialing Report prior to SED and for each six (6) months thereafter for the duration of the Contract. Refer to Appendix 14, Deliverables 44 and 45.

4.55.1 The report, as a minimum, must include the following information for each HCP:

a. Task Authorization number;

b. location;

c. occupation category;

d. HCP name;

e. credential type (e.g. licence, insurance, registration, certification, education, etc.);

f. credential description (e.g., name, regulatory body, level of education, etc.)

g. status (e.g. confirmed, pending, expired, etc.); and

h. expiry date.

4.56 **HCP Travel Report**

Throughout the duration of the Contract, the Contractor must prepare and deliver a monthly HCP Travel Report. Refer to Appendix 14, Deliverable 46.

4.56.1 The report is to be provided with the invoice but should be able to be generated through the Timesheet Tool. The report, as a minimum, must list:

a. every HCP authorized to travel under the Contract; and

b. include for each HCP the following distinct data elements:

(1) Task Authorization number;
(2) province;
(3) location;
(4) occupation and category;
(5) HCP surname;
(6) HCP given name;
(7) HCP start date;
(8) Task Authorization period (period of Travel);
(9) status (fulltime or part-time);
(10) total Task authorization travel amount;
(11) total travel costs expended during the reporting period;
(12) total accumulated travel costs to date.

4.57 **HCP Labor and Overtime Report**

Throughout the duration of the Contract, the Contractor must prepare and deliver a monthly HCP Labor and Overtime Report. Refer to Appendix 14, Deliverable 47.

4.57.1 The report is to be provided with the invoice, but should be able to be generated through the Timesheet Tool. The report, as a minimum, must include:

a. every HCP authorized to perform Work under the Contract;

b. Task Authorization number;

c. location;

d. occupation and category;

e. HCP surname;

f. HCP given name;

g. HCP start date;

h. Task Authorization end date;

i. authorized level of effort which is authorized hours of Work per week (regular and overtime hours if applicable) for the current month;

j. actual level of effort which is actual hours worked per week (regular and overtime hours if applicable) for the current month;

k. total cost for current month;

l. total costs incurred over duration of Contract; and

m. total Task Authorization authorized value.

4.58 **Recurring HCP Task Authorization Confirmation Report**

Throughout the duration of the Contract, the Contractor must prepare and deliver an Annual Recurring HCP Task Authorization Confirmation Report. Refer to Appendix 14, Deliverable 48.

4.58.1 The report, as a minimum, must include:

a. all HCPs whom have committed to continuing on the recurring Task Authorization;

b. Task Authorization number;

c. location;

d. occupation and category;

e. HCP surname;

g. HCP given name;

h. HCP start date;

i. Task Authorization end date;

j. authorized level of effort which is authorized hours of Work per week (regular and overtime hours if applicable) for the year;

k. actual level of effort which is actual hours worked per week (regular and overtime hours if applicable) for the year;

**Phase Three-Out-Going Phase**

4.59 **Out-Going Phase Plan**

The Contractor must develop and deliver a draft and final Out-Going Phase Plan that will outline outgoing activities and will propose timings for the range of deliverables listed below. Refer to Appendix 14, deliverable 49 and 50. The draft Out-Going Phase Plan must be presented at the Out-Going Phase Kick-Off Meeting.

4.59.1 The Out-Going Phase Plan can incorporate any out-going activities and practices but as a minimum, must include the following:

a. a list and description of Contractor out-going activities to be completed and the major milestones to be achieved during the Out-Going Phase to allow for orderly and timely transition and fully meet all the Annex A - SOW VAC requirements;

b. a schedule, which states the proposed timelines or timeframes for all activities and sub-activities related milestones, all dependencies, and the critical path; and

c. the Contractor's Senior Management structure for the Contract Out-Going Phase, including but not limited to: the Contractor's Out-Going Phase Management Team. The structure must indicate where participation is required or may be requested from the DTA, and what processes and procedures are recommended to ensure quick decision-making within the plan to facilitate the timely delivery of services.

4.59.2 The Contractor must revise and update, within 10 calendar days, the draft Out-Going Phase Plan if comments or recommendations are received from the DTA. Refer to Appendix 14, deliverable 50.

4.59.3 Once the Out-Going Phase Plan is approved by the DTA, it will be deemed the final Out-Going Phase Plan.

4.59.4 The Contractor must implement and carry out all out-going activities in accordance with the approved Out-Going Phase Plan during the Out-Going Phase.

4.60 **Out-Going Phase Kick-Off Meeting**

The Contractor will be required to attend an Out-Going Phase Kick-Off Meeting in the Out-Going Phase. As a minimum, the Contractor's senior representative and SDM must attend this meeting and may include other Contractor's personnel it deems appropriate.

4.60.1 The Out-Going Phase Kick-Off Meeting must take place within 30 calendar days after the Contractor has been officially notified of the commencement of the Out-Going Phase by the CA. The DTA will advise the Contractor of the date and address of the meeting.

4.60.2 The duration of the meeting is anticipated to be one (1) to two (2) calendar days.

4.60.3 This meeting will be co-chaired by the Contractor and DTA and will include, as a minimum, the following Agenda items:

a. an review of the Contractor's Out-Going Phase Plan and Schedule;

b. an review of the Contractor's Risks and Risk Analysis and the methods or procedures by which the impact of these risks were mitigated and managed;

c. confirmation of the CCO and CMT structure for the Out-Going Phase; and;

d. other items as required.

4.60.4 The Agenda for the Out-Going Phase Kick-Off Meeting will be prepared by the Contractor no less than five (5) calendar days before the meeting.

4.60.5 The minutes of the meetings will be prepared by the Contractor in accordance with the Annex A - SOW VAC Section titled "Minutes of the Meetings" and provided to the DTA and all attendees within seven (7) calendar days following the date of the meeting.

4.60.6 The minutes will be signed by the Chairs.

4.60.7 Should there be any action items resulting from the Out-Going Phase Kick-Off Meeting, the Contractor will prepare the Action Item Log (AIL) in accordance with the Annex A -

SOW VAC article titled "Action Item Log (AIL)". The AIL must be provided with the minutes.

4.60.8 The Contractor will coordinate responses to Action Items from the responsible parties and update the AIL.

4.60.9 All Action Items resulting from the Out-Going Phase Kick-Off Meeting must be responded to within 10 calendar days following the date of the meeting or by the date agreed upon at the Out-Going Phase Kick-Off Meeting.

4.60.10 The updated AIL will be distributed by the Contractor to all attendees within 15 calendar days from the date of the meeting and will contain all responses for the Action Items assigned to all parties.

4.61 **Out-Going Phase Contract Summary Reports**

During the Out-Going Phase, the Contractor may be requested to:

a. provide Contract summary reports such as, but not limited to:

(1) reports generated through the Timesheet Tool;

(2) Final HCP Certifications Report;

(3) Final HCP Labour Report (Regular and Overtime if applicable);

(4) Final HCP Travel Report; and

(5) Final HCP Credentialing Report;

b. export data electronically from the Timesheet Tool for accounting purposes, retention and audit requirements; and

c. provide Final Lessons Learned documents.

4.62 **Final Progress Review Meeting**

During the Out-Going Phase, the Contractor and its appropriate personnel must attend a Final Progress Review (FPR) meeting. The purpose of the FPR will be to perform a complete review of all of the Contractual requirements, deliverables, remaining or

outstanding PRM Action Items, and to discuss the Contractor's last closing invoice, to ensure all Contractual obligations are completed and the Contract can be closed.

4.62.1 The FPR meeting will take place no more than 30 and no less than 20 calendar days before the Contract expiry date. The CA will advise the Contractor of the date and address of the meeting. As a minimum, the Contractor's senior representative and SDM must attend this meeting and may include other Contractor personnel it deems appropriate.

4.62.2 The meeting duration is anticipated to be approximately three (3) to five (5) calendar days.

4.62.3 This meeting will be co-chaired by the CA and the DTA and will include, as a minimum, the following Agenda items for review and discussion:

a. Contractual requirements and deliverables;

b. remaining or outstanding PRM Action Items;

c. Contractor's Out-Going Phase Activities;

d. Contractor's closing invoice; and

e. other items, as required.

4.62.4 The Agenda for the FPR Meeting will be prepared by the Contractor and provided to the DTA no less than seven (7) calendar days before the meeting.

4.62.5 The minutes of the meeting will be prepared by the Contractor in accordance with the Annex A - SOW VAC article titled "Minutes of the Meetings" and provided to all attendees within seven (7) calendar days following the date of the meeting.

4.62.6 The minutes will be signed by the Chairs.

4.62.7 Should there be any action items resulting from the FPR meeting, the Contractor will prepare the Action Item Log (AIL) in accordance with the Annex A - SOW VAC article titled "Action Item Log (AIL)". The AIL must be provided with the minutes.

4.62.8 The Contractor will coordinate responses to Action Items from the responsible parties and update the AIL.

4.62.9 All Action Items resulting from the FPR meeting must be responded to and closed before the Contract expiry date.

## 5.0 DELIVERABLES

The Contractor must prepare and provide all deliverables in the consolidated table found in Appendix 14 to Annex A – SOW VAC.

The table specifies:

a. the number of the Deliverable;

b. the SOW Reference;

c. the Deliverable description;

d. the required delivery format(s) (electronic or paper, or both);

e. whether the Deliverables are being provided for Approval or Information;

f. Frequency of delivery;

g. required delivery date;

h. the authority/authorities to whom the Deliverables are to be provided.

5.1 All deliverables are to be in English only.

5.2 The Contractor must ensure that all deliverables have a cover page and the cover page must indicate the deliverable number, deliverable name, whether it is an original submission or re-submission, draft or final version (if applicable), and date in the format of DD-MM-YY.

5.3 All deliverables must:

a. be formatted to fit on Letter size paper (8.5 x 11) unless doing so make the content illegible, in which case, larger size paper may be used;

b. be provided in Microsoft Office format;

c. be legible and suitable for reproduction;

d. not be password protected; and

e. have pages numbered sequentially.

5.4 The process for approval of deliverables is as follows:

a. the DTA will acknowledge receipt of all deliverables within five (5) calendar days;

b. within 20 calendar days of receipt, the DTA will review all deliverables;

c. the DTA will advise the Contractor, via e-mail, if the deliverable has been approved or rejected;

d. if deliverable is rejected by the DTA, a notice of the deficiency(ies) will be provided;

e. the Contractor must address the deficiency(ies) noted and resubmit the corrected deliverable within seven (7) calendar days from the date of notification; and

f. the DTA will have an additional 14 calendar days to review and approve or reject the resubmitted deliverable.

## 6.0 GOVERNMENT FURNISHED RESOURCES

Government Furnished Resources (GFR) are Canada-owned Government Furnished Equipment (GFE), Government Supplied Material (GSM), and Government Furnished Information (GFI) that VAC will make available for use by the Contractor or Contractor's HCPs.

6.1 All GFE, GSM, and GFI provided to the Contractor or to the Contractor's HCPs in support of performing the Work under the Contract, will be provided to the Contractor, Free of Charge (FOC).

6.2 The Contractor HCPs must ensure that any GFE or GSM provided are returned in satisfactory condition, subject to normal wear and tear, to VAC upon completion of the Work under the Task Authorization.

6.3 Cost recovery action will be taken for any GFE or GSM lost or damaged excluding normal wear and tear.

6.4 VAC will provide the following GFE for each HCP:

a. all office related equipment necessary to support HCP tasks, such as office space, desk, chair, computer, printer access; and

b. medical equipment and supplies, as required to perform Pension Medical Exams.

6.5 VAC will provide the following GSM for each HCP:

a. all office related supplies required to perform HCP tasks such as pens, paper, forms, etc.; and

b. all medical consumables used in conducting Pension Medical Exams.

Any HCP ergonomic equipment, specialized equipment or material requested, are the responsibility of the Contractor.

## 7.0 Ownership and Control

All information (personal or otherwise) which is used, processed, handled, stored, and recorded by the Contractor for the purposes of fulfilling the requirements of the Contract, regardless of the format, medium, and physical characteristics, remains under the ownership and control of VAC. All applicable Federal legislations apply under all circumstances, even when such information is in the sole custody of the Contractor.

In accepting this Contract, the Contractor acknowledges that VAC maintains ownership and control over all personal information and any other information that is collected, created, captured, received, used, processed, handled, stored, and recorded by the Contractor when fulfilling the requirements outlined in the Contract.

Upon delivery of the final requirements of the Contract, the Contractor will ensure that all information referenced above is returned to the DTA.

## 7.1 Access to Information and Privacy

The Contractor agrees and understands that information under the ownership of VAC as defined in section 7, (whether in the possession of the Contractor or VAC) is subject to the terms and conditions of the *Access to Information* and the *Privacy Act.*

Should the Contractor receive a request for information from a third party, relating to VAC information (whether in the possession of the Contractor or VAC) for the purposes of the Contact, the Contractor must advise the DTA. Following the consultation with the VAC Access to Information and Privacy Coordinator, the DTA will provide the Contractor with guidance and direction on handling the request.

For the purpose of this Contract, personal health information will be referred to as personal information as defined in Section 3(b) of the *Privacy Act.*

## 7.2 Privacy Impact Assessment

The Contractor must provide, within thirty (30) calendar days, any requested information required to complete or update the Privacy Impact Assessment (PIA).

a. The DTA may be required to formulate, and routinely update, a comprehensive Privacy Impact Assessment (PIA) as part of the transition and ongoing administration for the Contract.

b. The PIA may include, but is not limited to, business process descriptions, business process diagrams, data and information flow diagrams, data and information flow tables,

segregation and security documentation, systems diagrams and specification, and an overview of organizational structure. The DTA may request the information and/or records at any time from the Contractor. This includes any records that are transferred to the Contractor or sub-contractor , or collected, created, obtained or maintained by the Contractor or sub-contractor in fulfilment of the responsibilities stated elsewhere in the Contract.

c. The Contractor must be responsible for providing access to its facilities and all documentation and resources associated with the Contract, and will provide the DTA access to desk space, telephones, computers, etc. to conduct the assessment. The Contractor must work with the DTA to address any deficiencies or recommendations as a result of the PIA.

d. Upon completion of a PIA, the Contractor must develop and implement a Corrective Action Plan, approved by DTA, including a schedule for implementation of corrective actions, to correct deficiencies identified within the PIA.

f. Provision of information by the Contractor to DTA in support of the PIA will be at the Contractor's own expense.

7.3 **Breach of Privacy or Security**

a. The Contractor shall notify, in writing, the DTA immediately upon becoming aware of an occurrence of breach of privacy or of the security requirements. This includes but is not limited to:

- Unauthorized access to or modification of the personal information in its custody;
- Unauthorized use of the personal information in its custody;
- Unauthorized disclosure of the personal information in its custody;
- A breach of privacy or security with respect to personal information in its custody or with respect to any computer system in its custody and that may be used to access personal information.

b. The Contractor and VAC shall work to achieve resolution and compliance with Government of Canada Privacy and Security requirements.

c. Any loss, suspected loss, theft or unauthorized disclosure or access to information must be reported immediately with the following details:

- The date and place of the incident;
- The circumstances surrounding the incident;
- A description of the information involved;
- The extent of known or probable compromise and the identity of unauthorized persons who had or are believed to have had access to the information;
- The action or contemplated to remedy the situation; and,

- Any further details which may assist in assessing the loss or compromise.

d. A follow-up report on an event must be forwarded promptly with the results of any investigation conducted following the initial search and notification, including corrective measures that have been or are being taken to prevent the recurrence of a security and/or privacy incident. The Contractor will notify the DTA if the information is subsequently found, including the circumstances under which it is found.

Standard Operating Procedures for this section of the Contract shall be developed during the contract implementation phase and should include the details noted above.

# APPENDIX 1 TO ANNEX A3

# GLOSSARY OF TERMINOLOGY

## GLOSSARY OF TERMS/ACRONYMS

| | |
|---|---|
| AIL | Action Items Log |
| CA | Contracting Authority (PSPC) |
| CCO | Contractor`s Central Office |
| CMP | Contractor's Management Plan |
| CMT | Contractor Management Team |
| CRMP | Contractor's Risk Management Plan |
| DA | Departmental Authorities |
| DSDM | Deputy Service Delivery Manager |
| DPA | Departmental Procurement Authority |
| DTA | Departmental Technical Authority |
| FPR | Final Progress Review |
| FY | Fiscal Year |
| GFE | Government Furnished Equipment |
| GFI | Government Furnished Information |
| GFR | Government Furnished Resources |
| GSM | Government Supplied Material |
| HCP | Health Care Provider |
| HCPC | Health Care Provider Contract |
| HCPC LL | Health Care Provider Contract Lessons Learned |
| LL | Lessons Learned |
| LOE | Level of Effort |
| MS | Microsoft |
| OL | Official Languages |
| POC | Point of Contact |
| PRM | Progress Review Meeting |
| PRMs | Program Review Meetings |
| SDM | Service Delivery Manager |
| SED | Service Effective Date |
| SOW | Statement of Work |
| TTP | Time to Provide |
| TsT | Timesheet Tool |
| TM | Task Manager |
| VAC | Veterans Affairs Canada |

**APPENDIX 2 TO 9 OF ANNEX A3**

**NOT APPLICABLE TO VAC**

# APPENDIX 10 TO ANNEX A3

# OCCUPATIONAL GROUPS AND CATEGORIES

## Appendix 10 - VAC Occupational Group and Categories

| Stream | Group | Category |
|---|---|---|
| 1 | Nurse | Field Nursing Services Officer |
| 1 | Occupational Therapist | Field Occupational Therapist Services Officer |
| 1 | Physician | Medical Advisor |
| 1 | Dentist | Dental Consultant |
| 1 | Audiologist | Audiologist Advisor |
| 1 | Respiratory Therapist | Registered Respiratory Therapist |
| 2 | Physician | Senior Area Medical Officer |

# APPENDIX 11 TO ANNEX A3

# HCP QUALIFICATIONS AND TASKS

**STREAM: 1**

**OCCUPATIONAL GROUP AND CATEGORY: Dentist - Dental Consultant**

**WORK AND ENVIRONMENT**

VAC's dental program provides basic dental care and some preauthorized comprehensive dental services from a dentist/denturist of the client's choice in their own community. The Dental Consultant provides expert advice, opinions and recommendations, in support of disability and treatment benefit decisions or appeals for VAC's Dental Program.

Language of work may be in English/ French or both, depending on geographic location.

**EDUCATION AND CREDENTIALS**

The Dental Consultant must, as a minimum, possess:

a. Graduation from a recognized school of dentistry. ( If the degree is from outside Canada, the contractor must provide the Canadian equivalency of the degree evaluated by a recognized third party.); and
b. A valid license to practice dentistry in the province of practice.

**EXPERIENCE**

The Dental consultant shall have the following experience within the last 5 years, as a minimum:

a. ten years clinical experience;
b. five years experience working with health and non-health professionals in a team setting;
c. five years experience in adjudicating claims or rendering adjudication decisions or providing dental consultations in response to individual clients requests for dental care options for senior citizens, Veterans, Canadian Forces and/or RCMP clients.

**<u>TASKS</u>**

The required tasks for this occupational group includes the following:

- provide expert dental consultations in response to individual clients requests for VAC benefits by:
    - reviewing the clients application, statement of case and relevant service documents, and client file information for disability benefits;
    - conducting research, as necessary, to become familiar with the client's medical/dental condition and status including factors which can cause and aggravate this condition;
    - analysing all information, including relevant VAC Legislation, policy, guidelines

and approval criteria, to arrive at an informed opinion concerning the presence of a disability, the result of service factors to this disability and the degree of disability from the pensioned condition; and
- preparing, pursuant to the above noted activities, and in keeping with current Departmental legislation, policy and guidelines, a dental opinion and supporting rationale to facilitate entitlement and assessment decisions by departmental adjudicators.

- provide information and/or education, in the format of presentations or other methods, in the area of dentistry to VAC staff or external consultants.

- other associated tasks relevant to this occupational group.

The dental consultant will be required to provide his/her professional opinion on forms provided to him/her by VAC. Where VAC provides the forms electronically the dental consultant will be required to complete them electronically. The dental consultant will be required to use VAC's systems and software to perform their work.

**STREAM: 1**

**OCCUPATIONAL GROUP AND CATEGORY: Occupational Therapist – Field Occupational Therapy Services Officer**

**WORK AND ENVIRONMENT:**

Occupational Therapist at VAC are responsible for providing occupational therapy advice, consultation, assessments and recommendations on client files and program and policy development in support of the Department's mission to provide client centered services and benefits that respond to the needs of clients.

Language of work may be in English/ French or both, depending on geographic location.

**EDUCATION AND CREDENTIALS:**

Field Occupational Therapy Services Officers must, as a minimum, possess:

a. a Baccalaureate Degree in Occupational Therapy from a recognized university ( If the degree is from outside Canada, the contractor must provide the Canadian equivalency of the degree evaluated by a recognized third party.);

b. a current licence to practice from a provincial or territorial College of Occupational Therapy in the province of practice.

c. a valid driver's license in the province where the work is to be performed.

**EXPERIENCE:**

The Field Occupational Therapy Services Officer shall possess, as a minimum:

- 24 months equivalence of full time experience as an occupational therapist (OT) within the last five (5) years providing occupational therapy treatment or services to adults; or, supervising or teaching the practice of occupational therapy treatment of adults. **part-time experience must be quantified in terms of full days, weeks or hours; concurrent experience from multiple settings must be reported by setting and amount of time in each.**

- A minimum of one year full-time equivalent experience, within the last five years, in providing occupational therapy treatment/services to clients enrolled in a formal psychiatric/mental health program.

**TASKS:**

The required tasks for this occupational group includes the following:

- Provide OT consultation services and advice on a wide variety of issues related to the treatment of adults and older adult clients. This includes, but is not limited to, the provision of professional advice and recommendations on client cases presented at Interdisciplinary Team (IDT) meetings and case conferences.

- Use a VAC computer and software for client documentation in a Windows environment, including word processing, electronic mail and Internet.

- Use the Departmental system Benefits and Health Services On-Line (BHSOL) to request OT assessments and reports from external occupational therapy providers; to review and finalize these reports and to follow-up with the respective VAC members of the IDT or others on services for the client; and, to monitor, report on, and follow-up on the "Due Dates" of forms assigned to external providers.

- Request, review and précis occupational therapy and related health professional reports from other community agencies and services.

- Follow-up with other service providers and vendors regarding quality and status of work.

- Provide training in the use of the BHSOL and Client Service Delivery Network (CSDN) systems to new OTs and others in the same or other Field Offices; and, t provide training in the use of BHSOL to external OTs and other providers completing assessments and reports on behalf of VAC.

- Participate in IDT meetings and case conferences on client or health-related issues. Make any follow-up calls and inquiries from an occupational therapy perspective related to clients discussed at Interdisciplinary Team meetings or during case conferences/consultations with staff.

- Liaise with health care professionals and agencies in the community, in clinics and in long-term care facilities in relation to specific client cases.

- Make recommendations and give professional approval or decline of various benefits or services for clients, in accordance with VAC policy, including determining the assessment instruments to be used, the related amount of time required, and advising the external providers via BHSOL; and, via use of CSDN Work Items and the FHCPS Portal, the Treatment Authorization Centre (TAC), and other staff who initiate expenditures, of the professional recommendations and/or approval.

- Develop and deliver information sessions and training to VAC staff, clients and others on health related topics.

- Facilitate access to treatment and benefits for Veterans.

- Complete Departmental occupational therapy assessments and reports on VAC clients in their homes, or, in the facilities in which the clients reside.

- Prepare reports on the functional status and treatment requirements of the clients using BHSOL and other Departmental systems.

- other associated tasks relevant to this occupational group.

**STREAM: 1**

**OCCUPATIONAL GROUP AND CATEGORY: Nurse – Field Nursing Services Officer (FNSO)**

**WORK AND ENVIRONMENT**

Nurses at VAC are responsible for providing health advice, consultation, assessments and decisions on legislation, policy, program management and client files in support of the Department's mission to provide client centered services and benefits that respond to the needs of clients.

Language of work may be in English/ French or both, depending on geographic location.

**EDUCATION AND CREDENTIALS**

Field Nursing Services Officer must, as a minimum, possess a:

a. Baccalaureate Degree in Nursing from a recognized university ( If the degree is from outside Canada, the contractor must provide the Canadian equivalency of the degree evaluated by a recognized third party.);

b. current licence to practice from a provincial or territorial College of Nurses in the province of practice; and

c. valid driver's license in the province where the work is to be performed.

**EXPERIENCE**

The Field Nursing Services Officer must possess, as a minimum:

- 24 months equivalence of full time experience as a Registered Nurse or Registered Psychiatric Nurse within the last five (5) years providing nursing care to adults; or, supervising or teaching the nursing care of adults.

- Experience related to providing nursing care to adults; or, supervising or teaching the nursing care of adults in an obstetrical or maternal-child care setting is not applicable experience. **part-time experience must be quantified in terms of full days, weeks or hours; concurrent experience from multiple settings must be reported by setting and amount of time in each.**

- A minimum of twelve months full-time equivalent experience as a Registered Nurse or as a Registered Psychiatric Nurse (within the last five (5) years) providing nursing care to adults with mental health conditions; or, supervising or teaching the practice of nursing of adults with mental health conditions.

**TASKS:**

The required tasks for this occupational group includes the following:

- Provide professional nursing consultation services and advice on a wide variety of nursing issues related to the care and treatment of adults and older adult clients. This includes, but is not limited to, the provision of professional advice and recommendations on client cases presented at Interdisciplinary Team (IDT) meetings and case conferences.

- Use a VAC computer and software for client documentation in a Windows environment, including word processing, electronic mail and Internet.

- Use the Departmental system Benefits and Health Services On-Line (BHSOL) to request nursing assessments and reports from nurses and other health professionals; to review and finalize these reports and to follow-up with the respective VAC members of the IDT or others on services for the client; and, to monitor, report on, and follow-up on the "Due Dates" of forms assigned to external providers.

- Request, review and précis nursing and related health professional reports from other community agencies and services.

- Follow-up with other service providers regarding quality and status of work.

- Provide training in the use of the BHSOL and Client Service Delivery Network (CSDN) systems to new nurses and others in the same or other Field Offices; and, to provide training in the use of BHSOL to external nursing and other providers completing assessments and reports on behalf of VAC.

- Participate in IDT meetings and case conferences on client or health-related issues. Make any follow-up calls and inquiries from a nursing perspective related to clients discussed at Interdisciplinary Team meetings or during case conferences/consultations with staff.

- Liaise with health care professionals and agencies in the community, in clinics and in long-term care facilities in relation to specific client cases.

- Make recommendations and give professional approval or decline of various benefits or services for clients, in accordance with VAC policy, including determining the assessment instruments to be used, the related amount of time required, and advising the external providers via BHSOL; and, via use of CSDN Work Items and the Federal Health Claims Processing System Portal, the Treatment Authorization Centre (TAC), and other staff who initiate expenditures, of the professional recommendations and/or approval.

- Develop and deliver information sessions and training to VAC staff, clients and others on health related topics.

- Facilitates access to care and benefits for Veterans.

- Complete Departmental nursing assessments and reports on VAC clients in their homes or the facilities in which the clients reside.

- Prepare reports on the health status and care needs of the clients using BHSOL and other departmental systems.

- other associated tasks relevant to this occupational group.

**STREAM: 1**

**OCCUPATIONAL GROUP AND CATEGORY: Physician – Medical Advisor**

**WORK AND ENVIRONMENT:**

The Medical Advisor provides formal and informal medical opinions; diagnosis clarifications and advice to management and staff of the Veterans Affairs Portfolio. This information is used in the determination of the medical assessment for disability pension and award programs on behalf of clients of Veterans Affairs Canada.

Language of work may be in English/ French or both, depending on geographic location.

**EDUCATION AND CREDENTIALS:**

Medical Advisors must, as a minimum, possess:

a. Graduation with a Medical Doctorate or equivalent from a recognized school of medicine ( If the degree is from outside Canada, the contractor must provide the Canadian equivalency of the degree evaluated by a recognized third party.);

b. Unrestricted license to practice medicine in Canada and in "good standing" with the College of Physicians and Surgeons in the province or territory in which the candidate is licensed to practice.

**EXPERIENCE:**

The Medical Advisor shall have the following experience, as a minimum:

- 3 years experience in active clinical practice of medicine;
- 3 years experience in the practice of disability medicine; and
- 3 years experience working in a team setting with other health and non-medical professionals.

**TASKS:**

The required tasks for this occupational group includes the following:

- Determines the medical assessment of entitled disabilities/awards on behalf of VAC clients at the first level of decision, all levels of entitlement appeal and reassessment.

- Provides evidence based formal/informal medical opinion/diagnosis clarification to Disability Adjudicators and Portfolio management/staff on a case-specific basis.

- Provides advice/guidance to Disability Adjudicators; Team Leaders, Disability

Adjudication; and Senior Area Medical Officers (SAMOs) with respect to the principles and practices of disability medicine; and identifies/forwards emerging issues to the attention of the National Medical Advisor.

- Assists in the provision of advice/guidance to Portfolio senior management, management and staff with respect to the medical aspects of new departmental policy, procedures, regulations and standards in light of evolving medical knowledge.

- Prepares and delivers formal presentations on medical and disability entitlement/ assessment topics to Disability Adjudicators; Team Leaders, Disability Adjudication; Pension Officers, Field Medical Team Leaders and Senior Area Medical Officers under the direction of the National Medical Advisor.

- Assists in the training of new and/or existing Medical Advisors, Authorized Medical Examiners, Disability Adjudicators, Field Medical Team Leaders and Senior Area Medical Officers.

- Represents the Department at medical symposiums and/or conferences.

- Assists in the maintenance/updating of medical guidelines (e.g., Table of Disabilities and Entitlement Eligibly Guidelines).

- other associated tasks relevant to this occupational group.

**STREAM: 2**

**OCCUPATIONAL GROUP AND CATEGORY: Physician – Senior Area Medical Officer**

**WORK AND ENVIRONMENT:**

The Senior Area Medical Officer provides non clinical medical services in support of Veterans Affairs Canada programs, health care and rehabilitation benefits and services.

Language of work may be in English/ French or both, depending on geographic location.

**EDUCATION AND CREDENTIALS:**

Senior Area Medical Officers must, as a minimum, possess:

a. Graduation with a Medical Doctorate or equivalent from a recognized school of medicine;

b. Unrestricted license to practice medicine in Canada and in "good standing" with the College of Physicians and Surgeons in the province or territory in which the candidate is licensed to practice.

**EXPERIENCE:**

The Senior Area Medical Officer shall have the following experience, as a minimum:

a. Five (5) years clinical experience in the examination and management of patients experiencing:
   - musculoskeletal conditions
   - mental health conditions
   - chronic pain
   - substance related and addictive disorders
   - complex/multiple medical conditions (operational health issues)

b. One (1) year of experience working with an Electronic Health Record or Microsoft Office or equivalent information system.

**TASKS:**

The required tasks for this occupational group includes the following:

- Performs Pension Medical Examinations (PMEs) and reports findings to Head Office to establish the medical assessment for Disability Pension (DP) and Disability Award (DA) benefits under the VAC Table of Disabilities and Entitlement Eligibility Guidelines.

- Trains, coordinates and quality assures the work of Authorized Medical Examiners

(AMEs) who are external physicians performing Pension Medical Examinations (PMEs).

- Determines and reviews medical investigations and specialized referrals required for the assessment of VAC disability benefits and health care benefits and services.

- Provides evidence based medical opinions and/or recommendations regarding the adjudication of VAC health care and rehabilitation benefits and services, including establishing the relationship of various health care benefits and services to entitled conditions.

- Provides client case consultation services to internal stakeholders individually or as a member of the Health Care Team and/or Interdisciplinary Client Service Team within the Area Office.

- Provides evidence based medical advice, guidance and information to VAC Area Office and Head Office middle/senior management and staff, OGDs, NGOs and the private sector.

- Liaises with internal and external stakeholders; and keeps abreast of evolving medical knowledge and changes to federal, provincial, municipal and VAC health services.

- Provides training and medical guidance to new and current VAC Area Office and Head Office middle/senior management and staff.

- Researches current medical information, client case histories, VAC programs and VAC policy governing disability benefit programs and health care and rehabilitation benefits and services.

- other associated tasks relevant to this occupational group.

**STREAM: 1**

**OCCUPATIONAL GROUP AND CATEGORY: Audiologist - Audiologist Advisor**

**WORK AND ENVIRONMENT**

The Audiologist provides expert advice, opinions and recommendations, in support of disability and treatment benefit decisions or appeals for Veterans Affairs Canada's (VAC's) Programs.

Language of work may be in English/ French or both, depending on geographic location.

**EDUCATION AND CREDENTIALS**

The Audiologist must, as a minimum, possess:

a. a master's degree in audiology from an accredited university; and
b. a current licence in good standing in the province/territory of practice.

**EXPERIENCE**

The Audiologist shall have the following experience within the last 5 years, as a minimum:

- five years clinical experience;
- five years experience working with health and non-health professionals in a team setting;
- five years experience in adjudicating claims or rendering adjudication decisions or providing audiology consultations in response to individual clients requests

**TASKS**

T The required tasks for this occupational group includes the following:

- provides expert clinical knowledge to VAC staff
- analysing information to inform decision making;
- provides feedback on policy;
- reviews client cases and provides expert opinion and recommendations;
- prepares information in keeping with current Departmental legislation, policy and guidelines, to facilitate entitlement, assessment and appeal decisions by departmental staff
- provides expert opinion to assist with creating or interpreting legislation, policies and business processes;
- provides information and/or education, in the format of presentations or other methods, in the area of Audiology to VAC staff or external consultants.

- other associated tasks relevant to this occupational group.

**STREAM: 1**

**OCCUPATIONAL GROUP AND CATEGORY: Respiratory Therapist - Registered Respiratory Therapist**

**WORK AND ENVIRONMENT:**

The RRT provides professional Respiratory Therapy consultation services and advice on a wide variety of issues related to the treatment and care of adult and older adult clients.

Language of work may be in English/ French or both, depending on geographic location.

**EDUCATION AND CREDENTIALS:**

The Registered Respiratory Therapist must, as a minimum, possess:

a. Graduation with a degree from a recognized university with an acceptable specialization leading to the designation of Registered Respiratory Therapist.

b. A certificate of current registration as an RRT in the province where the work is to be performed.

**EXPERIENCE:**

The Registered Respiratory Therapist shall have the following experience, as a minimum:

- 24 months equivalent full time experience as a RRT within the last seven (7) years providing RRT treatment or services to adults; or, supervising or teaching the practice of registered respiratory therapy treatment of adults.

  Experience related to providing RRT treatment to adults; or, supervising teaching the practice of occupational therapy treatment of adults in an obstetrical or maternal-child care setting is not applicable experience.

**TASKS:**

The required tasks for this occupational group includes the following:

- Provision of professional consultation services and advice on a wide variety of issues related to the treatment and care of adult and older adult clients including recommendations on client cases referred for review or presented at Interdisciplinary Team (IDT) meetings and case conferences;

- Research of existing and new treatment modalities related to oxygen, and respiratory therapy in general and conditions such as sleep apnea;

- Review and make recommendations on respiratory policies;

- Use of computer and software for client documentation in a Windows environment, including word processing, electronic mail and Internet;

- Direct follow-up with service providers/vendors regarding content, quality and status of work;

- If required, provide training on the treatment and care of client with respiratory and respirator-related condition;

- participation in IDT meetings and case conferences on client health-related issues. Make any follow-up calls and inquiries from an RRT perspective related to clients discussed at Interdisciplinary Team meetings or during case conferences/consultations with staff. This would be infrequent; and

- Liaise with health care professionals and agencies in the community and in long-term care facilities in relation to specific client cases.

- other associated tasks relevant to this occupational group.

**APPENDIX 12 TO ANNEX A3**

**WORK LOCATIONS**

Veterans Affairs Canada (VAC) may request resources for any of the locations listed below. The locations include: VAC offices; Integrated Personal Service Centres (IPSC); Satellite offices or Satellite IPSC; Service Centre

## VAC locations – Locations that could require services of a HCP[1]

| OFFICE TYPE | LANGUAGE E=English; F=French; B=Both (bilingual) | GEOGRAPHIC LOCATION |
|---|---|---|
| VAC Office | English | Penticton, British Columbia |
| VAC Office and IPSC | English | Vancouver, British Columbia |
| VAC Office | English | Victoria, British Columbia |
| VAC Office | English | Kelowna, British Columbia |
| Service Centre | English | Prince George, British Columbia |
| IPSC | English | Comox, British Columbia |
| Satellite IPSC | English | Chilliwack, British Columbia |
| IPSC | English | Esquimalt, British Columbia |
| | | |
| VAC Office and IPSC | English | Calgary, Alberta |
| VAC Office and IPSC | English | Edmonton, Alberta |
| IPSC | English | Cold Lake, Alberta |
| IPSC | English | Wainwright, Alberta |
| | | |
| VAC Office | English | Regina, Saskatchewan |
| VAC Office | English | Saskatoon, Saskatchewan |
| | | |
| VAC Office | English | Brandon, Manitoba |
| IPSC | English | Shilo, Manitoba |
| Satellite IPSC | English | Moose Jaw, Manitoba |
| VAC Office and IPSC | English | Winnipeg, Manitoba |
| | | |
| VAC Office | English | Hamilton, Ontario |
| VAC Office and IPSC | English | Kingston, Ontario |
| VAC Office | English | London, Ontario |
| VAC Office | English | Mississauga, Ontario |
| VAC Office Satellite IPSC | English | North Bay, Ontario |
| VAC Office | English | Thunder Bay, On |
| VAC Office and IPSC | Bilingual | Ottawa, Ontario |
| VAC Office | English | Pembroke, Ontario |
| VAC Office | English | Peterborough, Ontario |
| VAC Office and IPSC | English | Toronto, Ontario |
| VAC Office and IPSC | English | Trenton, Ontario |

| | | |
|---|---|---|
| VAC Office | English | Windsor, Ontario |
| IPSC | English | Borden, Ontario |
| IPSC | English | Meaford, Ontario |
| IPSC | English | Petawawa, Ontario |
| | | |
| IPSC | Bilingual and/or French | Bagotville, Quebec |
| VAC Office | Bilingual | Gatineau, Quebec |
| VAC Office | Bilingual and/or French | Quebec City, Quebec |
| VAC Office | Bilingual | Montreal, Quebec |
| IPSC | Bilingual and/or French | St.Jean, Quebec |
| IPSC | Bilingual and/or French | Valcartier, Quebec |
| | | |
| VAC Office | English | Charlottetown, PEI |
| VAC Office | English | Saint John, New Brunswick |
| VAC Office | English | Campbellton, New Brunswick |
| IPSC | English | Moncton, New Brunswick |
| IPSC | English | Gagetown, New Brunswick |
| | | |
| VAC Office and IPSC | English | Halifax, Nova Scotia |
| Satellite IPSC | English | Greenwood, Nova Scotia |
| VAC Office and Satellite IPSC | English | Sydney, Nova Scotia |
| | English | Charlottetown, Prince Edward Island |
| VAC Office and IPSC | English | St. John's, Newfoundland and Labrador |
| Satellite IPSC | English | Gander, Newfoundland |
| VAC Office | English | Cornerbrook, Newfoundland |

[1] VAC locations that could require services of a HCP are subject to change.

**APPENDIX 13 OF ANNEX A3**

**HCP REQUIREMENTS PLAN SAMPLE**

**(Attached)**

# APPENDIX 14 TO ANNEX A3

# DELIVERABLES

**List of VAC Deliverables**

| D # | SOW Para # | Deliverable Description | Format H: Hard Copy E: Electronic | Information (I) Approval (A) | Frequency | Required Delivery Date | Delivery To |
|---|---|---|---|---|---|---|---|
| **Electronic for all deliverables unless otherwise indicated** | | | | | | | |
| 1. | 4.3.6 | Contractor's Central Office toll free telephone number, teleconference number, and email address | E | I | Once | 10 calendar days After Contract Award (ACA) | CA, VAC TA, VAC PA |
| 2. | 4.3.7 and 4.4.1 | The names, titles, roles and contact information for each member of the CMT and CCO. | E | I | Once | At Initial Contract Kick-Off Meeting | CA, VAC TA, VAC PA |
| 3. | 4.3.8 and 4.4.2 | Changes made to the CMT or CCO personnel | E | I | As changed | Within two (2) calendar days of change | CA, VAC TA, VAC PA |
| 4. | 4.5.5 and 4.6.2 | Name and contact information for SDM and DSDM | E | I | Once | Within five (5) calendar days ACA | CA, VAC TA, VAC PA |
| 5. | 4.5.7 | Notice of intent to permanently replace SDM | E | I | As required | 30 calendar days before change | CA, VAC TA,VAC PA |
| 6. | 4.6.4 | Notice of intent to permanently replace DSDM | E | I | As required | 15 calendar days before change | CA, VAC TA, VAC PA |
| 7. | 4.7 | Contractor's Draft Start-Up Plan | E | A | Once | Within 14 calendar days of ACA | CA, VAC TA, VAC PA |

| D # | SOW Para # | Deliverable Description | Format H: Hard Copy E: Electronic | Information (I) Approval (A) | Frequency | Required Delivery Date | Delivery To |
|---|---|---|---|---|---|---|---|
| 8. | 4.7.3 | Final Start-Up Plan | E | A | Once | Within 10 calendar days of receiving final VAC feedback | CA, VAC TA, VAC PA |
| 9. | 4.8 | Contractor's Draft Recruitment Plan | E | A | Once | Within 30 calendar days ACA | CA, VAC TA, VAC PA |
| 10. | 4.8.3 | Contractor's Final Recruitment Plan | E | A | Once | Within 20 calendar days of receiving final feedback from VAC | CA, VAC TA, VAC PA |
| 11. | 4.8.6 | Contractor's Updated Recruitment Plan | E | A | As updated | Within 10 calendar days of any changes | CA, VAC TA, VAC PA |
| 12. | 4.9 | Contractor's Draft Risk Management Plan (CRMP) | E | A | Once | Within 30 calendar days ACA | CA, VAC TA, VAC PA |
| 13. | 4.9.4 | Contractor's Final Risk Management Plan | E | A | Once | Within 20 calendar days of receiving final feedback from VAC | CA, VAC TA, VAC PA |
| 14. | 4.9.6 | Contractor's Updated Contractor's Risk Management Plan | E | A | As updated and for PRM | Within 10 calendar days of any changes and for Progress Review Meetings (PRM) | CA, VAC TA, VAC PA |

| D # | SOW Para # | Deliverable Description | Format H: Hard Copy E: Electronic | Information (I) Approval (A) | Frequency | Required Delivery Date | Delivery To |
|---|---|---|---|---|---|---|---|
| 15. | 4.9.8 | Advance electronic copies of updated CRMP | E | I | As required | Five calendar days before each PRM | VAC TA, VAC PA |
| 16. | 4.9.9 | Hard Copies of updated CRMP for each attendee | H | I | As required | Day of PRM | VAC TA, VAC PA |
| 17. | 4.9.10 | Report occurrence of substantive risk | E | I | As required | Within three (3) calendar days of occurrence | VAC TA |
| 18. | 4.10 | Contractor's Draft Management Plan (CMP) | E | A | Once | Within 30 calendar days ACA | CA, VAC TA, VAC PA |
| 19. | 4.10.3 | Final Contractor's Management Plan | E | A | Once | Within 20 calendar days after final input from VAC | CA, VAC TA, VAC PA |
| 20. | 4.10.6 | Update Contractor's Management Plan | E | A | As Updated | Within 10 calendar days of any changes and PRM | CA, VAC TA, VAC PA |
| 21. | 4.11 | Contractor's draft communications | E | A | As each is developed | Within 30 calendar days of ACA | CA, VAC TA, VAC PA |
| 22. | 4.15 | Start-Up Phase Lessons Learned Document | H | I | Once | Within 30 calendar days of SED | VAC TA |
| 23. | 4.15 | Annual Lessons Learned Report | E and H | I | Annually | June of each year | VAC TA |
| 24. | 4.15 | Out-Going Phase Lessons Learned Report | H | I | Once | Two-months before the Contract expiry date | VAC TA |

| D # | SOW Para # | Deliverable Description | Format H: Hard Copy E: Electronic | Information (I) Approval (A) | Frequency | Required Delivery Date | Delivery To |
|---|---|---|---|---|---|---|---|
| 25. | 4.16.2 and 4.24 | Timesheet Tool and Training Manual | E and H | A | Once | 60 calendar days prior to SED | CA, VAC TA, VAC PA |
| 26. | 4.16.4 | Conduct a Timesheet Tool Demonstration for the DAs | | A | Once | Within 5 calendar days of setup notification of the HCP Timesheet Tool Setup Notification | DAs |
| 27. | 4.26 | Contractor TTP Acceptable Delay Justification | E | A | As required | Within 25 calendar days before the HCP required start date | VAC TA |
| 28. | 4.27.6 | Contractor Notification of HCP Licence Change | E | I | By occurrence | Same business day or next business day if following a weekend | VAC TA |
| 29. | 4.29.1 | Recurring HCP Task Authorization Confirmation Report | E and H | A | Annually | Within 30 calendar days from receipt of Annual Requirements Plan | VAC TA |
| 30. | 4.29.2 | Task Authorization Response Package | E | A | By Task Authorization | No later than 20 calendar days prior to HCP Start Date | VAC TA |
| 31. | 4.30.1 | Signed copy of Orientation Package - HCP Acknowledgement Form | H | I | As required | Within 2 weekS of completion of orientation | VAC PA |

| D # | SOW Para # | Deliverable Description | Format H: Hard Copy E: Electronic | Information (I) Approval (A) | Frequency | Required Delivery Date | Delivery To |
|---|---|---|---|---|---|---|---|
| 32. | 4.34.1 | HCP Overtime Authorization | H | A | As required | With each overtime invoice | VAC TA, VAC PA |
| 33. | 4.36.5 | HCP Site Visit Approval package and expense claim | H | A | As required | With each HCP Travel invoice | VAC TA, VAC PA |
| 34. | 4.37.4 | HCP Travel Claim with original receipts | H | A | As required | With each HCP Travel invoice | VAC TA, VAC PA |
| 35. | 4.47.6 | Minutes of Contract Kick-Off Meeting | E | I | Once | Within 7 days of Contract Kick-Off Meeting | All meeting participants |
| 36. | 4.47.8 And 4.51.1 | Prepare and Maintain Action Item Log (AIL) | E | A | Once | Provided with Kick-Off Meeting Minutes | All meeting participants |
| 37. | 4.47.11 And 4.51.5 | Update AIL | E | A | As required | Ongoing | All meeting participants |
| 38. | 4.48.5 | Agenda for Progress Review Meetings (PRM). | E | A | As required | Within 7 days before meeting. | VAC TA |
| 39. | 4.48.6 | Agenda for PRM. | E | I | As required | Within 5 days before meeting. | All meeting participants |
| 40. | 4.48.10 | Minutes of PRM | E | A | As required | Within 10 days of the meeting | VAC TA |
| 41. | 4.48.11 | Minutes of PRM | E | I | As required | Within 7 days of the meeting | All meeting participants |

| D # | SOW Para # | Deliverable Description | Format H: Hard Copy E: Electronic | Information (I) Approval (A) | Frequency | Required Delivery Date | Delivery To |
|---|---|---|---|---|---|---|---|
| 42. | 4.53 | Start-up Phase Report | E | I | Monthly | During Start-Up Phase | CA, VAC TA, VAC PA |
| 43. | 4.54 | Task Authorization Status Report | E | I | Monthly | Within 7 days following month end | VAC TA |
| 44. | 4.55 | Initial Credentialing Report | E | I | Once | At least 30 days prior to SED | VAC TA |
| 45. | 4.55 | Semi-annual Credentialing Report | E | I | Semi-annual | Within 7 days following the end of September, Within7 days following the end of March | VAC TA |
| 46. | 4.56 | Monthly HCP Travel Report | E | I | Monthly | Within 7 days following month end | VAC TA |
| 47. | 4.57 | Monthly HCP Labour and Overtime report | E | I | Monthly | Within 7 days following month end | VAC TA |
| 48. | 4.58 | Recurring HCP Task Authorization Confirmation Report | E | I | Annually | 30 calendar days from Receipt of Annual HCP Requirement Plan | VAC TA |
| 49. | 4.59 | Draft Out-Going Phase Plan | H | A | Once | At Out-Going Phase Kick-off meeting | All meeting participants |

| D # | SOW Para # | Deliverable Description | Format H: Hard Copy E: Electronic | Information (I) Approval (A) | Frequency | Required Delivery Date | Delivery To |
|---|---|---|---|---|---|---|---|
| 50. | 4.59.2 | Final Out-Going Phase Plan | H | A | Once | Within 10 calendar days based on comments or recommendations received from the VAC TA. | CA, VAC TA, VAC PA |

**APPENDIX 15 & 16 OF ANNEX A3**

**NOT APPLICABLE TO VAC**

**APPENDIX 17 TO ANNEX A3**

**FEDERAL GOVERNMENT HOLIDAYS**

## APPENDIX 17 – FEDERAL GOVERNMENT HOLIDAYS

### DESIGNATED AND OTHER HOLIDAYS

| Serial | Holiday | Date | Comments |
|---|---|---|---|
| 1 | New Year's Day | 1 January | Notes 1,3 |
| 2 | Good Friday | TBD | Notes 3 |
| 3 | Easter Monday | TBD | Notes 3 |
| 4 | Victoria Day/Queen's Birthday | preceding 25 May | Notes 3 |
| 5 | Canada Day | 1 July | Notes 1,3 |
| 6 | Labour Day | First Monday in September | Notes 3 |
| 7 | Thanksgiving Day | Second Monday in October | Notes 3 |
| 8 | Remembrance Day | 11 November | Notes 1,3 |
| 9 | Christmas Day | 25 December | Notes 2,3 |
| 10 | Boxing Day | 26 December | Notes 2,3 |
| 11 | One additional day when proclaimed by an Act of Parliament as a national holiday. | TBD | NA |
| 12 | One provincial or local civic holiday per leave year may be observed at the discretion of the Technical Authority | TBD | NA |

Notes:

1. When 1 January, 1 July or 11 November fall on a Saturday or Sunday, the following Monday will be taken as the designated holiday.
2. When Christmas Day falls on a Saturday or Sunday the following Monday and Tuesday will be taken as the designated Christmas/Boxing Day holidays. When Christmas falls on a Friday, the following Monday will be taken as the designated Boxing Day holiday.
3. Serials 1 to 10 are designated holidays.

**APPENDIX 18 TO 20 OF ANNEX A3**

**NOT APPLICABLE TO VAC**

# ANNEX B
# BASIS OF PAYMENT

## 1.0 GENERAL

The Contractor will be paid in accordance with the terms and conditions as specified in this Annex. Unless otherwise indicated, all applicable taxes are extra.

## 2.0 CONTRACT START-UP PHASE

2.1 The Start-Up activities are the requirements and deliverables that support the set-up and preparation of the provision and management of Health Care Providers (HCPs) in accordance with Section 4 of the Statement of Work (SOW).

2.2 The Contractor will be paid Milestone Payments, subject to acceptance of the milestones by the client department. Each milestone will be comprised of one or multiple deliverables and/or activities, as identified in section 4 of the SOW. The weighting and value of the milestones are found in the table below. The total value of all the milestones combined is ***$To be identified by the Contractor in its bid***.

**Milestone Table 1: Contract Start-up Phase**

| MILESTONE | DELIVERABLES / ACTIVITIES | VALUE |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |

## 3.0 CONTRACT IN-SERVICE PHASE

The In-Service activities are the requirements and deliverables that support the provision and management of HCPs in accordance with Section 4 of the SOW.

### 3.1 Firm Fixed All-Inclusive Hourly Rate (FFAHR)

a. **Initial Contract Period (From Contract Award date to March 31, 2020)**
The Contractor will be paid the applicable Firm Fixed All-Inclusive Hourly Rate (FFAHR) for the Work performed by the Contractor's HCP in accordance with Pricing Schedule A of Appendix "X" of this Annex.

b. **Initial Contract Period (From April 1, 2020 to March 31, 2022)**
The Contractor will be paid the applicable FFAHR for the Work performed by the Contractor's HCP in accordance with Pricing Schedule B of Appendix "X" of this Annex.

c. **Optional Contract Periods**
The Contractor will be paid the applicable FFAHR for the Work performed by the Contractor's HCP in accordance with article 7 of this Annex.

## 4.0 CONTRACT OUT-GOING PHASE

4.1 The Out-Going activities are the requirements and deliverables that support the provision and management of HCPs in accordance with Section 4 of the SOW.

4.2 The Contractor will be paid Milestone Payments, subject to acceptance of the milestones by the client department. Each milestone will be comprised of one or multiple deliverables and/or activities, as identified in section 4 of the SOW. The weighting and value of the milestones are found in the table below. The total value of all the milestones combined is ***$To be identified by the Contractor in its bid***.

**Milestone Table 2: Contract Out-going Phase**

| MILESTONE | DELIVERABLES / ACTIVITIES | VALUE |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |

4.3 In addition to Milestone Payments, the Contractor will also be paid the applicable FFAHR for the Work performed by the Contractor's HCP in accordance with the Pricing Schedule in effect at the time.

## 5.0 ESTABLISHING RATES FOR ADDITIONAL SERVICES

5.1 When Canada elects to establish a FFAHR for an additional category, or a location, or both, for which no corresponding rates are listed, the Contractor will be paid a FFAHR for the Work performed by the Contractor's HCPs based upon rates negotiated between Canada and the Contractor. This rate negotiation process is detailed in Appendix 1 of this Annex.

5.2 Newly negotiated rates will only go into effect once the Contract has been updated through a finalized Contract amendment.

## 6.0 INCREASE TO ESTABLISHED RATES

6.1 When Canada permits the Contractor to increase the established FFAHR for certain categories or locations, or both, the Contractor will be paid a FFAHR for the Work performed by the Contractor's HCPs based upon rates negotiated between Canada and the Contractor. This rate negotiation process is detailed in Appendix 2 of this Annex.

6.2 Newly negotiated rates will only go into effect once the Contract has been updated through a Contract amendment.

## 7.0 ESCALATION - CONSUMER PRICE INDEX (CPI)

7.1 At the start of the option period, and every 12 month period thereafter, the FFAHR will be adjusted by the percentage change in the average Consumer Price Index (CPI) for Canada, All Items, Not Seasonally Adjusted, Stats Canada Catalogue No. 62-001-X, Table 5, over the two immediately preceding Calendar years. Information is available electronically from http://www.statcan.gc.ca/.

Escalation = (Sum of indices from the most recent completed calendar year ÷ Sum of indices from the preceding calendar year - 1) x 100

EXAMPLE: At the start of option period 1 commencing September 1, 2019, the FFAHR would be increased by 3.02% based on the following assumptions:

Sum of indices from calendar year 2018 = 1386.9
Sum of indices from calendar year 2017 = 1346.3

Escalation = (1386.9 ÷ 1346.3 - 1) x 100
Escalation = 3.02%

For the option period commencing September 1, 2020, the escalated rate as calculated above will be adjusted by the percentage change in the CPI over the 2019 and 2018 calendar years.

7.2 Any amount determined by using the escalation index which is less than zero, will be deemed to be equal to zero.

7.3 For the option periods, until the adjustments to the rates are made through a Contract amendment, the incumbent rates will be used. Once the new rates have been incorporated into the Contract, the Contractor may submit a claim for any underpayment that may have occurred as a result of any delays on the part of Canada in actioning the annual adjustment.

7.4 Discontinuation of Adjustment Indices - If the price adjustment index set out in the Contract is discontinued, the parties should immediately thereafter agree to establish replacement indices or formulate adjustments consistent with those set forth in the Contract.

## 8.0 OVERTIME

Overtime, as defined in the SOW, under the paragraph titled HCP Overtime, is payable at the rate of 1.5 times the applicable FFAHR.

## 9.0 EXTENDED HOURS

Extended Hours, as defined in the SOW under the paragraph titled Extended Hours, is payable at the regular FFAHR.

**10.0 ON-CALL TIME (not applicable to VAC)**

10.1 On-call time, as defined in the SOW, under the paragraph titled HCP On-Call, is payable at the rate of 1 applicable FFAHR hour for every 8 hours, or less, of being on-call.

10.2 In the event that the On-call time is greater than 8 hours, and no more than 16 hours, the On-call time is payable at the rate of 2 applicable FFAHR hours. In the event that the On-call time is greater than 16 hours, and no more than 24 hours, the On-call time is payable at the rate of 3 applicable FFAHR hours, and so forth.

EXAMPLES: If the HCP is on-call for 6 hours, the On-call time is payable at the rate of 1 applicable FFAHR hour. If the HCP is on-call for 13 hours, the On-call time is payable at rate of 2 applicable FFAHR hours. If the HCP is on-call for 17 hours, the On-call time is payable at rate of 3 applicable FFAHR hours, and so forth.

**11.0 CALL-BACK TIME (not applicable to VAC)**

11.1 Call-back time is defined in the SOW, under the paragraph titled HCP Call-back.

11.2 Regardless of the number of call-backs during the same On-call time, the Contractor will be paid the greater of:

a. three hours at the applicable FFAHR; or

b. the actual time worked at the applicable FFAHR.

11.3 Multiple call-back claims for the same On-call time will not be accepted.

11.4 Call-back time is payable in addition to the associated payable On-call time.

11.5 The Overtime rate does not apply to Call-back hours worked.

**12.0 TELE-HEALTH**

When the HCP is required to provide Tele-health work (defined in the SOW under the paragraph titled HCP Tele-Health Work Requirements), the Contractor will be paid the FFAHR in effect at the HCP's primary location assignment.

**13.0 STATUTORY HOLIDAYS**

During Statutory Holidays, regardless if the HCP is working Overtime, On-call time, or Call-back time, the Contractor will only be paid the Overtime rate of 1.5 times the applicable FFAHR.

**14.0 ADDITIONAL LICENSES and REGISTRATION FEES**

14.1 Where the HCP requires an additional professional license or registration certificate in order to perform the Work at an out-of-province short term location, the Contractor will be paid:

a. a firm administration fee of $ ***To be identified by the Contractor in its bid*** for the process of obtaining the additional license or registration certificate; and

b. the actual cost of the license or registration certificate incurred and supported by a copy of all receipts, without any allowance for overhead or profit.

14.2 The firm administrative fee is in effect until the end of the Contract period and is not be subject to any increase.

14.3 For out-of-province services performed, the Contractor will be paid the FFAHR in effect at the HCP's primary location assignment.

14.4 Travel and living expenses associated with the services performed out-of-province will be reimbursed in accordance with article 16 of this Annex.

## 15.0 PERFORMANCE INCENTIVE FEE (PIF)

15.1 In accordance with the Performance Incentive Fee (PIF) clauses found in Annex F Performance Measurement Framework, Canada will make available a PIF (taxes extra) in the following amounts:

| CONTRACT PERIOD | | PIF AMOUNT (MAXIMUM) |
|---|---|---|
| INITIAL CONTRACT PERIOD | Contract Award Date - March 31, 2019 | |
| | April 1, 2019 - March 31, 2020 | |
| | April 1, 2020 - March 31, 2021 | |
| | April 1, 2021 - March 31, 2022 | |
| OPTIONAL CONTRACT PERIOD | April 1, 2022 - March 31, 2023 | |
| | April 1, 2023 - March 31, 2024 | |
| | April 1, 2024 - March 31, 2025 | |
| | April 1, 2025 - March 31, 2026 | |
| | April 1, 2026 - March 31, 2027 | |
| | April 1, 2027 - March 31, 2028 | |
| | April 1, 2028 - March 31, 2029 | |
| | April 1, 2029 - March 31, 2030 | |

## 16.0 TARGETED INVESTMENT (TI)

16.1 The Targeted Investment (TI) process is detailed in article 7.17 of the contract.

16.2 The basis of payment for each TI will be determined at the time the TI requirement is presented by Canada.

## 17.0 TRAVEL AND LIVING EXPENSES

### 17.1 General Instructions

a. Any required travel, as defined in the SOW, must be authorized in advance by the Departmental Technical Authority in charge of submitting the Task Authorization (TA) form for a specific requirement.

b. Canada will reimburse required travel costs at cost, with no allowance for overhead, profit, travel agency fees and/or consulting fees. The cost of transportation is not to exceed the cost to be incurred from the closest point of departure, and travel arrangements are to be made in accordance with the terms and conditions for travel herein and in accordance with the Treasury Board National Joint Council Travel Directive in effect at the time of travel. The Treasury Board National Joint Council Travel Directive site is available at: http://www.njc-cnm.gc.ca/directive/travel-voyage/index-eng.php. All related transportation costs must be supported by original receipts.

### 17.2 Special Instructions

a. The Contractor is responsible for the management of the travel and living arrangements for all services under the Contract.

b. If a HCP is required to travel, it will be specified in the TA form. This only represents that the HCP will be required to travel during the period of the Task Authorization. Each travel (type or trip) must be authorized in accordance with the process outlined in the SOW, under the paragraph titled HCP Travel.

c. In the event of an environmental disaster (fire, flood, oil spill, etc.), Canada is responsible only for travel costs associated with removing a HCP from one of Canada’s locations.

d. Where there are extenuating circumstances (e.g. poor weather which would delay the HCP's arrival), Canada will pay for accommodation at the economy rate for one night only and other related costs, but such extenuating circumstances will need the pre-approval of the Departmental Technical Authority.

e. All payments are subject to government audit.

# APPENDIX 1
# RATE INCREASE PROPOSAL

**1.** When problems in the areas of recruitment and retention of Health Care Providers exist, and these problems can be attributed to one or more of the following conditions, which occurred after the closing date of the solicitation and during the period of the contract, the Contractor may submit a Rate Increase Proposal to the Contracting Authority for consideration:

a. significant increase in provincial/federal public service rates;

b. significant increase in union wage rates;

c. significant change in the workforce i.e. worker shortage or worker migration (e.g.: Oil patch, etc.)

**2.** Rate Increase Proposals shall include the following information:

a. the name of the affected HCP group(s) and location(s);

b. the reason(s) for the request, including an explanation of why the CPI increase is insufficient;

c. clear evidence of recruitment/retention issues of HCPs in the affected group(s) at the affected locations (e.g. number of vacancies, turnover rate, length of time that active recruitment has been undertaken, methods of recruitment used, what has been done to resolve retention and recruitment problems, number of times actual rate has been refused, etc.);

d. a source of comparison (e.g. copy of union pay scales, industry standards, public service pay scales, etc.); and

e. the requested rate(s) in accordance with SACC 1031-2 – Contract Cost Principles.

**3.** All proposed rate increases must take into account the most recent adjustment determined from the CPI calculation and applied to the HCP rates in the Contract.

**4.** There will be two implementation dates for rate increases per year - April 1st and October 1st.

**5.** Rate Increase Proposals are to be submitted no less than 2 months prior to the proposed implementation date.

**6.** Rate Increase Proposals will be reviewed by Canada, and a response to the Contractor will be sent within 6 weeks of receipt.

**7.** Rate increases approved by Canada will only be in force once the Contract has been updated through a Contract amendment.

**8.** No rate increases will be applied retroactively.

# APPENDIX 2
# NEW RATE PROPOSAL

**1.** Upon request by Canada, the Contractor will submit a New Rate Proposal for the HCP group(s) or location(s) where no rate for that particular HCP group(s) or location(s) already exists.

**2.** The New Rate Proposals shall include the following information:

a. the name of affected HCP group(s) and location(s);

b. a source of comparison (e.g. copy of union pay scales, industry standards, public service pay scales, etc.);

c. clear justification for any differences between the proposed rate and the rate identified in the source of comparison (e.g. evidence of recruitment/retention issues of HCP category at the locations, rarity of the resource, recruitment challenges/problems, etc.); and

d. the requested rate(s) in accordance with SACC 1031-2 – Contract Cost Principles

**3.** New rates approved by Canada will only be in force once the Contract has been updated through a Contract amendment.

**4.** New Rate Proposals are to be submitted no more than 4 weeks after a request.

**5.** New Rate Proposals will be reviewed by Canada, and a response to the Contractor will be sent within 4 weeks of receipt.

## ANNEX C1 SECURITY REQUIREMENTS CHECK LIST (SRCL) – DND

Government of Canada / Gouvernement du Canada

Contract Number / Numéro du contrat: W3931-13-KM01/C

Security Classification / Classification de sécurité: UNCLASSIFIED

### SECURITY REQUIREMENTS CHECK LIST (SRCL)
### LISTE DE VÉRIFICATION DES EXIGENCES RELATIVES À LA SÉCURITÉ (LVERS)

**PART A - CONTRACT INFORMATION / PARTIE A - INFORMATION CONTRACTUELLE**

1. Originating Government Department or Organization / Ministère ou organisme gouvernemental d'origine: Département of National Defence

2. Branch or Directorate / Direction générale ou Direction: Directorate of Health Services Delivery

3. a) Subcontract Number / Numéro du contrat de sous-traitance

3. b) Name and Address of Subcontractor / Nom et adresse du sous-traitant

4. Brief Description of Work / Brève description du travail

The Health Care Provider Requirement Contract (HCPRC) is used to supplement existing DND/CAF health professional resources at CF Health Services Group locations across Canada. The work includes the recruiting, hiring, provision and management of contract Health Care Providers (HCPs) that perform work at CF locations. The work also includes the necessary administrative, financial and program management functions required to meet the contract requirements.

| | | |
|---|---|---|
| 5. a) Will the supplier require access to Controlled Goods? Le fournisseur aura-t-il accès à des marchandises contrôlées? | ✓ No Non | Yes Oui |
| 5. b) Will the supplier require access to unclassified military technical data subject to the provisions of the Technical Data Control Regulations? Le fournisseur aura-t-il accès à des données techniques militaires non classifiées qui sont assujetties aux dispositions du Règlement sur le contrôle des données techniques? | ✓ No Non | Yes Oui |

6. Indicate the type of access required / Indiquer le type d'accès requis

| | | |
|---|---|---|
| 6. a) Will the supplier and its employees require access to PROTECTED and/or CLASSIFIED information or assets? Le fournisseur ainsi que les employés auront-ils accès à des renseignements ou à des biens PROTÉGÉS et/ou CLASSIFIÉS? (Specify the level of access using the chart in Question 7. c) (Préciser le niveau d'accès en utilisant le tableau qui se trouve à la question 7. c) | No Non | ✓ Yes Oui |
| 6. b) Will the supplier and its employees (e.g. cleaners, maintenance personnel) require access to restricted access areas? No access to PROTECTED and/or CLASSIFIED information or assets is permitted. Le fournisseur et ses employés (p. ex. nettoyeurs, personnel d'entretien) auront-ils accès à des zones d'accès restreintes? L'accès à des renseignements ou à des biens PROTÉGÉS et/ou CLASSIFIÉS n'est pas autorisé. | ✓ No Non | Yes Oui |
| 6. c) Is this a commercial courier or delivery requirement with **no** overnight storage? S'agit-il d'un contrat de messagerie ou de livraison commerciale **sans** entreposage de nuit? | ✓ No Non | Yes Oui |

7. a) Indicate the type of information that the supplier will be required to access / Indiquer le type d'information auquel le fournisseur devra avoir accès

| Canada | NATO / OTAN | Foreign / Étranger |
|---|---|---|
| ✓ | ☐ | ☐ |

7. b) Release restrictions / Restrictions relatives à la diffusion

| | | |
|---|---|---|
| No release restrictions / Aucune restriction relative à la diffusion: ✓ | All NATO countries / Tous les pays de l'OTAN: ☐ | No release restrictions / Aucune restriction relative à la diffusion: ☐ |
| Not releasable / À ne pas diffuser: ☐ | | |
| Restricted to: / Limité à: ☐ | Restricted to: / Limité à: ☐ | Restricted to: / Limité à: ☐ |
| Specify country(ies): / Préciser le(s) pays : | Specify country(ies): / Préciser le(s) pays : | Specify country(ies): / Préciser le(s) pays : |

7. c) Level of information / Niveau d'information

| | | |
|---|---|---|
| PROTECTED A / PROTÉGÉ A: ☐ | NATO UNCLASSIFIED / NATO NON CLASSIFIÉ: ☐ | PROTECTED A / PROTÉGÉ A: ☐ |
| PROTECTED B / PROTÉGÉ B: ✓ | NATO RESTRICTED / NATO DIFFUSION RESTREINTE: ☐ | PROTECTED B / PROTÉGÉ B: ☐ |
| PROTECTED C / PROTÉGÉ C: ☐ | NATO CONFIDENTIAL / NATO CONFIDENTIEL: ☐ | PROTECTED C / PROTÉGÉ C: ☐ |
| CONFIDENTIAL / CONFIDENTIEL: ☐ | NATO SECRET / NATO SECRET: ☐ | CONFIDENTIAL / CONFIDENTIEL: ☐ |
| SECRET / SECRET: ✓ | COSMIC TOP SECRET / COSMIC TRÈS SECRET: ☐ | SECRET / SECRET: ☐ |
| TOP SECRET / TRÈS SECRET: ☐ | | TOP SECRET / TRÈS SECRET: ☐ |
| TOP SECRET (SIGINT) / TRÈS SECRET (SIGINT): ☐ | | TOP SECRET (SIGINT) / TRÈS SECRET (SIGINT): ☐ |

TBS/SCT 350-103(2004/12)

Security Classification / Classification de sécurité: UNCLASSIFIED

Canada

Government of Canada / Gouvernement du Canada

Contract Number / Numéro du contrat
W3931-13-KM01/C

Security Classification / Classification de sécurité
UNCLASSIFIED

**PART A (continued) / PARTIE A (suite)**

8. Will the supplier require access to PROTECTED and/or CLASSIFIED COMSEC information or assets?
Le fournisseur aura-t-il accès à des renseignements ou à des biens COMSEC désignés PROTÉGÉS et/ou CLASSIFIÉS?
If Yes, indicate the level of sensitivity:
Dans l'affirmative, indiquer le niveau de sensibilité :
☑ No Non ☐ Yes Oui

9. Will the supplier require access to extremely sensitive INFOSEC information or assets?
Le fournisseur aura-t-il accès à des renseignements ou à des biens INFOSEC de nature extrêmement délicate?
☑ No Non ☐ Yes Oui

Short Title(s) of material / Titre(s) abrégé(s) du matériel :
Document Number / Numéro du document :

**PART B - PERSONNEL (SUPPLIER) / PARTIE B - PERSONNEL (FOURNISSEUR)**

10. a) Personnel security screening level required / Niveau de contrôle de la sécurité du personnel requis

| | | | |
|---|---|---|---|
| ☑ RELIABILITY STATUS / COTE DE FIABILITÉ | ☐ CONFIDENTIAL / CONFIDENTIEL | ☑ SECRET / SECRET | ☐ TOP SECRET / TRÈS SECRET |
| ☐ TOP SECRET– SIGINT / TRÈS SECRET – SIGINT | ☐ NATO CONFIDENTIAL / NATO CONFIDENTIEL | ☐ NATO SECRET / NATO SECRET | ☐ COSMIC TOP SECRET / COSMIC TRÈS SECRET |
| ☐ SITE ACCESS / ACCÈS AUX EMPLACEMENTS | | | |

Special comments:
Commentaires spéciaux : Individual task requests may require SECRET for specific clinician based on operational requirements.

NOTE: If multiple levels of screening are identified, a Security Classification Guide must be provided.
REMARQUE : Si plusieurs niveaux de contrôle de sécurité sont requis, un guide de classification de la sécurité doit être fourni.

10. b) May unscreened personnel be used for portions of the work?
Du personnel sans autorisation sécuritaire peut-il se voir confier des parties du travail?
☑ No Non ☐ Yes Oui

If Yes, will unscreened personnel be escorted?
Dans l'affirmative, le personnel en question sera-t-il escorté?
☐ No Non ☐ Yes Oui

**PART C - SAFEGUARDS (SUPPLIER) / PARTIE C - MESURES DE PROTECTION (FOURNISSEUR)**

**INFORMATION / ASSETS / RENSEIGNEMENTS / BIENS**

11. a) Will the supplier be required to receive and store PROTECTED and/or CLASSIFIED information or assets on its site or premises?
Le fournisseur sera-t-il tenu de recevoir et d'entreposer sur place des renseignements ou des biens PROTÉGÉS et/ou CLASSIFIÉS?
☑ No Non ☐ Yes Oui

11. b) Will the supplier be required to safeguard COMSEC information or assets?
Le fournisseur sera-t-il tenu de protéger des renseignements ou des biens COMSEC?
☑ No Non ☐ Yes Oui

**PRODUCTION**

11. c) Will the production (manufacture, and/or repair and/or modification) of PROTECTED and/or CLASSIFIED material or equipment occur at the supplier's site or premises?
Les installations du fournisseur serviront-elles à la production (fabrication et/ou réparation et/ou modification) de matériel PROTÉGÉ et/ou CLASSIFIÉ?
☑ No Non ☐ Yes Oui

**INFORMATION TECHNOLOGY (IT) MEDIA / SUPPORT RELATIF À LA TECHNOLOGIE DE L'INFORMATION (TI)**

11. d) Will the supplier be required to use its IT systems to electronically process, produce or store PROTECTED and/or CLASSIFIED information or data?
Le fournisseur sera-t-il tenu d'utiliser ses propres systèmes informatiques pour traiter, produire ou stocker électroniquement des renseignements ou des données PROTÉGÉS et/ou CLASSIFIÉS?
☑ No Non ☐ Yes Oui

11. e) Will there be an electronic link between the supplier's IT systems and the government department or agency?
Disposera-t-on d'un lien électronique entre le système informatique du fournisseur et celui du ministère ou de l'agence gouvernementale?
☑ No Non ☐ Yes Oui

Government of Canada / Gouvernement du Canada

| Contract Number / Numéro du contrat |
|---|
| W3931-13-KM01/C |
| Security Classification / Classification de sécurité |
| UNCLASSIFIED |

**PART C - *(continued)* / PARTIE C - *(suite)***

For users completing the form **manually** use the summary chart below to indicate the category(ies) and level(s) of safeguarding required at the supplier's site(s) or premises.
Les utilisateurs qui remplissent le formulaire **manuellement** doivent utiliser le tableau récapitulatif ci-dessous pour indiquer, pour chaque catégorie, les niveaux de sauvegarde requis aux installations du fournisseur.

For users completing the form **online** (via the Internet), the summary chart is automatically populated by your responses to previous questions.
Dans le cas des utilisateurs qui remplissent le formulaire **en ligne** (par Internet), les réponses aux questions précédentes sont automatiquement saisies dans le tableau récapitulatif.

**SUMMARY CHART / TABLEAU RÉCAPITULATIF**

| Category / Catégorie | PROTECTED / PROTÉGÉ | | | CLASSIFIED / CLASSIFIÉ | | | NATO | | | | COMSEC | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | A | B | C | CONFIDENTIAL / CONFIDENTIEL | SECRET | TOP SECRET / TRÈS SECRET | NATO RESTRICTED / NATO DIFFUSION RESTREINTE | NATO CONFIDENTIAL / NATO CONFIDENTIEL | NATO SECRET | COSMIC TOP SECRET / COSMIC TRÈS SECRET | PROTECTED / PROTÉGÉ A | PROTECTED / PROTÉGÉ B | PROTECTED / PROTÉGÉ C | CONFIDENTIAL / CONFIDENTIEL | SECRET | TOP SECRET / TRÈS SECRET |
| Information / Assets / Renseignements / Biens | | | | | | | | | | | | | | | | |
| Production | | | | | | | | | | | | | | | | |
| IT Media / Support TI | | | | | | | | | | | | | | | | |
| IT Link / Lien électronique | | | | | | | | | | | | | | | | |

12. a) Is the description of the work contained within this SRCL PROTECTED and/or CLASSIFIED?
La description du travail visé par la présente LVERS est-elle de nature PROTÉGÉE et/ou CLASSIFIÉE?

☑ No / Non ☐ Yes / Oui

**If Yes, classify this form by annotating the top and bottom in the area entitled "Security Classification".**
**Dans l'affirmative, classifier le présent formulaire en indiquant le niveau de sécurité dans la case intitulée « Classification de sécurité » au haut et au bas du formulaire.**

12. b) Will the documentation attached to this SRCL be PROTECTED and/or CLASSIFIED?
La documentation associée à la présente LVERS sera-t-elle PROTÉGÉE et/ou CLASSIFIÉE?

☑ No / Non ☐ Yes / Oui

**If Yes, classify this form by annotating the top and bottom in the area entitled "Security Classification" and indicate with attachments (e.g. SECRET with Attachments).**
**Dans l'affirmative, classifier le présent formulaire en indiquant le niveau de sécurité dans la case intitulée « Classification de sécurité » au haut et au bas du formulaire et indiquer qu'il y a des pièces jointes (p. ex. SECRET avec des pièces jointes).**

## ANNEX C2 SECURITY REQUIREMENTS CHECK LIST (SRCL) - RCMP

Government of Canada / Gouvernement du Canada

AUG 23 2010
CISD

Contract Number / Numéro du contrat
M7594-10-0563
Security Classification / Classification de sécurité
Unclassified

### SECURITY REQUIREMENTS CHECK LIST (SRCL)
### LISTE DE VÉRIFICATION DES EXIGENCES RELATIVES À LA SÉCURITÉ (LVERS)

**PART A - CONTRACT INFORMATION / PARTIE A - INFORMATION CONTRACTUELLE**

| | |
|---|---|
| 1. Originating Government Department or Organization / Ministère ou organisme gouvernemental d'origine: Royal Canadian Mounted Police | 2. Branch or Directorate / Direction générale ou Direction: Occupational Health Services |
| 3. a) Subcontract Number / Numéro du contrat de sous-traitance | 3. b) Name and Address of Subcontractor / Nom et adresse du sous-traitant |
| 4. Brief Description of Work / Brève description du travail: Health Care Provider Requirement Procurement Joint between - DND, RCMP and Veterans Affairs. | |

| | | |
|---|---|---|
| 5. a) Will the supplier require access to Controlled Goods? Le fournisseur aura-t-il accès à des marchandises contrôlées? | ☑ No Non | ☐ Yes Oui |
| 5. b) Will the supplier require access to unclassified military technical data subject to the provisions of the Technical Data Control Regulations? Le fournisseur aura-t-il accès à des données techniques militaires non classifiées qui sont assujetties aux dispositions du Règlement sur le contrôle des données techniques? | ☑ No Non | ☐ Yes Oui |
| 6. Indicate the type of access required / Indiquer le type d'accès requis | | |
| 6. a) Will the supplier and its employees require access to PROTECTED and/or CLASSIFIED information or assets? Le fournisseur ainsi que les employés auront-ils accès à des renseignements ou à des biens PROTÉGÉS et/ou CLASSIFIÉS? (Specify the level of access using the chart in Question 7. c) (Préciser le niveau d'accès en utilisant le tableau qui se trouve à la question 7. c) | ☐ No Non | ☑ Yes Oui |
| 6. b) Will the supplier and its employees (e.g. cleaners, maintenance personnel) require access to restricted access areas? No access to PROTECTED and/or CLASSIFIED information or assets is permitted. Le fournisseur et ses employés (p. ex. nettoyeurs, personnel d'entretien) auront-ils accès à des zones d'accès restreintes? L'accès à des renseignements ou à des biens PROTÉGÉS et/ou CLASSIFIÉS n'est pas autorisé. | ☑ No Non | ☐ Yes Oui |
| 6. c) Is this a commercial courier or delivery requirement with no overnight storage? S'agit-il d'un contrat de messagerie ou de livraison commerciale sans entreposage de nuit? | ☑ No Non | ☐ Yes Oui |

7. a) Indicate the type of information that the supplier will be required to access / Indiquer le type d'information auquel le fournisseur devra avoir accès

| Canada ☑ | NATO / OTAN ☐ | Foreign / Étranger ☐ |
|---|---|---|
| 7. b) Release restrictions / Restrictions relatives à la diffusion | | |
| No release restrictions / Aucune restriction relative à la diffusion ☑ | All NATO countries / Tous les pays de l'OTAN ☐ | No release restrictions / Aucune restriction relative à la diffusion ☐ |
| Not releasable / À ne pas diffuser ☐ | | |
| Restricted to: / Limité à : ☐ | Restricted to: / Limité à : ☐ | Restricted to: / Limité à : ☐ |
| Specify country(ies): / Préciser le(s) pays : | Specify country(ies): / Préciser le(s) pays : | Specify country(ies): / Préciser le(s) pays : |

| 7. c) Level of information / Niveau d'information | | | | | |
|---|---|---|---|---|---|
| PROTECTED A / PROTÉGÉ A | ☐ | NATO UNCLASSIFIED / NATO NON CLASSIFIÉ | ☐ | PROTECTED A / PROTÉGÉ A | ☐ |
| PROTECTED B / PROTÉGÉ B | ☑ | NATO RESTRICTED / NATO DIFFUSION RESTREINTE | ☐ | PROTECTED B / PROTÉGÉ B | ☐ |
| PROTECTED C / PROTÉGÉ C | ☐ | NATO CONFIDENTIAL / NATO CONFIDENTIEL | ☐ | PROTECTED C / PROTÉGÉ C | ☐ |
| CONFIDENTIAL / CONFIDENTIEL | ☐ | NATO SECRET / NATO SECRET | ☐ | CONFIDENTIAL / CONFIDENTIEL | ☐ |
| SECRET / SECRET | ☐ | COSMIC TOP SECRET / COSMIC TRÈS SECRET | ☐ | SECRET / SECRET | ☐ |
| TOP SECRET / TRÈS SECRET | ☐ | | | TOP SECRET / TRÈS SECRET | ☐ |
| TOP SECRET (SIGINT) / TRÈS SECRET (SIGINT) | ☐ | | | TOP SECRET (SIGINT) / TRÈS SECRET (SIGINT) | ☐ |

Government of Canada / Gouvernement du Canada

Contract Number / Numéro du contrat
M7594-16-0563
Security Classification / Classification de sécurité
Unclassified

PART A (continued) / PARTIE A (suite)

8. Will the supplier require access to PROTECTED and/or CLASSIFIED COMSEC information or assets? — No / Non ☑ Yes / Oui ☐
Le fournisseur aura-t-il accès à des renseignements ou à des biens COMSEC désignés PROTÉGÉS et/ou CLASSIFIÉS?
If Yes, indicate the level of sensitivity:
Dans l'affirmative, indiquer le niveau de sensibilité :

9. Will the supplier require access to extremely sensitive INFOSEC information or assets? — No / Non ☑ Yes / Oui ☐
Le fournisseur aura-t-il accès à des renseignements ou à des biens INFOSEC de nature extrêmement délicate?

Short Title(s) of material / Titre(s) abrégé(s) du matériel :
Document Number / Numéro du document :

PART B - PERSONNEL (SUPPLIER) / PARTIE B - PERSONNEL (FOURNISSEUR)

10. a) Personnel security screening level required / Niveau de contrôle de la sécurité du personnel requis

| | | | |
|---|---|---|---|
| ☑ RELIABILITY STATUS / COTE DE FIABILITÉ | ☐ CONFIDENTIAL / CONFIDENTIEL | ☐ SECRET / SECRET | ☐ TOP SECRET / TRÈS SECRET |
| ☐ TOP SECRET - SIGINT / TRÈS SECRET – SIGINT | ☐ NATO CONFIDENTIAL / NATO CONFIDENTIEL | ☐ NATO SECRET / NATO SECRET | ☐ COSMIC TOP SECRET / COSMIC TRÈS SECRET |
| ☐ SITE ACCESS / ACCÈS AUX EMPLACEMENTS | | | |

Special comments:
Commentaires spéciaux : _____

NOTE: If multiple levels of screening are identified, a Security Classification Guide must be provided.
REMARQUE : Si plusieurs niveaux de contrôle de sécurité sont requis, un guide de classification de la sécurité doit être fourni.

10. b) May unscreened personnel be used for portions of the work? — No / Non ☑ Yes / Oui ☐
Du personnel sans autorisation sécuritaire peut-il se voir confier des parties du travail?
If Yes, will unscreened personnel be escorted? — No / Non ☐ Yes / Oui ☐
Dans l'affirmative, le personnel en question sera-t-il escorté?

PART C - SAFEGUARDS (SUPPLIER) / PARTIE C - MESURES DE PROTECTION (FOURNISSEUR)

**INFORMATION / ASSETS / RENSEIGNEMENTS / BIENS**

11. a) Will the supplier be required to receive and store PROTECTED and/or CLASSIFIED information or assets on its site or premises? — No / Non ☑ Yes / Oui ☐
Le fournisseur sera-t-il tenu de recevoir et d'entreposer sur place des renseignements ou des biens PROTÉGÉS et/ou CLASSIFIÉS?

11. b) Will the supplier be required to safeguard COMSEC information or assets? — No / Non ☑ Yes / Oui ☐
Le fournisseur sera-t-il tenu de protéger des renseignements ou des biens COMSEC?

**PRODUCTION**

11. c) Will the production (manufacture, and/or repair and/or modification) of PROTECTED and/or CLASSIFIED material or equipment occur at the supplier's site or premises? — No / Non ☑ Yes / Oui ☐
Les installations du fournisseur serviront-elles à la production (fabrication et/ou réparation et/ou modification) de matériel PROTÉGÉ et/ou CLASSIFIÉ?

**INFORMATION TECHNOLOGY (IT) MEDIA / SUPPORT RELATIF À LA TECHNOLOGIE DE L'INFORMATION (TI)**

11. d) Will the supplier be required to use its IT systems to electronically process, produce or store PROTECTED and/or CLASSIFIED information or data? — No / Non ☑ Yes / Oui ☐
Le fournisseur sera-t-il tenu d'utiliser ses propres systèmes informatiques pour traiter, produire ou stocker électroniquement des renseignements ou des données PROTÉGÉS et/ou CLASSIFIÉS?

11. e) Will there be an electronic link between the supplier's IT systems and the government department or agency? — No / Non ☑ Yes / Oui ☐
Disposera-t-on d'un lien électronique entre le système informatique du fournisseur et celui du ministère ou de l'agence gouvernementale?

Government of Canada / Gouvernement du Canada

Contract Number / Numéro du contrat
M7594-10-0503
Security Classification / Classification de sécurité
Unclassified

PART C - (continued) / PARTIE C - (suite)

For users completing the form manually use the summary chart below to indicate the category(ies) and level(s) of safeguarding required at the supplier's site(s) or premises.
Les utilisateurs qui remplissent le formulaire manuellement doivent utiliser le tableau récapitulatif ci-dessous pour indiquer, pour chaque catégorie, les niveaux de sauvegarde requis aux installations du fournisseur.

For users completing the form online (via the internet), the summary chart is automatically populated by your responses to previous questions.
Dans le cas des utilisateurs qui remplissent le formulaire en ligne (par Internet), les réponses aux questions précédentes sont automatiquement saisies dans le tableau récapitulatif.

**SUMMARY CHART / TABLEAU RÉCAPITULATIF**

| Category / Catégorie | PROTECTED / PROTÉGÉ | | | CLASSIFIED / CLASSIFIÉ | | | NATO | | | | COMSEC | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | A | B | C | CONFIDENTIAL / CONFIDENTIEL | SECRET | TOP SECRET / TRÈS SECRET | NATO RESTRICTED / NATO DIFFUSION RESTREINTE | NATO CONFIDENTIAL / NATO CONFIDENTIEL | NATO SECRET | COSMIC TOP SECRET / COSMIC TRÈS SECRET | PROTECTED / PROTÉGÉ A | PROTECTED / PROTÉGÉ B | PROTECTED / PROTÉGÉ C | CONFIDENTIAL / CONFIDENTIEL | SECRET | TOP SECRET / TRÈS SECRET |
| Information / Assets / Renseignements / Biens | | | | | | | | | | | | | | | | |
| Production | | | | | | | | | | | | | | | | |
| IT Media / Support TI | | | | | | | | | | | | | | | | |
| IT Link / Lien électronique | | | | | | | | | | | | | | | | |

12. a) Is the description of the work contained within this SRCL PROTECTED and/or CLASSIFIED?
La description du travail visé par la présente LVERS est-elle de nature PROTÉGÉE et/ou CLASSIFIÉE?

☑ No / Non ☐ Yes / Oui

**If Yes, classify this form by annotating the top and bottom in the area entitled "Security Classification".**
**Dans l'affirmative, classifier le présent formulaire en indiquant le niveau de sécurité dans la case intitulée « Classification de sécurité » au haut et au bas du formulaire.**

12. b) Will the documentation attached to this SRCL be PROTECTED and/or CLASSIFIED?
La documentation associée à la présente LVERS sera-t-elle PROTÉGÉE et/ou CLASSIFIÉE?

☑ No / Non ☐ Yes / Oui

**If Yes, classify this form by annotating the top and bottom in the area entitled "Security Classification" and indicate with attachments (e.g. SECRET with Attachments).**
**Dans l'affirmative, classifier le présent formulaire en indiquant le niveau de sécurité dans la case intitulée « Classification de sécurité » au haut et au bas du formulaire et indiquer qu'il y a des pièces jointes (p. ex. SECRET avec des pièces jointes).**

## ANNEX C3 SECURITY REQUIREMENTS CHECK LIST (SRCL) - VAC

Government of Canada / Gouvernement du Canada

RECEIVED JUN 29 2016

Contract Number / Numéro du contrat: 51019-16-6001

Security Classification / Classification de sécurité: UNCLASSIFIED

**SECURITY REQUIREMENTS CHECK LIST (SRCL)**
**LISTE DE VÉRIFICATION DES EXIGENCES RELATIVES À LA SÉCURITÉ (LVERS)**

**PART A - CONTRACT INFORMATION / PARTIE A - INFORMATION CONTRACTUELLE**

| | |
|---|---|
| 1. Originating Government Department or Organization / Ministère ou organisme gouvernemental d'origine: Veterans Affairs Canada | 2. Branch or Directorate / Direction générale ou Direction: SD-Health Professionals |
| 3. a) Subcontract Number / Numéro du contrat de sous-traitance | 3. b) Name and Address of Subcontractor / Nom et adresse du sous-traitant |

4. Brief Description of Work / Brève description du travail
To provide physician, nursing, occupational therapy, dental and respiratory services.

| | | |
|---|---|---|
| 5. a) Will the supplier require access to Controlled Goods? Le fournisseur aura-t-il accès à des marchandises contrôlées? | ✓ No Non | Yes Oui |
| 5. b) Will the supplier require access to unclassified military technical data subject to the provisions of the Technical Data Control Regulations? Le fournisseur aura-t-il accès à des données techniques militaires non classifiées qui sont assujetties aux dispositions du Règlement sur le contrôle des données techniques? | ✓ No Non | Yes Oui |
| 6. Indicate the type of access required / Indiquer le type d'accès requis | | |
| 6. a) Will the supplier and its employees require access to PROTECTED and/or CLASSIFIED information or assets? Le fournisseur ainsi que les employés auront-ils accès à des renseignements ou à des biens PROTÉGÉS et/ou CLASSIFIÉS? (Specify the level of access using the chart in Question 7. c) (Préciser le niveau d'accès en utilisant le tableau qui se trouve à la question 7. c) | No Non | ✓ Yes Oui |
| 6. b) Will the supplier and its employees (e.g. cleaners, maintenance personnel) require access to restricted access areas? No access to PROTECTED and/or CLASSIFIED information or assets is permitted. Le fournisseur et ses employés (p. ex. nettoyeurs, personnel d'entretien) auront-ils accès à des zones d'accès restreintes? L'accès à des renseignements ou à des biens PROTÉGÉS et/ou CLASSIFIÉS n'est pas autorisé. | ✓ No Non | Yes Oui |
| 6. c) Is this a commercial courier or delivery requirement with **no** overnight storage? S'agit-il d'un contrat de messagerie ou de livraison commerciale **sans** entreposage de nuit? | ✓ No Non | Yes Oui |

7. a) Indicate the type of information that the supplier will be required to access / Indiquer le type d'information auquel le fournisseur devra avoir accès

| Canada ✓ | NATO / OTAN | Foreign / Étranger |
|---|---|---|

7. b) Release restrictions / Restrictions relatives à la diffusion

| | | |
|---|---|---|
| No release restrictions / Aucune restriction relative à la diffusion ✓ | All NATO countries / Tous les pays de l'OTAN | No release restrictions / Aucune restriction relative à la diffusion |
| Not releasable / À ne pas diffuser | | |
| Restricted to: / Limité à : | Restricted to: / Limité à : | Restricted to: / Limité à : |
| Specify country(ies): / Préciser le(s) pays : | Specify country(ies): / Préciser le(s) pays : | Specify country(ies): / Préciser le(s) pays : |

7. c) Level of information / Niveau d'information

| | | |
|---|---|---|
| PROTECTED A / PROTÉGÉ A | NATO UNCLASSIFIED / NATO NON CLASSIFIÉ | PROTECTED A / PROTÉGÉ A |
| PROTECTED B / PROTÉGÉ B ✓ | NATO RESTRICTED / NATO DIFFUSION RESTREINTE | PROTECTED B / PROTÉGÉ B |
| PROTECTED C / PROTÉGÉ C | NATO CONFIDENTIAL / NATO CONFIDENTIEL | PROTECTED C / PROTÉGÉ C |
| CONFIDENTIAL / CONFIDENTIEL | NATO SECRET / NATO SECRET | CONFIDENTIAL / CONFIDENTIEL |
| SECRET / SECRET | COSMIC TOP SECRET / COSMIC TRÈS SECRET | SECRET / SECRET |
| TOP SECRET / TRÈS SECRET | | TOP SECRET / TRÈS SECRET |
| TOP SECRET (SIGINT) / TRÈS SECRET (SIGINT) | | TOP SECRET (SIGINT) / TRÈS SECRET (SIGINT) |

TBS/SCT 350-103(2004/12)

Security Classification / Classification de sécurité: UNCLASSIFIED

Canada

Government of Canada / Gouvernement du Canada

Contract Number / Numéro du contrat
51019-16-6001
Security Classification / Classification de sécurité
UNCLASSIFIED

**PART A *(continued)* / PARTIE A *(suite)***

8. Will the supplier require access to PROTECTED and/or CLASSIFIED COMSEC information or assets? ☑ No / Non ☐ Yes / Oui
Le fournisseur aura-t-il accès à des renseignements ou à des biens COMSEC désignés PROTÉGÉS et/ou CLASSIFIÉS?
If Yes, indicate the level of sensitivity:
Dans l'affirmative, indiquer le niveau de sensibilité :

9. Will the supplier require access to extremely sensitive INFOSEC information or assets? ☑ No / Non ☐ Yes / Oui
Le fournisseur aura-t-il accès à des renseignements ou à des biens INFOSEC de nature extrêmement délicate?

Short Title(s) of material / Titre(s) abrégé(s) du matériel :
Document Number / Numéro du document :

**PART B - PERSONNEL (SUPPLIER) / PARTIE B - PERSONNEL (FOURNISSEUR)**

10. a) Personnel security screening level required / Niveau de contrôle de la sécurité du personnel requis

| | | | |
|---|---|---|---|
| ☑ RELIABILITY STATUS / COTE DE FIABILITÉ | ☐ CONFIDENTIAL / CONFIDENTIEL | ☐ SECRET / SECRET | ☐ TOP SECRET / TRÈS SECRET |
| ☐ TOP SECRET– SIGINT / TRÈS SECRET – SIGINT | ☐ NATO CONFIDENTIAL / NATO CONFIDENTIEL | ☐ NATO SECRET / NATO SECRET | ☐ COSMIC TOP SECRET / COSMIC TRÈS SECRET |
| ☐ SITE ACCESS / ACCÈS AUX EMPLACEMENTS | | | |

Special comments:
Commentaires spéciaux : _____

NOTE: If multiple levels of screening are identified, a Security Classification Guide must be provided.
REMARQUE : Si plusieurs niveaux de contrôle de sécurité sont requis, un guide de classification de la sécurité doit être fourni.

10. b) May unscreened personnel be used for portions of the work? ☑ No / Non ☐ Yes / Oui
Du personnel sans autorisation sécuritaire peut-il se voir confier des parties du travail?
If Yes, will unscreened personnel be escorted? ☑ No / Non ☐ Yes / Oui
Dans l'affirmative, le personnel en question sera-t-il escorté?

**PART C - SAFEGUARDS (SUPPLIER) / PARTIE C - MESURES DE PROTECTION (FOURNISSEUR)**

**INFORMATION / ASSETS / RENSEIGNEMENTS / BIENS**

11. a) Will the supplier be required to receive and store PROTECTED and/or CLASSIFIED information or assets on its site or premises? ☑ No / Non ☐ Yes / Oui
Le fournisseur sera-t-il tenu de recevoir et d'entreposer sur place des renseignements ou des biens PROTÉGÉS et/ou CLASSIFIÉS?

11. b) Will the supplier be required to safeguard COMSEC information or assets? ☑ No / Non ☐ Yes / Oui
Le fournisseur sera-t-il tenu de protéger des renseignements ou des biens COMSEC?

**PRODUCTION**

11. c) Will the production (manufacture, and/or repair and/or modification) of PROTECTED and/or CLASSIFIED material or equipment occur at the supplier's site or premises? ☑ No / Non ☐ Yes / Oui
Les installations du fournisseur serviront-elles à la production (fabrication et/ou réparation et/ou modification) de matériel PROTÉGÉ et/ou CLASSIFIÉ?

**INFORMATION TECHNOLOGY (IT) MEDIA / SUPPORT RELATIF À LA TECHNOLOGIE DE L'INFORMATION (TI)**

11. d) Will the supplier be required to use its IT systems to electronically process, produce or store PROTECTED and/or CLASSIFIED information or data? ☑ No / Non ☐ Yes / Oui
Le fournisseur sera-t-il tenu d'utiliser ses propres systèmes informatiques pour traiter, produire ou stocker électroniquement des renseignements ou des données PROTÉGÉS et/ou CLASSIFIÉS?

11. e) Will there be an electronic link between the supplier's IT systems and the government department or agency? ☑ No / Non ☐ Yes / Oui
Disposera-t-on d'un lien électronique entre le système informatique du fournisseur et celui du ministère ou de l'agence gouvernementale?

Government of Canada / Gouvernement du Canada

| Contract Number / Numéro du contrat |
|---|
| 51019-16-6001 |
| Security Classification / Classification de sécurité<br>UNCLASSIFIED |

**PART C - *(continued)* / PARTIE C - *(suite)***

For users completing the form **manually** use the summary chart below to indicate the category(ies) and level(s) of safeguarding required at the supplier's site(s) or premises.
Les utilisateurs qui remplissent le formulaire **manuellement** doivent utiliser le tableau récapitulatif ci-dessous pour indiquer, pour chaque catégorie, les niveaux de sauvegarde requis aux installations du fournisseur.

For users completing the form **online** (via the Internet), the summary chart is automatically populated by your responses to previous questions.
Dans le cas des utilisateurs qui remplissent le formulaire **en ligne** (par Internet), les réponses aux questions précédentes sont automatiquement saisies dans le tableau récapitulatif.

**SUMMARY CHART / TABLEAU RÉCAPITULATIF**

| Category<br>Catégorie | PROTECTED<br>PROTÉGÉ | | | CLASSIFIED<br>CLASSIFIÉ | | | NATO | | | | COMSEC | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | A | B | C | CONFIDENTIAL<br>CONFIDENTIEL | SECRET | TOP SECRET<br>TRÈS SECRET | NATO RESTRICTED<br>NATO DIFFUSION RESTREINTE | NATO CONFIDENTIAL<br>NATO CONFIDENTIEL | NATO SECRET | COSMIC TOP SECRET<br>COSMIC TRÈS SECRET | PROTECTED PROTÉGÉ<br>A | <br>B | <br>C | CONFIDENTIAL<br>CONFIDENTIEL | SECRET | TOP SECRET<br>TRÈS SECRET |
| Information / Assets<br>Renseignements / Biens | | | | | | | | | | | | | | | | |
| Production | | | | | | | | | | | | | | | | |
| IT Media /<br>Support TI | | | | | | | | | | | | | | | | |
| IT Link /<br>Lien électronique | | | | | | | | | | | | | | | | |

12. a) Is the description of the work contained within this SRCL PROTECTED and/or CLASSIFIED?
La description du travail visé par la présente LVERS est-elle de nature PROTÉGÉE et/ou CLASSIFIÉE?

☑ No / Non ☐ Yes / Oui

**If Yes, classify this form by annotating the top and bottom in the area entitled "Security Classification".**
**Dans l'affirmative, classifier le présent formulaire en indiquant le niveau de sécurité dans la case intitulée « Classification de sécurité » au haut et au bas du formulaire.**

12. b) Will the documentation attached to this SRCL be PROTECTED and/or CLASSIFIED?
La documentation associée à la présente LVERS sera-t-elle PROTÉGÉE et/ou CLASSIFIÉE?

☑ No / Non ☐ Yes / Oui

**If Yes, classify this form by annotating the top and bottom in the area entitled "Security Classification" and indicate with attachments (e.g. SECRET with Attachments).**
**Dans l'affirmative, classifier le présent formulaire en indiquant le niveau de sécurité dans la case intitulée « Classification de sécurité » au haut et au bas du formulaire et indiquer qu'il y a des pièces jointes (p. ex. SECRET avec des pièces jointes).**

## ANNEX D

## INSURANCE REQUIREMENT

### 1. Commercial General Liability Insurance

**1.1** The Contractor must obtain Commercial General Liability Insurance, and maintain it in force throughout the duration of the Contract, in an amount usual for a contract of this nature, but for not less than $5,000,000 per accident or occurrence and in the annual aggregate.

**1.2** The Commercial General Liability policy must include the following:

a. Additional Insured: Canada is added as an additional insured, but only with respect to liability arising out of the Contractor's performance of the Contract. The interest of Canada should read as follows: Canada, as represented by Public Works and Government Services Canada.

b. Bodily Injury and Property Damage to third parties arising out of the operations of the Contractor.

c. Products and Completed Operations: Coverage for bodily injury or property damage arising out of goods or products manufactured, sold, handled, or distributed by the Contractor and/or arising out of operations that have been completed by the Contractor.

d. Personal Injury: While not limited to, the coverage must include Violation of Privacy, Libel and Slander, False Arrest, Detention or Imprisonment and Defamation of Character.

e. Cross Liability/Separation of Insured: Without increasing the limit of liability, the policy must protect all insured parties to the full extent of coverage provided. Further, the policy must apply to each Insured in the same manner and to the same extent as if a separate policy had been issued to each.

f. Blanket Contractual Liability: The policy must, on a blanket basis or by specific reference to the Contract, extend to assumed liabilities with respect to contractual provisions.

g. Employees and, if applicable, Volunteers must be included as Additional Insured.

h. Employers' Liability (or confirmation that all employees are covered by Worker's compensation (WSIB) or similar program)

i. Broad Form Property Damage including Completed Operations: Expands the Property Damage coverage to include certain losses that would otherwise be excluded by the standard care, custody or control exclusion found in a standard policy.

j. Notice of Cancellation: The Insurer will endeavour to provide the Contracting Authority thirty (30) days written notice of policy cancellation.

k. If the policy is written on a claims-made basis, coverage must be in place for a period of at least 12 months after the completion or termination of the Contract.

l. Owners' or Contractors' Protective Liability: Covers the damages that the Contractor becomes legally obligated to pay arising out of the operations of a subcontractor.

m. Non-Owned Automobile Liability - Coverage for suits against the Contractor resulting from the use of hired or non-owned vehicles. All Risks Tenants Legal Liability - to protect the Contractor for liabilities arising out of its occupancy of leased premises.

n. Sudden and Accidental Pollution Liability (minimum 120 hours): To protect the Contractor for liabilities arising from damages caused by accidental pollution incidents.

o. Litigation Rights: Pursuant to subsection 5(d) of the *Department of Justice Act*, S.C. 1993, c. J-2, s.1, if a suit is instituted for or against Canada which the Insurer would, but for this clause, have the right to pursue or defend on behalf of Canada as an Additional Named Insured under the insurance policy, the Insurer must promptly contact the Attorney General of Canada to agree on the legal strategies by sending a letter, by registered mail or by courier, with an acknowledgement of receipt.

For the province of Quebec, send to:

Director Business Law Directorate,
Quebec Regional Office (Ottawa),
Department of Justice,
284 Wellington Street, Room SAT-6042,
Ottawa, Ontario, K1A 0H8

For other provinces and territories, send to:

Senior General Counsel,
Civil Litigation Section,
Department of Justice
234 Wellington Street, East Tower
Ottawa, Ontario K1A 0H8

A copy of the letter must be sent to the Contracting Authority. Canada reserves the right to co-defend any action brought against Canada. All expenses incurred by Canada to co-defend such actions will be at Canada's expense. If Canada decides to co-defend any action brought against it, and Canada does not agree to a proposed settlement agreed to by the Contractor's insurer and the plaintiff(s) that would result in the settlement or dismissal of the action against Canada, then Canada will be responsible to the Contractor's insurer for any difference between the proposed settlement amount and the amount finally awarded or paid to the plaintiffs (inclusive of costs and interest) on behalf of Canada.

**2. Errors and Omissions Liability Insurance**

**2.1** The Contractor must obtain Errors and Omissions Liability (a.k.a. Professional Liability) insurance, and maintain it in force throughout the duration of the Contract, in an amount usual for a contract of this nature but for not less than $1,000,000 per loss and in the annual aggregate, inclusive of defence costs.

**2.2** If the policy is written on a claims-made basis, coverage must be in place for a period of at least 12 months after the completion or termination of the Contract.

**2.3** The following endorsement must be included:

Notice of Cancellation: The Insurer will endeavour to provide the Contracting Authority thirty (30) days written notice of cancellation.

**3. Medical Malpractice Liability Insurance**

**3.1** The Contractor must obtain Medical Malpractice Liability Insurance, and maintain it in force throughout the duration of the Contract, in an amount usual for a contract of this nature, but for not less than $1,000,000 per loss and in the annual aggregate, inclusive of the defence costs.

**3.2** Coverage is for what is standard in a Medical Malpractice policy and must be for claims arising out of the rendering or failure to render medical services resulting in injury, mental injury, illness, disease or death of

any person caused by any negligent act, error or omission committed by the Contractor in or about the conduct of the Contractor's professional occupation or business of good samaritan acts.

**3.3** If the policy is written on a claims-made basis, coverage must be in place for a period of at least 12 months after the completion or termination of the Contract.

**3.4** Notice of Cancellation: The Insurer will endeavour to provide the Contracting Authority thirty (30) days written notice of cancellation.

**ANNEX E1**

**TASK AUTHORIZATION**

# TASK AUTHORIZATION

| **All invoices/progress claims must show the reference Contract and Task numbers**<br><br>**Toutes les factures doivent indiquer les numéros du contrat et de la tâche** | Contract no. - Nº du contrat<br><br>Task no. - Nº de la tâche |
|---|---|

| Amendment no. - Nº de la modification | Increase/Decrease – Augmentation/Réduction | Value – Valeur |
|---|---|---|
| | | |

| **TO – À** | **TO THE CONTRACTOR**<br><br>You are requested to supply the following services in accordance with the terms of the above reference contract. Only services included in the contract shall be supplied against this task.<br><br>Please advise the undersigned if the completion date cannot be met. Invoices/progress claims shall be prepared in accordance with the instructions set out in the contract. |
|---|---|
| **Delivery location – Expédiez à** | **À L'ENTREPRENEUR**<br><br>Vous êtes prié de fournir les services suivants en conformité des termes du contrat mentionné ci-dessus. Seuls les services mentionnés dans le contrat doivent être fournis à l'appui de cette demande.<br><br>Prière d'aviser le signataire si la livraison ne peut se faire dans les délais |
| **Delivery/Completion date – Date de livraison/d'achèvement** | _____ Date<br><br>_____ for the Department of National Defence<br>pour le ministère de la Défense nationale |

| Contract item no.<br>Nº 'article du contrat | Services | Cost<br>Prix |
|---|---|---|
| | | |
| | **GST/HST**<br>**TPS/TVH** | |
| | **Total** | |

**APPLICABLE ONLY TO PWGSC CONTRACTS:** The Contract Authority signature is required when the total value of the DND 626 exceeds the threshold specified in the contract.

**NE S'APPLIQUE QU'AUX CONTRATS DE TPSGC :** La signature de l'autorité contractante est requise lorsque la valeur totale du formulaire DND 626 est supérieure au seuil précisé dans le contrat.

_____
for the Department of Public Works and Government Services
pour le ministère des Travaux publics et services gouvernementaux

DND 626 (01-05)

Design: Forms Management 993-4050
Conception : Gestion des formulaires 993-4062

**ANNEX E2**

**TASK AUTHORIZATION**

# TASK AUTHORIZATION FORM

| ALL INVOICES MUST SHOW THE REFERENCE CONTRACT AND TASK NUMBERS<br>TOUTES LES FACTURES DOIVENT INDIQUER LES NUMÉROS DU CONTRAT ET DE LA TÂCHE | Contract no. - N° du contrat<br>Task no. - N° de la tâche |
|---|---|

| Amendment no. - N° de la modification | Increase/Decrease – Augmentation/Réduction | Value – Valeur |
|---|---|---|
| | | |

| Financial Coding : | | Expenditure Limit |
|---|---|---|
| Commitment: | | |
| Fund: | | |
| GL: | | |
| IO: | | |
| | **Applicable Taxes Total** | |

**TO THE CONTRACTOR:**

You are requested to supply the following services in accordance with the terms of the above referenced contract. Only services included in the Contract shall be supplied against this task.

Please advise the undersigned if the delivery date cannot be met. Invoices shall be prepared in accordance with the instructions set out in the contract.

**TO – Â**

**SERVICE DELIVERY LOCATION**
**LIEU DE LIVRAISON DES SERVICES**

**Â L'ENTREPRENEUR:**

Vous êtes prié de fournir le les services suivants en conformité des termes du contrat mentionné ci-dessus. Seuls les services mentionnés dans le contrat doivent être fournis dans cette demande.

Prière d'aviser le signataire si la livraison ne peut se faire dans les délais prescrits. Les factures doivent être établies selon les instructions énoncées dans le contrat.

**Task Authorization Period (start and finish dates):**
période de l'autorisation de tâche (dates de début et de fin)

| Date | For the Client Department<br>Pour le ministère Client |
|---|---|
| | |

| TA Item No.<br>N° d'article de l'AT | **SERVICES** | **Cost Prix** |
|---|---|---|
| | | |
| | **Total Cost (applicable taxes excluded)** | |
| | **Applicable taxes (specify %)** | |
| | **GRAND TOTAL**<br>**Task Authorization Limitation of Expenditure**<br>**(applicable taxes included)** | |

**APPLICABLE ONLY TO PWGSC CONTRACTS:** The Contracting Authority signature is required when the total value of the TA exceeds the threshold specified in the contract.

**NE S'APPLIQUE QU'AUX CONTRATS DE TPSGC :** La signature de l'autorité contractante est requise lorsque la valeur totale du formulaire AT est supérieure au seuil précisé dans le contrat.

for the Department of Public Works and Government Services
pour le ministère des Travaux publics et services gouvernementaux

**ANNEX E3**

**TASK AUTHORIZATION**

# TASK AUTHORIZATION FORM

| ALL INVOICES MUST SHOW THE REFERENCE CONTRACT AND TASK NUMBERS<br>TOUTES LES FACTURES DOIVENT INDIQUER LES NUMÉROS DU CONTRAT ET DE LA TÂCHE | Contract no. - N° du contrat<br>Task no. - N° de la tâche |
|---|---|

| Amendment no. - N° de la modification | Increase/Decrease – Augmentation/Réduction | Value – Valeur |
|---|---|---|
| | | |

| Financial Coding : | | Expenditure Limit |
|---|---|---|
| Commitment: | | |
| Fund: | | |
| GL: | | |
| IO: | | |
| | **Applicable Taxes Total** | |

**TO THE CONTRACTOR:**

You are requested to supply the following services in accordance with the terms of the above referenced contract. Only services included in the Contract shall be supplied against this task.

Please advise the undersigned if the delivery date cannot be met. Invoices shall be prepared in accordance with the instructions set out in the contract.

**TO – Â**

**SERVICE DELIVERY LOCATION**
**LIEU DE LIVRAISON DES SERVICES**

**Â L'ENTREPRENEUR:**

Vous êtes prié de fournir le les services suivants en conformité des termes du contrat mentionné ci-dessus. Seuls les services mentionnés dans le contrat doivent être fournis dans cette demande.

Prière d'aviser le signataire si la livraison ne peut se faire dans les délais prescrits. Les factures doivent être établies selon les instructions énoncées dans le contrat.

**Task Authorization Period (start and finish dates):**
période de l'autorisation de tâche (dates de début et de fin)

| Date | For the Client Department<br>Pour le ministère Client |
|---|---|
| | |

| TA Item No.<br>N° d'article de l'AT | **SERVICES** | **Cost Prix** |
|---|---|---|
| | | |
| | **Total Cost (applicable taxes excluded)** | |
| | **Applicable taxes (specify %)** | |
| | **GRAND TOTAL**<br>**Task Authorization Limitation of Expenditure**<br>**(applicable taxes included)** | |

**APPLICABLE ONLY TO PWGSC CONTRACTS:** The Contracting Authority signature is required when the total value of the TA exceeds the threshold specified in the contract.

**NE S'APPLIQUE QU'AUX CONTRATS DE TPSGC :** La signature de l'autorité contractante est requise lorsque la valeur totale du formulaire AT est supérieure au seuil précisé dans le contrat.

for the Department of Public Works and Government Services
pour le ministère des Travaux publics et services gouvernementaux

**ANNEX F1**
**PERFORMANCE MEASUREMENT FRAMEWORK (DND)**

## INTRODUCTION

1. The Contract contains terms for payment of a Performance Incentive Fee (PIF). The PIF is made available by DND to encourage the Contractor to provide the HCPs, and for the management and supervision required to ensure excellent performance under the Contract. The maximum PIF amount is paid for achieving the maximum level of beneficial performance.

2. This Performance Measurement Framework (PMF) covers the administration of performance evaluation indicators and measures in order to award a Performance Incentive Fee (PIF).

## AIM

3. The aim of the PMF is to provide a method to measure the Contractor's performance levels. It takes into consideration contributing circumstances and the Contractor's resourcefulness; it establishes clear communication on evaluation procedures, and provides for effective communication between the Contractor and DND/CAF personnel

4. The PMF focuses on and supports the main goal of the HCP Contract, which is to have the Contractor provide and manage Health Care Providers (HCPs) needed to supplement our workforce in delivering health care and health care support services to members (right HCP, right place, right Level of Effort (LOE), and right time). To that end, the measure with the highest weighting is the Percentage of Positions Filled.

5. This performance evaluation is based on quantitative and qualitative measurements. Canada recognizes that throughout the duration of the contract, the PMF may be required to be modified in order to accommodate changes to management emphasis, motivate higher performance levels, improve the performance incentive determination process, or any other changes as required. Any recommended changes to the PMF, whether made by the Contractor or Canada, require approval from both parties. Once approved, the revised PMF will only go into effect once a Contract Amendment has been issued to reflect the changes.

6. DND will make available a Performance Incentive Fee in the following amounts:

   a. $3,000,000.00 for the performance year from 1 April 2018 to 31 March 2019;

   b. $3,000,000.00 for the performance year from 1 April 2019 to 31 March 2020;

   c. $3,000,000.00 for the performance year from 1 April 2020 to 31 March 2021;

   d. $3,000,000.00 for the performance year from 1 April 2021 to 31 March 2022;

   e. $3,250,000.00 for the performance year from 1 April 2022 to 31 March 2023;

   f. $3,250,000.00 for the performance year from 1 April 2023 to 31 March 2024;

g. $3,250,000.00 for the performance year from 1 April 2024 to 31 March 2025;

h. $3,250,000.00 for the performance year from 1 April 2025 to 31 March 2026;

i. $3,500,000.00 for the performance year from 1 April 2026 to 31 March 2027;

j. $3,500,000.00 for the performance year from 1 April 2027 to 31 March 2028;

k. $3,500,000.00 for the performance year from 1 April 2028 to 31 March 2029;

l. $3,500,000.00 for the performance year from 1 April 2029 to 31 March 2030.

**ORGANIZATION**

7. The organizational structure of the PMF includes the following three-level structure:

   a. Performance Evaluation Board (PEB): duties will be carried out by the Executive Steering Committee (please refer to the Statement of Work for composition);

   b. Performance Evaluation Team (PET): duties will be carried out by the Senior Management Oversight Committee (please refer to the Statement of Work for composition); and

   c. Performance Monitors (PMs): duties will be carried out by the DND Technical Authority (TA), the DND Task Managers (TM), and the DND Procurement Authority (PA).

8. General Information:

   a. Performance evaluations will be conducted every six months. The available yearly PIF amount will be divided into two (2) equal amounts;

   b. The PIF will be determined for each evaluation period by the PET in accordance with this PMF;

   c. PIF determinations are not subject to the Dispute Resolution clauses of the Contract. Whether work is added and/or deleted from the Contract, the PIF amount available will remain as per article 6 above;

   d. In order to be considered for a PIF, a minimum of 85% of all positions filled must be achieved. Refer to article 23 below.

   e. The threshold value for PIF evaluation is set at a Semi-Annual Performance score (SAP) of 80. Refer to article 35 below.

**EVALUATION PROCEDURES**

9. The Evaluation Process will follow the Fiscal Year calendar and is described in the following articles.

10. Daily As required, DND Departmental Authorities (DAs) (comprised of the DND TA and DND PA) maintain ongoing communication with their Contractor counterparts; conduct assessments in an open, objective and cooperative spirit; raise issues for resolution by the Contractor; emphasize the positive and the negative performance; raise appropriate observation reports for review, information, and action by, or discussion with, the Contractor, throughout the duration of the Contract.

11. Quarterly

a. The DND TA will generate a Quarterly Performance Report using the KPI Score and the Surveys. The Quarterly Performance Report will be reviewed by the TA in conjunction with the Contractor's Service Delivery Manager (SDM). The Contractor's SDM will then have the opportunity to raise observations and concerns on the evaluation to the DND TA within five (5) working days.
b. The Contractor will provide the Key Performance Indicators (KPI) Score to the DND TA.

12. Semi-Annually

13. Within approximately 15 working days after the end of the evaluation period, a PET meeting will be held to generate the Semi-Annual Performance Report. This will be done using the Quarterly Performance Reports and will determine the amount of PIF to be recommended.

14. Within approximately five (5) working days after the PET meeting, the Semi-Annual Performance Report outlining the overall performance of the work delivered by the Contractor during the evaluation period and the PIF amount recommended will be sent to the Contractor. The Contractor will have the opportunity to raise observations and concerns on the evaluation to the PET representatives within five (5) working days.

15. The final Semi-Annual Performance Report will be sent to the Contractor and the PEB no later than five (5) working days after the Contractor's feedback has been received.

16. Within approximately 30 working days after the end of the evaluation period, if not approved secretarially by the PEB, a meeting will be held to review the Semi-Annual Performance Report and to render a decision regarding the awarding of the PIF. Following the PEB meeting, the PEB Secretariat will generate a letter summarizing its decision, including the awarded PIF amount. The PEB decision, once rendered, will be considered final.

17. Annually Within approximately 30 working days from 31 March, the PET will generate the Annual Performance Report. This will be done using the Semi-Annual Performance Reports.

18. The Annual Performance Report will be sent to the Contractor and the PEB Secretariat. The Contractor will have seven (7) working days after the receipt of the Annual

Performance Report in which to study the report and make any final observations. If observations are raised, the Contractor shall be afforded reasonable opportunity to make a written submission or present its case in person to the PEB for re-consideration. In such case, the TA should be provided with the observations made by the Contractor and be afforded an opportunity to comment on the submission by the Contractor.

19. Within approximately 45 working days after the end of the yearly evaluation period, a PEB meeting will be held to review the Annual Performance Report. Following the PEB meeting, the PEB Secretariat will generate a letter summarizing its decisions. The PEB decisions, once rendered, will be considered final.

20. The following table outlines the estimated schedule of activities covering the performance evaluation period.

| SEMI-ANNUAL PERFORMANCE EVALUATION | ESTIMATED SCHEDULE |
|---|---|
| DND TA Prepare Quarterly Report | 3rd week Jul/3rd week Oct/3rd week Jan/3rd week Apr |
| Semi- Annual Self-assessment received from Contractor | 1st week Oct/1st week Apr |
| PET meeting generate Semi-Annual Report | 3rd week Oct/3rd week Apr |
| Semi-Annual Report sent to Contractor | 4th week Oct/4th week Apr |
| PEB meeting to review the Semi-Annual Performance Report | 2nd week Nov/2nd week May |
| Incentive Fee letter provided to Contractor | 2nd week Nov/2nd week May |

| ANNUAL PERFORMANCE EVALUATION | WORKING DAYS |
|---|---|
| PET will generate the Annual Performance Report | 15 |
| Contractor review Annual Report | 20 |
| PEB meeting to review the Annual Performance Report | 25 |

**EVALUATION CRITERIA AND SCORE**

21. This PMF consists of four (4) distinct measures: two (2) Key Performance Indicators (KPIs) and two (2) Performance Monitors Surveys. The Contractor's quarterly performance will be graded using the evaluation criteria below:

    a. KPI 1: Recurring Position Filled (RPF);

    b. KPI 2: New Position Filled (NPF);

    c. Performance Monitor's Survey;

        (1) Task Manager Survey (TM Survey); and

        (2) Departmental Authority Survey (DA Survey).

POSITION FILL PERFORMANCE SCORE

22. Description These indicators measure how many positions have been filled in relation to the number of positions that have been tasked to be filled through Task Authorizations, for two (2) separate categories:

a. KPI 1: Recurring Position Filled (RPF); and

b. KPI 2: New Position Filled (NPF);

Note: For the first year, KPI 1 will measure the Initial Requirement Plan Position filled and KPI 2 will measure all new positions not included in the Initial Requirement Plan.

Each Task Authorization will be measured in the appropriate category depending on the type of requirement.

23. Applicability A position is considered filled when the obligations, as detailed on the TA Form for that position, are met by the Contractor's HCP(s). Conversely, a position is considered unfilled when the obligations, as detailed on the TA Form for that position, are not met at the time the Time to Provide (TTP) for that position has expired. TTP is defined in the Statement of Work article titled Time to Provide.

24. Source of data As calculated by Canada.

25. Frequency of data collection Data will be collected and analyzed on a quarterly basis.

26. Basis for Measuring Position Fill Percentage Comparison of the number of positions filled versus the number of positions filled plus the number of positions unfilled.

27. Method of Determining Performance Scores

a. Recurring Positions Filled (KPI 1 Score) The KPI 1 Score will be calculated as follows:

$$KPI\ 1\ (\%) = \left( \frac{RPF}{RPF + RPU} \right) \times 100$$

**RPF** (Recurring Positions Filled) and **RPU** (Recurring Positions Unfilled) represent the Contractor's performance. On the last day of the quarter being assessed, the KPI 1 Score will be calculated using the number of Recurring Positions Filled over the number of Recurring Positions Filled plus the number of Recurring Positions Unfilled since the beginning of the quarter.

b. New Positions Filled (KPI 2 Score) The KPI 2 Score will be calculated as follows:

$$KPI\ 2\ (\%) = \left( \frac{NPF}{NPF + NPU} \right) \times 100$$

**NPF** (New Positions Filled) and **NPU** (New Positions Unfilled) represent the Contractor's performance. On the last day of the quarter being assessed, the KPI 1 Score will be calculated using the number of New Positions Filled over the number of New Positions Filled plus the number of New Positions Unfilled since the beginning of the quarter.

c. KPI Score Once KPI 1 (weighted at 70%) and KPI 2 (weighted at 30%) have been determined, the KPI Score shall be calculated as follows:

KPI Score = [(KPI 1 Score X 0.70) + (KPI 2 Score x 0.30)] x 0.70

The KPI Score (Position Filled Performance) will be calculated on a quarterly basis. The overall weighting for the Position Fill Performance will be 70% of the quarterly performance calculations.

**PERFORMANCE MONITORS SURVEYS (PM SURVEYS) SCORE**

28. Description This performance measure provides an overview of DND's overall satisfaction towards the flexibility, quality and accuracy of the Contractor performance in the following five (5) areas: the performance of work of Contractor Management Team, the quality of the work of the HCPs at the clinic level, the quality of the management and administration of the Contractor's Management Team, the quality and effectiveness of the communications with the Contractor's Management Team and the timeliness, accuracy and completeness of the reports and invoices provided by the Contractor:

a. Applicability This performance measure applies to Contractor's Management Team and all HCPs provided under the contract;

b. Source of data The Performance Monitors Surveys;

c. Frequency of data collection Data will be collected and analyzed on quarterly basis; and

d. Basis for Measuring Quality of Work The PM will use the relative weighting of the performance areas on the PM Surveys in accordance with the table below. The PM Surveys will be provided by the TMs (Medical and Dental Clinics), the DA's (DND TA and the DND PA).

| PERFORMANCE AREAS | | WEIGHT | DATA SOURCES FOR EVALUATION |
|---|---|---|---|
| 1 | **Performance of Work** (Positions Filled, delivery of SOW line Deliverables and line items) | 20% | TM Survey and DA Survey<br>- Time to fill position<br>- Quality of proposed candidates<br>- Resolution of issues |
| 2 | **Quality of Work** (HCP Quality of Work, TM satisfaction surveys) | 15% | TM Survey<br>- Clinical measures (ex: charting accuracy/timeliness, adherence to clinical directives, the Surgeon General's platform, etc.)<br>- Collaborative practice, patient centered care<br>- Non-clinical Admin (ex: on-time for work, timesheet submission, notice for leave, etc.)<br>- Commendations and complaints, awards, etc. |
| 3 | **Management and Administration** (use of IM/IT tools, cooperation, report, plans, contracts administration) | 30% | DA Survey |
| 4 | **Communications with all stakeholders** (Contractor's communication and issue resolution) | 25% | DA Survey<br>- Contractor's responsiveness<br>- Effectiveness<br>- Timeliness, etc.<br>- Issue resolution |
| 5 | **Invoicing and Time Recording** (timeliness accuracy and completeness) | 10% | DA Survey |
| | **Total** | 100% | |

SURVEY SCORES

29. The Survey Scores will be used to calculate the overall service level received by Canada from the Contractor. The Survey Scores will provide a balanced perspective on the Contractor's performance by capturing the Performance Managers' (TM and DA) satisfaction level at multiple intervals throughout the year. It also allows Canada to ensure that it is receiving value for money from the contracted services. The Survey Scores will indicate, over a period of time, a performance trend, and highlight to the Contractor on specific areas requiring improvement.

30. There will be two (2) surveys: the Task Manager Survey (TM Survey) and the Departmental Authority Survey (DA Survey). The TM Survey will consist of a questionnaire completed by the TMs, and will concentrate on the following areas:

a. the performance of work; and

b. the quality of the work.

c. management and administration;

d. communication will all stakeholders; and

e. invoicing and time recording.

The DA Survey will consist of a questionnaire completed by the DAs at the Headquarters level and concentrate on the following areas:

a. the performance of work;

b. management and administration;

c. communication will all stakeholders; and

d. invoicing and time recording.

31. The calculation details of Survey Scores are described below:

a. TM Survey Score = [(Medical Survey Score x 0.70) + (Dental Survey Score x 0.30)] x 0.80;

b. DA Survey Score = [(PA Survey Score x 0.50) + (TA Survey Score x 0.50)] x 0.20; and

c. Performance Monitor Survey Score = (TM Survey Score + DA Survey Score) x 0.30.

32. The Survey scores will be calculated as follows:

a. Medical Survey Score. The score will be calculated by adding all the Medical survey results; and dividing by the number of surveys received;

b. Dental Survey Score. The score will be calculated by adding all the Dental survey results; and dividing by the number of surveys received;

c. PA Survey Score. The score will be calculated by adding all the PA survey results, and dividing by the number of surveys received; and

d. TA Survey Score. The score will be calculated by adding all the TA survey results, and dividing by the number of surveys received; and

e. the weighting for the Performance Monitor Survey Score will be 30% of the overall Quarterly Performance Score.

QUARTERLY AND SEMI-ANNUAL PERFORMANCE SCORE

33. The Contractor's Quarterly Performance will be evaluated by adding the KPI Score and the Performance Monitor Survey Score. The Quarterly Performance Score (QP Score) is calculated as follows:

QP Score = KPI Score + Survey Score.

34. The Contractor's Semi-Annual Performance will be evaluated using the average of the 2 QP Scores and this will be used to determine the awarding of the PIF, if applicable. The Semi-Annual Performance Score (SAP Score) is calculated as follows:

a. April 1 to September 30:

SAP Score = [(1st QP score) + (2nd QP score)] / 2;

b. October 1 to March 31:

SAP Score = [(3rd QP score) + (4th QP score)] / 2; and

c. the SAP Score will be rounded to the closest digit (no decimal).

35. Performance Incentive Fee Pool. The following schedule establishes the incentive fee percentage to be awarded for the Semi-Annual Performance Score earned:

| Semi-Annual Performance Score | Percentage of Performance Incentive Fee Pool |
|---|---|
| 80 | 2.2% |
| 81 | 5.2% |
| 82 | 8.9% |
| 83 | 11.9% |
| 84 | 14.4% |
| 85 | 18.9% |
| 86 | 25.3% |
| 87 | 32.6% |
| 88 | 40.6% |
| 89 | 48.8% |
| 90 | 57.1% |
| 91 | 64.9% |

| | |
|---|---|
| 92 | 72.1% |
| 93 | 78.5% |
| 94 | 83.9% |
| 95 | 88.3% |
| 96 | 91.9% |
| 97 | 94.8% |
| 98 | 97.0% |
| 99 | 98.7% |
| 100 | 100% |
| No fee will be paid when the SAP score is 79 or less. | |

ANNUAL PERFORMANCE REPORT (AP Report)

36. The intent of the Annual Performance (AP) Report is to provide an overall evaluation of the Contractor's performance for the year. The AP Report is for informational purposes only and has no PIF implications associated with it.

37. The Contractor's annual performance will be evaluated using the average of the four (4) QP Scores. The Annual Performance Score (AP Score), which can then be used to briefly summarize the Contractor's overall performance for the year, is calculated as follows:

AP Score = [(1st QP score) + (2nd QP score) + (3rd QP score) + (4th QP score)] / 4

38. The performance levels – outstanding, superior, satisfactory, and unsatisfactory, and their relation to performance excellence are illustrated in the following table:

**Annual Performance Level**

| Score Category | AP Score | Narrative Description |
|---|---|---|
| Outstanding | 95-100 | The Contractor has demonstrated creativity, ingenuity, initiative, and/or excellent performance under adverse conditions; consistently exceeding the performance standard for stated requirements; monitors cannot cite any areas requiring improvement; the Annual Performance Report includes concrete examples of outstanding support provided by the Contractor and the PEB supports the grade |
| Superior | 86-94 | The Contractor has consistently maintained a high level of service; frequently exceeded the performance standard for stated requirements. Although there may be minor room for improvement, monitors have not specified the need |

| | | |
|---|---|---|
| | | for corrective actions and the Annual Performance Report supports the monitors' findings. Furthermore, the PEB supports the grade. |
| Satisfactory | 80-85 | The performance standard for stated requirements have been satisfactorily met and in some cases marginally exceeded; monitors have cited only a few minor areas requiring improvement; the Annual Performance report supports monitors' findings and the PEB supports the grade. |
| Unsatisfactory | Below 80 | The Contractor has failed to meet the standards set forth in the Performance Management Framework, either due to poor quality and/or a lack of performance; monitors have cited multiple areas requiring improvement. The PEB shall make a final determination after due consideration of the findings of the monitors, the Contracting Authority and the PET and the Contractor submissions, if any. |

## APPENDIX 1 TO ANNEX F1

## Performance Monitors Survey - Health Care Provider Contract (HCPC)

| | Outstanding | Superior | Satisfactory | Unsatisfactory | Non Applicable | Total |
|---|---|---|---|---|---|---|
| **Overall Satisfaction** | **5** | **4** | **3** | **0** | | |
| O1. What is your overall level of satisfaction with Contracted Health Care Providers (HCPs)? Justify "Outstanding" and "Unsatisfactory" ratings and indicate this in the comments. | | | | | | |
| O2. How would you rate the overall Contractor's Management Team performance? Justify "Outstanding" and "Unsatisfactory" ratings and indicate this in the comments. | | | | | TM | |
| O3. How do you rate the Contractor's approach to customer service? Justify "Outstanding" and "Unsatisfactory" ratings and indicate this in the comments. | | | | | TM | |
| O4. How would you rate the Service Delivery Manager (SDM) and the Contractor's Management Team in responding to your request? Justify "Outstanding" and "Unsatisfactory" ratings and indicate it in the comments. | | | | | | |
| O5. How would you rate the Service Delivery Manager (SDM) and the Contractor's Management Team in resolving issues that may come up? Justify "Outstanding" and "Unsatisfactory" ratings and indicate it in the comments. | | | | | | |
| **Total** | | | | | | **/** |
| | | | | | | |
| **Performance of Work (of HCPs & Contractor) and Recruiting Strategy** | **5** | **4** | **3** | **0** | | |
| P1. How would you rate the Service Delivery Manager (SDM) and the Contractor's Management Team outcomes / efforts in filling vacant positions? Justify "Outstanding" and "Unsatisfactory" ratings and indicate whether "Outstanding" or "Unsatisfactory" in justification. | | | | | | |
| P2. What is your overall level of satisfaction with the selection of Proposed HCPs? Justify "Outstanding" and "Unsatisfactory" ratings and indicate it in the comments. | | | | | DA | |
| P3. How effective is the Contractor in responding to Task Manager (TM) and Departmental Authorities (DA) by presenting qualified HCPs that meet your clinic needs within 60 calendar days of receiving a TD approved by the Technical Authority? Justify "Outstanding" and "Unsatisfactory" ratings and indicate it in the comments. | | | | | | |
| **Total** | | | | | | **/** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Quality of Work** | **5** | **4** | **3** | **0** | | |
| Q1. How would you rate HCP performance for "Accurate charting"? Justify "Outstanding" and "Unsatisfactory" ratings and indicate this in the comments. | | | | | DA | |
| Q2. How would you rate HCP performance for "Delivery of appropriate care"? Justify "Outstanding" and "Unsatisfactory" ratings and indicate it in the comments. | | | | | DA | |
| Q3. How would you rate HCP performance in adhering to pre-defined practice standards and guidelines? Justify "Outstanding" and "Unsatisfactory" ratings and indicate it in the comments. | | | | | DA | |
| **Total** | | | | | | **/** |
| | | | | | | |
| **Management and Administration** | | | | | | |
| M1. Overall satisfaction that HCPs have the necessary credentials to do their work? Justify "Outstanding" and "Unsatisfactory" ratings and indicate it in the comments. | | | | | | |
| M2. How would you rate the Contractor's due-diligence in ensuring health service providers are in good standing with provincial/federal associations and are not under investigation before work begins? Justify "Outstanding" and "Unsatisfactory" ratings and indicate it in the comments. | | | | | | |
| M3. How would you rate the Contractor's Management Team in managing HCPs during the provision of services under this Contract? Justify "Outstanding" and "Unsatisfactory" ratings and indicate it in the comments. | | | | | | |
| M4. How would you rate the Contractor's Management Team in providing and maintaining the skills set required by HCPs to provide health services under this Contract? Justify "Outstanding" and "Unsatisfactory" ratings and indicate it in the comments. | | | | | | |
| M5. How would you rate the Contractor's Management Team in making sure as well as informing the DA that every HCP under this Contract carries or is covered by appropriate liability insurance? Justify "Outstanding" and "Unsatisfactory" ratings and indicate it in the comments. | | | | | | |
| M6. How would you rate the Contractor's Management Team and the HCP efforts in ensuring the HCP are appropriately identified as such during the course of their work and understand their roles and responsibilities as a Contractor? Justify "Outstanding" and "Unsatisfactory" ratings and indicate it in the comments. | | | | | | |
| **Total** | | | | | | **/30** |
| | | | | | | |
| **Communication with Departmental Authorities (DA)** | **5** | **4** | **3** | **0** | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| C1. The Statement of Work requires the Contractor to communicate monthly with DA. How would you rate the frequency of your communications with the Contractor's Management Team? Justify "Outstanding" and "Unsatisfactory" ratings and indicate it in the comments. | | | | | TM | |
| C2. How would you rate the quality & effectiveness of your communications with the Service Delivery Manager (SDM) and the Contractor's Management team as a whole? Justify "Outstanding" and "Unsatisfactory" ratings and indicate it in the comments. | | | | | | |
| C3. How would you rate the response time of the Service Delivery Manager (SDM) and the Contractor's Management Team in responding to your queries? Justify "Outstanding" and "Unsatisfactory" ratings and indicate it in the comments. | | | | | | |
| C4.How would you rate the Service Delivery Manager (SDM) and the Contractor's Management Team efforts in keeping you abreast of the status of your requirements? Justify "Outstanding" and "Unsatisfactory" ratings and indicate it in the comments. | | | | | | |
| C5. How would you rate the response time of the Service Delivery Manager (SDM) and the Contractor's Management Team in tracking issues and issues resolution? Justify "Outstanding" and "Unsatisfactory" ratings and indicate it in the comments. | | | | | | |
| **Total** | | | | | | **/** |
| | | | | | | |
| **Invoicing and Time Recording** | **5** | **4** | **3** | **0** | | |
| I1. How would you rate the timeliness & accuracy of the reports sent to DAs listing all the medical & dental costs separately for the particular clinic? Justify "Outstanding" and "Unsatisfactory" ratings and indicate it in the comments. | | | | | TM | |
| I2. How would you rate the HCP's accuracy, completeness and timely completion of the weekly Time sheets or on-line Time sheet Tool? Justify "Outstanding" and "Unsatisfactory" ratings and indicate it in the comments. | | | | | | |
| **Total** | | | | | | **/** |
| **Grand Total** | | | | | | |

**ANNEX F2**
**PERFORMANCE MEASUREMENT FRAMEWORK (RCMP)**

## INTRODUCTION

1. The Contract contains terms for payment of a Performance Incentive Fee (PIF). The PIF is made available by the RCMP to encourage the Contractor to provide the Health Care Providers (HCPs), and for the management and supervision required to ensure excellent performance under the Contract. The maximum PIF amount is paid for achieving the maximum level of beneficial performance.

2. The Performance Measurement Framework (PMF) covers the administration of performance evaluation indicators and measures in order to award a PIF.

## AIM

3. The aim of the PMF is to provide a method to measure the Contractor's performance levels. It establishes clear evaluation procedures and provides for effective communication between the Contractor and the RCMP.

4. The PMF focuses on and supports the main goal of the HCP Contract which is to have the Contractor provide and manage Health Care Providers (HCPs) needed to supplement our workforce in delivering occupational health and safety services. To that end, the measure with the highest weighting is the percentage of positions filled.

5. This performance evaluation is based on quantitative and qualitative measurement. Canada recognizes that throughout the duration of the contract, the PMF may be required to be modified in order to accommodate changes to management emphasis, motivate higher performance levels, improve the performance incentive determination process, or any other changes as required. Any recommended change to the PMF, whether made by the Contractor or Canada, require approval from both parties. Once approved, the revised PMF will only go into effect once a Contract Amendment has been issues to reflect the changes.

6. RCMP will make available as PIF the following amount:

    a. $200,000.00 for the performance year from 1 April 2018 to 31 March 2019;
    b. $200,000.00 for the performance year from 1 April 2019 to 31 March 2020;
    c. $200,000.00 for the performance year from 1 April 2020 to 31 March 2021;
    d. $200,000.00 for the performance year from 1 April 2021 to 31 March 2022;
    e. $225,000.00 for the performance year from 1 April 2022 to 31 March 2023;
    f. $225,000.00 for the performance year from 1 April 2023 to 31 March 2024;
    g. $225,000.00 for the performance year from 1 April 2024 to 31 March 2025;
    h. $225,000.00 for the performance year from 1 April 2025 to 31 March 2026;
    i. $250,000.00 for the performance year from 1 April 2026 to 31 March 2027;
    j. $250,000.00 for the performance year from 1 April 2027 to 31 March 2028;
    k. $250,000.00 for the performance year from 1 April 2028 to 31 March 2029; and
    l. $250,000.00 for the performance year from 1 April 2029 to 31 March 2030.

**ORGANIZATION**

7. The organizational structure of the PMF includes the following structure:

   a. Performance Evaluation will be carried out by the Performance Evaluation Team (PET) and,

   b. Performance Monitors (PMs) duties will be carried out by the RCMP Technical Authority (TA), in consultation with the RCMP Procurement Authority (PA) and RCMP Task Managers (TM).

8. General Information:

   a. The Contractor's performance will be monitored throughout the fiscal year period. The PIF amount will be available at the end of annual performance evaluation period;

   b. The annual PIF will be determined by the RCMP PET in accordance with the RCMP PMF;

   c. PIF determinations are not subject to the Dispute Resolution clauses of the Contract. Whether work is added and/or deleted from the Contract, the PIF amount available will remain as per article 6 above.

   d. In order to be considered for PIF, a minimum of 90% of all positions filled must be achieved. Refer to article 15 below.

   e. The threshold value for PIF evaluation is set at an Annual Performance Score (AP Score) of 90. Refer to article 28 herein.

**ANNUAL PERFORMANCE EVALUATION PROCEDURES**

9. The annual performance evaluation procedure is described in the following articles.

10. <u>Daily</u>

    As required, RCMP Departmental Authorities (DAs), comprised of the RCMP TA and RCMP PA, maintain ongoing communication with their Contractor counterparts; conduct assessments in an open, objective and cooperative spirit; raise issues for resolution by the Contractor; emphasize the positive and the negative performance; raise appropriate observation reports for review, information, and action by, or discussion with, the Contractor, throughout the duration of the Contract.

11. <u>Annually</u>

    a. Within approximately fifteen (15) working days PRIOR to the end of annual evaluation period, the RCMP TA, in consultation with RCMP PA and Task

Managers (TMs) complete the RCMP Performance Monitors Survey (PM Survey);

b. Within approximately five (5) working days AFTER the end of annual evaluation period, the Contractor will provide the Key Performance Indicators (KPI) Score to the RCMP TA;

c. Within approximately ten (10) working days post KPI score to RCMP, the RCMP DAs will generate an Annual Performance Report using the KPI Score and PM Survey Score;

d. Subsequent to the Annual Performance Report being prepared, it will be reviewed by the RCMP TA in conjunction with the Contractor's Service Delivery Manager (SDM);

e. After review by the RCMP and SDM, the RCMP Annual Performance Report outlining the overall performance of the work delivered by the Contractor during the evaluation period and the PIF amount recommended will be sent to the Contractor. The Contractor will have the opportunity to raise observations and concerns on the evaluation to the PET representatives within five (5) working days.

f. Within approximately thirty (30) working days after the end of the annual performance evaluation period, a PET meeting will be held to approve Annual Performance Report;

g. Within approximately five (5) working days, the final RCMP Annual Performance Report including PIF amount will be sent to the Contractor and internal finance unit. The PET decision, once rendered, will be considered final.

12 The following table outline the schedule of activities covering the performance evaluation period.

| ANNUAL PERFORMANCE EVALUATION | Estimated Schedule |
|---|---|
| RCMP PM Survey completed | 2nd week March |
| Contractor's KPI Indicators Score received | 1st week April |
| RCMP DAs prepare Annual Performance Report | 3rd week April |
| Contractor's input on RCMP Annual Performance Report received | 4th week April |
| RCMP PET Meeting | 1st week May |
| RCMP Final Annual Performance Report / PIF Decision rendered | 2nd week May |

**PERFORMANCE EVALUATION CRITERIA AND SCORE**

13 This PMF consists of three (3) distinct measures: two (2) Key Performance Indicators (KPIs) and one (1) Performance Monitor's Survey. The Contractor's performance in the annual evaluation periods will be graded using the evaluation criteria below and will be used to determine PIF. The evaluation criteria are as follow:

a. KPI 1: Recurring Position Filled (RPF);

b. KPI 2: New Position Filled (NPF);

c. Performance Monitors Survey (PM Survey).

The criteria elements, weight structure, and data source for evaluation are shown below.

**KEY PERFORMANCE INDICATORS**

14 Description These indicators measure how many positions have been filled in relation to the number of positions that have been tasked to be filled through RCMP Task Authorizations, for two (2) separate categories:

a. KPI 1: Recurring Position Filled (RPF);

b. KPI 2: New Position Filled (NPF);

NOTE: For the first year, KPI 1 will measure the Initial Requirements Plan Position filled and KPI 2 will measure all new positions not included in the Initial Requirements Plan.

15 Applicability A position is considered filled when the obligations, as detailed on the TA Form for that position, are met by the Contractor's HCP(s). Conversely, a position is considered unfilled when the obligations, as detailed on the TA Form for that position, are not met at the time the Time to Provide (TTP) for that position has expired. TTP is defined in the Statement of Work article titled Time to Provide.

16 Source of data As calculated by Canada.

17 Frequency of data collection Data will be collected and analyzed on an annual basis.

18 Basis for Measuring Position Fill Percentage Comparison of the number of positions filled versus the number of positions filled plus the number of positions unfilled.

**Method of Determining KPI Score**

19 Positions Filled (KPI 1 Score) The KPI 1 Score will be calculated as follows:

$$KPI\ 1\ (\%) = \left( \frac{RPF}{RPF + RPU} \right) \times 100$$

**RPF** (Recurring Positions Filled) and **RPU** (Recurring Positions Unfilled) represent the Contractor's performance. On the last day of the quarter being assessed, the KPI 1 Score will be calculated using the number of Recurring Positions Filled over the number of Recurring Positions Filled plus the number of Recurring Positions Unfilled since the beginning of the quarter.

20 New Positions Filled (KPI 2 Score) The KPI 2 Score will be calculated as follows:

$$KPI\ 2\ (\%) = \left( \frac{NPF}{NPF + NPU} \right) \times 100$$

**NPF** (New Positions Filled) and **NPU** (New Positions Unfilled) represent the Contractor's performance. On the last day of the quarter being assessed, the KPI 1 Score will be calculated using the number of New Positions Filled over the number of New Positions Filled plus the number of New Positions Unfilled since the beginning of the quarter.

21 KPI Score Once **KPI 1** and **KPI 2** have been determined, the KPI Score shall be calculated as follows:

KPI Score = [(KPI 1 X 0.70) + (KPI 2 x 0.30)]

22 The weighting for the KPI Score will be 80% of the Annual Performance score.

**PERFORMANCE MONITORS SURVEY (PM Survey)**

23 Description This performance measure provides an overview of the RCMP's overall satisfaction towards the flexibility, quality and accuracy of the Contractor performance in the following four (4) areas: the performance of work of Contractor Management Team, the quality of the work of the HCPs, the quality of the management and administration of the Contractor's Management Team, and the quality and effectiveness of the communication with all stakeholders.

a. Applicability This performance measure applies to Contractor's Management Team and all HCPs provided under the contract

b. Source of data The PM Survey, conducted by the RCMP annually;

c. Frequency of data collection Data will be collected and analyzed annually, and

d. Basis for Measuring Quality of Work PM will use the relative weighting of the performance areas on the PM Survey in accordance with the table below.

| | PM Survey Criteria | Weight |
|---|---|---|
| 1 | **Performance of Work**<br>- Positions filled<br>- SOW deliverables<br>- Issue resolution | 25% |
| 2 | **Quality of Work**<br>- HCP quality of work | 25% |

| | | |
|---|---|---|
| 3 | **Management and Administration**<br>- Contract administration<br>- Reports and planning<br>- Invoicing and time recording | 25% |
| 4 | **Communication with all stakeholders** | 25% |
| **Total** | | 100% |

PM SURVEY SCORE

24 The PM Survey Score will be used to calculate the overall service level received by the RCMP from the Contractor. It will capture the RCMP's satisfaction level with the Contractor's performance, throughout the year, indicate performance trends and highlight specific areas requiring improvement.

25 The PM Survey will consist of a questionnaire completed by the RCMP DAs.

26 The weighting for the PM Survey will be 20% of the Annual Performance Score.

**ANNUAL PERFORMANCE SCORE (AP Score)**

27 The Contractor's annual performance will be graded by adding the KPI Score and the PM Survey Score. The AP Score is calculated as follows:

AP Score = (KPI Score X 0.80) + (PM Survey Score X 0.20)

AP Score will be rounded to the closest digit (no decimal).

28 Performance Incentive Fee Pool The following schedule establishes the PIF percentage in relation to obtained AP Score:

| Annual Performance Score | Percentage of Performance Incentive Fee Pool |
|---|---|
| 90 | 9 % |
| 91 | 27% |
| 92 | 43% |
| 93 | 57% |
| 94 | 69% |
| 95 | 79% |
| 96 | 87% |
| 97 | 93% |
| 98 | 95% |
| 99 | 98% |
| 100 | 100% |
| No Performance Incentive Fee will be paid when the AP Score is 89 or less. | |

## ANNUAL PERFORMANCE REPORT

29 The Annual Performance Report will provide an overall evaluation of the Contractor's performance for the year and the PIF recommendation.

## APPENDIX 1 TO ANNEX F2

## PERFORMANCE MONITOR SURVEY

The performance Monitor Survey provides an overview of RCMP's overall satisfaction towards the flexibility, quality and accuracy of the Contractor performance in the following four (4) areas: performance of work by the Contractor's management team; quality of the work of the HCPs; the quality of the management and administration of the Contractor's management team; quality and effectiveness of the communication with all stakeholders.

The performance levels – outstanding, superior, satisfactory, and unsatisfactory, and their relation to performance excellence are illustrated in the following table:

| **RATING SCALE:** Please use the following ratings to complete the attached Survey | | |
|---|---|---|
| **Rating** | **Score** | **Definition** |
| Outstanding | 5 | The Contractor has demonstrated creativity, ingenuity, initiative, and excellent performance; consistently exceeding expectations. There are no apparent areas requiring improvement. |
| Superior | 4 | The Contractor has consistently maintained a high level of service; frequently exceeded expectations. There is minor room for improvement. |
| Satisfactory | 3 | Performance met contractual requirements. The contractual performance of the element being assessed contains some minor problems for which corrective actions taken by the contractor appear to be or were satisfactory. |
| Unsatisfactory | 0 | Performance does not meet most contractual requirements. The contractual performance of the element being assessed contains serious problem(s). |

Please justify your scoring with examples or an explanation in the Comment section of the Survey.

| | | Outstanding<br>5 | Superior<br>4 | Satisfactory<br>3 | Unsatisfactory<br>0 | Non Applicable | Total |
|---|---|---|---|---|---|---|---|
| **Performance of Work by the Contractor** | | | | | | | |
| P1. | How would you rate the Contractor's outcomes / efforts in filling vacant positions? | | | | | | |
| P2. | What is your overall level of satisfaction with the Contractor's selection of Proposed HCPs? | | | | | | |
| P3. | How effective is the Contractor in presenting HCPs that meet your needs within the Time to Provide requirements? | | | | | | |
| P4. | How would you rate the Contractor's recruitment strategy? | | | | | | |
| P5. | How would you rate the Contractor's ability to retain HCPs? | | | | | | |
| P6. | How would you rate the Contractor's performance in resolving issues? Issue Resolution includes: issue identification; steps taken to resolve issues; time taken to resolve issues; issue tracking; outcomes and lessons learned? | | | | | | |
| | **Total** | | | | | | **/30** |
| **Quality of Work of HCPs** | | | | | | | |
| Q1. | How would you rate the HCPs overall performance with regards to quality of work? | | | | | DTA/DPA | |
| Q2. | How would you rate HCP performance within the interdisciplinary teams? | | | | | DTA/DPA | |
| Q3. | What is your level of satisfaction with regards to HCPs having the necessary skills and experience to do their work? | | | | | DTA/DPA | |
| | **Total** | | | | | | **/15** |

| | | Outstanding<br>5 | Superior<br>4 | Satisfactory<br>3 | Unsatisfactory<br>0 | Non Applicable | Total |
|---|---|---|---|---|---|---|---|
| **Management and Administration** | | | | | | | |
| M1. | How successful was the performance of the Contractor's Management Team? | | | | | TM | |
| M2. | How would you rate the Contractor's approach to customer service? | | | | | | |
| M3. | How well did the Contractor perform in providing flexible, proactive, and effective solutions to issues? | | | | | TM | |
| M4. | How successful was the Contractor in managing HCPs during the provision of services under this Contract? (management includes training; planning for absences) | | | | | | |
| M5. | How would you rate the Contractor's accuracy and timeliness of reporting HCP good standing within respective associations and notifying the Department of any change of status? | | | | | | |
| M.6 | How would you rate the Contractor's performance in ensuring that every HCP has appropriate liability insurance? | | | | | | |
| M7. | How would you rate the Contractor's performance in ensuring that HCP's maintain the skills set required to provide health services under this Contract? | | | | | | |
| M8. | How would you rate the Contractor's performance in ensuring that HCPs understand their roles and responsibilities? | | | | | | |
| M9. | How successful was the Contractor in submitting timely and accurate reports? | | | | | | |
| M10. | How would you rate the HCP's Accuracy, completeness and timely completion of weekly time sheets | | | | | **DTA/DPA** | |
| M11. | How would you rate the functionality of the Time Sheet Tool? | | | | | | |
| M12. | How would you rate the user support of the Time Sheet Tool? | | | | | | |
| | **Total** | **0** | | **0** | | | **/60** |

| | | Outstanding<br><br>5 | Superior<br><br>4 | Satisfactory<br><br>3 | Unsatisfactory<br><br>0 | Non Applicable | Total |
|---|---|---|---|---|---|---|---|
| | **Communication with all Stakeholders** | | | | | | |
| C1. | How would you rate the quality & effectiveness of your communications with the Contractor? | | | | | | |
| C2. | How would you rate the Contractor's response time? | | | | | | |
| C3. | How would you rate the Contractor's efforts in keeping you abreast of the status of your requirements? | | | | | | |
| C4. | How well did the Contractor present information and correspondence in a clear and concise manner? | | | | | | |
| C5. | How well did the Contractor promptly notify you of emerging/urgent issues? | | | | | | |
| | **Total** | **0** | | **0** | | | **/25** |
| | **Grand Total** | **0** | | **0** | | | **/135** |

Please Justify your scoring below:

| Performance of Work by the Contractor | | Comments and Justification of scoring |
|---|---|---|
| P1. | How would you rate the Contractor's outcomes / efforts in filling vacant positions? | |
| P2. | What is your overall level of satisfaction with the Contractor's selection of Proposed HCPs? | |
| P3. | How effective is the Contractor in presenting HCPs that meet your needs within the Time to Provide requirements? | |
| P4. | How would you rate the Contractor's recruitment strategy? | |
| P5. | How would you rate the Contractor's ability to retain HCPs? | |
| P6. | How would you rate the Contractor's performance in resolving issues?<br>Issue Resolution includes: issue identification; steps taken to resolve issues; time taken to resolve issues; issue tracking; outcomes and lessons learned? | |
| **Quality of Work of HCPs** | | **Comments and Justification of scoring** |
| Q1. | How would you rate the HCPs overall performance with regards to quality of work? | |
| Q2. | How would you rate HCP performance within the interdisciplinary teams? | |
| Q3. | What is your level of satisfaction with regards to HCPs having the necessary skills and experience to do their work? | |
| **Management and Administration** | | **Comments and Justification of scoring** |
| M1. | How successful was the performance of the Contractor's Management Team? | |
| M2. | How would you rate the Contractor's approach to customer service? | |

| | | |
|---|---|---|
| M3. | How well did the Contractor perform in providing flexible, proactive, and effective solutions to issues? | |
| M4. | How successful was the Contractor in managing HCPs during the provision of services under this Contract? (management includes training; planning for absences) | |
| M5. | How would you rate the Contractor's accuracy and timeliness of reporting HCP good standing within respective associations and notifying the Department of any change of status? | |
| M.6 | How would you rate the Contractor's performance in ensuring that every HCP has appropriate liability insurance? | |
| M7. | How would you rate the Contractor's performance in ensuring that HCP's maintain the skills set required to provide health services under this Contract? | |
| M8. | How would you rate the Contractor's performance in ensuring that HCPs understand their roles and responsibilities? | |
| M9. | How successful was the Contractor in submitting timely and accurate reports? | |
| M10. | How would you rate the HCP's Accuracy, completeness and timely completion of weekly time sheets | |
| M11. | How would you rate the functionality of the Time Sheet Tool? | |
| M12. | How would you rate the user support of the Time Sheet Tool? | |
| **Communication with all Stakeholders** | | **Comments and Justification of scoring** |
| C1. | How would you rate the quality & effectiveness of your communications with the Contractor? | |
| C2. | How would you rate the Contractor's response time? | |
| C3. | How would you rate the Contractor's efforts in keeping you abreast of the status of your requirements? | |
| C4. | How well did the Contractor present information and correspondence in a clear and concise manner? | |

| | | |
|---|---|---|
| C5. | How well did the Contractor promptly notify you of emerging/urgent issues? | |

**ANNEX F3**
**PERFORMANCE MEASUREMENT FRAMEWORK (VAC)**

## INTRODUCTION

1. The Contract contains terms for payment of a Performance Incentive Fee (PIF). The PIF is made available by Veterans Affairs Canada (VAC) to encourage the Contractor to provide the Health Care Providers (HCPs), and for the management and supervision required to ensure excellent performance under the Contract. The maximum PIF amount is paid for achieving the maximum level of beneficial performance.

2. The Performance Measurement Framework (PMF) covers the administration of performance evaluation indicators and measures in order to award a PIF.

## AIM

3. The aim of the PMF is to provide a method to measure the Contractor's performance levels. It establishes clear communications on evaluation procedures; and provides for effective communication between the Contractor and VAC.

4. The PMF focuses on and supports the main goal of the HCP Contract, which is to have the Contractor provide and manage Health Care Providers (HCPs) needed to supplement VAC's workforce in delivering health care support services. To that end, the measure with the highest weighting is the percentage of positions filled.

5. The performance evaluation is based on quantitative and qualitative measurement. Canada recognizes that throughout the duration of the contract, the PMF may be required to be modified in order to accommodate changes to management emphasis, motivate higher performance levels, improve the performance incentive determination process, or any other changes as required. Any recommended changes to the PMF, whether made by the Contractor or Canada, require approval from both parties. Once approved, the revised PMF will only go into effect once a Contract Amendment has been issued to reflect the changes.

6. VAC will make the following amounts available for the PIF :

   a. $165,000.00 for the performance year from 1 April 2018 to 31 March 2019;
   b. $165,000.00 for the performance year from 1 April 2019 to 31 March 2020;
   c. $165,000.00 for the performance year from 1 April 2020 to 31 March 2021;
   d. $165,000.00 for the performance year from 1 April 2021 to 31 March 2022;
   e. $180,000.00 for the performance year from 1 April 2022 to 31 March 2023;
   f. $180,000.00 for the performance year from 1 April 2023 to 31 March 2024;
   g. $180,000.00 for the performance year from 1 April 2024 to 31 March 2025;
   h. $180,000.00 for the performance year from 1 April 2025 to 31 March 2026;
   i. $190,000.00 for the performance year from 1 April 2026 to 31 March 2027;
   j. $190,000.00 for the performance year from 1 April 2027 to 31 March 2028;
   k. $190,000.00 for the performance year from 1 April 2028 to 31 March 2029; and,
   l. $190,000.00 for the performance year from 1 April 2029 to 31 March 2030.

**ORGANIZATION**

7. The organizational structure of the PMF includes the following:

    a. Performance Evaluation carried out by the Performance Evaluation Team (PET) and;

    b. Performance Monitors (PMs) duties carried out by the VAC Technical Authority (TA) in consultation with the VAC Procurement Authority (PA) and the VAC Task Managers (TM).

8. General Information:

    a. The Contractor's performance will be monitored throughout the fiscal year. The PIF amount will be available at the end of the annual evaluation period;

    b. The annual PIF will be determined by the VAC PET in accordance with the VAC PMF;

    c. PIF determinations are not subject to the Dispute Resolution clauses of the Contract. Whether work is added and/or deleted from the Contract, the PIF amount available will remain as per article 6 above;

    d. In order to be considered for PIF, a minimum of 90% of all positions filled must be achieved. Refer to article 15 below.

    e. The threshold value for PIF evaluation is set at an Annual Performance Score (AP Score) of 90. Refer to article 28 herein.

**ANNUAL PERFORMANCE EVALUATION PROCEDURES**

9. The annual performance evaluation procedure is described in the following articles.

10. <u>Daily</u>

    As required, VAC Departmental Authorities (DAs), comprised of the VAC TA and VAC PA, maintain ongoing communication with their Contractor counterparts; conduct assessments in an open, objective and cooperative spirit; raise issues for resolution by the Contractor; emphasize the positive and the negative performance; raise appropriate observation reports for review, information, and action by, or discussion with, the Contractor, throughout the duration of the Contract.

11. Annually

a. Within approximately fifteen (15) working days PRIOR to the end of each annual evaluation period, the VAC TA, in consultation with VAC PA and Task Managers (TMs) complete the VAC Performance Monitors Survey (PM Survey);

b. Within approximately five (5) working days AFTER the end of each annual evaluation period, the Contractor will provide the Key Performance Indicators (KPI) Score to the VAC TA.

c. Within approximately ten (10) working days post KPI Score being provided to VAC, the VAC DAs will generate an Annual Performance Report using the KPI Score and the PM Survey Score.

d. Subsequent to the Annual Performance Report being prepared, it will be reviewed by the VAC TA in conjunction with the Contractor's Service Delivery Manager (SDM).

e. After review by the VAC TA and SDM, the VAC Annual Performance Report outlining the overall performance of the work delivered by the Contractor during the evaluation period and the PIF amount recommended, will be sent to the Contractor. The Contractor will have the opportunity to raise observations and concerns on the evaluation within five (5) working days.

f. Within approximately thirty (30) working days after the end of the annual performance evaluation period, a PET meeting will be held to approve the Annual Performance Report.

g. Within approximately five (5) working days after the PET meeting, the final Annual Performance Report including the PIF amount will be sent to the Contractor and internal finance unit. The PET decision, once rendered, will be considered final.

12. The following table outlines the schedule of activities covering the performance evaluation period.

| PERFORMANCE EVALUATION | Schedule |
|---|---|
| | |
| VAC PM Survey completed | 2nd week March |
| Contractor's KPI Indicators Score received | 1st week April |
| VAC DAs prepare Annual Performance Report | 3rd week April |
| Contractor's input Annual Performance Report received | 4th week April |
| VAC PET meeting | 1st week May |
| VAC Final Annual Performance Report/PIF decision rendered | 2nd week May |

**PERFORMANCE EVALUATION CRITERIA AND SCORE**

13. This PMF consists of three (3) distinct measures: two (2) Key Performance Indicators (KPIs) and one (1) Performance Monitor's Survey. The Contractor's performance in the annual evaluation periods will be graded using the evaluation criteria below and will be used to determine PIF. The evaluation criteria are as follow:

    a. KPI 1: Recurring Positions Filled (RPF);

    b. KPI 2: New Positions Filled (NPF);

    c. Performance Monitor's Survey (PM Survey);

    The criteria elements, weight structure, and data source for evaluation are shown below.

KEY PERFORMANCE INDICATORS

14. Description These indicators measure how many positions have been filled in relation to the number of positions that have been tasked to be filled through VAC Task Authorizations, for two (2) separate categories:

    a. KPI 1: Recurring Positions Filled (RPF); and

    b. KPI 2: New Positions Filled (NPF);

    Note: For the first year, KPI 1 will measure the Initial Requirements Plan's positions filled and KPI 2 will measure all new positions not included in the Initial Requirements Plan.

15. Applicability A position is considered filled when the obligations, as detailed on the TA Form for that position, are met by the Contractor's HCP(s). Conversely, a position is considered unfilled when the obligations, as detailed on the TA Form for that position, are not met at the time the Time to Provide (TTP) for that position has expired. TTP is defined in the Statement of Work article titled Time to Provide.

16. Source of data As calculated by Canada.

17. Frequency of data collection Data will be collected and analyzed on an annual basis.

18. Basis for Measuring Position Fill Percentage Comparison of the number of positions filled versus the number of positions filled plus the number of positions unfilled.

**Method of Determining KPI Score**

19. Positions Filled (KPI 1 Score) The KPI 1 Score will be calculated as follows:

$$KPI\ 1\ (\%) = \left( \frac{RPF}{RPF + RPU} \right) \times 100$$

**RPF** (Recurring Positions Filled) and **RPU** (Recurring Positions Unfilled) represent the Contractor's performance. On the last day of the quarter being assessed, the KPI 1 Score will be calculated using the number of Recurring Positions Filled over the number of Recurring Positions Filled plus the number of Recurring Positions Unfilled since the beginning of the quarter.

20. New Positions Filled (KPI 2 Score) The KPI 2 Score will be calculated as follows:

$$KPI\ 2\ (\%) = \left( \frac{NPF}{NPF + NPU} \right) \times 100$$

**NPF** (New Positions Filled) and **NPU** (New Positions Unfilled) represent the Contractor's performance. On the last day of the quarter being assessed, the KPI 1 Score will be calculated using the number of New Positions Filled over the number of New Positions Filled plus the number of New Positions Unfilled since the beginning of the quarter.

21. KPI Score. Once **KPI 1** and **KPI 2** have been determined, the KPI Score shall be calculated as follows:

KPI Score = [(KP1 X 0.70) + (KPI 2 x 0.30)]

22. The weighting for the annual KPI calculation will be 80% of the Annual Performance Score.

PERFORMANCE MONITOR SURVEY (PM Survey)

23. Description The performance measure provides an overview of VAC's overall satisfaction towards the flexibility, quality and accuracy of the Contractor performance in the following four (4) areas: performance of work by the Contractor's management team; quality of the work of the HCPs; the quality of the management and administration of the Contractor's management team; quality and effectiveness of the communication with all stakeholders.

    a. Applicability This performance measure applies to Contractor's Management Team and all HCPs provided under the contract.

    b. Source of data The PM Survey, conducted by VAC annually.

    c. Frequency of data collection Data will be collected and analyzed annually;

d. Basis for Measuring Quality of Work The relative weighting of the performance areas on the PM Survey in accordance with the table below:

| **Performance Criteria** | | **Weight** |
|---|---|---|
| 1 | **Performance of Work by Contractor**<br>**-** Time to fill Positions<br>- SOW deliverables<br>- Issue Resolution | 25% |
| 2 | **Quality of Work of HCPs**<br>- Quality of work<br>- Interdisciplinary Teamwork | 25% |
| 3 | **Management and Administration** -<br>- Contract Administration<br>- Planning and Reports<br>- Invoicing | 25% |
| 4 | **Communications with all stakeholders** | 25% |
| | **Total** | 100% |

**PM SURVEY SCORE:**

24. The PM Survey Score will be used to calculate the overall service level received by VAC from the Contractor. It will capture VAC's satisfaction level with the Contractor's performance throughout the year, indicate performance trends and highlight specific areas requiring improvement.

25. The PM Survey will consist of questionnaires completed by the VAC DAs.

26. The weighting of the PM Survey will be 20% of the Annual Performance Score.

**ANNUAL PERFORMANCE SCORE (AP Score)**

27. The Contractor's annual performance will be calculated by adding the KPI Score and the PM Survey Score as described below:

AP Score = (KPI Score X 0.80) + (PM Survey Score X 0.20)

AP Score will be rounded to the closest digit (no decimal).

28. Performance Incentive Fee Pool. The following schedule establishes the PIF percentage in relation to obtained AP Score:

| Annual Performance Score | Percentage of Performance Incentive Fee Pool |
|---|---|
| 90 | 9 % |
| 91 | 27% |
| 92 | 43% |
| 93 | 57% |
| 94 | 69% |
| 95 | 79% |
| 96 | 87% |
| 97 | 93% |
| 98 | 95% |
| 99 | 98% |
| 100 | 100% |
| No Performance Incentive Fee will be paid when the AP Score is 89 or less. | |

**ANNUAL PERFORMANCE REPORT**

29. The Annual Performance Report will provide an overall evaluation of the Contractor's performance for the year and the PIF recommendation.

## APPENDIX 1 TO ANNEX F3

## PERFORMANCE MONITOR SURVEY

The performance Monitor Survey provides an overview of VAC's overall satisfaction towards the flexibility, quality and accuracy of the Contractor performance in the following four (4) areas: performance of work by the Contractor's management team; quality of the work of the HCPs; the quality of the management and administration of the Contractor's management team; quality and effectiveness of the communication with all stakeholders.

The performance levels – outstanding, superior, satisfactory, and unsatisfactory, and their relation to performance excellence are illustrated in the following table:

| **RATING SCALE:** Please use the following ratings to complete the attached Survey | | |
|---|---|---|
| **Rating** | **Score** | **Definition** |
| Outstanding | 5 | The Contractor has demonstrated creativity, ingenuity, initiative, and excellent performance; consistently exceeding expectations. There are no apparent areas requiring improvement. |
| Superior | 4 | The Contractor has consistently maintained a high level of service; frequently exceeded expectations. There is minor room for improvement. |
| Satisfactory | 3 | Performance met contractual requirements. The contractual performance of the element being assessed contains some minor problems for which corrective actions taken by the contractor appear to be or were satisfactory. |
| Unsatisfactory | 0 | Performance does not meet most contractual requirements. The contractual performance of the element being assessed contains serious problem(s). |

Please justify your scoring with examples or an explanation in the Comment section of the Survey.

| | | Outstanding<br>5 | Superior<br>4 | Satisfactory<br>3 | Unsatisfactory<br>0 | Non Applicable | Total |
|---|---|---|---|---|---|---|---|
| **Performance of Work by the Contractor** | | | | | | | |
| P1. | How would you rate the Contractor's outcomes / efforts in filling vacant positions? | | | | | | |
| P2. | What is your overall level of satisfaction with the Contractor's selection of Proposed HCPs? | | | | | | |
| P3. | How effective is the Contractor in presenting HCPs that meet your needs within the Time to Provide requirements? | | | | | | |
| P4. | How would you rate the Contractor's recruitment strategy? | | | | | | |
| P5. | How would you rate the Contractor's ability to retain HCPs? | | | | | | |
| P6. | How would you rate the Contractor's performance in resolving issues? Issue Resolution includes: issue identification; steps taken to resolve issues; time taken to resolve issues; issue tracking; outcomes and lessons learned? | | | | | | |
| | **Total** | | | | | | **/30** |
| **Quality of Work of HCPs** | | | | | | | |
| Q1. | How would you rate the HCPs overall performance with regards to quality of work? | | | | | DTA/DPA | |
| Q2. | How would you rate HCP performance within the interdisciplinary teams? | | | | | DTA/DPA | |
| Q3. | What is your level of satisfaction with regards to HCPs having the necessary skills and experience to do their work? | | | | | DTA/DPA | |
| | **Total** | | | | | | **/15** |

| | | Outstanding<br>5 | Superior<br>4 | Satisfactory<br>3 | Unsatisfactory<br>0 | Non Applicable | Total |
|---|---|---|---|---|---|---|---|
| **Management and Administration** | | | | | | | |
| M1. | How successful was the performance of the Contractor's Management Team? | | | | | TM | |
| M2. | How would you rate the Contractor's approach to customer service? | | | | | | |
| M3. | How well did the Contractor perform in providing flexible, proactive, and effective solutions to issues? | | | | | TM | |
| M4. | How successful was the Contractor in managing HCPs during the provision of services under this Contract? (management includes training; planning for absences) | | | | | | |
| M5. | How would you rate the Contractor's accuracy and timeliness of reporting HCP good standing within respective associations and notifying the Department of any change of status? | | | | | | |
| M.6 | How would you rate the Contractor's performance in ensuring that every HCP has appropriate liability insurance? | | | | | | |
| M7. | How would you rate the Contractor's performance in ensuring that HCP's maintain the skills set required to provide health services under this Contract? | | | | | | |
| M8. | How would you rate the Contractor's performance in ensuring that HCPs understand their roles and responsibilities? | | | | | | |
| M9. | How successful was the Contractor in submitting timely and accurate reports? | | | | | | |
| M10. | How would you rate the HCP's Accuracy, completeness and timely completion of weekly time sheets | | | | | **DTA/DPA** | |
| M11. | How would you rate the functionality of the Time Sheet Tool? | | | | | | |
| M12. | How would you rate the user support of the Time Sheet Tool? | | | | | | |
| | **Total** | **0** | | **0** | | | **/60** |

| | | Outstanding<br><br>5 | Superior<br><br>4 | Satisfactory<br><br>3 | Unsatisfactory<br><br>0 | Non Applicable | Total |
|---|---|---|---|---|---|---|---|
| | **Communication with all Stakeholders** | | | | | | |
| C1. | How would you rate the quality & effectiveness of your communications with the Contractor? | | | | | | |
| C2. | How would you rate the Contractor's response time? | | | | | | |
| C3. | How would you rate the Contractor's efforts in keeping you abreast of the status of your requirements? | | | | | | |
| C4. | How well did the Contractor present information and correspondence in a clear and concise manner? | | | | | | |
| C5. | How well did the Contractor promptly notify you of emerging/urgent issues? | | | | | | |
| | **Total** | **0** | | **0** | | | **/25** |
| | **Grand Total** | **0** | | **0** | | | **/135** |

Please Justify your scoring below:

| Performance of Work by the Contractor | | Comments and Justification of scoring |
|---|---|---|
| P1. | How would you rate the Contractor's outcomes / efforts in filling vacant positions? | |
| P2. | What is your overall level of satisfaction with the Contractor's selection of Proposed HCPs? | |
| P3. | How effective is the Contractor in presenting HCPs that meet your needs within the Time to Provide requirements? | |
| P4. | How would you rate the Contractor's recruitment strategy? | |
| P5. | How would you rate the Contractor's ability to retain HCPs? | |
| P6. | How would you rate the Contractor's performance in resolving issues?<br>Issue Resolution includes: issue identification; steps taken to resolve issues; time taken to resolve issues; issue tracking; outcomes and lessons learned? | |
| **Quality of Work of HCPs** | | **Comments and Justification of scoring** |
| Q1. | How would you rate the HCPs overall performance with regards to quality of work? | |
| Q2. | How would you rate HCP performance within the interdisciplinary teams? | |
| Q3. | What is your level of satisfaction with regards to HCPs having the necessary skills and experience to do their work? | |
| **Management and Administration** | | **Comments and Justification of scoring** |
| M1. | How successful was the performance of the Contractor's Management Team? | |
| M2. | How would you rate the Contractor's approach to customer service? | |

| | | |
|---|---|---|
| M3. | How well did the Contractor perform in providing flexible, proactive, and effective solutions to issues? | |
| M4. | How successful was the Contractor in managing HCPs during the provision of services under this Contract? (management includes training; planning for absences) | |
| M5. | How would you rate the Contractor's accuracy and timeliness of reporting HCP good standing within respective associations and notifying the Department of any change of status? | |
| M.6 | How would you rate the Contractor's performance in ensuring that every HCP has appropriate liability insurance? | |
| M7. | How would you rate the Contractor's performance in ensuring that HCP's maintain the skills set required to provide health services under this Contract? | |
| M8. | How would you rate the Contractor's performance in ensuring that HCPs understand their roles and responsibilities? | |
| M9. | How successful was the Contractor in submitting timely and accurate reports? | |
| M10. | How would you rate the HCP's Accuracy, completeness and timely completion of weekly time sheets | |
| M11. | How would you rate the functionality of the Time Sheet Tool? | |
| M12. | How would you rate the user support of the Time Sheet Tool? | |
| **Communication with all Stakeholders** | | **Comments and Justification of scoring** |
| C1. | How would you rate the quality & effectiveness of your communications with the Contractor? | |
| C2. | How would you rate the Contractor's response time? | |
| C3. | How would you rate the Contractor's efforts in keeping you abreast of the status of your requirements? | |
| C4. | How well did the Contractor present information and correspondence in a clear and concise manner? | |

| | | |
|---|---|---|
| C5. | How well did the Contractor promptly notify you of emerging/urgent issues? | |

# ATTACHMENT 1 TO PART 4

# TECHNICAL CRITERIA

# ATTACHMENT 1 TO PART 4
# TECHNICAL CRITERIA

## 1.1 Technical Evaluation

### 1.1.1 Mandatory Technical Criteria

The bid must meet the mandatory technical criteria specified below. The Bidder must provide the necessary documentation identified in each mandatory technical criterion to demonstrate compliance with each requirement.

Bids which fail to meet the mandatory technical criteria will be declared non-responsive. Each mandatory technical criterion should be addressed separately.

**Mandatory Technical Criteria (MT)**

**Bid Preparation Instructions:** As stipulated in Part 3 of the Bid Solicitation, technical bids should address clearly and in sufficient depth the points that are subject to the evaluation criteria against which the bid will be evaluated. Simply repeating the statement contained in the bid solicitation is not sufficient. Also, if key pieces of information are not provided, the evaluators will not be in a position to assess the criteria, which will render the bid non-responsive, e.g. if the period of time over which the service was rendered is not provided in the requested format, the evaluators will not consider partial information and the bid may be considered non-responsive.

**Evaluation of experience:**

- For the purpose of mandatory technical criteria MT1 and MT4 evaluation, the minimum 60 months of experience required does not correspond to a period of continuous months, but a total of 60 months in which services were rendered, within the last 10 years of the Bid Solicitation issuance date.
- Experience listed must include the month and year for both the start and finish dates and should also include the day. If the day is not provided, it will be evaluated as the last day of the month, in the case of the start date, and the first day of the month, in the case of the finish date.
- For the purpose of mandatory technical criteria evaluation, Human Resources is defined as individuals of an organization, and individuals provided to a third party.
- For the purpose of mandatory technical criteria evaluation, provision of Human Resources includes the recruiting, hiring and associated service delivery administration functions and activities.
- Experience can be demonstrated using one or more contracts of services rendered. The services could have been rendered by either subcontractors or employees of the Bidder to a client or to the Bidder itself.
- For the purpose of mandatory technical criteria evaluation, management of Human Resources includes, where applicable: licence administration, invoicing, training, performance measurement and monitoring, communication with resources, and problem resolution.

| **The Bidder** | | |
|---|---|---|
| **Bidder's Experience** | | |
| **Number** | **Mandatory Technical Criterion** | **Bid Preparation Instructions** |
| **MT 1** | The Bidder must have a minimum of 60 months of experience, within the last 10 years as of the Bid Solicitation issuance date, in the provision of human resources totaling a minimum value of $350M in the 60 months. | To demonstrate its experience, the Bidder must provide at least the following information for each client reference for which the experience meets the requirements of evaluation criterion MT1:<br>1. Short description of the services provided to the client;<br>2. The period of time over which the service was provided, in a format including month and year information, e.g. from (month/year) to (month/year); |

| | | |
|---|---|---|
| | | 3. The contract value or salary value for the services provided during the period mentioned in 2.; and<br>4. The name and contact information of the individual who would be able to confirm the information provided by the Bidder. |
| **MT 2** | The Bidder must have experience, within the last 10 years of Bid Solicitation issuance date, in providing a minimum of 5 different occupational groups in Canada as identified in the *Occupational Group Definition Map (Appendix A)* lasting a minimum period of 90 consecutive calendar days service per occupational group.<br><br>Occupational groups are those occupations identified in the *Occupational Group* column of appendix A (e.g. Air Operations, Auditing, Commerce, Law Practitioner, Administrative Services, Information Services, Nursing, General Labour & Trades, General Services, etc.). | The experience can be demonstrated using one or more contracts of services rendered.<br><br>To demonstrate its experience, the Bidder must provide at least the following information for each client reference for which the experience meets the requirements of evaluation criterion MT2:<br>1. Short description of the services provided to the client;<br>2. The period of time over which the service was provided, in a format including month and year information, e.g. from (month/year) to (month/year);<br>3. The occupational group(s) provided during the period mentioned in 2;<br>4. The number of days of service provided during the period mentioned in 2. by resource for each occupational group; and<br>5. The name and contact information of the individual who would be able to confirm the information provided by the Bidder. |
| **MT 3** | The Bidder must have experience, within the last 3 years of Bid Solicitation issuance date, providing a minimum of 100 different human resources associated with a minimum of 5 different professional and occupational regulatory, licencing, or certification bodies in Canada. | The experience can be demonstrated using one or more contracts of services rendered.<br><br>To demonstrate its experience, the Bidder must provide at least the following information for each client reference for which the experience meets the requirements of evaluation criterion MT3:<br>1. Short description of the services provided to the client;<br>2. The period of time over which the service was provided, in a format including month and year information, e.g. from (month/year) to (month/year);<br>3. The occupational group(s) provided during the period mentioned in 2.;<br>4. The professional and occupational regulatory body or associations in Canada associated with the occupational group(s) mentioned in 3.; and<br>5. The name and contact information of the individual who would be able to confirm the information provided by the Bidder. |

| | | |
|---|---|---|
| | | |
| **MT 4** | The Bidder must have a minimum of 60 months of experience, within the last 10 years as of the Bid Solicitation issuance date, in the management of a minimum of 3,500 human resources in the 60 months. | The experience can be demonstrated using one or more contracts of services rendered.<br><br>To demonstrate its experience, the Bidder must provide at least the following information for each client reference for which the experience meets the requirements of evaluation criterion MT4:<br>1. Detailed description of the management services provided to the client, including occupational group(s);<br>2. The period of time over which the service was provided, in a format including month and year information, e.g. from (month/year) to (month/year) ~~for each month~~; and<br>3. The name and contact information of the individual who would be able to confirm the information provided by the Bidder. |

### 1.1.2 Point Rated Technical Criteria

Bids which meet all the mandatory technical criteria will be evaluated and scored as specified in the tables inserted below.

Bids which fail to obtain the required minimum number of points specified will be declared non-responsive. Each point rated technical criterion should be addressed separately.

| Point Rated Technical Criteria (RT) | | Required Minimum Number of Points | Maximum Number of Points |
|---|---|---|---|
| **RT 1** | Bidder's Experience | **600 (60%)** | **1000** |
| RT 1.1 | | | 150 |
| RT 1.2 | | | 100 |
| RT 1.3 | | | 150 |
| RT 1.4 | | | 100 |
| RT 1.5 | | | 150 |
| RT 1.6 | | | 150 |
| RT 1.7 | | | 100 |
| RT 1.8 | | | 50 |
| RT 1.9 | | | 50 |
| **RT 2** | Bidder's Approach and Methodology | **257 (60%)** | **428** |
| RT 2.1 | | | 64 |
| RT 2.2 | | | 150 |
| RT 2.3 | | | 64 |
| RT 2.4 | | | 150 |
| **OVERALL SCORE** | | | **1428** |

**Point Rated Technical Criteria (RT)**

**Bid Preparation Instructions:** As stipulated in Part 3 of the Bid Solicitation, technical bids should address clearly and in sufficient depth the points that are subject to the evaluation criteria against which the bid will be evaluated. Simply repeating the statement contained in the bid solicitation is not sufficient. Also, if key pieces of information are not provided, the evaluators will not be in a position to assess the criteria, the Bidder's experience and understanding may not be sufficiently demonstrated and points will be awarded accordingly, e.g. if the period of time over which the service was rendered is not provided in the requested format, the evaluators will not consider partial information and no points will be awarded for the Bidder's experience or understanding to be demonstrated.

**Evaluation of experience:**

- For the purpose of Point Rated Technical Criteria evaluation, the minimum period of experience required does not correspond to a period of continuous months but a total of months in which services were rendered, except when indicated otherwise.
- The experience can be demonstrated using one or more contracts of services rendered, i.e. one or more clients.
- Experience listed must include the month and year for both the start and finish dates and should also include the day. If the day is not provided, it will be evaluated as the last day of the month, in the case of the start date, and the first day of the month, in the case of the finish date.
- For the purpose of Point Rated Technical Criteria evaluation, Human Resources is defined as individuals of an organization and individuals provided to a third party.
- For the purpose of Point Rated Technical Criteria evaluation, provision of Human Resources includes the recruiting, hiring and associated service delivery administration functions and activities.
- For the purpose of rated technical criteria evaluation, management of Human Resources includes, where applicable: licence administration, invoicing, training, performance measurement and monitoring, communication with resources, and problem resolution.

**Rating scheme for RT2.1 - RT2.4:**

| Rating | Description |
|---|---|
| 100% | Outstanding response; the rated area is fully met or exceeded; rigorous approach and methodology that meets all of the elements of the rated area. The Bidder receives 100% of the available points for this area. |
| 75% | Response to the rated area is well addressed; good approach and methodology or missing minor elements. The Bidder receives 75% of the available points for this area. |
| 50% | Response to the rated criteria is less than satisfactorily addressed; adequate approach and methodology or missing many points including some major elements. The Bidder receives 50% of the available points for this area. |
| 25% | Unsatisfactory response; the approach and methodology are weak or missing many major elements. The Bidder receives 25% of the available points for this area. |
| 0% | The rated area is not addressed. The Bidder receives 0% of the available points for this area. |

| Number | Point Rated Technical Criterion | Bid Preparation Instructions | Weighting (Points) |
|---|---|---|---|
| **THE BIDDER** | | | |
| **RT1. BIDDER'S EXPERIENCE - Maximum: 1000 points. Minimum pass mark: 600 points** | | | |
| **RT 1.1** | The Bidder should have a minimum of 60 months of experience, within the last 10 years as of the Bid Solicitation issuance date, in the provision of human resources to a third party for a total value of more than $350M. | The experience can be demonstrated using one or more contracts of services rendered.<br><br>To demonstrate its experience, the Bidder should provide at least the following information for each client reference for which the experience meets the requirements of evaluation for this criterion:<br><br>1. Short description of the services provided to the client;<br><br>2. The period of time over which the service was provided, in a format including month and year information, e.g. from (month/year) to (month/year);<br><br>3. The contract value for the services provided during the period mentioned in 2.;<br><br>4. The name and contact information of the individual who would be able to confirm the information provided by the Bidder. | Points will be awarded as follows for demonstrated experience that meets the requirements of this criterion:<br><br>0 to $350M = 0 points<br><br>More than $350M to less than $375M= 30 points<br><br>$375M to less than $400M = 60 points<br><br>$400M to less than $425M= 90 points<br><br>$425M to less than $450M = 120 points<br><br>$450M and more = 150 points<br><br>**Maximum Points: 150** |
| **RT 1.2** | The Bidder should demonstrate its experience, within the last 10 years of Bid Solicitation issuance date, in providing more than 5 different occupational groups in Canada as identified in the *Occupational Group Definition Map (Appendix A)* lasting a minimum period of 90 consecutive calendar days service per occupational group.<br><br>Occupational groups are those occupations identified in the *Occupational Group* column of appendix A (e.g. Air Operations, Auditing, Commence, Law Practitioner, Administrative | The experience can be demonstrated using one or more contracts of services rendered.<br><br>To demonstrate its experience, the Bidder should provide at least the following information for each client reference for which the experience meets the requirements of evaluation for this criterion:<br><br>1. Short description of the services provided to the client;<br><br>2. The period of time over which the service was provided, in a format including month | Points will be awarded as follows for demonstrated experience that meets the requirements of this criterion:<br><br>0 – 5 different categories = 0 points<br><br>6 different categories = 20 points<br><br>7 different categories = 40 points<br><br>8 different categories = 60 points |

| Number | Point Rated Technical Criterion | Bid Preparation Instructions | Weighting (Points) |
|---|---|---|---|
| | Services, Information Services, Nursing, General Labour & Trades, General Services, etc.). | and year information, e.g. from (month/year) to (month/year);<br><br>3. The occupational group(s) provided during the period mentioned in 2.; and<br><br>4. The name and contact information of the individual who would be able to confirm the information provided by the Bidder. | 9 different categories = 80 points<br><br>10 different categories and more = 100 points<br><br>**Maximum Points: 100** |
| **RT 1.3** | The Bidder should demonstrate its experience, within the last 5 years as of the Bid Solicitation issuance date, in the provision and management of more than 3,500 human resources. | The experience can be demonstrated using one or more contracts of services rendered.<br><br>To demonstrate its experience, the Bidder should provide at least the following information for each client reference for which the experience meets the requirements of evaluation for this criterion:<br><br>1. Detailed description of the provision and management services provided to the client, including occupational group(s).<br><br>2. The period of time over which the service was provided, in a format including month and year information, e.g. from (month/year) to (month/year)<br><br>3. The number of human resources provided during the period mentioned in 2.; and<br><br>4. The name and contact information of the individual who would be able to confirm the information provided by the Bidder. | Points will be awarded as follows for demonstrated experience that meets the requirements of this criterion:<br><br>0 to 3500 human resources = 0 points<br><br>More than 3500 to 3999 human resources = 30 points<br><br>4000 to 4499 human resources = 60 points<br><br>4500 to 4999 human resources = 90 points<br><br>5000 to 5499 human resources = 120 points<br><br>5500 or more human resources = 150 points<br><br>**Maximum Points: 150** |
| **RT 1.4** | The Bidder should demonstrate its experience, within the last 5 years as of the Bid Solicitation issuance date in providing a minimum of 5 human | The experience can be demonstrated using one or more contracts of services rendered. | Points will be awarded as follows for demonstrated experience that meets the requirements of this criterion: |

| Number | Point Rated Technical Criterion | Bid Preparation Instructions | Weighting (Points) |
|---|---|---|---|
| | resources per Canadian province or territory, for any duration of time. | To demonstrate its experience, the Bidder should provide at least the following information for each client reference for which the experience meets the requirements of evaluation for this criterion:<br><br>1. Short description of the services provided to the client;<br><br>2. The period of time over which the services were provided, in a format including month and year information, e.g. from (month/year) to (month/year;<br><br>3. The number of human resources provided during the period mentioned in 2., per Canadian province or territory; and<br><br>4. The name and contact information of the individual who would be able to confirm the information provided by the Bidder. | 0 to 1 Canadian provinces or territories = 0 points<br><br>2 Canadian provinces or territories = 10 points<br><br>3 Canadian provinces or territories = 20 points<br><br>4 Canadian provinces or territories = 30 points<br><br>5 Canadian provinces or territories = 40 points<br><br>6 Canadian provinces or territories = 50 points<br><br>7 Canadian provinces or territories = 60 points<br><br>8 Canadian provinces or territories = 70 points<br><br>9 Canadian provinces or territories = 80 points<br><br>10 Canadian provinces or territories = 90 points<br><br>11 or more Canadian provinces or territories = 100 points<br><br>**Maximum Points: 100** |
| **RT 1.5** | The Bidder should have a minimum of 60 months of experience, within the last 10 years as of the Bid Solicitation issuance date, in the provision of Health Care Providers for a total value of more than $25M for the 5 year period. | The experience can be demonstrated using one or more contracts of services rendered.<br><br>To demonstrate its experience, the Bidder must provide at least the following information for each | Points will be awarded as follows for demonstrated experience that meets the requirements of this criterion:<br><br>0 to less than $25M = 0 points |

| Number | Point Rated Technical Criterion | Bid Preparation Instructions | Weighting (Points) |
|---|---|---|---|
| | Provision of Health Care Providers (HCPs) includes the recruiting, hiring and associated service delivery administration functions and activities.<br><br>For the purpose of this evaluation an HCP is a professional working in one of the occupations identified in the Occupational SH or SV Groups of appendix A that are considered an HCP for the purpose of this evaluation (e.g. Medicine, Nursing, Psychology, Social Work, Hospital Services, etc.). | client reference for which the experience meets the requirements of evaluation for this criterion:<br><br>1. Short description of the health services provided to the client, including the occupational group(s);<br><br>2. The period of time over which the service was provided, in a format including month and year information, e.g. from (month/year) to (month/year);<br><br>3. The contract value for the HCPs provided during the period mentioned in 2.; and<br><br>4. The name and contact information of the individual who would be able to confirm the information provided by the Bidder. | $25M to less than $50M = 30 points<br><br>$50M to less than $75M = 60 points<br><br>$75M to less than $100M = 90 points<br><br>$100M to less than $125M = 120 points<br><br>$125M and more = 150 points<br><br>**Maximum Points: 150** |
| **RT 1.6** | The Bidder should demonstrate its experience within the last 5 years of Bid Solicitation issuance date in providing and managing different Occupational Sub-Groups of HCPs. Each HCP must have been provided for a minimum period of 90 consecutive calendar days of service per category.<br><br>For the purpose of this evaluation an HCP is a professional working in one of the occupations identified in the *Occupational SH or SV Groups* of appendix A that are considered an HCP for the purpose of this evaluation (e.g. Medicine, Nursing, Psychology, Social Work, Hospital Services, etc.). | The experience can be demonstrated using one or more contracts of services rendered.<br><br>To demonstrate its experience, the Bidder should provide at least the following information for each client reference for which the experience meets the requirements of evaluation for this criterion:<br><br>1. A detailed description of HCP provision and management services provided to the client.<br><br>2. The period of time over which the services were provided, in a format including month and year information, e.g. from (month/year) to (month/year;<br><br>3. The list of Occupational Sub-Group of HCP(s) provided during the period mentioned in 2.; and | Points will be awarded as follows for demonstrated experience that meets the requirements of this criterion:<br><br>0 category of HCPs = 0 points<br><br>1 category of HCPs = 30 points<br><br>2 different categories of HCPs = 60 points<br><br>3 different categories of HCPs = 90 points<br><br>4 different categories of HCPs = 120 points<br><br>5 and more different categories of HCPs = 150 points |

| Number | Point Rated Technical Criterion | Bid Preparation Instructions | Weighting (Points) |
|---|---|---|---|
| | | 4. The name and contact information of the individual who would be able to confirm the information provided by the Bidder. | **Maximum Points: 150** |
| **RT 1.7** | The Bidder should demonstrate its experience, within the last 5 years as of the Bid Solicitation issuance date in providing a minimum of 1 Health Care Provider (HCP) per Canadian province or territory, for any duration of time.<br><br>For the purpose of this evaluation an HCP is a professional working in one of the occupations identified in the Occupational SH or SV Groups of appendix A that are considered an HCP for the purpose of this evaluation (e.g. Medicine, Nursing, Psychology, Social Work, Hospital Services, etc.). | The experience can be demonstrated using one or more contracts of services rendered.<br><br>To demonstrate its experience, the Bidder should provide at least the following information for each client reference for which the experience meets the requirements of evaluation for this criterion:<br><br>1. Short description of the Health services provided to the client;<br><br>2. The period of time over which the services were provided, in a format including month and year information, e.g. from (month/year) to (month/year;<br><br>3. The list of provinces and territories where the services were provided during the period mentioned in 2.;<br><br>4. The list of Occupational Sub-Group of HCP(s) provided during the period mentioned in 2.; and<br><br>5. The name and contact information of the individual who would be able to confirm the information provided by the Bidder. | Points will be awarded as follows for demonstrated experience that meets the requirements of this criterion:<br><br>0 to 1 Canadian province or territory = 0 points<br><br>2 Canadian provinces or territories = 10 points<br><br>3 Canadian provinces or territories = 20 points<br><br>4 Canadian provinces or territories = 30 points<br><br>5 Canadian provinces or territories = 40 points<br><br>6 Canadian provinces or territories = 50 points<br><br>7 Canadian provinces or territories = 60 points<br><br>8 Canadian provinces or territories = 70 points<br><br>9 Canadian provinces or territories = 80 points<br><br>10 Canadian provinces or territories = 90 points |

| Number | Point Rated Technical Criterion | Bid Preparation Instructions | Weighting (Points) |
|---|---|---|---|
| | | | 11 or more Canadian provinces or territories = 100 points<br><br>**Maximum Points: 100** |
| **RT 1.8** | The Bidder should demonstrate its experience, within the last 5 years as of the Bid Solicitation issuance date, in providing and managing Health Care Providers (HCPs) in at least 1 of the Canadian provinces or territories for shorter periods of time referred to as short term requirements.<br><br>For the purpose of the evaluation of this criterion, short term requirements are those planned non-recurring requirements where the duration of the Task Authorization requirement is 30 days or less.<br><br>For the purpose of this evaluation an HCP is a professional working in one of the occupations identified in the Occupational SH or SV Groups of appendix A that are considered an HCP for the purpose of this evaluation (e.g. Medicine, Nursing, Psychology, Social Work, Hospital Services, etc.). | The experience can be demonstrated using one or more contracts of services rendered.<br><br>To demonstrate its experience, the Bidder should provide at least the following information for each client reference for which the experience meets the requirements of evaluation for this criterion:<br><br>1. Short description of the provision and management services provided to the client, including HCP Occupational Sub-Group(s);<br><br>2. The period of time over which the service was provided, in a format including month and year information, e.g. from (month/year) to (month/year;<br><br>3. The number of human resources provided during the period mentioned in 2., per Canadian province or territory; and<br><br>4. The name and contact information of the individual who would be able to confirm the information provided by the Bidder. | Points will be awarded as follows for demonstrated experience that meets the requirements of this criterion:<br><br>0 HCPs = 0 points<br>1 to 9 HCPs = 10 points<br>10 to 14 HCPs = 20 points<br>15 to 19 HCPs = 30 points<br>20 to 24 HCPs = 40 points<br>25 HCPs and more = 50 points<br><br>**Maximum Points: 50** |
| **RT 1.9** | The Bidder should demonstrate its experience, within the last 5 years as of the Bid Solicitation issuance date, in providing newly sourced HCP resources in less than 30 calendar days, for any duration of time in Canada. A newly sourced HCP resource is defined as an HCP resource that was not previously under a contract with the Bidder at the time the HCP resource was requested. | The experience can be demonstrated using one or more contracts of services rendered.<br><br>To demonstrate its experience, the Bidder should provide at least the following information for each client reference for which the experience meets the requirements of evaluation for this criterion: | Points will be awarded as follows for demonstrated experience that meets the requirements of this criterion:<br><br>0 HCPs = 0 points<br>1 to 9 HCPs = 10 points<br>10 to 14 HCPs = 20 points<br>15 to 19 HCPs = 30 points<br>20 to 24 HCPs = 40 points |

<table>
<tr><th>Number</th><th>Point Rated Technical Criterion</th><th>Bid Preparation Instructions</th><th>Weighting (Points)</th></tr>
<tr><td></td><td>For the purpose of this evaluation an HCP is a professional working in one of the occupations identified in the Occupational SH or SV Groups of appendix A that are considered an HCP for the purpose of this evaluation (e.g. Medicine, Nursing, Psychology, Social Work, Hospital Services, etc.).</td><td>1. Short description of the services provided to the client, including HCP Occupational Sub-Group(s);<br><br>2. The period of time over which the service was provided, in a format including month and year information, e.g. from (month/year) to (month/year;<br><br>3. The time response for the provision of HCP to the client, expressed in days;<br><br>4. The number of HCPs provided during the period mentioned in 2., ; and<br><br>5. The name and contact information of the individual who would be able to confirm the information provided by the Bidder.</td><td>25 HCPs and more = 50 points<br><br>Maximum Points: 50</td></tr>
<tr><td colspan="4">RT 2 BIDDER’S APPROACH AND METHODOLOGY - Maximum: 428 points, Minimum Pass Mark: 257 points</td></tr>
<tr><td>RT 2.1</td><td>Start-up Phase<br><br>The Bidder should describe its approach and methodology for meeting the requirements of the start-up phase.<br><br>The description should include the following components:<br><br>a) a list and description of Contractor start-up and set-up activities to complete the following milestones during the Contract Start-Up Phase to allow for orderly and timely set up:<br><br>(i) Contractor Central Office and Contractor Management Team set up; selection and hiring of the Service Delivery Manager and Deputy Service Delivery Manager;</td><td>The Bidder's bid should provide a sufficiently detailed description of its proposed approach to meet the requirements of criterion RT2.1 and demonstrate the Bidder’s understanding of DND, RCMP and VAC HCP requirements as defined in the SOW.</td><td>Points will be awarded as follows for the detailed description of the proposed approach that meets the requirements of this criterion:<br><br>For each of the elements addressed, points will be awarded in accordance with the rating scheme above and based on the following maximum of points.<br><br><table><tr><th>Component/ Sub-component</th><th>Maximum Points</th></tr><tr><td>a.</td><td>40 maximum</td></tr><tr><td>(i)</td><td>10</td></tr><tr><td>(ii)</td><td>10</td></tr><tr><td>(iii)</td><td>10</td></tr><tr><td>(iv)</td><td>10</td></tr><tr><td>b.</td><td>24</td></tr></table></td></tr>
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<tr><th>Number</th><th>Point Rated Technical Criterion</th><th>Bid Preparation Instructions</th><th>Weighting (Points)</th></tr>
<tr><td></td><td>(ii) Contractor’s Management approach and methodology and Contractor’s communications plan for the circulation to the public;<br>(iii) Timesheet Tool set up and conduct of a Timesheet Tool Demonstration for the DA’s; and<br>(iv) Credentialing approach and methodology.<br><br>b) the Contractor’s Senior Management structure for the Contract Start-Up Phase, including but not limited to: the Contractor’s Start-Up Phase management team; any oversight committees; or working groups to be established by the Contractor, etc. The structure should indicate where participation is required or may be requested from the TA, and what processes and procedures are recommended to ensure quick decision-making within the plan to facilitate the timely delivery of services.<br><br>For the purpose of evaluation of this criterion, the Start-up Period is defined as a period of approximately 6 months.</td><td></td><td><table><tr><td></td><td></td></tr></table><br>Maximum Points: 64</td></tr>
<tr><td>RT 2.2</td><td>Recruitment<br><br>The Bidder should describe their proposed approach and recruitment activities that will be completed in order to:<br><br>a) recruit the initial HCPs required at SED; and new HCPs requirements after the SED and during the In-Service Phase;<br><br>b) meet Cadet Training Centre HCP requirements;<br><br>c) meet short-term HCP requirements;<br><br>d) for urgent HCP requirements within the reduced Time To Provide timelines;</td><td>The Bidder's bid should provide a sufficiently detailed description of its proposed recruitment approach to meet the requirements of criterion RT2.2 and demonstrate the Bidder’s understanding of DND, RCMP and VAC HCP requirements as defined in the SOW.</td><td>Points will be awarded as follows for the detailed description of the proposed recruitment approach and methodology that meets the requirements of this criterion:<br><br>For each of the attributes addressed, points will be awarded in accordance with the rating scheme above, based on the following maximum of points.<br><br><table><tr><th colspan="2">Recruitment<br>150 Maximum Points</th></tr><tr><th>Attributes</th><th>Maximum Points</th></tr><tr><td>a.</td><td>35</td></tr></table></td></tr>
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<tr><th>Number</th><th>Point Rated Technical Criterion</th><th>Bid Preparation Instructions</th><th>Weighting (Points)</th></tr>
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<td>e) the pro-active recruitment strategies for HCP occupational groups and categories that may require an additional 30 calendar days for the Time to Provide;<br><br>f) the pro-active recruitment strategies for HCP occupational groups and categories that experience a higher requirement volume, including continuous and on-going advertising activities;<br><br>g) the replacement approach when HCPs are absent for an extended period of time;<br><br>h) the recruiting communications strategies for:<br><br>(i) promotional material development and distribution;<br><br>(ii) communication channels, streams, and methodologies; and<br><br>(iii) advertising plans and strategies; and<br><br>i) Contractor’s recruiting innovations.</td>
<td></td>
<td>
<table>
<tr><td>b.</td><td>20</td></tr>
<tr><td>c.</td><td>20</td></tr>
<tr><td>d.</td><td>10</td></tr>
<tr><td>e.</td><td>15</td></tr>
<tr><td>f.</td><td>15</td></tr>
<tr><td>g.</td><td>10</td></tr>
<tr><td>h.<br>(i)<br>(ii)<br>(iii)</td><td>15 maximum<br>5<br>5<br>5</td></tr>
<tr><td>i.</td><td>10</td></tr>
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<tr><th>Number</th><th>Point Rated Technical Criterion</th><th>Bid Preparation Instructions</th><th>Weighting (Points)</th></tr>
<tr><td>RT 2.3</td><td>Retention<br><br>The Bidder should describe its approach for the retention of its human resources, and include its practices for:<br><br>a. its current retention practices;<br><br>b. innovative ways to retain its human resources in addition to its current practices;<br><br>c. continuing professional education and training;<br><br>d. roles and regulations;<br><br>e. retention strategies for outgoing phase; and<br><br>f. salary innovation including benefit packages.</td><td>The Bidder's bid should provide a sufficiently detailed description of its proposed retention approach to meet the requirements of criterion RT2.4 and demonstrate the Bidder’s understanding of DND, RCMP and VAC HCP requirements as defined in the SOW.</td><td>Points will be awarded as follows for the detailed description of the proposed retention approach and methodology that meets the requirements of this criterion:<br><br>For each of the attributes addressed, points will be awarded in accordance with the rating scheme above, based on the following maximum of points.<br><br><table><tr><th colspan="2">Retention<br>150 Maximum Points</th></tr><tr><th>Attributes</th><th>Maximum Points</th></tr><tr><td>a.</td><td>35</td></tr><tr><td>b.</td><td>45</td></tr><tr><td>c.</td><td>30</td></tr><tr><td>d.</td><td>5</td></tr><tr><td>e.</td><td>5</td></tr><tr><td>f.</td><td>30</td></tr></table></td></tr>
<tr><td>RT 2.4</td><td>Risk Management<br><br>The Bidder should provide what it perceives as the 3 most significant risks associated with each Phase of the Contract, in relation to the stated requirements in the SOW.<br><br>The Bidder’s response should:<br><br>a. list and identify the 3 most significant risks in each of the Contract Phases;<br><br>b. provide a short description of each risk;<br><br>c. provide a Risk Analysis (Probabilities and Effects) and Risk Assessment of each of the three risk in each Contract phase; and</td><td>The Bidder's bid should provide a relevant and sufficiently detailed description of its proposed Risk Management approach to meet the requirements of this criterion and demonstrate the Bidder’s understanding of DND, RCMP and VAC HCPs requirements as defined in the SOW.</td><td>Points will be awarded as follows for the detailed description of the proposed Risk Management approach and methodology that meets the requirements of this criterion:<br><br>For each of the attributes addressed, points will be awarded in accordance with the rating scheme above, based on the following maximum of points.<br><br><table><tr><th colspan="2">Risk Management<br>64 Maximum Points</th></tr><tr><th>Attributes</th><th>Maximum Points</th></tr><tr><td>a.</td><td>20</td></tr><tr><td>b.</td><td>4</td></tr></table></td></tr>
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| Number | Point Rated Technical Criterion | Bid Preparation Instructions | Weighting (Points) |
|---|---|---|---|
| | d. provide a Risk Response (Avoid, Transfer, Mitigate, and Accept) of the three risks in each Contract Phase. | | c. 20<br>d. 20 |

**ATTACHMENT 2 TO PART 4**

**PRICING SCHEDULE A**

**(ATTACHED)**

**ATTACHMENT 2 TO PART 4**

**PRICING SCHEDULE B**

**(ATTACHED)**