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Chief Review Services

REVIEW OF CF MEDICAL SERVICES – EXECUTIVE SUMMARY AND ACTION PLAN RESULTING FROM THE CDS TASK FORCE

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EXECUTIVE SUMMARY TO THE CRS REVIEW OF MEDICAL SERVICES

Background

1. In January 1999, at the request of the CDS, the Chief Review Services undertook a review of the provision of in-garrison medical services in the CF. The team was specifically tasked to examine the issues of *Continuity of Care* and the *Administration of Temporary Medical Categories,* as well as to examine other issues relating to the provision of care to CF members. The scope of this review has been restricted to in-garrison medical care delivered to Regular Force CF members and did not address medical matters relating to the Reserve Force, delivery of medical care in operations, or the delivery of dental services in the CF.

2. The Canadian Forces Medical Service (CFMS) has been on a journey of renewal and reengineering which began in 1990 when deficiencies in the operational deployability of its medical service were identified. Ten years later the CFMS can be characterized as a change-fatigued organization which has taken significant steps towards improving its operational focus while coping with downsizing, budget reductions and striving to maintain a high level of in-garrison care. The Op Phoenix reengineering exercise that began in 1994/95 was the principal architect of the restructured CFMS and provided the blue print to bring a greater operational focus to the medical services.

3. A basic premise of the Op Phoenix concept was to place greater reliance on the public sector health care systems to secure in-garrison medical care. However, concurrent with the downsizing and reengineering activity that was taking place in the CF, the civilian health care system was also experiencing a similar restructuring process. As a result, the CF was faced with the requirement to obtain many of its services from a system that was experiencing challenges of its own and under public scrutiny for the way it is delivering health care services.

Major Findings

4. Overarching Issues Impacting the Delivery of In-garrison Medical Care. There are two significant overarching issues impacting the delivery of in-garrison medical care. It was noted early in the review that significant regional differences exist across the country and hence, rather than taking a 'one size fits all' approach to addressing the in-garrison needs of CF members, corporate strategies need to be interpreted and tailored to meet local circumstances. As well, issues related to delivery of in-garrison medical services identified in the CFMS are closely interrelated and improvements in one functional area will have a ripple effect and alleviate other problems. Similarily, problems that are not attended to will worsen and possibly contribute to other problems.

5. Strategic Direction. The CFMS is currently operating without strategic direction. An impact of operating without that direction is high levels of staff frustration. As staffs are working hard for the organization, they are questioning how their efforts fit within an overall strategy for the Branch and how they can contribute to the accomplishment of goals that they are not aware of. As well, units in the field are looking for broad guidance to assist them in better managing their respective medical facilities.

6. Concept of Operations. While there is well-founded logic supporting the concept of operations for the CFMS, it is not yet working effectively for a range of reasons discussed throughout the report. Two of those reasons include a complex command and control structure without having internal mechanisms to ensure that it functions well, and the fact that the primary means of delivering in-garrison services was changed without ensuring that adequate mechanisms were in place to provide for the continuity of a comprehensive health care delivery system.

7. Standard of Care. Although excluded from provincial health care insurance plans, the Canada Health Act (1984) mandates that members of the CF receive the same level of health care services as all Canadians. Due to the reliance on the civilian health care sector for medical treatments and services that cannot be provided by in-garrison facilities, CF members receive a portion of their health care in the same manner as members of the public. Similarly, provincial licensure requirements for CF medical officers and extensive use of civilian physicians on contract to the CFMS ensure that professional standards are consistent with the public sector. The CFMS Spectrum of Health Care Document provides CF members with a range of medical services which are more comprehensive than the publicly funded provincial systems, while also providing for the unique aspects of CF occupational medicine along with other services such as over-the-counter medicines, therapy services etc. However, significant patient concerns exist in the areas of timeliness and access to medical services, regional inconsistencies in levels of service and the manner in which in-garrison care is being delivered as a result of a focus on operational responsibilities. CF members have expressed particular frustration with poor administration relating to the delivery of their in-garrison medical care.

8. Continuity of Care. Continuity of care is a significant concern of the CF leadership and CF members. The review team saw significant evidence to indicate that where continuity of care has been weak, patient care has been negatively impacted. The CF is pursuing strategies similar to their allied counterparts in attempting to strengthen continuity of care through increased civilianization. Evidence indicates that leadership must assume a more prominent role in this aspect of medical care than it has in the past.

9. Administration of Temporary Medical Categories. The concepts on which temporary medical categories (TMC)s are premised are sound. When they are injured, CF members need to have an opportunity to heal and not risk further injury to themselves or endanger other members of their units. When members are assigned TMCs they are not consistently well-attended to administratively and at times they are ostracized by their units. Leaders need to play an active role to ensure that members on TMCs are not

mismanaged or inappropriately administered within the system. While judgement is required in each individual case timely attention to matters related to TMCs is required in order that the needs of the patient and the CF are appropriately provided for.

10. CFMS Organizational and Command and Control Issues. This is a very complex area for the CFMS. The rationale to change from pre-Op Phoenix organization structures is sound as these earlier organizations that were structured to deliver in-garrison care proved not to work well when medical personnel were required for deployment. The structure that is in place today is responding to the requirement to fulfill operational needs, but is awkward, at times difficult to manage and not consistently supportive of the effective delivery of in-garrison medical care. Standing up the capability to secure contract physicians through the Designated Provider Plan and putting in place service level agreements between CF medical facilities and operational units, should ameliorate some of the difficulties being experienced. In order to carry out the mandate assigned to the CFMS through the Op Phoenix review, the existing command and control structure remains the most practical one at this time. However, consideration should be given in 18 to 24 months to establishing a centralized health services organization for the long term benefit of delivery of in-garrison care to CF members.

11. CFMS Resources, Establishment and Staffing. Making informed, objective judgements on the adequacy of the resourcing of the CFMS is difficult because of the current and prolonged high tempo of operations, unavailability of workload statistics since the discontinuance of that data gathering capability, significant numbers of unfilled billets and lack of an effective system for backfilling medical officers with civilian replacements. There is a preponderance of medical personnel with clinician skills performing management and administrative roles in the CFMS. At a time when certain clinician trades are operating short of establishment (medical officers and medical assistants) the resourcing question is broader than one of sufficiency, but extends to how appropriately and effectively the resources available are being applied.

12. Recruitment and Retention of Medical Officers. Staffing of medical officer positions is approaching critical levels (70 per cent vacancy forecasted by FY 2001) as recruitment of new general duty medical officers (GDMO)s into the Medical Officer Training Program (MOTP) is decreasing while the rate of attrition is rising (approaching 80 per cent attrition at the end of the obligatory period of service). The combination of these two trends is creating critical shortages of practicing MO clinicians. While the CFMS is pursuing strategies to increase recruitment, the effectiveness of which remain to be seen, little has been done to actively retain MOs. Recommendations in this report strive to address this problem.

13. Morale, Attitude and Capacity for Change. Morale in the CFMS is generally low. A significant factor contributing to low levels of morale is a widespread sentiment that the medical service is in a downward spiral, which is felt by clinicians and administrators alike and fed back to CFMS personnel during patient contacts. Attrition is high, particularly among MOs. Negative feedback reported in the media, government reports, and Standing Committee on National Defence and Veterans Affairs

(SCONDVA) hearings has further contributed to a decrease in morale amongst CFMS staff. Highly stressed professionals and support staff, wondering about the organization's strategic direction, fatigued by seemingly endless process changes and heavy workloads with little end in sight, are showing the strain through their attitude towards their work and patient care. While this group is left with little reserve capacity for change, further change is required. It will only be through significant assistance and support from the Branch, departmental leadership, and other sources that this group will be able to carry on to accomplish what remains to be done to address current deficiencies in the delivery of in-garrison care.

14. Administration of In-garrison Patient Care. CF patients closely associate the administration related to their care to the actual quality of care they are receiving. In many cases patients felt that they had been let down by the system's inability to staff in-garrison facilities with civilian doctors (continuity of care), physicians consumed with paper work during appointments rather than delivering care, patient records getting lost, incomplete files, lab test results going astray, and patient files not arriving in time for specialist consultations. Also, members attending civilian clinics when military medical facilities are not available are having to deal with administrative problems such as civilian clinics demanding cash payments for services rendered to CF patients. While some of these problems are being addressed by the CFMS, the review team offers recommendations and strategies to address others. Solutions being developed by the CFMS do not assure immediate fixes. Accordingly, in the interim, the patient continues to experience frustration and inconvenience with a consequent loss of trust and confidence in their medical system.

15. Migration of Ideas. The CFMS is comprised of a series of organizational and occupational stovepipes. These stovepipes interfere with the migration of ideas. The CFMS needs to take specific steps and actions in order to cross these boundaries and make sure good ideas and experiences with ideas that haven't worked so well, are shared within and across organizations. With high staff turnover, unfilled established positions and lack of depth in organizations due to staff reductions, there is no longer the opportunity for all CFMS personnel to learn by trial and error on their own. The regular sharing of ideas is critical to the future effectiveness of the CFMS. The sharing of ideas, knowledge, experiences and solutions to health care issues is critical within such a small cadre of health care professionals to ensure the ongoing effectiveness of the CFMS. It will be the responsibility of the leadership and senior management of the medical service to facilitate and encourage forums for the migration of ideas across the Branch.

16. Information Management and Information Technology. The CFMS does not yet have a centrally driven IM/IT system to support the delivery of in-garrison care. Similar systems are still in their infancy in the civilian sector with none known to be fully functional at this time. The CF has security implications to consider as it moves increasingly towards interfacing with the civilian sector. The *Migration of Ideas* concept offers the opportunity for sharing of interim IM/IT solutions that have been developed at the local level to bridge the gap between the present situation and the time that a corporate level CF IM/IT system is put in place.

17. New Initiatives. The CFMS, in cooperation with organizations within and outside the CF, is at various stages of implementing a range of new initiatives intended to better meet the service members' in-garrison medical needs. The CFMS and its various partners should be recognized for the important contributions that they are or will be making in these areas. From the perspective of improving the management of in-garrison care, the review team sees enormous potential for Staff Assistance Visits, under the direction of CFMG HQ, to identify potential site specific improvements and serve as a catalyst for the migration of ideas across CFMS MOCs and organizations. Other important initiatives identified in the report are:

- Designated Provider Plan - a mechanism to assist the member and health care providers to secure health information and medical services from the civilian sector;

- DND/Veterans Affairs Canada (VAC) Centre for the Support of Injured and Retired Members and their Families - a point of liaison to assist members in their transition from being cared for by the military to obtaining services from VAC and other organizations;

- CF 98 Report on Injuries and Immediate Death - measures being taken to ensure the completeness and availability of this form when members need to seek pension benefits related to medical problems;

- Canadian Forces Member Assistance Program (CFMAP) - a confidential program focused on assisting members who have been victims of harassment, sexual assault or sexual harassment to seek timely psychosocial assistance;

- Operational Behavioural Sciences Centres - 5 centres located across Canada where members with illnesses or normal reactions to abnormal situations can go to receive confidential assistance. Post traumatic stress disorder is an illness that is highly prevalent in the military today and will be treated at these centres; and

- Information Guide for CF Health Services - a single guide that provides a comprehensive information package to members to assist them in understanding their medical entitlements and advising how to access them.

18. Benchmarking. The CF medical service was benchmarked with those services provided by three allied countries - United Kingdom, New Zealand, and the United States. There is a general trend among militaries to extract themselves from the business of running hospitals and partner more with the civilian sector. Other countries are experiencing similar recruitment and retention problems of MOs as the CFMS. There are also differing strategies being pursued such as the US primary care manager concept for

strengthening in-garrison care. Just as migration of ideas is important within DND/CF, the CFMS must also look to our allies to see if there are successful approaches being pursued by them which would be applicable in the Canadian context.

Overall Conclusions

19. The CFMS, staffed for the most part by highly skilled, fully competent, dedicated and committed military and civilian personnel, is a fatigued organization without clear strategic direction and perceived by some to be in a downward spiral. The CFMS has been downsized, restructured, reengineered, suffered high levels of attrition and turnover, and is experiencing consequent low levels of morale and diminished attitudes reflected in the service being offered to patients seeking in-garrison medical care. It is an organization with little reserve capacity for further change.

20. Recognizing that the CFMS has already been through dramatic changes in recent years, the review team has endeavored to offer meaningful and relevant recommendations, and an action plan which was developed by a special CDS Task Force has also been included in this report. The recommendations and action plan are intended to address correctable deficiencies and proposing more general strategies for approaching the issues where solutions are less clear. Making recommendations that would result in more radical outcomes, with potentially debatable benefits, could run the risk of negating some of the positive work done under Op Phoenix, and throwing an already stressed organization into further turmoil. The review team offers its suggestions and recommendations in the spirit of assisting the CFMS to make a strengthened contribution to the quality of life of CF members through its critical role of providing medical services.

PART 1 - CONCLUSIONS AND RECOMMENDATIONS RESULTING FROM THE CRS REVIEW

Conclusions Related to Strategic Direction

1.1 The review team has concluded that:

a. providers of health care services within the CFMS do not feel there is a clearly articulated strategic direction for the provision of medical services in the CF;

b. lack of strategic direction has left a change-fatigued CFMS wondering what the long term plan for the organization is and what are its strategic priorities for getting there;

c. development of strategic direction requires a thoughtful, interactive, iterative process that fully engages those who are clients, stakeholders and deliverers of the program; and

d. CFMS staff need to know that that this process is in train, that they will have an opportunity to contribute to the plan and that there will be comprehensive communications on the outcome of strategic direction for the Branch.

Recommendations Related to Strategic Direction

1.2 The review team recommends that:

a. steps be taken without delay to put in place a process to develop strategic direction for the CFMS Branch;

b. a communication strategy be developed to inform all members of the CFMS of the objectives and process related to formulation of 'Strategic Direction'; and

c. the casting of strategic direction be an exercise that is inclusive of all aspects of Health Services and not restricted to medical services.

Conclusions Related to the Impact of Op Phoenix on In-garrison Care

1.3 The review team has concluded that:

a. implementation of Op Phoenix has had both positive and negative impacts;

b. from a positive perspective, putting in place aspects of Op Phoenix, such as accessing services from the civilian sector, has educated the CFMS on challenges that may not have been fully appreciated at the planning phases of the reengineering effort; and

c. on a more negative note, there has been a partial and fragmented approach to implementation of the Op Phoenix concepts. The process, which has been extended over a prolonged period of time, and is not yet complete, has been very difficult for medical service providers and their clients to the point that issues of morale and trust are surfacing in significant ways. The result has been an erosive effect in these areas from which the review team believes it will take the CFMS considerable time to recover.

Conclusions Related to the Standard of Health Care Provided to CF Members

1.4 The review team has concluded that:

a. the CFMS, through its enabling documentation (QR&Os) and Spectrum of Care publication, has the authority to provide health care services which, at a minimum, are comparable to those offered under provincial health care plans;

b. in areas relevant to the occupational aspects of the CF, the comprehensiveness of medical coverage actually exceeds that provided to "insured Canadians";

c. focus group and interviewee responses acknowledge this coverage, but indicate that the CFMS falls short in the delivery of this capability due to administrative burdens, the perceived decline in service levels due to delays imposed by interfacing with provincial health systems, and customer service levels offered by the CFMS; and

d. from a medical skills, health treatment and spectrum of care perspective, the CFMS is comparable to provincial health care services available to all Canadians. However, the manner in which these services are delivered to the CF member appears to fall short of the civilian health care sector. As determined by the Review Team through interviews and focus groups, CF medical personnel have collectively admitted to a low level of morale

coupled with a lack of professional challenge, which has contributed to an approach to their work reflected in patient care and the patients' perception of the care they are receiving.

Recommendations Related to the Standard of Health Care Provided to CF Members

1.5 The review team recommends that:

a. CFMS professional medical staff be given clear direction on the level of care that they are expected to provide in-garrison. This would include a statement on the scope and range of services that are to be provided;

b. process re-engineering be conducted at the Health Care Centre/Base Clinic-level to evaluate current administrative procedures and, where they are lacking, make necessary adjustments to improve customer service at all in-garrison clinical settings;

c. an option for trans-regional accessibility to civilian health care treatment be made available to CF patients in order to align operational and medical priorities with optimal availability of care to reduce access delays. Judgements on making trans-regional treatment available to members should be made on a case by case basis;

d. appoint an external organization to conduct independent audits of CF health care facilities (in addition to the Staff Assistance Visits (SAVs) conducted by CFMG/DGHS staff) to measure and benchmark delivery standards; and

e. consideration be given to seeking provincial certification/accreditation of CF health care facilities from the Canadian Council on Health Service Accreditation to assure CF patients of comparable care to that which is available through provincial / civilian sector facilities.

Conclusions Related to Continuity of Care

1.6 The review team has concluded that:

a. continuity of care is a fundamental concept in the practice of family medicine and is not perceived as being delivered to the extent that it could or should be in the CF;

b. allied military and paramilitary organizations are implementing similar strategies to those being pursued by the CFMS by striving to improve continuity of care for their personnel through greater use of civilian medical resources. There are other strategies that some of the allies are

implementing in addition to civilianization that may warrant consideration by Canada. It would be worthwhile for the CFMS to be aware both of initiatives that worked for other defence forces and those that didn't, in order to derive maximum benefit from these other experiences;

c. achieving continuity of care is generally considered by the medical profession to be more important in the treatment of chronic cases than in the treatment of ailments of a more routine nature; and

d. the extent to which continuity of care is not achieved in the military impacts patient morale and, at times, threatens the quality of care being received.

Recommendations Related to Continuity of Care

1.7 It is recommended that:

a. initiatives to facilitate the hiring of civilian physicians for temporary and indeterminate assignments, such as the Designated Provider Plan and other strategies, be pursued as a matter of priority;

b. strategies that other nations have pursued (e.g., primary care manager in the US military) be examined for their applicability either site-by-site or on a more national basis in the CFMS;

c. Surgeon General highlight for all CFMS staff through the Branch Newsletter, personal site visits, the Defence Information Network web site, and other venues, the importance of achieving continuity of patient care to the extent practical and implementable in the in-garrison setting, with the highest priority being placed on members with chronic ailments;

d. procedures be developed at health care centres which will optimize the opportunity to provide continuity of care to the patient and implement CFMO 27-02 to the maximum extent possible;

e. steps be taken to ensure that continuity of care is featured as a curriculum item in all CF courses that have application to clinical and administrative matters relating to the delivery of in-garrison care; and

f. CFMS personnel and leaders in the operational chain of command be reminded of their leadership responsibilities to support CF members in receiving continuity of medical care.

Conclusions Related to the Administration of Temporary Medical Categories

1.8 The review team has concluded that:

a. the temporary medical category concept is premised on sound rationale;

b. while the TMC process is sound, there are administrative aspects that could be improved upon for the benefit of the member and the CF;

c. patients who are currently on or who have been on TMCs, for the most part do not have a good understanding of the process;

d. members are distrustful of the TMC process from a career implications perspective;

e. members often feel ostracized by their peers and sometimes their superiors when they are assigned a TMC;

f. while members had varying views and opinions on how quickly they wanted decisions taken related to their TMCs, it is generally to the benefit of the member and the CF for these matters to be resolved in a timely way;

g. a combination of significant numbers of members assigned repeated TMCs and a sparing use of the medical patient holding list serves as a major frustration for COs who are trying to do the right thing for the patient, but must also accomplish the operational mission with reduced resources;

h. MOs may be subjected to pressures from members and more senior COs on decisions related to TMCs - these pressures pose significant ethical dilemmas for the MOs;

i. while lack of leadership involvement can be linked to a number of cases where the TMC process has not functioned as expected, COs and supervisors recognize that the process is an administrative one and they have a significant role to play to make sure it functions well;

j. IM/IT offers the potential to assist in the administration of TMCs and some standalone systems in the field are being developed, used and contributing to the administration of TMCs;

k. there are significant costs attached to having members on TMCs; and

l. to their credit, D Med Pol staff have made considerable progress in recent months to reduce the backlog of TMC files referred to NDHQ to manageable levels.

Recommendations Related to Temporary Medical Categories

1.9 The review team recommends that:

a. efforts be made to improve patient knowledge and awareness levels on temporary medical categories;

(1) all CFMS clinical staff should be knowledgeable on the TMC concept and process and be ready to answer frequently asked questions on TMCs; and

(2) supplies of the brochure recently issued by D Med Pol on TMCs should be made readily available in medical facilities where in-garrison care is provided to CF members and copies should be distributed freely to members;

b. leaders be sufficiently involved in the administration of TMCs so that the member is not administratively put off to the side, without sufficient supervision or support;

c. leaders fulfill their responsibilities to ensure that colleagues of the member on TMC are aware of the process and understand why TMCs are used;

d. as a general rule, decisions related to the administration of TMCs be taken in as timely a way as possible and practical, taking account of the best interests of the patient, the unit and the CF;

e. training venues that introduce MOs to the practice of medicine in the CF and address the concept of TMCs, make provision for educating the MO not only on mechanics of TMCs, but also on some of the related human resource dynamics; and

f. when Surgeon General and other CFMS personnel are briefing various forums of CF leadership, they take the opportunity to highlight leadership responsibilities related to TMCs and continuity of care.

Conclusions Related to Command and Control of Delivery of in-Garrison Care

1.10 The review team has concluded that:

a. lack of clarity of responsibilities, authorities and accountabilities is having an impact on the delivery of the care;

b. delivery of in-garrison health care is very dependent on the successful coordination and integration of the resources of three separate chains of command. This structure is highly influenced by personalities and differing priorities rather than organizational principles;

c. the current command and control structures within the CFMS hinder the DGHS / CO CFMG from providing corporate, strategic direction or leadership to the bulk of medical resources which belong to the environmental commands;

d. lack of unity of command by the HCC over resources providing in-garrison care impact the ability of the HCC to effectively administer the base health care facility and provide patient focused service; and

e. the existing mandate of the CFMS as provided for by the Op Phoenix concept is best served by the current structure, at this time.

Recommendations Related to Command and Control of Delivery of In-Garrison Care

1.11 It is recommended that:

a. the commitment of CFMG and Command resources in support of in-garrison patient care be stabilized. Service-level agreements between CFMG detachments, Command units and the CF medical facilities should be established to ensure minimum resource commitments in support of in-garrison care;

b. improvements to the delivery of in-garrison care be achieved in the immediate timeframe through administrative, procedural and staffing adjustments rather than structural realignment of the function;

c. the responsibilities, authorities and accountabilities for the provision of in-garrison patient care be clarified between CFMG staff, Command staff, Base Commanders and Health Care providers;

d. HCC responsibilities focus solely on the provision of in-garrison care for CF members and the operation of the CF medical facility. Operational and other CF related medical issues that were formerly addressed by the Base Surgeon pre-OP Phoenix should be addressed by Command medical staffs; and

e. consideration be given in 18 to 24 months to establishing a centralized health services organization.

Conclusions Related to CFMS Resources, Establishment and Staffing

1.12 The review team has concluded that:

a. the provision of in-garrison health care services remains highly dependent on the availability of CFMS uniformed personnel. Arrangements with the public health care sector have not yet matured to meet the objectives envisioned by Op Phoenix;

b. workload and case load statistics and data are not being gathered to permit analysis to determine minimum staffing requirements for both uniformed and civilian health care providers;

c. a decrease in the number of physicians relative to the Canadian population has severely impacted the availability of and access to the public sector health care sector by the CF;

d. the ratio of the number of general practitioners and medical specialists (established positions) to the CF patient population, generally exceeds the ratios of similar occupations in the civilian sector;

e. attention to management and utilization of medical specialist resources, including staffing currently unfilled positions will yield greater benefits to the provision of in-garrison services than increasing the number of established positions;

f. the distribution of a CF population over a wide geographical area (coast to coast), may negate the benefit of having more favourable ratios of medical professionals to patient population than exist in the civilian sector;

g. the CFMS' capability to provide health care services is augmented by accessing services in the civilian sector, thereby increasing the leverage of a dedicated CF medical service;

h. shortfalls of personnel in the CFMS do not equate to insufficient established positions;

i. current shortfalls in the medical assistant occupational category will have a future impact on those medical specialist trades which draw on the medical assistant occupational category;

j. health care coordinators are lacking managerial and administrative training specifically to manage the CF medical facility function;

k. at a time when significant shortfalls are forecast in the availability of GDMOs to provide in-garrison care, greater involvement of the health care administrator in the role of managing activities in the CF medical facility function would optimize the availability of GDMOs for clinical duties; and

l. there is insufficient consideration of command leadership experience in the selection of candidates to fill senior management positions in the CFMS.

Recommendations Related to CFMS Resources, Establishment and Staffing

1.13 It is recommended that:

a. workload, caseload and other performance measurement data be gathered at all CF sites providing in-garrison medical care;

b. existing established CFMS positions be staffed before additional positions are authorized for the respective MOCs;

c. strategies be developed to address current shortfalls in the medical assistant occupation;

d. a two-pronged strategy be pursued to address managerial deficiencies in the CF medical facilities;

(1) HCCs be given appropriate management training before assuming the position and on-going training while they are in the post, and

(2) HCAs and HSOs located in the health care centres assume more of the administrative responsibilities related to delivery of in-garrison care, thereby freeing up clinical practice time of the health care coordinator.

e. position analysis statements of senior positions in the CFMS be examined by appropriate staffs to determine the skill sets required to perform the duties of the respective positions.

Conclusions Related to Recruitment and Retention of Medical Officers

1.14 The review team has concluded that:

a. as the attrition rate for MOs is significantly higher than historical averages, at the same time as little interest is being expressed in traditional entry venues (Medical Officer Training Program), the CFMS will be facing significant military physician shortages over the next several years;

b. the CFMS has a strategy for attracting direct entry officers and is implementing it; and

c. there is no specific strategy being pursued to retain CF medical officers, yet MOs have a range of concerns that could be addressed to make being an MO more attractive.

Recommendations Related to Recruitment and Retention of Medical Officers

1.15 The review team recommends that:

a. the effectiveness of the bonus that has been put in place to attract DEOs be assessed periodically. If it is determined not to be meeting the objective then it should be reassessed and alternate strategies developed;

b. strategies be pursued to ensure an equitable sharing of deployment assignments among GDMOs and specialist MOs;

c. the CFMS represent or otherwise support CF MOs in discussions with various provincial and territorial medical licensing bodies on an as required basis on matters unique to serving CF medical officers (licensing issues, maintaining billing numbers etc.);

d. with the assistance of expert consultant support, the CFMS undertake a study to determine appropriate ways of encouraging clinicians to make a career of practicing clinical medicine with the CF;

e. a validation of the training being provided to MOs be completed to ensure that:

(1) MOs are receiving sufficient and appropriate maintenance of competence and CME to meet their operational and in-garrison responsibilities, and

(2) complete training records are maintained and available to leaders who will be taking decisions on the deployment of MOs (trauma, burns, geriatrics, pediatrics etc.); and

f. the CFMS leadership examine ways to increase the profile of the contribution of MOs in the CF.

Conclusions Related to Morale, Attitude and Capacity for Change in the CFMS

1.16 The review team has concluded that:

a. low morale exists in the CFMS on a widespread basis, and is negatively impacting the attitudes of health care personnel in the clinical setting;

b. reasons for low morale are varied and include but are not restricted to:

(1) change fatigue being felt at all levels of the CFMS,

(2) lack of understanding where the organization is headed strategically,

(3) CFMS personnel sensing a lack of appreciation or understanding from the CF of the demands that have been placed on them,

(4) a perception that the corporate focus on health care has shifted from patient care to the task of implementing OP Phoenix,

(5) leadership concerns within the CFMS, and

(6) heavy workload, including in-garrison and operational responsibilities, to which there appears to be no end in sight; and

c. some CFMS personnel have expressed the view that they no longer have the reserves to continue to do their jobs and to cope with further change initiatives. While there are significant initiatives yet to be implemented to strengthen the provision of in-garrison care, the success of these initiatives will be dependent on the capacity of the CFMS health care professionals who must implement the changes necessary for the long term benefit of the CF.

Recommendations Related to Morale, Attitude and Capacity for Change in the CFMS

1.17 It is recommended that:

a. an assessment be made of the amount of assistance that will be required to enable implementation of the recommendations of the CRS review; and

b. the Department support the requirement, once validated, with appropriate financial and human resources.

Conclusions Related to the Administration of In-garrison Patient Care

1.18 The review team has concluded that:

a. patients take a holistic view of their medical care which includes the administration associated with it;

b. CF patients who experience poor administrative practices when receiving in-garrison medical care frequently interpret those problems as poor medical care being provided to the member;

c. not all health care centres have reasonable records management tools in place (Bradma Plates or equivalent) to reduce administrative workload and minimize opportunities for error;

d. lack of internal policy and procedural guidance on the handling of patient files has left CF in-garrison units with very wide latitude in this important process;

e. given the sensitive and very personal nature of medical information it is necessary that protocols be in place for the handling of patient files within the CFMS;

f. the high turnover of medical personnel flowing through the CF medical facilities, particularly Med As who are responsible for the administration and management of the files, has the potential to negatively impact on how files are managed;

g. placing greater responsibilities on the student for learning patient record management through self-study rather being trained under the guidance of an instructor has increased the risk that the Med A may not cover all of the material or, if they do, may not understand it all. While this may be an economical way to deliver the training, it may be less effective and this would never be known without an appropriate validation process;

h. patients' administrative needs are not consistently being provided for when visiting CF in-garrison facilities leaving members with a poor impression of the CFMS and consequently eroding their confidence and trust in the system serving them;

i. medical situations are arising that are not being readily provided for by either the CFMS or the civilian medical system;

j. while these issues may arise due to local circumstances that exist at a particular time similar problems are surfacing in multiple locations; and

k. while workable (not always ideal) solutions are generally found, the more that HCCs know about how others have handled similar situations, the better placed they should be to respond appropriately when required.

Recommendations Related to the Administration of In-garrison Patient Care

1.19 It is recommended that:

a. CF health care centres examine their internal administrative functions and processes to ensure that:

(1) such basic information management tools as Bradma Plates or equivalents are in place, and

(2) other mechanisms for streamlined processing of in-garrison patients are in place and functioning as intended;

b. the CF policy and procedural guidance on handling of patient records be made sufficiently clear and complete as to provide an appropriate level of protection for the documents, provide a reasonable degree of assurance of the integrity of the information contained there in and provide assurance to the member that their medical information is being adequately safeguarded while in the custody of the CFMS and civilian medical service providers;

c. standard operating procedures be put in place and kept up to date at all CF medical facility sites to assure consistent high quality administration supports the delivery of in-garrison medical care;

d. HCCs track medical incidents that have arisen that cannot be accommodated through CF in-garrison patient care arrangements or the civilian system. These incidents should be advised to Surgeon General for his / her information; and

e. sharing of how these experiences were handled should take place at forums where HCCs are brought together with migration of ideas being one of the objectives of the session.

Conclusions Related to Mechanisms for Obtaining Civilian Physician Services In-garrison

1.20 The review team has concluded that:

a. the decision to realign the CFMS organization structures to support a more operational focus without having systems in place to backfill MO positions with contract civilian physicians has placed an enormous burden on HCCs responsible for the delivery of in-garrison patient care;

b. this burden has in turn been passed on to military MOs who have not only had to respond to the demands of an increased tempo of operations, but have also had to make further personal sacrifices to ensure that patient care continues to be delivered in garrison (recalled from leave, leave cancelled, MO on TMC supposed to work half days working 12 to 14 hour shifts etc.); and

c. use of stop-gap measures for contracting civilian doctors has become a matter of routine in most CF medical facilities in most cases is unfair to the contract physician and contravenes accepted public service hiring practices as provided for in the Public Service Staff Relations Act. For many CF medical facilities the DPP is not scheduled for implementation for sometime.

Recommendations Related Mechanisms for Obtaining Civilian Physician Services In-garrison

1.21 It is recommended that:

a. the Surgeon General with the support of the CF, progress implementation of the DPP at CFMS in-garrison medical facilities across Canada as expeditiously as is reasonably achievable; and

b. pending implementation of the DPP, CF sites providing in-garrison care review the appropriateness of continued use of the DND 2058 form when engaging temporary civilian physicians. If a more appropriate mechanism cannot reasonably be put in place before inception of the DPP, then HCCs should, at the very least, advise civilian doctors currently on contract with the CF that the DPP is coming and what the implications of that change could mean for them.

Conclusions Related to Securing Specialist Services for Delivery of In-garrison Care

1.22 The review team has concluded that:

a. as a general practice, it would likely not be appropriate for DND/CF to be seen to be jumping the civilian sector queue by sending CF members to fee for service health care providers; and

b. there are strategies that could be pursued in order to obtain specialist services quickly under extraordinary circumstances. Two sources are through purchasing blocks of physician time and trans-regional treatment.

Recommendations Related to Securing Specialist Services for Delivery of In-garrison Care

1.23 It is recommended that:

a. statistics be gathered and analyzed to determine areas where the CF generates unusually high numbers of cases requiring certain specialty care from the civilian sector. Where regular patterns exist and there is difficulty securing that care then arrangements should be made to purchase block amounts of physician time; and

b. in non-emergency situations, on a case-by-case basis, assessments be made to determine if extraordinary steps should be taken to secure specialist care for the member, outside his or her geographical posting area, on a more timely basis than could be provided locally.

Conclusions Relating to Provision of First Responder Care In-garrison

1.24 The review team has concluded that:

a. while first responder care is a peripheral issue for the medical services branch, the fact that confusion exists among those responsible for provision of in-garrison care makes it an issue that could impact the level of patient care provided the soldier, sailor and air man or woman; and

b. the Surgeon General has a responsibility to provide medical advice to the CDS on the adequacy of the current arrangements for the provision of first responder care. He should be able to tell the CDS if the CF member is receiving first responder care that is equivalent to that being received by the average Canadian and, to the extent that it may fall short, the degree of increased risk for the member.

Recommendations Relating to Provision of First Responder Care In-garrison

1.25 It is recommended that:

a. Surgeon General be prepared to offer medical advice to the chain of Command, including Base Commanders, on matters related to the delivery of first responder care in-garrison;

b. as part of the staff assistance visits to CF in-garrison locations the Director Health Services Delivery include the adequacy of first responder care as an area to examine. Recommendations resulting from such assessments should serve as a point of discussion with the Base Commander, the Health Care Coordinator, Fire Chief and any local authorities that might be impacted. Appropriate actions should result based on the direction of the Base Commander; and

c. communication be issued at the base/wing/formation level explaining the local arrangements for delivery of first responder care.

Conclusions Related to Migration of Ideas

1.26 The review team concluded that:

a. there is little opportunity within the CFMS to readily share innovative ideas and solutions that would contribute to the efficient and effective delivery of in-garrison health care;

b. CFMS personnel are generating good ideas, particularly ones relating to data base management of patient information, and are putting those ideas into place at some sites. Sharing of these IM/IT ideas offers the opportunity for leveraging on ideas that have already been developed; and

c. the sharing of ideas will not occur on its own, but will require a deliberate effort in order to derive maximum benefit from this concept.

Recommendations Related to Migration of Ideas

1.27 It is recommended that:

a. CFMS personnel ensure that, when setting up training programs, workshops, conferences or other forums where branch members will be brought together, that some time is set aside for sessions where sharing of ideas could take place; and

b. the Staff Assistance Visit (SAV) capability that has recently been stood up in the Assistant Chief of Staff Health Services Delivery (ACOS HS Del) be utilized to the fullest extent possible as an impetus and catalyst behind the migration of ideas across the CFMS.

Conclusions Related to Information Management/Information Technology Support to CF Health Services

1.28 The review team has concluded that:

a. the CFMS does not have an adequate IM/IT system to provide real time knowledge of the health status of its operational units to support operational roles;

b. an integrated health information system is needed to support the CFMS due to the high mobility of the CF population, operational requirement for the health status of the CF, increased reliance on the civilian health care sector and the requirement to manage a uniform quality of health care delivery at all CF sites;

c. the CF in-garrison health care delivery models have not been adequately established and refined to facilitate the development of a CFMS IM/IT infrastructure;

d. increased integration between the CFMS in-garrison and the civilian health care sectors raises security issues as the CF has higher security standards for health information than the civilian sector; and

e. the ability of the CFMS to make appropriate management and resource allocation decisions has been constrained by the lack of available health care data, and workload volumes and statistics.

Recommendations Related to Information Management/Information Technology Support to CF Health Services

1.29 It is recommended that:

a. the in-garrison health care delivery model be established and be put in place to determine the necessary IM/IT support that will be required;

b. the CF develop policy related to acquiring, handling and release of health information for CF members both internally and externally;

c. the information requirements to support CF occupational health requirements be determined, along with the methods on how this information will be acquired and controlled;

d. the CFMS update and streamline business and management practices currently in use in order to streamline administrative processes and improve handling of patient information in the clinical setting;

e. CFMS business practices be adapted to take advantage of commercial off-the-shelf health care software applications to reduce design and development costs and facilitate integration with civilian health care providers;

f. plans be progressed to implement IM/IT solutions to support the CFMS that can be quickly put into place with the flexibility to meet changing requirements and conditions in both the CF and civilian health care sectors; and

g. a security risk assessment be conducted with regard to CF health information to facilitate the necessary links to the civilian health care sector.

General Conclusions Related to New Initiatives

1.30 The review team has concluded that:

a. the CF and the CFMS have recognized that their have been systemic deficiencies in DND/CF related to provision of in-garrison care and quality of life for members. By embarking on these new initiatives CF members should realize that their feedback has been heard and is being taken seriously;

b. putting these new initiatives in place is not an isolated CFMS effort, but rather calls for cooperation support and assistance from other areas of DND/CF and other government departments. One area where the CFMS was in particular need of support at the time of writing this report is from ADM (Mat) and PW/GSC procurement / contracting staffs to assist in progressing the DPP;

c. these new initiatives provide a start point down a long road to regaining the trust and confidence of CF members in the senior leadership's commitment to providing appropriate in-garrison medical care and taking significant steps to improve the service member's quality of life. Announcements and delivery of new initiatives will not be sufficient on their own. CF members not only expect high quality in garrison medical care they need to perceive that they are receiving it. Continuity of care, appropriate medical treatment and associated administration while on TMCs, proper management of their patient records, courteous professional treatment by staff providing direct and ancillary services related to in-garrison care all need an appropriate level of attention to assure required levels of patient trust and confidence; and

d. the CFMS and its associated CF and VAC partners deserve credit for pursuing initiatives that have proven to be successful in the civilian sector and recognizing their applicability for the military (e.g., the 1-800 call centre concept for triage and other patient assistance has been extremely popular and well-received in the province of New Brunswick and is now being looked at seriously for Ontario).

Conclusions Related to Benchmarking the Canadian Forces Medical System

1.31 The review team has concluded that:

a. there is a widespread reliance on the civilian health care sector by other military organizations to provide in-garrison medical care in order to preserve a capability to deploy uniformed medical personnel to support operational missions;

b. military medical establishments are primarily based on identified operational requirements, resulting in a need to supplement in-garrison care with civilian resources;

c. timely access to medical care is a major concern of the service member and remains a goal of the military health service;

d. socio/psychological issues, and strategies to deal with them, are a significant concern of military health services;

e. attrition of physicians is high (40 per cent to 80 per cent) after completion of obligatory service in all organizations benchmarked with the CFMS; and

f. all organizations included in the benchmarking review indicated their military medical organizations were involved in developing strategies and new initiatives in order to provide appropriate health care services to military members while preserving the capability to meet operational medical commitments.

PART 2 - ACTION PLAN RESULTING FROM THE CDS TASK FORCE

CDS Task Force - Health Care Support to the Canadian Forces
Putting the 'Care' back into 'Health Care'

EXECUTIVE SUMMARY

2.1 When the CDS was briefed on the draft CRS report on the Review of the Medical Services, he concluded that it could not be released without an accompanying action plan and leadership commitment to make it happen now. To develop the action plan, he assembled a Task Force comprised of military health care professionals and civilian advisors (Annex A). The Task Force went beyond the 59 CRS recommendations and addressed the areas that CRS had identified as requiring further study. The action plan produced contains hundreds of recommendations for action.

BACKGROUND

2.2 The picture painted by CRS is not a pretty one. Yet, it is clear that it is just the tip of the iceberg. The medical system is broken. When the Task Force finished reading the CRS report and completed its first week of in camera briefings, the members were overwhelmed. It did not matter where we looked, something was either badly broken or barely hanging on by a thread. It made us wonder when this was going to start having a serious impact on the Medical Service's ability to provide adequate operational health care support - assuming it did not already.

2.3 Before we move on, lets take a moment to reflect on the Canadian and Military standards of health care. We often hear that the Canadian standard of health care is one of the highest in the world. What is the Canadian standard? Is it the same in Tuktoyaktuk as it is in Toronto? Intuitively, we know that there is a significant difference between the standard available at these two locations. Yet, both are representative of the Canadian standard of care.

2.4 Even when the CFMS was considered 'rich and elitist', the military capability was falling short of the expected or assumed Canadian standard. Why? Because to be able to provide operational health care support where CF members happen to be, we employ some multi-skilled but unlicensed personnel, some of the drugs we administer are unlicensed, and not all of our medical equipment is CSA approved. For the most part, as a training vehicle, we operate in garrison as we do in operations. This is perfectly acceptable under federal statute.

2.5 Whereas before we were able to maintain the gap between the two capabilities at a reasonable level, the closure of CF Hospitals has caused the gap to widen sharply in the last few years. This is not to suggest that we should go back to the ways in which we used to operate. However, it presents a phenomenal challenge. On the one hand, the civilian trend is expected to be a positive one as new techniques, equipment and drugs are developed and implemented and, as governments reinvest significantly in what many consider to be an underfunded health care system. On the other hand, as unlicensed military personnel cannot work in civilian facilities to maintain clinical competence, the military downward trend is expected to continue and possibly accelerate as skills, knowledge and availability of certain groups of uniformed health care personnel continue to dwindle and deteriorate.

LEGAL BASIS FOR THE CF HEALTH CARE MANDATE

2.6 The CF health care mandate is to provide the health care support necessary to sustain a multi-purpose, deployable, combat capable force across the full spectrum of military scenarios.

2.7 Health is an amorphous field that is distributed to the federal or provincial level of government depending on the purpose and effect of the particular measure at issue. It is for this reason that section 91(7) of the Constitution Act, 1867, serves as the constitutional basis for the CF's health care mandate.

2.8 The 1984 Canada Health Act, the purpose of which is to set out the conditions under which the Federal Government will transfer health care money to the Provinces, explicitly defined CF members out of the definition of 'insured persons'. To have CF personnel included in the definition of 'insured persons' would require Parliament amending the Canada Health Act. The legislation of nine of the ten Provinces provides for the exclusion of anyone having entitlement to health care under federal statute. Furthermore, the legislation of Alberta, Saskatchewan and Prince Edward Island specifically exclude CF members and would also have to be amended accordingly.

2.9 To approach the provinces, the Department would require a bureaucratic and political consensus with Health Canada, PCO, Intergovernmental Affairs, TB, Finance, Corrections Canada, and the Solicitor General (on behalf of the RCMP). The Federal Interdepartmental Health Policy Committee, chaired by Health Canada, is the forum through which the required consensus would have to be reached.

2.10 In short, DND is legally bound to provide for the health care needs of CF members, at home or abroad, in a universal, portable, comprehensible, accessible and publicly administered way. How health care is provided to CF members is left to DND to determine.

RATIONALE FOR A UNIFORMED HEALTH CARE SERVICE

2.11 The physical and mental, health and fitness of CF members are inextricably linked to the readiness, effectiveness, and efficiency of the military as a fighting force. Before sending troops into harm's way, the Chain of Command must know, not only the physical and/or mental health limitations which may preclude successful completion of military tasks, but also the health and fitness levels and employment limitations of CF personnel. In addition, military training and operations frequently result in serious injuries necessitating immediate access to life-saving health care resources. The military itself is in the best, if not unique, position to provide the necessary timely care.

2.12 This is not to say that uniformed health care providers have to be able to do it all themselves. It is clear that for most of the CF member's career, health care will be provided through a partnership between civilian and uniformed health care providers. However, just as CF members have done, uniformed health care providers have made the informed choice that they would give up their individual rights and freedoms by placing 'Service before Self'. This premeditated decision of unlimited liability to serve, allows uniformed health care providers to serve CF members, anywhere and anytime. They can go where our civilian counterparts sometimes cannot go. They are trained and ready, as other CF members are trained and ready, to respond to our country's demands.

CONTINUITY OF CARE

2.13 Concern over continuity of care, or lack thereof, is the main issue that led the CDS to ask CRS to conduct a *Review of the Medical Services.*

2.14 We all agree, the broken minds and broken bodies that populate the CF require nurturing. Symptoms are complex, treatment regimes comprehensive. For CF members, the ability to establish a strong, stable therapeutic relationship with health care providers is vital. For DND, the responsibility to provide a minimum of 'continuity of care' is fundamental.

2.15 To provide continuity of care, especially in the many under-serviced areas where the CF operate, DND needs to provide a health care structure that offers a minimum of stability, that is accredited, and that is managed with clearly articulated direction and guidance.

2.16 How do we go about establishing a stable health care structure? First, the Task Force undertook to articulate the areas of health care where uniformed health care providers should concentrate their effort. Annex B summarises the outcome of that work. As you can see, civilian employees or contractual arrangements, especially at home, could take care of approximately 60 per cent of the mandated work. Who does the work right now? Often nobody. This affects all areas of health services delivery, at home and abroad. Civilian resources are required to offset these shortfalls.

2.17 Second, the Task Force undertook to articulate the essential in-garrison health care functions that, if provided in a stable environment by means of a core civilian capability, would have the greatest impact on continuity of care. Forces-wide, Certified Health Service Executives should manage clinics. The intent would be to create a network of Certified Health Service Executives to enhance accessibility, both locally and trans-regionally. In addition, there should be a number of civilian general practitioners, nurse practitioners, and/or care managers, at each site for the larger sites or in every region, to cater to those individuals who require more nurturing by virtue of the complexity of their medical conditions. Finally, core civilian personnel should perform the reception, appointment, medical records and patient tracking functions. Civilian resources, the number of which will be site specific, are required to offset current shortfalls and ensure continuity. Additionally, this presupposes the existence of hiring mechanisms that facilitate and support the process, and that ideally, would not see us competing against provinces for scarce health professionals.

2.18 Third, the Task Force tackled the standard of in-garrison health care. Evidence presented to the team indicates that the standard of in-garrison health care needs serious improvement. To address this concern, the team resolved to establish partnerships with the Canadian College of Health Service Executives and with the Canadian Council on Health Services Accreditation. The latter organisation surveys establishments and declares them 'Accredited' providing they meet a set of standards. The idea would be to confirm the standards, survey all sites to determine the capability gap and resource it, thus restoring the standard of in-garrison health care. We have yet to determine what resources will be required to offset these shortfalls.

2.19 Fourth, the Task Force considered other ways to enhance accessibility and relieve shortages such as the Designated Provider Plan. With the advent of the DNC/VAC MOU on 1 April 2000, the Designated Provider Plan will open up a network of caregivers to care for the health care needs of CF members. This will provide some relief, however, it will be of little help to those located in under-serviced areas.

2.20 Reservists are a primary pool of resources from which to draw to enhance accessibility and relieve shortages. Health care professionals, who join the Medical Reserve, hold the same licenses and train to the same standards as their Regular Force colleagues. In addition, they are networked or employed, often full-time, in the civilian health care sector. Significant benefits would accrue from the amalgamation of Reserve and Regular Force health care personnel into a unified military component of the total health care team.

2.21 Fifth, the Task Force considered the requirement for maintenance of clinical competence of health care providers. As indicated previously, the gap between the civilian and military health care capabilities is widening rapidly. The solution is to secure maintenance of clinical competence opportunities in the civilian community for uniformed health care providers. In partnership with the Canadian College of Health Service Executives, it is proposed to enlist the support of some of the largest Canadian health care organisations to secure maintenance of clinical competence opportunities. To

this end, we must move forward with the licensing of medical/physician assistants or with the development of a licensed alternative to this occupation. In addition, we must also find a way to deal with provincial-licensing barriers – another impediment we will have to overcome.

2.22 Finally, the Task Force considered the complexity of current command and control relationships and its impact on existing departmental vertical and horizontal accountability structures. It surmised that there is a need to centralise the capacity to command and control health care resources and develop the required accountability framework.

2.23 Health care concerns touch everyone, irrespective of service affiliations. Without healthy sailors, soldiers and air personnel, the CF cannot deploy. A corporate account has already been set up to finance the delivery of health services to CF members. Because of his ready access to the full spectrum of uniformed health care expertise, DGHS already does most, if not all of ADM (HR-Mil)'s health policy and managing authority work. The latter will be especially true with the Medical School becoming a unit of DGHS instead of CFRETS. DGHS is the joint force generator of the CF health care capability. He has to be able to support the navy and provide diving medicine support. He has to be able to support the army and provide operational health care support anywhere on the non-linear battlefield. He has to be able to support the air force and provide flight medicine support. Finally, by virtue of his unique role, DGHS has to be able to work at the strategic, operational and tactical levels. DGHS is in a unique position that argues for his becoming a Level One. Designating DGHS as a Level One in the NDHQ hierarchy would send CF members the key message of the importance DND attaches to health care issues.

KEY ENABLERS

2.24 Putting the 'care' back into 'health care' is a massive undertaking on par if not bigger than our Quality of Life initiative. It will take a lot of concerted effort and it will take time. What are the essential enablers to success? First, a Senior Review Board comprised of the CDS/DM and selected DMC members. Second, there is a requirement to create a PMO, with CRS oversight. Third, the Chain of Command must get involved in the design and implementation of command and control arrangements that will enhance the provision of the health care support necessary to sustain a multi-purpose, deployable, combat capable force across the full spectrum of military scenarios. Fourth, there is a need to partner with essential civilian health care organisations such as the Canadian College of Health Service Executives and the Canadian Council on Health Services Accreditation. Finally, there is a need for a strong Communications Approach, which has been developed by DGPA.

COMMITMENT

2.25 In the Task Force's opinion, it is not the work ethic, dedication or professionalism of Medical Branch personnel that resulted in the problems identified by CRS. Before restructuring, uniformed health care providers lacked operational focus, as they were too busy providing in-garrison health care. Post restructuring, uniformed health care providers found that they had fewer resources to provide in-garrison health care; an impossible command structure; a reduced and heavily scrutinised budget; a downsized and restructured civilian health care system, which they had planned to partner with; and sicker people to treat – reflective of the effect of multiple and often stressful deployments.

2.26 The proposed plan provides a well-reasoned strategy for delivery of '*Health Care – One standard, anytime, anywhere*'.

ANNEX A

CDS TASK FORCE - MEDICAL SUPPORT TO THE CF

Team Leader	-	Col Lise Mathieu, EA/CDS
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Team Support	-	Maj P. O'Grady, CFMG Ms J. Maloney, SO3/CDS

ANNEX B

PRIORITY OF EFFORT

Operational health care support 1. **Mil** 2. **Civ**

Health Prevention

Preventive Medicine General Hygiene Sanitation Pest Control Public Health/Mandated Programs	 **Civ** **Civ** **Civ** **Civ**	**Collectively – Mil**
Industrial Hygiene In-Garrison Deployed	 **Civ** 1. **Civ** 2. **Mil**	
Operational Medicine Flight Surg/Diving Medicine NBC Policy/Plans	 1. **Mil** 2. **Civ** 1. **Mil** 2. **Civ** **Mil**	
Infectious Disease Control	1. **Mil** 2. **Civ**	
Epidemiology/Disease Tracking	**Civ**	
Medical Intelligence	1. **Mil** 2. **Civ**	
Regulatory Affairs	**Civ**	
R & D	**Civ**	
Human Factors/Ergonomics	**Civ**	
PHE/Medical Category/Screening	1. **Mil** 2. **Civ**	
Immunization Policy R & D Delivery Program administration (records, etc.)	 1. **Mil** 2. **Civ** **Civ** **Civ** **Civ**	

Treatment 1. **Civ** 2. **Mil**

4. Health Promotion **Civ**