National Defence / Défense nationale

Chief Review Services / Chef - Service d'examen

CRS / CS Ex

Contracting for Professional Healthcare Services

September 2003

7055-42-3 (CRS)



Canada

CAVEAT

This Quick-Time review was conducted as a special project and was not included in the annual Chief Review Services Work Plan. The review conclusions do not have the weight of an audit or formal evaluation. While sufficient to enable the development of recommendations for consideration by management, the assessments provided and conclusions rendered, are not based on the rigorous inquiry, or evidence required, of an audit or program evaluation. Accordingly, they are not represented as such.

It should also be noted that the review is not intended to assess the performance of the contractor; rather it is an internal review of processes and practices within the DND/CF. The contractor has not been interviewed or otherwise asked to provide comment or feedback.

SYNOPSIS

In June 2003, the DND/CF required fast-tracked approval, through Public Works and Government Services Canada (PWGSC), to increase the ceiling on a contracting arrangement for health services at CF medical facilities. This was required because contract spending had reached its 3-year limit, after only two years, and timely authorization to increase the contract ceiling had not been sought or obtained. Accordingly, the DND Chief Review Services (CRS) was asked to perform an independent, quick-time review of the situation. This report presents the results of that review.

It is necessary to note, at the outset, that the staff of the Canadian Forces Medical Group (CFMG) are in the process of implementing a major reform initiative, Rx2000. Implementation of this reform involves many complex components, certain of which are outside CFMG control (e.g., increased demand for services, due to CF recruiting and operations). Our review also encountered people who are very much dedicated to ensuring the provision of responsive and quality care to CF members.

The following are the key conclusions of the review:

- **Initial estimates of services required were low**, in large part, because they were developed, and the contract signed, before the adoption, by the DND/CF, of a comprehensive healthcare reform model (Rx2000).
- **Increased costs for healthcare services were primarily due to:**
  - An increase in the required number of healthcare service providers at medical clinics.
  - Growth in requirements associated with new initiatives (recruiting, and treatment of post-traumatic stress disorder).
  - Use of the contract to hire 150 personnel who are not direct healthcare service providers.
  - Payment of high-end rates to some healthcare service providers (i.e., at the high-end of market rates).
  - Apparent difficulty offering competitive compensation to recruit healthcare employees.

- **Approval to amend the contract was not obtained in a timely manner due:**
  - In part, to an acknowledged PWGSC misinterpretation of the nuances of the conditions of contract approval. This led CFMG to believe that approval of an increased contract ceiling would be a straight-forward administrative undertaking by PWGSC.
  - To the apparent inability of CFMG to develop a forecast of required medical clinic resources and to provide PWGSC with information necessary for the preparation of a submission for amendment to the contract approval.
  - To difficulty experienced by CFMG in obtaining departmental contracting advice to confirm or challenge that given by PWGSC.
- **Actions already taken to improve the situation:**
  - An ADM(Mat) procurement officer has assumed management of the contract from the CFMG technical authority.
  - PWGSC has set a ceiling on the number of service providers and on expenditures ($16M) to 7 September 2003.
  - ADM(Mat) is providing contract-related training to CFMG personnel.
  - A private firm has completed a mandatory evaluation of the contracted services and made recommendations to CFMG.
  - The ADM(HR-Mil) Comptroller has completed a contract management study and made improvement recommendations.

CRS has recommended additional specific actions targeted at improved human resource planning, as well as strengthened business and contracting processes within CFMG. These recommendations have been accepted by ADM(Human Resources - Military)/CFMG and ADM(Materiel). Both organizations have provided management action plans to appropriately address the concerns raised in this report, including: clarification of roles and responsibilities related to contracting; ongoing training in contract management, as well as regular reporting, by both CFMG and ADM(Mat), on contract status. Consideration is also being given to establishing a high-level Governance Committee to oversee the balance between patient care and resource management, ensuring that resources are devoted to highest and best use within the CF Medical System. Corrective action will also require the involvement of responsible comptrollers. **Recommendations and corresponding management action plans are presented in matrix format, at pages 17-20 of the report.**

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RESULTS IN BRIEF

INTRODUCTION & BACKGROUND

On 5 June 2003, the DND/CF required fast-tracked approval by Public Works and Government Services Canada (PWGSC) to increase the ceiling on a contracting arrangement for health services to support CF medical clinics. In these circumstances, the Chief Review Services (CRS) was asked to perform an independent review of the situation. Accordingly, this report presents the results of a CRS quick-time review.

- Following a competitive procurement process, a PWGSC submission to contract for the supply of healthcare services to the Canadian Forces was signed in March 2001. The Canadian Forces Medical Group (CFMG) manages the contract.
- The contract was for an initial period of 3 years with an option for an additional 3 years.
- A total of $225M over 6 years was approved, but the spending authority was divided into two 3-year periods valued at approximately $90M and $135M, respectively. These amounts include GST.
- The second 3-year spending authorization would be granted only after DND had provided a report assessing the performance of the initiative.
- On 5 June 2003, the contract spending reached the 3-year limit after only 2 years.
- This situation prompted a request for a “fast-track” approach by PWGSC for “approval of a contract amendment.”
- As an interim measure, on 5 June 2003, PWGSC approved a contract amendment that added $16,221,979.00 (GST included) to increase the contract’s limitation of expenditure in order to pay the contractor for services for an estimated 93 days (5 June 2003 – 7 September 2003). Ratification of this $16M increase will be sought in Summer 2003.
- It is expected that a submission will also be prepared that will address the additional base and option period requirements.

OVERALL ASSESSMENT

The Canadian Forces Medical System (CFMS) is undergoing a major and complex reform, known as *Rx2000*. In this context, and with a sincere commitment to ensuring necessary care for CF members, management of a major contract for healthcare service providers has involved lack of adherence to sound financial/contracting control and authority. It is apparent that the currently strong service orientation must be complemented by better business practices to ensure that limited resources are prudently managed. Patients will ultimately benefit if business systems assist in ensuring that resources are demonstrably allocated to highest and best use. Similarly, good business practice will require that contingency plans be developed to ensure continuity of service in the event that third-party service arrangements experience delivery problems.

We observed that services obtained under a major contractual arrangement were increasing steadily such that annual expenditures would soon be almost double those originally contemplated by the 6-year, $250M contract. CFMG staff could have projected, as early as October 2001, that labour costs for the first 3-year contract term would be exceeded by at least 27 per cent. A misunderstanding of the approval conditions compounded the situation. While there are legitimate reasons for much of the cost growth, we noted the expressed confidence/expectation, at least at the staff level within CFMG, that funding would be available to cover the cumulative impact of day-to-day decisions on patient care as well as the hiring of management consultants and administrative assistance.

Our recommendations are targeted at improved human resource (HR) planning as well as strengthened business and contracting processes. This will require the involvement of the Materiel Group as well as pertinent comptrollers. Action has been taken to mitigate the observed lack of compliance with contract approval conditions. Additional initiatives are required to preclude similar situations from occurring in the future.

RECOMMENDATIONS

It is recommended that the following actions be taken:

- For the benefit of CFMG staff, ADM(Mat) should take the lead, in consultation with ADM(HR-Mil) and CFMG to clarify the pertinent advisory roles and control responsibilities of PWGSC, ADM(Mat), the project procurement officer, the CFMG technical authority, as well as the CFMG and ADM(HR-Mil) Group comptrollers.

- ADM(HR-Mil) and CFMG re-evaluate the future healthcare service requirements and develop corresponding HR plans – specifically addressing contracting/staffing options.

- ADM(Mat), in conjunction with ADM(HR-Mil) and CFMG, develop a plan for continued contract-related training for CFMG personnel.

- ADM(HR-Mil), in consultation with the CFMG and ADM(HR-Mil) comptrollers, develop an initial framework that will indicate how the "patient first" culture will be balanced with a better appreciation of financial, contractual and resource implications.

- ADM(HR-Mil) require CFMG to report on actions that will be taken to adhere to fundamental project management practices.

- CRS commence a risk analysis of all CFMG contracting in order to target requirements for future audit work.

MANAGEMENT ACTION PLAN

- ADM(HR-Mil)/CFMG and ADM(Mat) have accepted the CRS recommendations and have provided management action plans which are included on pages 17 to 20 of this report.

- The plans appropriately address the concerns raised in the report including: clarification of roles and responsibilities related to contracting/procurement; ongoing contract/procurement related training as well as regular reporting by both CFMG and ADM(Mat) on contract status; consideration of a Level 0 Governance Committee to ensure a balance between patient care and resource management; and improvements to project management practices. Also, CRS has undertaken a risk assessment of all contracts managed by CFMG.

REVIEW OBJECTIVES, SCOPE & METHODOLOGY

OBJECTIVES

This CRS 'quick-time' review was initiated specifically to determine why approval to amend a healthcare services contract was not obtained in a timely fashion, and to propose recommendations for improvements.

SCOPE

The review centred on one professional healthcare services contract managed by CFMG and for which PWGSC was the contracting authority. Specifically, our work centred on circumstances associated with the lack of adherence to the conditions of contract renewal. The review also identified potential risks associated with continuity of healthcare services and the need for a CFMG contingency plan; this matter was brought immediately to the attention of CFMG, ADM(Mat) and PWGSC. The scope of the review has not included a detailed assessment of the administration and quality of the services contracted; this was addressed by a separate ADM(HR-Mil) study and a private-sector evaluation.

METHODOLOGY

The "quick-time" review was conducted in a five-day time period. Interviews were held with key personnel from CFMG, ADM(Mat), ADM(HR-Mil) and PWGSC.

As well, an analysis of pertinent documents was undertaken and supplemented by research of data held in the Financial Management and Accounting System (FMAS) and the DND/CF personnel information system (People Soft).

The report focuses on answering the following five questions:

- **Why were initial estimates of requirements low?**
- **Why did costs increase?**
- **Why was the approval to amend the contract not obtained in a timely manner?**
- **What has already been done to improve the situation?**
- **What can be done to avoid similar situations in the future?**

REVIEW OBSERVATIONS AND FINDINGS

CONTRACT AUTHORITY

Section 20(1) b) c) of AIA Third Party

It had become apparent in October 2002 that the number of contracted service providers had reached 800, relative to a contracting arrangement which anticipated 300-400 providers. Accordingly, labour costs alone could have been projected at $116M for the first 3-years of the contract; the contract actually included provision for labour costs of about ……. for this period.

Details and Discussion:

The contract was awarded in March 2001 for an initial period of 3 years (37 months), with an option for an additional 3 years.

The second 3-year spending authorization would be granted only after DND had provided a report reviewing the performance of the initiative. This report was not completed until April 2003.

$225.1M (GST included) over 6 years was approved, but the spending authority was divided into two, 3-year periods valued at $92,517,436.58 and $132,595,119.04 respectively (GST included). For the purposes of this report, the figures have been rounded to $225M, $90M and $135M respectively.

The contract included a breakdown for the first 3 years, as indicated in Table 1. The labour costs, base/initial management fee and the incremental management fee, were based on an estimate of 400 service providers for the first 3-year period.

Table 1 – Contract Authority for First 3-Years (based on an estimated 400 service providers)

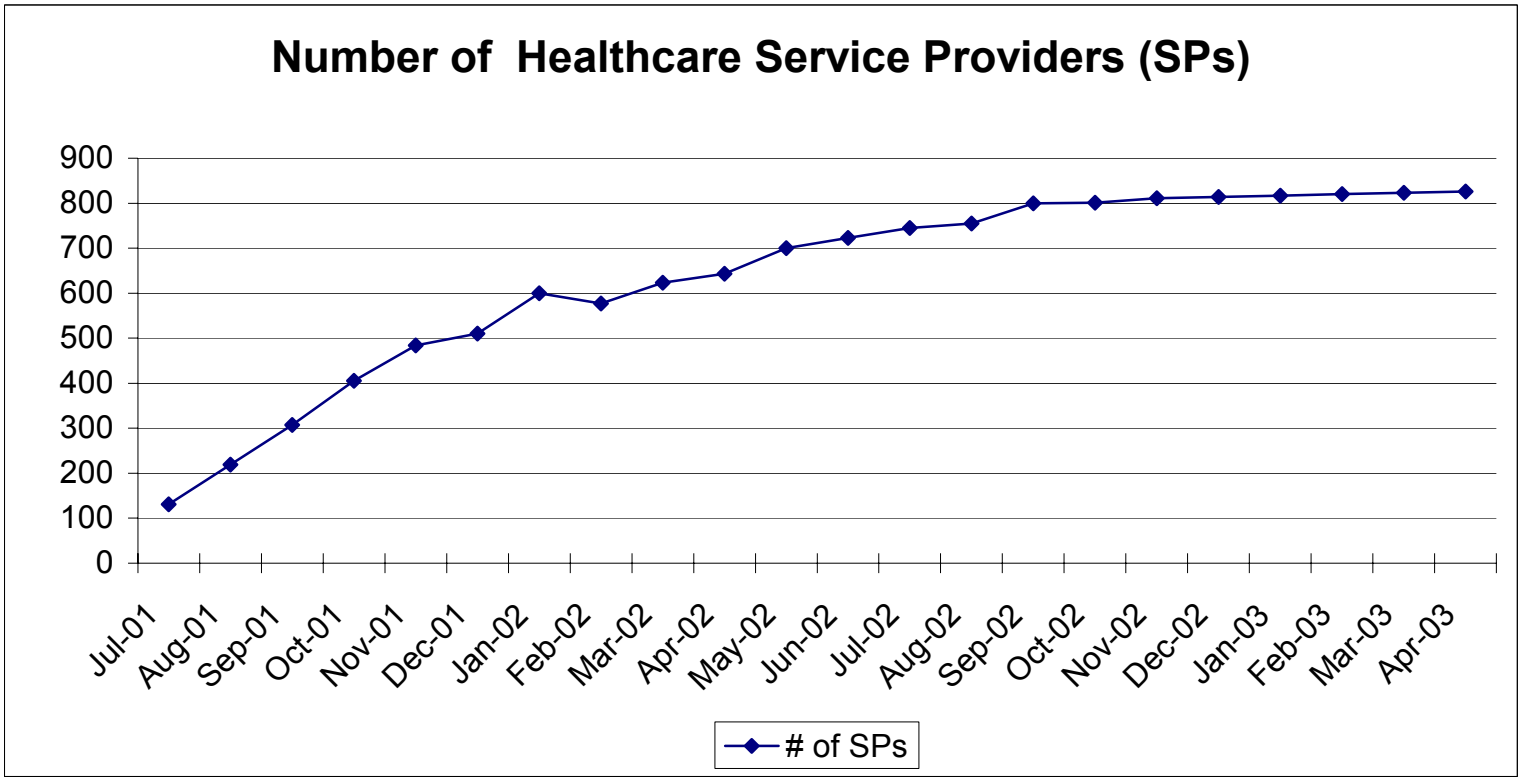
Section 20(1) b) c) of AIA Third Party

Contract Components	Authority (GST Excluded)	Approx % of Total
Labour Costs	…….	…….
Base Management Fee	…….	…….
Incremental Management Fee	…….	…….
Milestone Payments	…….	…….
Other (travel, relocation, training, etc.)	…….	…….
Total	$86,630,894	100%

Initially, the contract was to be used to hire 300-400 healthcare service providers. However, at the time of the review, more than 800 had been hired.

Table 2 indicates that by October 2001, over 400 health care providers had already been engaged and the numbers grew steadily thereafter.

Table 2 – Number of Healthcare Service Providers Engaged



Notes: 1) Some monthly figures are estimates as complete data was unavailable.
2) Figures are exclusive of any outstanding service requests.

Once the number of healthcare service providers had reached 400, and there were indications that the number would continue to grow, CFMG could have projected the labour costs for the first three years of the contract. A projection would have resulted in the following estimates:

- 500 Service Providers - $76M
- 600 Service Providers - $91M
- 800 Service Providers - $116M

This information would have been helpful to senior DND management and to PWGSC in highlighting at a very early stage an expected requirement to seek approval to amend the contract. The critical milestones for the management of this contract are indicated in Annex A.

MANAGEMENT FEE

The contract included provision for the payment of a management fee, based on a forecast of 400 healthcare providers. It also provided for incremental fees for every 100 providers above this threshold. By end May 2002, incremental fees totalled $1.8M, providing a further indication of the growth in requirements. The contract had projected maximum incremental management fees of …… for the first 3-years of the contract.

Details & Discussion

Section 20(1) b) c) of AIA Third Party

The contract included provision for an incremental, monthly management fee. This incremental fee of …… was to be paid to the contractor for every 100 healthcare service providers over the initial 400. Therefore, at 401 healthcare service providers, an additional monthly fee of ……. would have been paid.

In October 2001, the number of healthcare service providers exceeded the base rate of 400, and the incremental management fee was applied.

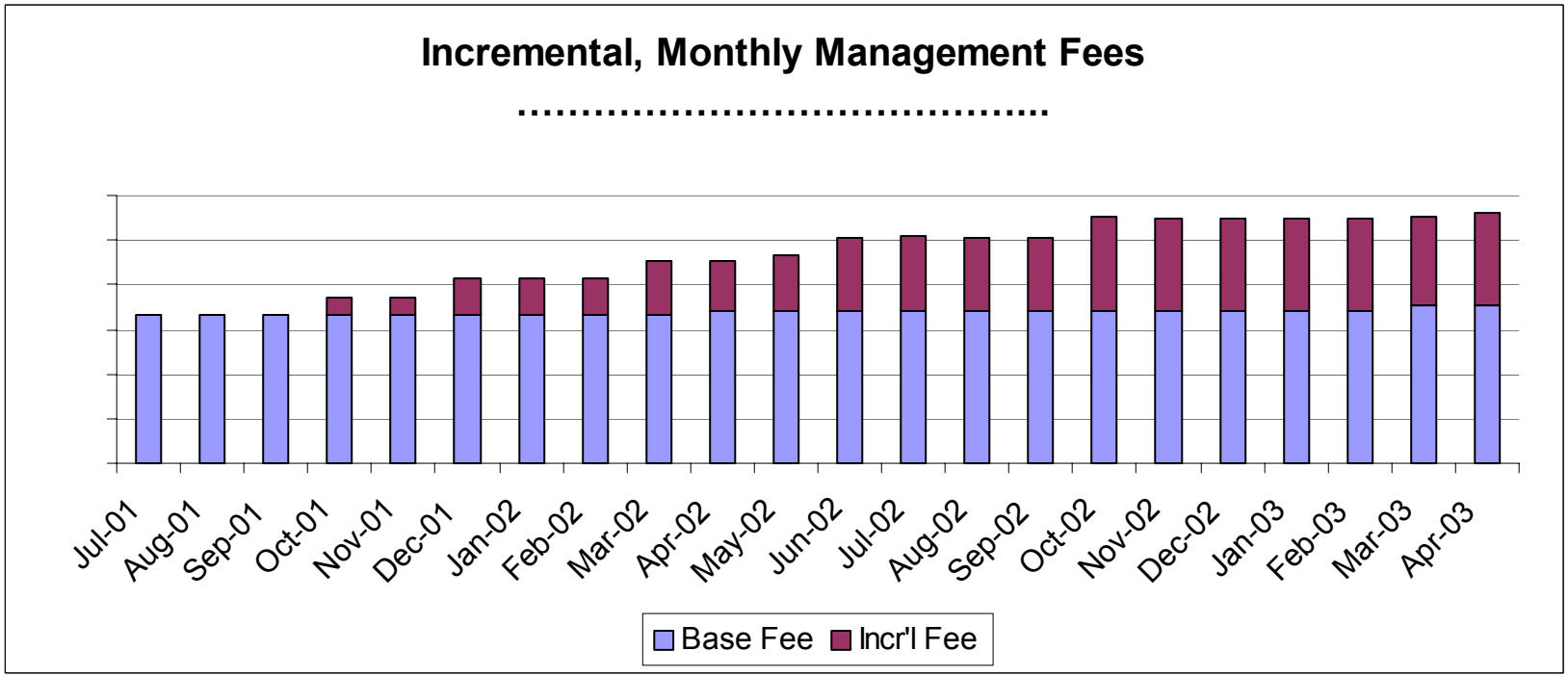
The incremental management fees were estimated at …….. for the first 3-year period. Actual incremental management fees, at the end of May 2002, had reached ……..

CFMG staff had a warning as early as October 2001 and could have developed initial projections and raised concerns about the requirement for approval to amend the contract much earlier than actually occurred.

Table 3 indicates how quickly the incremental, monthly management fees escalated after October 2001.

Table 3 – Management Fees Paid to the Contractor

Section 20(1) b) c) of AIA Third Party



Note: Base Fee of ……./month charged for up to 400 service providers.
Incremental Monthly Management Fee of ……. / month charged per block of 100 service providers above base rate.

MONTHLY SPENDING AND MONTHLY TARGET RATES

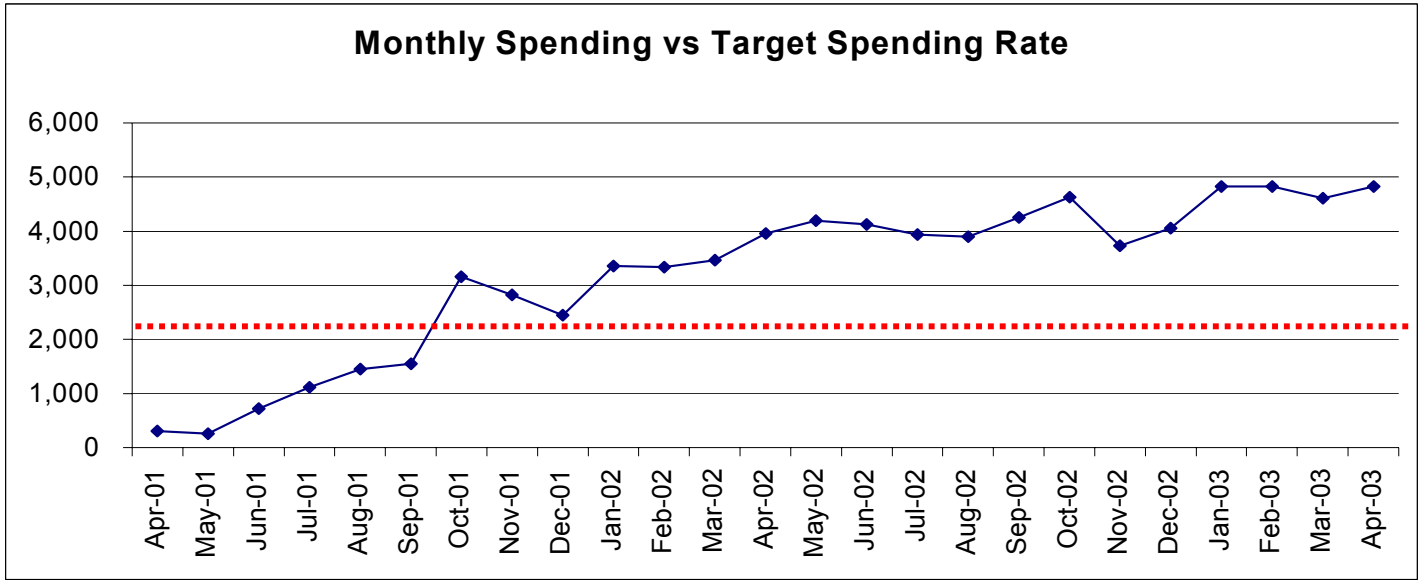
As early as October 2001, monthly spending on the contract had exceeded the $2.3M "target" amount necessary to remain within the authorized contract limit for the first 3-years.

Details & Discussion

Assuming an equal amount of spending in each of the first 37 months of the contract, CFMG could have estimated a monthly target rate and would then have been able, as early as October 2001, to compare the actual monthly spending rate to the targeted spending rate.

Table 4 indicates the monthly spending compared to the targeted spending rate. The red dotted line represents the monthly target rate assuming an equal amount of spending in each of the 37 months of the contract ($2.3M * 37months = $86M).

Table 4 – Monthly Spending vs Target Spending Rate

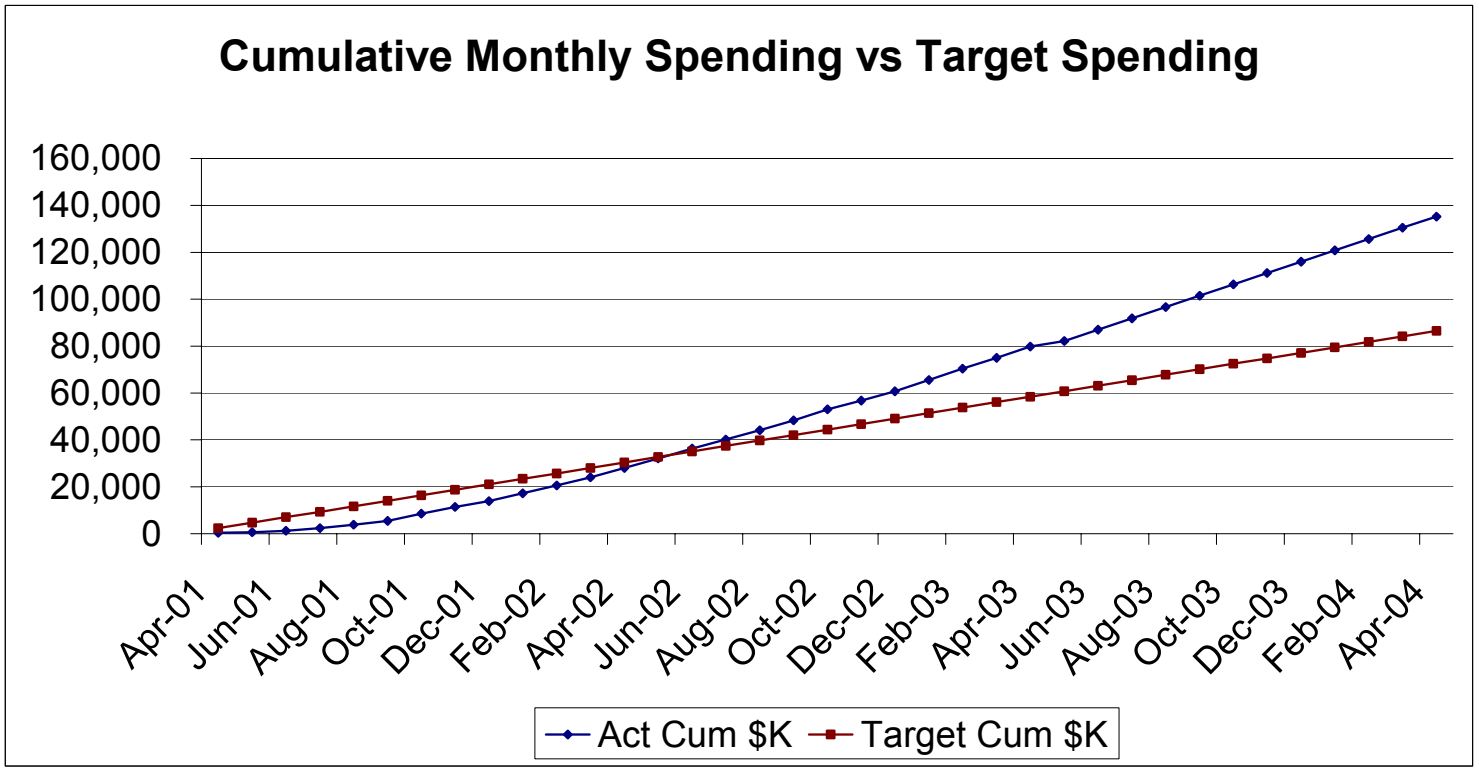


Red Line --Targeted Monthly Spending Rate ($2.3M) Blue Line – Actual Monthly Spending Rate

Note: Monthly spending (GST excluded) shown in Tables 4 and 5 is based on the month in which the expenses were incurred vs. the month in which the expenses were posted in FMAS.

In June 2002, actual cumulative spending exceeded the target cumulative spending rate. By the end of May 2003, total spending was $84.4M (98 per cent of contract authority). As depicted in Table 5, and using forecasted figures for the period of June 2003 to April 2004, total contract costs over the 37 months would exceed the contract authority by a minimum of $40M.

Table 5 – Cumulative Monthly Spending vs Target Spending Rate



Note: Figures are estimated for the period of June 2003 to April 2004.

In addition to these tables, **Annex A** provides a summary of the contract management milestones and **Annex B** includes additional tables indicating the contract spending by Fund Centre, by Type of Service and by Fiscal Year, respectively.

RESPONSES TO KEY QUESTIONS

With the benefit of the previously described analysis and information, the review team undertook to address key questions, as follows:

Why were the initial estimates low?

- Initial estimates were low, in large part, because they were developed**,** and the contract signed, just before the DND/CF adopted a more comprehensive healthcare reform model (Rx2000).

- A trial of the "third-party contract" concept had been successfully conducted in Halifax in 1999. Accordingly, estimates for a new healthcare services contract were developed based on simply replacing the number of civilian healthcare professionals who were being contracted through the Halifax trial or through a direct contract (a DND 2058), as well as replacing approximately 25 per cent of the military healthcare professionals. This was estimated to be about 300-400 healthcare professionals. The view was that this would be a bridging mechanism and that over the term of the contract, a significant number of the required 300-400 providers would be recruited as public servants.

What caused the increased costs?

- The Rx2000 concept of healthcare service called for a more comprehensive approach to patient care and a requirement for more personnel than originally estimated to perform duties such as case management and to staff primary care clinics. Medical and dental clinics have doubled in size since the original estimate.

- For a number of years, various internal and external reports were critical of DND/CF healthcare services. As well, the Corporate Priority of "Putting People First" thrust Rx2000 forward as a critical DND/CF reform initiative. This situation helped to engender a health services culture of "putting the patient first". The culture can best be described through the following quotes from interviewees. "No patient will be denied care due to a lack of funding." "Provide the care and the funds will follow." "We are in the life saving business."

- Additional healthcare service providers resulted in more lab tests, more prescriptions, and the requirement for more health care support. The types of contracted services provided are shown in **Annex B**.

- At the same time, new initiatives such as increased recruiting, a requirement for healthcare expertise for the Croatia Board of Inquiry, and the important emphasis on treating post-traumatic stress disorder, called for an increased requirement for healthcare professionals.

- In addition to the need for more healthcare professionals, the management and implementation of all of the components of Rx2000 were complex and required expertise and advice that was not available within the DND/CF.

- Initially, an omnibus contract for administrative and management services could not be implemented, and ADM(Mat) advised CFMG to use the healthcare services contract to acquire these services. While not the intent of the contract, this was not strictly contrary to its terms. It is estimated that some 150 people were contracted to provide these services.

- According to a recent private-sector report, healthcare professionals recruited by the contractor tended to be compensated at the high-end of the market range. This was due to the limited supply of healthcare professionals in Canada, the intermittent nature of the service and the requirement for healthcare professionals at relatively isolated locations.

Section 20(1) b) c) of AIA Third Party

- The contract stipulates that the contractor is to be paid a monthly flat rate for the first 400 healthcare professionals. For every additional block of 100 engagements, a ……..... monthly management fee is charged. CFMG began paying the contractor the incremental monthly management fee in October 2001 and the total amount paid as of 01 June 2003 was …..… or …….. higher than the original …… estimate.

- The contract was decentralized, easy to use and was not closely monitored so it became a fully utilized tool much sooner than anticipated.

- Although this contract was intended as a bridge to allow CFMG the time to hire indeterminate public servants, this was not fully successful due to the differential in public service and market pay rates. In addition, the public service hiring mechanisms are considered too time consuming and cumbersome.

- Increased parental leave benefits required increased backfilling.

- Medical salaries escalated at a higher rate than originally forecast (6 per cent vice 2.8 per cent).

- Increased operational tempo required backfilling of in-garrison healthcare military positions.

Why was a contract amendment not obtained in a timely manner?

- CFMG

  - Did not wish to seek an amendment until there was more certainty surrounding the total requirement for additional personnel to support the new Rx2000 health care services model.

  - Was unable to meet PWGSC's expectations in terms of the development of sound estimates that could be used to seek contract amendment approval.

  - Knew as early as October 2001 that the contract would likely exceed the contract ceiling but did not take timely action to seek contract amendment approval.

  - Was confident in acquiring additional funds through the business planning process, however, it is not clear, if at the time, it was understood that there was also a need to obtain increased spending authority.

  - Managed the contract rather than having it managed by an ADM(Mat) procurement officer. The procurement officer assigned to Rx2000 only provided advice when asked by CFMG. Also, a senior procurement officer was only available intermittently due to language training and leave issues.

  - Dealt directly with PWGSC and did not involve ADM(Mat) in a way that would have allowed an earlier preparation of the contract amendment.

  - Did not appreciate the lead time (5 months) necessary for a contract renewal submission.

- PWGSC

    - Staff misunderstood the nuances of the Record of Decision for contract approval and, consequently, advised CFMG that it was just a cash phasing issue that would be handled by the transfer of funds from the 3-year option period.

    - Had requested and was waiting for CFMG to provide credible financial data regarding future needs before seeking a contract amendment.

    - Was waiting for the completion of the mandatory evaluation before proceeding with the contract renewal. (Completed by a private sector firm, April 2003).

What actions have already been taken to improve this situation?

- An ADM(Mat) procurement officer has assumed management of the contract from the CFMG technical authority and should ensure that there is contract compliance.

- A ceiling of 901 contracted service providers and expenditures of $16M has been set and approved by PWGSC for the period ending 7 September 2003.

- A private firm has conducted an evaluation of the contract and has provided recommendations to CFMG. Consideration of these recommendations should provide valuable input towards improving the management and administration of the contract.

- ADM(HR-Mil) Comptroller has conducted a study of the contract and has recommended changes that would improve the management and monitoring of the contract.

- ADM(Mat) is providing some contract related training for CFMG personnel.

- CFMG has established other mechanisms for hiring management consultants and administrative personnel in order to reduce the number of non-regulated health care provider call-ups against the contract.

- CFMG has removed inactive service providers from the management fee list.

RECOMMENDATIONS

What improvements can be made to avoid this situation in the future?

It is recommended that the following actions be taken no later than 30 September 2003:

1. For the benefit of CFMG staff, ADM(Mat) should take the lead, in consultation with ADM(HR-Mil) and CFMG to clarify the pertinent advisory roles and control responsibilities of PWGSC, ADM(Mat), the project procurement officer, the CFMG technical authority, as well as the CFMG and ADM(HR-Mil) Group comptrollers.

2. ADM(HR-Mil) and CFMG re-evaluate future healthcare service requirements and develop corresponding HR plans – specifically addressing contracting/staffing options.

3. ADM(Mat), in conjunction with ADM(HR-Mil) and CFMG, develop a plan for continued contract-related training for CFMG personnel.

4. ADM(HR-Mil), in consultation with the CFMG and ADM(HR-Mil) comptrollers, develop an initial framework that will indicate how the "patient first" culture will be balanced with a better appreciation of financial, contractual and resource implications.

5. ADM(HR-Mil) require CFMG to report on the actions that will be taken to adhere to fundamental project management practices.

6. CRS commence a risk analysis of all CFMG contracting in order to target requirements for future audit work. (Already directed by Deputy Minister.)

Other Related Issues

- Due to the critical nature of healthcare services, we have communicated publicly available information to PWGSC and ADM(Mat), which indicates potential risks to the contract.

- A CFMG contingency plan, to ensure continuity of service, in the event that the contractor experiences difficulty, has not been developed. CFMG requires a sound contingency plan that addresses service continuity. This has been brought to the attention of Comd CFMG.

MANAGEMENT ACTION PLAN

RECOMMENDATION	OPI/ACTION
1. For the benefit of CFMG staff, ADM(Mat) should take the lead, in consultation with ADM(HR-Mil) and CFMG to clarify the pertinent advisory roles and control responsibilities of PWGSC, ADM(Mat), the project procurement officer, the CFMG technical authority, as well as the CFMG and ADM(HR-Mil) Group comptrollers.	**ADM(HR-Mil) AND CFMG** • Assist ADM(Mat) in the preparation of Terms of Reference that clarify the roles and responsibilities of PWGSC, ADM(Mat), the project procurement officer, the CFMG technical authority, as well as the CFMG and ADM(HR-Mil) Comptrollers. ADM(Mat) has the lead on this activity. **ADM(MAT)** • Prepare and communicate Terms of Reference to define the roles and responsibilities of PWGSC, ADM(Mat), DGHS and ADM(HR-Mil) comptroller for the Third Party Health Care contract. • Summary Terms of Reference. • Detailed Terms of Reference.
2. ADM(HR-Mil) and CFMG re-evaluate future healthcare service requirements and develop corresponding HR plans – specifically addressing contracting/staffing options.	**ADM(HR-Mil) AND CFMG** • Consistent with the end of the definition phase for Project Rx2000, ADM(HR-Mil) will provide an update on future healthcare service requirements. The update will address contracting/staffing options during the implementation phase of the various initiatives and at steady state.

RECOMMENDATION	OPI/ACTION
3. ADM(Mat), in conjunction with ADM(HR-Mil) and CFMG, develop a plan for continued contract-related training for CFMG personnel.	**ADM(HR-Mil) AND CFMG** • Ensure that CFMG staff members involved with contracting receive training on procurement and contract management. As a baseline activity CFMG will prepare a list of all personnel requiring training and work with ADM(Mat) to coordinate delivery of the requisite training. Actions required include: o Prepare and submit list of CFMG personnel. o Ensure staff receives baseline training recommended by ADM(Mat). o In conjunction with ADM(Mat), develop a program for on-going training and development of CFMG personnel in the area of procurement and contract management. **ADM(MAT)** • Continue provision of training to CFMG staff on procurement and contract management. This includes Director Major Service Delivery Procurement (DMSDP) and Director Contracting Policy (DCP) conducted training and use of ADM(Mat) specialty courses.
4. ADM(HR-Mil), in consultation with the CFMG and ADM(HR-Mil) comptrollers, develop an initial framework that will indicate how the "patient first" culture will be balanced with a better appreciation of financial, contractual and resource implications.	**ADM(HR-Mil) AND CFMG** • ADM(HR-Mil) will review the feasibility of creating a Level 0 Governance Committee that will provide guidance on expectations and levels of healthcare services. This level of governance will help to balance the patient first culture with a better appreciation of financial, resource, contractual and resource implications. o Prepare draft Terms of Reference for the Governance Committee. o ADM(HR-Mil) submit proposal to VCDS.

RECOMMENDATION	OPI/ACTION
5. ADM(HR-Mil) require CFMG to report on the actions that will be taken to adhere to fundamental project management practices.	**ADM(HR-Mil) AND CFMG** • Prepare regular updates in conjunction with ADM(Mat) on all major contracts. The updates will detail the contract status with respect to deliverables, financial expenditures, issues and potential risks. The report will also provide an update on steps taken by CFMG to adhere to fundamental project management practices. o Develop report template. o Submit reports.
6. CRS commence a risk analysis of all CFMG contracting in order to target requirements for future audit work. (Directed by Deputy Minister.)	**CRS** • CRS commence a risk analysis of all CFMG contracting in order to target requirements for future audit work.

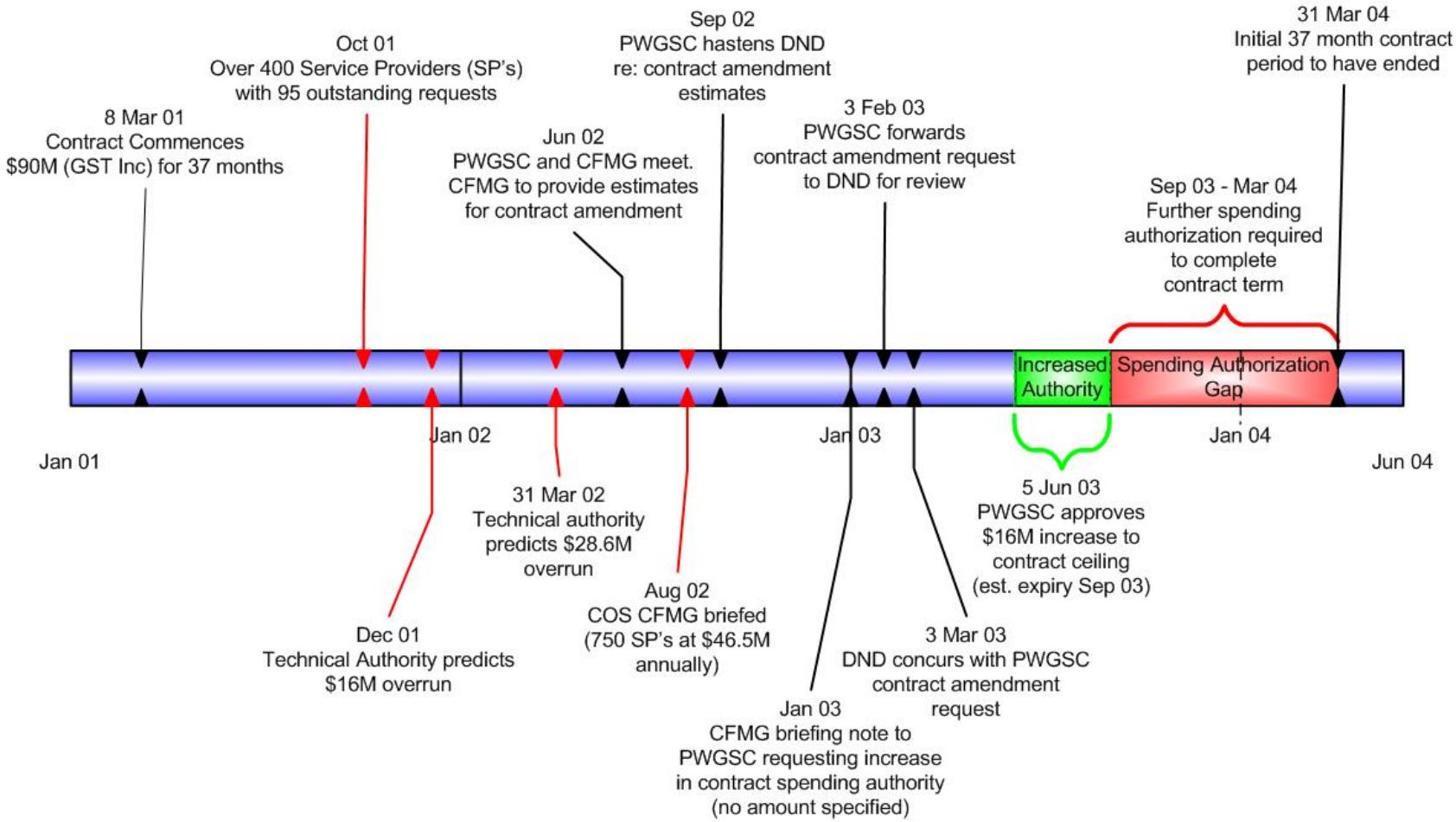
ADM(HR-Mil) AND CFMG have proposed the following additional related initiatives:

- Develop and implement a plan to reduce the number of contractors hired under the Third Party Contract. The plan will also include controls to maintain the number of contractors at a level consistent with the terms of the contract while still meeting the critical health requirements of the Canadian Forces Health Services.
    - Develop plan.
    - Implement actions to reduce the number of contractors.
    - Implement actions to maintain control of the number of contractors on this contract.
- Work with ADM(Mat) to track and report spending against the contract to CFMG and PWGSC.
- Assist in the preparation of the Statement of Work and other documentation required for a new contract with a target date of contract award of 30 September 2004.

ADM(MAT) has proposed the following additional related initiatives

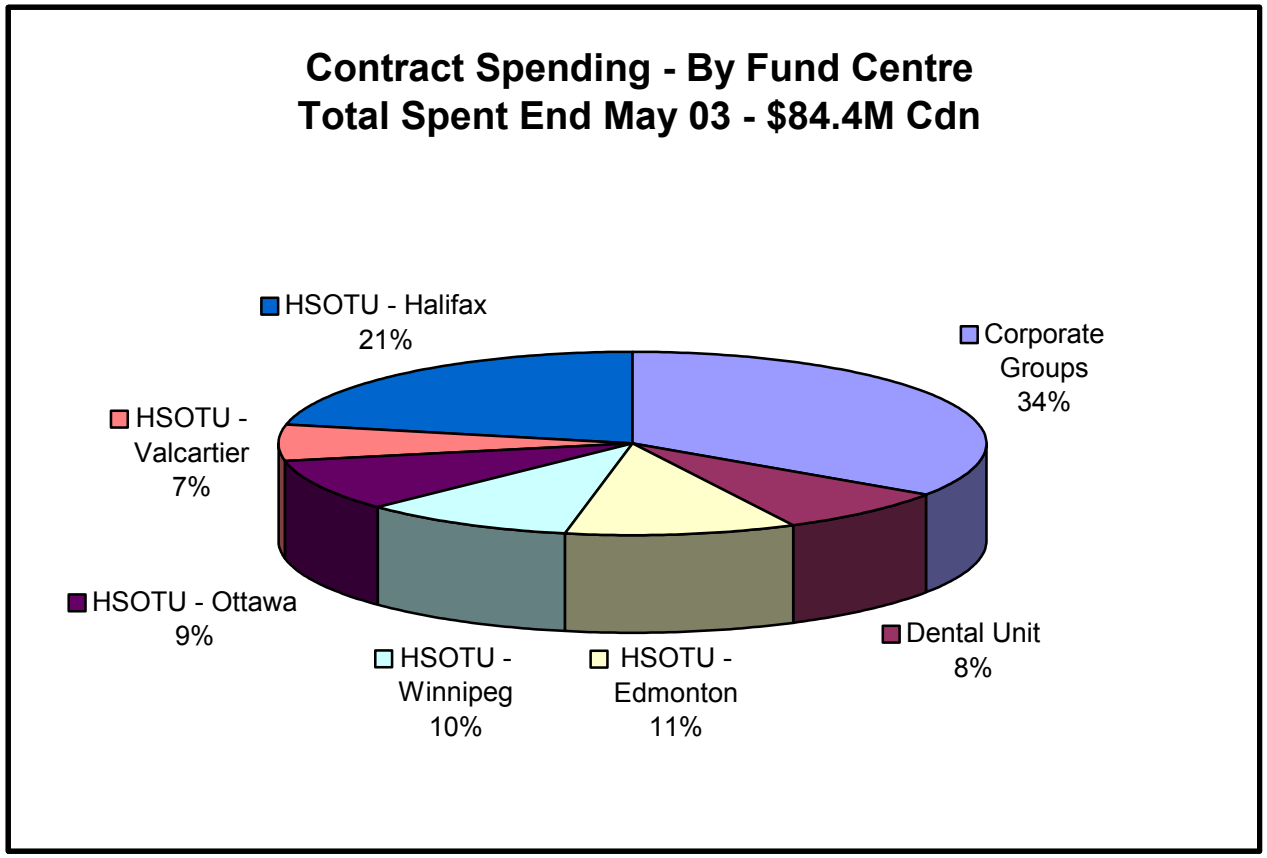
- Provide management updates to CFMG on any contract and administration issues.
- Track and report spending against the contract to CFMG and PWGSC.
- Initiate procurement planning for a new contract. The contract award date is 30 September 2004.

ANNEX A – CONTRACT MANAGEMENT MILESTONES



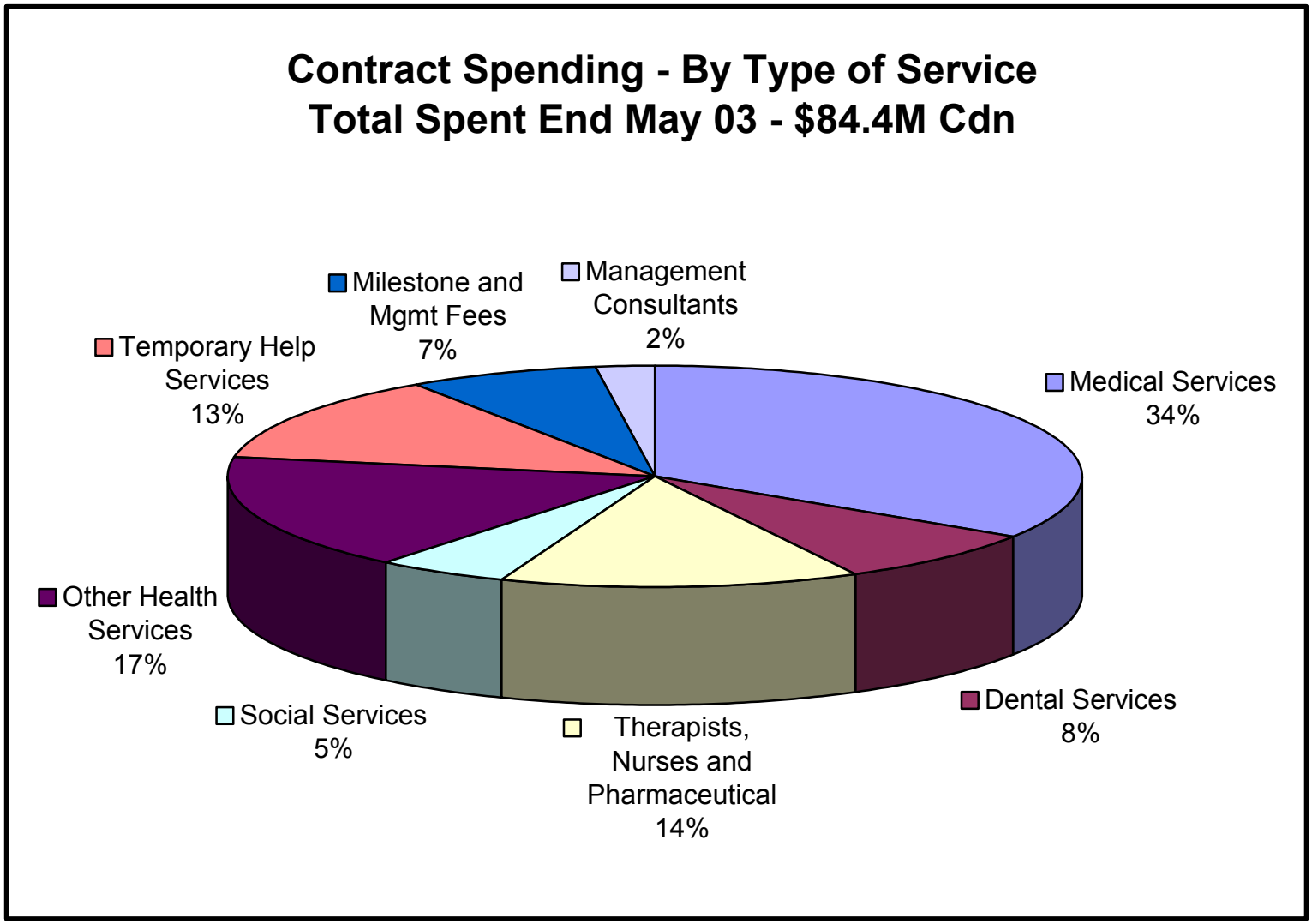
Note * Red Arrows indicate points in time where CFMG had sufficient information to know that the initial 3-year contract spending ceiling would be exceeded and that a contract amendment would be necessary in order to meet obligations through to 31 March 2004.

ANNEX B – CONTRACT SPENDING – BY FUND CENTRE, BY TYPE OF SERVICE & BY FY



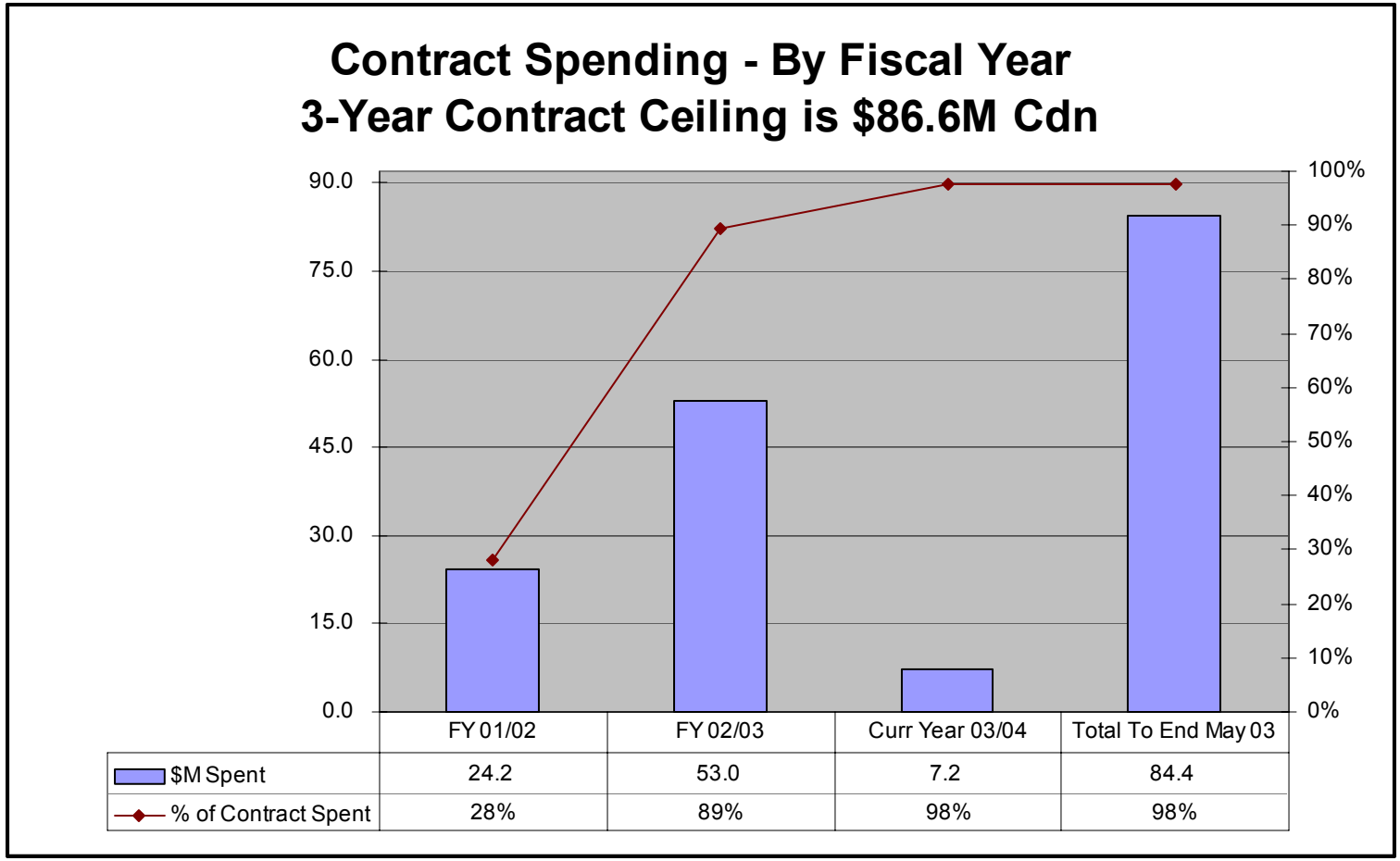
Notes: HSOTU– Health Services Operational Training Unit.
Corporate Groups includes Chief Health Services, DGHS, Rx200, PMO, CF Environmental Medical Establishment and CF Medical Group.
Data from FMAS as of 31 May 2003 – Figures are exclusive of GST.

ANNEX B



Data from FMAS as of 31 May 2003 – Figures are exclusive of GST.

ANNEX B



Data from FMAS as of 31 May 2003 – Figures are exclusive of GST.