--------- Health Care Policy Contribution Program---------

CONTRIBUTION AGREEMENT

Made in duplicate

BETWEEN: **HER MAJESTY THE QUEEN IN RIGHT OF CANADA**, as represented by the Minister of Health, acting through the Department of Health (hereinafter referred to as "Canada")

AND: **HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA** as represented by the Minister of Health (hereinafter referred to as British Columbia)

Canada and British Columbia are also referred to individually as a "Party", or collectively as the "Parties".

CONTRIBUTION AGREEMENT

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PREAMBLE:

WHEREAS Canada is responsible for the Program entitled the Health Care Policy Contribution Program;

WHEREAS British Columbia has submitted to Canada a proposal for the funding of a Project called **"Expansion and Distribution of IMG-BC Program for Underserved Communities in BC (2011-2016)"** under the Health Care Policy Contribution Program; and

WHEREAS Canada wishes to provide financial assistance to support the Project;

THEREFORE, the Parties agree as follows:

1. DEFINITIONS

In this Agreement,

1.1 "Agreement" means this contribution agreement and includes all Appendices, and any amendments made to this Agreement in accordance with section 23;

1.2 "Appropriation" means any authority of Parliament to pay money out of the Consolidated Revenue Fund;

1.3 "Asset" means any asset(s) acquired with contribution funds provided under this Agreement or under a previous agreement funded by the same Program;

1.4 "Budget" means the total forecasted expenditures for the Project, as set out in Appendix B;

1.5 "Eligible Expenditures" means the costs described in Appendix B to this Agreement that Canada has agreed to contribute to, and that are incurred and paid by British Columbia in carrying out the Project;

1.6 "Evaluation" means the systematic collection and analysis of evidence on the outcomes of projects and programs used to make judgments about their relevance, results and cost effectiveness, as well as find alternative ways to deliver them or to achieve the same results;

1.7 "Fiscal Year" means the twelve-month period beginning April 1 of any year, and ending March 31 of the following year, and including parts thereof in the event that this Agreement commences after April 1st or expires or terminates before March 31st;

1.8 "Material" means anything that is created or developed by British Columbia with funding under this Agreement including designs, reports, photographs, drawings, plans, specifications, documents, tools, resources, computer software, surveys, databases and Web sites;

1.9 "Performance Measurement" means the process of developing measurable indicators that can be systematically tracked to assess progress made in achieving predetermined goals and using such indicators to assess progress in achieving these goals;

1.10 "Program" means Health Care Policy Contribution Program; and

1.11 "Project" means the objectives, activities and expected results described in Appendix A to this Agreement.

2. PURPOSE

British Columbia shall use the funding provided under this Agreement solely to carry out the Project in a diligent and professional manner, in accordance with the terms of this Agreement and applicable laws.

3. EFFECTIVE DATE AND TERM

3.1 This Agreement will take effect on the date of signature of the last of the Parties and will end on **March 31, 2015** unless terminated earlier in accordance with the terms of this agreement.

3.2 Subject to termination, this Agreement applies to, and the funding herein may be used for, Eligible Expenditures incurred by British Columbia in carrying out Project activities in accordance with this Agreement for the period commencing on **December 29, 2010** and expiring on **March 31, 2015**.

4. FINANCIAL CONTRIBUTION AND OBLIGATIONS

4.1 Subject to the terms of this Agreement, Canada will make a contribution to **British Columbia** of up to **FIVE MILLION NINE HUNDRED EIGHTY THOUSAND EIGHT HUNDRED TWENTY FOUR** dollars (**$5,980,824.00**) toward Eligible Expenditures.

Canada's contribution will be paid as follows:

In fiscal year 2010-2011 up to $18,625.00
In fiscal year 2011-2012 up to $1,695,304.00
In fiscal year 2012-2013 up to $2,836,787.00
In fiscal year 2013-2014 up to $711,554.00
In fiscal year 2014-2015 up to $718,554.00

4.2 Reimbursement

Payments shall be made in the form of reimbursement to British Columbia for Eligible Expenditures, within thirty (30) calendar days of receipt and acceptance by Canada of the Cashflow Forecast and Record of Expenditures Form (Appendix D) (hereinafter called the Cashflow), submitted by British Columbia in accordance with the Reporting Plan (Appendix C).

4.3 Cashflow Forecast and Record of Expenditures

4.3.1 The Cashflow (Appendix D) shall be certified by British Columbia's authorized representative(s), be satisfactory to Canada, and contain the following information:

4.3.1.1 a forecast of expenditures to be incurred during the agreed upon upcoming reporting period and for the remainder of the Fiscal Year, by category of Eligible Expenditures;

4.3.1.2 the actual Eligible Expenditures for the previous reporting period;

4.3.1.3 such additional supporting documentation as Canada may require.

4.4 Adjustment

Notwithstanding any other provisions of this Agreement, Canada may withhold or reduce any payments to be made to British Columbia pursuant to this Agreement in

the event that:

4.4.1 any report has not been submitted by British Columbia in accordance with the requirements of Appendix C; or

4.4.2 any such report or any audit conducted under this Agreement indicates that British Columbia's actual Eligible Expenditures for the Project have been lower than the amount disbursed to British Columbia up to the date of such report or audit.

4.5 Holdback

Canada shall be entitled to withhold **SEVENTY ONE THOUSAND AND EIGHT HUNDRED FIFTY FIVE DOLLARS ($ 71,855.00)** of the amount of funding payable in the final year of funding of this Agreement. This holdback will be released upon submission by British Columbia and acceptance by Canada of the following items:

4.5.1 British Columbia's final Cashflow;

4.5.2 all reports that British Columbia is required to submit pursuant to the Reporting Plan (Appendix C); and

4.5.3 such other documentation and information that Canada may request from British Columbia

Canada will be entitled to make any necessary adjustments to the holdback before releasing the final amount.

4.6 Claims for Eligible Expenditures upon termination or expiration

British Columbia shall submit its claims for any outstanding Eligible Expenditures to Canada within thirty (30) calendar days after the termination or expiration of this Agreement. Canada shall not be obliged to reimburse any Eligible Expenditures claimed beyond that point.

4.7 Overpayments

British Columbia shall be required to repay Canada the amount of any overpayment or disallowed expenditure under this Agreement. Canada may deduct the amount from any future payments under this Agreement, or if no further payments remain to be made, British Columbia shall, unless otherwise agreed, repay the amount within thirty (30) calendar days of written notice to Canada. The repayment shall be made by cheque payable to the Receiver General for Canada and shall be sent to Canada's representative(s) identified in section 26.

4.8 Underspending

British Columbia shall inform Canada in writing of any potential underspending for any given Fiscal Year, on or before **October 31st**.

4.9 Funding subject to Appropriation and Program Funding Authorities

4.9.1 Notwithstanding any other provision of this Agreement, the amount of funding to be provided to British Columbia pursuant to this Agreement is subject to there being an Appropriation of funds by the Parliament of Canada for the Fiscal Year in which any commitment would come due for payment.

4.9.2 In the event that authorities for the Program are amended or terminated or

if funding levels are reduced or cancelled (by Parliament or otherwise) for any Fiscal Year in which a payment is to be made under this Agreement, Canada may reduce or terminate any further payments to be made under this Agreement.

4.9.3 Where funding under this Agreement is to be reduced or terminated under section 4.9.2 Canada shall provide British Columbia with at least sixty (60) calendar days written notice of the reduction or termination and shall reimburse British Columbia for any Eligible Expenditures to the date upon which the reduction/termination is to take effect.

4.9.4 In the event of termination under section 4.9.2 British Columbia shall make no further commitments in relation to the use of Canada's contribution and shall cancel or otherwise reduce, to the extent possible, the amount of any outstanding commitments in relation thereto.

4.10 Budget adjustments

British Columbia may, within a given Fiscal Year's budget, make minor adjustments to budget amounts among the approved broad budget expenditure categories. For the purposes of this section, a minor adjustment is an adjustment that does not exceed 15% of the originally approved amount for an expenditure category (calculated cumulatively) except in the case of the category of Personnel where an adjustment of up to 5% may be made. Where the proposed adjustment exceeds 5% in Personnel or 15% in all other originally approved budget categories, British Columbia must seek Canada's prior written consent before implementing the adjustment. The adjustments under this section may not increase the total amount of Canada's contribution in any given Fiscal Year of the Agreement.

5. AUDIT

5.1 British Columbia will share with Canada the results of any audit (financial or otherwise), prepared by or on behalf of British Columbia in respect of funds received under this Agreement within sixty (60) calendar days of the completion of such audit.

5.2 Canada shall have the right to audit or cause to be audited British Columbia's accounts and records relating to the Project for a period of up to six years following the expiration or termination of this Agreement to ensure compliance with the terms of this Agreement.

5.2.1 The scope, coverage and timing of this audit will be determined by Canada in consultation with British Columbia and carried out by mutually agreed upon external auditors. British Columbia will provide to the auditors in a timely manner, any records, documents and information necessary to conduct the audit and shall provide such other information as may be reasonably required, upon request by the auditors.

6. INFORMATION MANAGEMENT

6.1 Site visits

On prior written notice from Canada, British Columbia will meet with Canada to discuss the Project

6.2 Disclosure

Either Canada or British Columbia may disclose any information relating to this Agreement or the Project.

6.3 Personal and confidential information

The Parties shall comply with applicable laws pertaining to privacy and confidentiality in dealing with information and records related to the Project.

7. PERFORMANCE MEASUREMENT

British Columbia shall:

7.1 carry out Performance Measurement using the Recipient Reporting and Evaluation Template: Part 2 (Appendix E) and an Evaluation of the Project as described in Appendix A, and provide a copy of the resulting report(s) in accordance with the Reporting Plan (Appendix C), and

7.2 participate in any Performance Measurement and/or Evaluation activities at a regional, provincial/territorial and/or national scale led by or on behalf of Canada.

8. REPORTING

Progress Reports

British Columbia shall track the progress of all activities undertaken and completed as part of the Project and, using the Recipient Reporting and Evaluation Template: Part 1 (Appendix E), British Columbia shall submit progress reports for Canada's approval, describing its progress in meeting the Project's objectives, activities undertaken, the results achieved and materials produced (if any) as part of the Project. Such reports shall be submitted to Canada in accordance with the schedule set out in Appendix C.'

9. BREACH OF COMMITMENTS AND RECOURSE

9.1 The following constitute a breach of commitment:

9.1.1 British Columbia fails to perform or comply with any term, condition or obligation of this Agreement; or

9.1.2 British Columbia has made a materially false or misleading representation to Canada on any matter related to this Agreement, other than in good faith; or

9.1.3 in the opinion of Canada acting reasonably British Columbia fails to proceed diligently with the implementation of the Project so as to jeopardize the success or outcome of the Project.

9.2 In the event of a breach of commitment Canada may, with prior notice to British Columbia and in addition to any other remedy provided by law or under this Agreement, exercise any of the following remedies:

9.2.1 require that British Columbia take such reasonable action as may be necessary to remedy the breach of commitment;

9.2.2 suspend or reduce the payment of any amount under this Agreement; and/or

9.2.3 terminate this Agreement.

10. ASSETS

10.1 British Columbia shall report to Canada on Assets in accordance with the requirements in the Reporting Plan (Appendix C).

10.2 During the term of this Agreement, Assets acquired through the course of this Agreement shall be the responsibility of, and remain the property of British Columbia and shall be used for Project purposes.

11. LIABILITY

Canada shall not be held liable for any injury, including death, to any person, or for any loss or damage to property belonging to British Columbia or anyone else, or for any obligation of British Columbia incurred or suffered by British Columbia or its agents, employees, contractors or voluntary workers in carrying out the Project, including where British Columbia has entered into loans, capital leases or other long-term obligations in relation to this Agreement.

12. INDEMNIFICATION

British Columbia shall indemnify and save harmless Canada and its officers, employees and agents from and against all claims losses, damages, costs, expenses, actions, and other proceedings made, sustained, brought, prosecuted, threatened to be brought or prosecuted in any manner based upon, occasioned by or attributable to any injury to or death of a person or damage or to loss of property infringement of rights or any other loss or damages whatsoever arising directly or indirectly from any wilful or negligent act, omission, or delay on the part of the British Columbia, British Columbia's elected or non-elected officials, employees, contractors or agents in carrying out the Project or as a result of the Project, except that Canada shall not claim indemnification under this section to the extent that the injury, loss or damage has been caused by Canada or its officers, employees or agents.

13. LOBBYING

British Columbia warrants that no consultant lobbyists within the meaning of the federal Lobbying Act were retained to negotiate or secure this Agreement.

14. INTELLECTUAL PROPERTY RIGHTS

Any Material created or developed by British Columbia in carrying out its obligations under this Agreement shall vest in and remain the property of British Columbia, unless otherwise agreed to by the Parties. British Columbia shall report to Canada what Materials, if any, have been created or developed under this Agreement, and provide copies of such Materials to Canada, if requested to do so.

15. MEMBERS OF PARLIAMENT

No Member of the House of Commons or Senate shall be admitted to any share or part of this Agreement or to any benefit arising from it, that is not otherwise available to the general public.

16. CONFLICT OF INTEREST

British Columbia declares that no current or former public servant or public office holder to whom the *Conflict of Interest Act,* or the *Values and Ethics Code for the Public Service* apply, shall derive any direct benefit from this Agreement, unless the provision and receipt of such benefit are in compliance with such legislation or code.

17. ASSIGNMENT

British Columbia shall not assign this Agreement or any payment to be made thereunder without the prior written consent of Canada. Any assignment made without that prior written consent is void.

18. RELATIONSHIP OF THE PARTIES

Nothing contained in this Agreement shall be construed to place the Parties in a relationship of principal-agent, employer-employee, partnership, or joint venture, and neither Party shall have the right to obligate or bind the other Party in any manner. British Columbia shall not represent itself as the agent, employee or partner of Canada, including in any agreement with a third party.

19. SUCCESSORS

This Agreement is to the benefit of and binds the Parties and their respective successors and permitted assigns.

20. GOVERNING LAWS

This Agreement shall be governed by, interpreted and enforced in accordance with the laws in force in British Columbia and the laws of Canada applicable therein.

21. DISPUTE RESOLUTION

In the event of a dispute under this Agreement, the Parties, or their representatives, agree to meet promptly for the purposes of attempting, in good faith, to negotiate a settlement.

22. COMMUNICATIONS

22.1 Acknowledgment

British Columbia shall acknowledge Canada's support in all public communications materials and products (including, but not limited to, information and advertising campaigns, invitations to participate in activities, printed/audio/visual electronic Materials, Web sites and exhibits). Such acknowledgment shall be in a form satisfactory to Canada. British Columbia shall withdraw the acknowledgment upon the written request of Canada.

22.2 Disclaimer

British Columbia shall, unless otherwise directed by Canada, ensure that the following disclaimer appears on any Materials developed for public distribution under this Agreement:

"The views expressed herein do not necessarily represent the views of Health Canada."

22.3 Language of communication

British Columbia shall provide services as well as oral and written communications funded under this Agreement to the public in English in the manner described in Appendix A.

23. AMENDING OR TERMINATING THE AGREEMENT

23.1 This Agreement may only be amended, in writing, by mutual consent of the Parties.

23.2 This Agreement may be terminated, in writing, by mutual consent of the Parties.

23.3 Nothing in section 23.2 limits Canada's ability to terminate this Agreement pursuant to sections 4.9 or 9.

23.4 This Agreement may be terminated by either party on ninety (90) days notice.

24. ENTIRE AGREEMENT

This Agreement (including all documents referred to herein as well as all Appendices attached hereto) sets forth the entire agreement between the Parties with respect to its subject-matter and supersedes and cancels all prior agreements, understandings, negotiations and discussions, both oral or written, between the Parties with respect to the Project.

25. OBLIGATIONS SURVIVING TERMINATION

All of **Canada's** and **British Columbia's** obligations shall expressly, or by their nature, survive termination or expiration of this Agreement until, and unless, they are fulfilled, or by their nature expire.

26. REPRESENTATIVES OF THE PARTIES AND NOTICE

Communications, including reporting and any notice, demand, request or other communication, shall be in writing and sent to the coordinates below. Communications that are delivered in person shall be deemed to have been received upon delivery; communications transmitted by facsimile or by e-mail shall be deemed to have been received the day of having been sent; and communications that are sent by mail shall be deemed to have been received eight (8) days after being mailed.

Any Notice to Canada shall be addressed to:

Paule Giguere
Senior Policy Analyst
Health Canada
Health Human Resources Policy Division
200 Eglantine Driveway
Tunney's Pasture, Ottawa, ON K1A 0K9

Paule_giguere@hc-sc.gc.ca

Telephone: 613-948-7789

Facsimile: 613-948-8081

OR

Heather Sperry
Senior Program Officer
Health Canada
Health Human Resources Policy Division
200 Eglantine Driveway
Tunney's Pasture, Ottawa, ON K1A 0K9

heather_sperry@hc-sc.gc.ca

Telephone: 613-948-8266

Facsimile: 613-948-8081

Any notice to British Columbia shall be addressed to:

Libby Posgate
Executive Director, Health Human Resources
Ministry of Health, Province of British Columbia
2-1, 1515 Blanshard Street
Victoria, BC V8W 3C8

Libby.Posgate@gov.bc.ca

Telephone: 250-952-1107

Facsimile: 250-952-2125

27. **Signatories**

This Agreement has been executed on behalf of British Columbia and on behalf of Canada by their duly authorized representatives.

For British Columbia:

30 March 2011
Date:

Sheila Taylor
Assistant Deputy Minister
Medical Services and Health Human Resources Division
BC Ministry of Health

WITNESS:

L Posgate
(Signature)

L Posgate
(Print Name)

For Canada:

30 March. 2011
Date:

Abby Hoffman
Acting Assistant Deputy Minister
Health Canada

WITNESS:

(Signature)

Gavin Brown
(Print name)

Appendix A

Project

Executive Summary

BC proposes to expand and distribute the *IMG-BC Program* in family medicine residencies for underserved/rural communities. Beginning in 2012, the program will expand by 8 entry-level positions each year, over five years, for a total of 40 entry-level positions. All 40 positions will be in family medicine, and distributed to health authorities which have underserved/rural communities. At a steady state the *IMG-BC Program* will have 134 residents in training at any one time. Today the *IMG-BC Program* has 18 entry-level positions: 12 in family medicine; 6 in core specialties for a steady state of 54 residents in training at any one time.

Since 2004, BC has doubled both undergraduate and postgraduate medical education to 256 entry-level positions a year, and distributed medical education to all of the province's health regions. There are now medical programs in the North, Vancouver/Fraser, the Island, and soon the Interior (2011).

The University of British Columbia (UBC) Faculty of Medicine (FoM) has partnered with three universities (University of Northern British Columbia, University of British Columbia-Okanagan, University of Victoria) and six health authorities (Northern, Interior, Vancouver Coastal, Fraser, Vancouver Island, Provincial Health Services) to deliver medical education. All students receive their degree from UBC.

During this time of rapid expansion and distribution, the *IMG-BC Program* has tripled to 18 entry-level positions (2005), but remains located in Vancouver. International medical graduates (IMGs) who access the program sign a return-of-service contract before starting. In exchange for returning service in an underserved/rural community, the province agrees to fund their postgraduate medical education. The community is usually one listed in BC's *Rural Practice Subsidiary Agreement*, but may also be a community 'of need', such as Vancouver's downtown eastside.

Since 2008, IMGs have returned service in rural communities such as Bella Bella (Waglisla), Bowen Island, Gibson, Powell River, Sechelt, Fort Nelson, Prince Rupert, and Terrace. Each year, however, more IMGs seek an amendment to their contract. One element of the problem is immigrant IMGs tend to be older and have families situated in the Lower Mainland. Understandably, they would prefer to live with their families. Often, while returning service, they commute/split their time between the return-of-service community and their family's community.

In 2009, parents of Canadians studying abroad (CSAs) began to press the BC Government for their sons' and daughters' greater access to postgraduate medical education. CSAs would like to return to BC to complete their medical education and practice.

Now, BC would like to address both issues by expanding and distributing the *IMG-BC Program* in family medicine residencies for underserved communities. The Faculty of Medicine and BC Ministry of Health Services envision:

- Adding five distributed training sites for family medicine.
    - Accreditation requires family medicine residents be primarily based in an office setting.
    - The *IMG-BC Program* is located in Vancouver's St. Paul's Hospital where a major part of the training is hospital-based the first year, and then out in practicing family physicians' offices the second year.
    - To distribute the *IMG-BC Program*, it will merge with the distribution of family medicine residencies for Canadian medical graduates, and five new sites will be added outside Vancouver. There will be physical space in the health region's clinical academic campus/affiliated regional centre (teaching hospital), audiovisual connectivity, as well as a network of practicing family physicians in whose offices residents train.
- Practicing physicians' offices will extend to those in underserved/rural communities, as much as possible. Accreditation requires clinical faculty have the College of Family Physicians of Canada designation, and training meets curriculum content and practice-based experience requirements.
- After completing postgraduate medical education, the IMG will return service in the health authority (region) in which he/she has trained (a health authority that has underserved/rural communities or communities of 'need').
- Before entering postgraduate medical education, the new family medicine residencies with the *IMG-BC Program* will be posted in the Canadian Resident Matching Service (CaRMS) with two conditions – the majority of training will be in a specific health authority, followed by a two-year return of service in an underserved/rural community in that health authority.

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Sect 13

- Audiovisual information technology will be used to help further distribute medical education. UBC FoM has earned an international reputation based on its use of information technology to deliver medical education and the evidence to support accreditation requirements.
- The postgraduate program for family medicine will restructure to better support clinical faculty engagement and optimize clinical teaching resources.

Summary of Schedule to Expand and Distribute the *IMG-BC Program*

Existing		Proposed Expansion to Distributed Sites				
When	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Where	Vancouver	Fraser Valley	Vancouver Island	Interior	Northern	Fraser
Number of R1 positions	18	8	8	8	8	8
Specialty	12 Family medicine; 6 Royal College specialty	Family Medicine	Family Medicine	Family Medicine	Family Medicine	Family Medicine
Grand total R1 positions	18	26	34	42	50	58

Project Goals are to:

1. Attract the right residents to family medicine to train in a health region which has underserved/rural communities.

2. Improve access to primary health care for British Columbians in underserved/rural communities.

The project will:

1. Increase the number of residents training in family medicine. Practicing physicians/clinical-academic experiences will extend to those in underserved/rural communities, as much as possible.
2. Increase alignment of academic and primary health care services delivery. More residents will work with physicians engaged in integrated health networks (IHNs) or divisions of family practice.
3. Increase access to primary health care for underserved/rural communities. More residents (who are physicians providing service within a recognized training program, under the supervision of a fully licensed physician) will be offering primary health care services in a health authority (region) that has underserved/rural communities or communities of 'need'.
4. Join together a physician's training with a return-of-service commitment. In total, these physicians will provide four years of service in a health region, thereby 'tipping' them to relocate and engage in their new community, rather than commute.
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6. Restructure the postgraduate program for family medicine to better support clinical faculty engagement and optimize clinical teaching resources.

Official Languages Requirements

In British Columbia, the majority of the province's population has English as its first language, the majority of medical services are delivered in English, and all postgraduate medical education is conducted in English. In support of patient safety, residents participating in the *Expansion and Distribution of the IMG-BC Program (2011-2016)* are to hold an educational license with the College of Physician and Surgeons of BC. The College has a regulated English language proficiency requirement.

Performance Measurement and/or Evaluation Plan

This project will use the UBC FoM Physician Human Resource Framework (logic model 1) and create another for international medical graduates (logic model 2) to help report results. The project will call upon the resources already in place to evaluate and monitor the UBC FoM distributed medical education's impact on physician human resources (HR) (distribution, recruitment and retention) in BC. Dr. C. Lovato and Helen Hsu developed the framework.

FoM is the primary provider of trained physicians to BC and works closely with MoHS to ensure the health human resources needs of the province are met. The expansion and distribution of medical education is about increasing the supply of physicians *and* encouraging UBC graduates to practice in rural, remote and northern communities.

In its commitment to transparency and continuous improvement, FoM has placed high priority on evaluation and social accountability. It is important to note that any expansion requires time and commitment to accomplish. Figure 1 below illustrates the timeline of this strategy from planning to training to practice. For example, the first expansion class entered undergraduate MD education in 2004, graduated in 2008, and entered their postgraduate training in July 2008. Those training in family medicine entered full practice in July 2010, and those in other specialities will enter practice in July 2013. Therefore evidence for success on physician HR distribution will begin to emerge in 2010.

Evaluation Purpose

The primary goal of UBC FoM distributed medical education is to enhance health and human resources (HHR) to reduce health disparities and enhance community capacity in BC. The logic model presented below depicts the overall strategy UBC FoM has undertaken to advance provincially distributed medical education and the effective recruitment and retention of physicians in areas of need and in a distributed format, including the resources required, activities and expected outcomes to achieve these goals.

Evaluation Scope

Two key evaluation areas for physician HR in BC are: (1) hard-to-serve communities (rural, remote, and northern), and (2) special populations.

The scope of evaluation includes physicians in postgraduate training and professional practice that were enrolled in the distributed medical program since 2004 onward and are currently contributing to the health human resource needs of BC. Students in the undergraduate MD education program are not included nor are students that were not trained through the distributed curriculum.

The stakeholders involved in and are impacted by this work are: MoHS; UBC FoM Senior Leadership; UBC FoM Teaching Faculty; UBC FoM Students/Residents; Health Authorities; British Columbians (including special population groups).

Evaluation Process

Process	Key Activities
Planning	1. Identify stakeholders needs 2. Engage stakeholders in defining evaluation scope, question, and criteria
Implementation	3. Collect, analyze, summarize data
Reporting	4. Prepare draft evaluation reports for review and discussion 5. Assess relevance of recommendations to educational context 6. Incorporate stakeholder feedback into final reports and agree on recommendations
Continuous Program Improvement	7. Monitor for continuous program improvement 8. Include monitoring findings in reports for appropriate committees and accreditation

Evaluation Plan

A longitudinal approach is being used to evaluate the distribution of physician HR in BC. Table 1 outlines the evaluation methods, criteria, data source, analytic approach and standards. In 2006, the Evaluation Studies Unit (ESU) at FoM developed FoM database to track medical students from admissions through to postgraduate training and practice location. The database was developed for purposes of both institutional evaluation and research, as well as to serve as a resource for medical education researchers. The database is being populated with information for the entering class of 2004 and beyond. Some data have also been entered for entering classes between 1999 and 2003 for baseline comparison. The data is organized into seven categories from Admission characteristics to postgraduate training sites and specialty.

Currently, the main data source that will provide data for this evaluation is from CaRMS and CAPER, which provides information on residency program and practice location. Plans are in place to collect data from individual UBC postgraduate programs (e.g. family medicine) that have their own database to track physicians for detailed data that CAPER does not capture. In addition, ESU will be working with programs that do not have monitoring mechanism tracking their students/graduates to implement a database and ongoing monitoring strategy to collect information on training and practice location.

Table 1 - Evaluation Methods, Criteria and Standards

Evaluation Area	Evaluation Questions	Evaluation Criteria	Data Sources	Analytic Methods & Reporting	Standards of Acceptability
Physician HR recruitment	Is there an increase in the number of medical graduates training in family practice and general specialties?	medical graduates by specialty, by practice location, by year	FoM Database (include internal and external data sources)	Descriptive GIS Mapping (see sample map)	Historical provincial and national comparisons
Hard-to-serve communities	Are BC medical graduates practicing in hard-to-serve communities – rural, remote, northern – in BC?	Number of practicing medical graduates by practice location, by specialty, by year, by rural, remote, northern communities	FoM Database (include internal and external data sources)	Descriptive GIS Mapping (see sample map)	Historical provincial and national standards
Special Populations	Are BC physicians serving special populations?	Number of practicing physicians by practice location (proxy), by specialty, by year	FoM Database (include internal and external data sources)	Descriptive GIS Mapping (see sample map)	Historical provincial and national standards
Physician HR retention	Is there an increase in retention of BC trained physicians remaining to practice in BC?	Number of practicing physicians trained in BC by practice location, by specialty, by year	CAPER, Departmental Data	Descriptive GIS Mapping	Historical provincial, and national comparisons
Community health capacity and quality of care	What is the impact of Northern Medical Program on the Prince George Community?	Perceptions of key stakeholders in the community. Impact on Education, health services, economy,	Interviews (follow up to 2004, 2007 studies) Quantitative indicators from available databases (CHSPR and other)	Descriptive	Historical provincial comparisons

This project will use the UBC FoM Physician Human Resource Framework (logic model 1) and create another, complementary logic model for international medical graduates (logic model 2). The key evaluation areas will focus on the **Project Goals** of attracting the right residents to family medicine to train in a health region which has underserved/rural communities, and improving access to primary health care for British Columbians in underserved/rural communities.

Table 2 - Evaluation Methods, Criteria and Standards

Evaluation Area	Evaluation Questions	Evaluation Criteria	Data Sources	Analytic Methods & Reporting	Standards of Acceptability
Underserved / Rural Communities	1. Are the **assessment** strategies attracting the right IMG-BC family practice residents to **train** and **practice** in distributed sites, underserved/ rural communities of need and IHNs? 2.Are the IMGs remaining in the ROS community?	1. Number of IMGs assessed 2. Number of IMG-BC residents -by practice location -by specialty -by year -by rural /underserved community -by IHN or Division of Family Practice? 3. Number of IMG-BC medical graduates with ROS **practicing in BC** -by practice location -by specialty -by year -by rural /underserved community -by IHN or Division of Family Practice? 4. Number of IMGs remaining in the ROS community?	FoM Database	Descriptive GIS Mapping (see sample map)	Historical provincial and national standards

Immediate Outcomes of the project are expected to be:

1) *IMG-BC Program* policy changes enable distributed medical education for IMGs in family medicine.
2) *Return of Service Program* policy changes enable the assignment of the return of service to be attached to the health authority in which the IMG trains. At present, location of training and health region where one returns service is not linked.
3) Family physicians practicing in the Fraser Health Authority engage in the academic enterprise and agree to train residents.
4) 8 new entry-level positions in the *IMG-BC Program* are registered with CaRMS in 2011 for the 2012 match. These positions have two conditions: training is in the Fraser Health region, and is followed by a return of service in that health region, preferably in an underserviced/rural community.
5) The postgraduate family medicine program restructures to better support clinical faculty engagement and optimize clinical teaching resources.

Intermediate Outcomes expected are:

1) More *IMG-BC* residents are training in family medicine, and training in underserved/rural communities.
2) Clinical Placement Liaison Office (CPLO) opens.
3) More family physicians practicing in Fraser Health, Vancouver Island Health and Interior Health engage in the academic enterprise and agree to train residents.
4) 16 new entry-level positions in the *IMG-BC Program* are registered with CaRMS in 2012 for the 2013 match: 8 in Fraser Health and 8 in Vancouver Island Health regions. These positions have two conditions: training is in the specific health region, and is followed by a return of service in that health region, preferably in an underserviced/rural community.

5) 24 new entry-level positions in the *IMG-BC Program* are registered with CaRMS in 2013 for the 2014 match: 8 in Fraser Health; 8 in Vancouver Island Health; 8 in Interior Health. These positions have two conditions: training is in the specific health region, and is followed by a return of service in that health region, preferably in an underserviced/rural community.
6) New assessment strategies to attract the right resident to a family medicine residency position in the right health authority are tested for system implementation in 2013.

Long-term Outcomes expected are:

1) More family physicians practicing in Northern Health engage in the academic enterprise and agree to train residents.
2) Better alignment of academic and primary health care services delivery. More residents are training/working with physicians engaged in integrated health networks (IHNs) or divisions of family practice.
3) Increased access to primary health care for underserved/rural communities. More residents (who are physicians providing service within a recognized training program, under the supervision of a fully licensed physician) are providing primary health care services in a specific health region.
4) By joining training and return of service conditions in CaRMS, IMGs provide four years of service in a health region which has underserved/rural communities, thereby 'tipping' them to relocate and engage, rather than commute.

Dissemination Plan

The *Postgraduate Planning Task Force* (PPTF) and the *Task Force for the Assessment, Training and Support of IMGs in BC* (IMG TF) are the two task forces engaged in issues about HHR, the expansion and distribution of medical education, the health authorities physician human resources needs, a health region's population health needs - all of these in order for BC to have the right kind of the number of physicians in the right places with the rights skills to deliver medical services the population needs. These two mechanisms will be the key mechanisms used to inform stakeholders about the project, its progress, its findings, and the dissemination of information.

The Faculty of Medicine, MoHS, Health Match BC, the *IMG-BC Program*, and the College of Physicians and Surgeons of BC all have their own websites which can help to link or directly distribute the information. The Association of International Medical Graduates of BC is an interest group which has two representatives on the (IMG TF). They say their membership has 600 physicians, and they too will help to ensure critical pieces of information, findings will be shared so their members may benefit.

Sustainability Plan

Faculty of Medicine and MoHS are committed to expanding and distributing the *IMG-BC Program* in family medicine. The Faculty of Medicine, MoHS, and the Ministry of Science and Universities have signed a letter of intent, where the parties have agreed to expand and distribute the *IMG-BC Program* by a further 40 entry-level positions in family medicine, beginning in 2011/12 (8 family medicine residency positions a year over five years). Health Canada's funding will contribute to the expansion and distribution of the *IMG-BC Program* in family medicine; MoHS intends to continue with the program's expansion and distribution on a sustained basis, as Health Canada's funding ends.

Work Plan

Reporting Period: January 1, 2011 – March 31, 2011

Project Objective 1: Increase the number of residents training in family medicine. Practicing physicians/clinical-academic experiences will extend to those in underserved/rural communities, as much as possible.

Planned Activities / Timeframes January 1, 2011 – March 31, 2011: Fraser Health Authority	Outputs	Outcomes	Anticipated Challenges
Begin to set up program infrastructure for distributed family medicine in **Fraser Health**. Identify or have site-specific: regional assistant program director; program administration support; clinical faculty engagement activities for teaching (with clinical placement liaison office); clinical faculty development for those working with IMGs	Begin arrangements to hire site personnel Begin to identify family physicians (clinical faculty) and their practices in underserved/rural communities for teaching residents Begin to identify at least 10 family physicians with CFPC certification who are willing to teach Begin to arrange for 2 training sessions to orient clinical faculty to teaching/working with IMGs	Distributed medical education for *IMG-BC Program* begins Academic enterprise begins to become part of physician culture in health authority/region Health authority medical director and physician recruitment office are aware of new entry-level positions for their region	Physician base for teaching in health authority/region may lack CFPC certification Physician community may choose to not engage in the academic program Physician community may become side tracked by other distracting interests/agendas that surface from time to time Timely and sufficient financial resources may not be available for postgraduate family medicine program reorganization

Project Objective 2: Increase alignment of academic and primary health care services delivery. More residents will work with physicians engaged in integrated health networks (IHNs) or divisions of family practice.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
January 1, 2011 - March 31, 2011: Fraser Health Authority			
Begin to engage more family physicians interested in the academic enterprise	Have more clinical faculty in health authority/region engaged	More practicing family physicians in health authority engage in the academic enterprise and agree to train residents	Clinical faculty require CFPC certification and may not have this

Project Objective 3: Increase access to primary health care for underserved communities. More residents (who are physicians providing service within a recognized training program, under the supervision of a fully licensed physician) will be offering primary health care services in a particular health region.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
January 1, 2011 - March 31, 2011: Fraser Health Authority			
Begin to identify family physicians (clinical faculty) serving underserved/rural communities who are interested in teaching residents	Begin to identify at least 10 family physicians with CFPC certification who are willing to teach	More family residents are training and providing primary care services in health authority/region, preferably in underserved/rural communities More residents are training in physicians' practices that belong to an IHN or division of family practice More family physicians are engaged in the academic enterprise which helps to strengthen primary health care delivery in health authority/region Physician culture changes	There may not be enough family physicians with CFPC certification who want to teach IMGs may not choose health authority/region for training Timely and sufficient financial resources may not be available for postgraduate family medicine training program reorganization

Project Objective 4: Join together a physician's training with a return of service commitment. In total, physicians are looking at providing four years of service in a particular health region, thereby 'tipping' IMGs to relocate and engage, rather than commute.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
January 1, 2011 - March 31, 2011, Fraser Health Authority			
n/a			

Project Objective 5: Sect 13

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
January 1, 2011 - March 31, 2011, Fraser Health Authority			
n/a			

Project Objective 6: Restructure the postgraduate program for Family Medicine to better support clinical faculty and optimize clinical teaching resources.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
January 1, 2011 - March 31, 2011, Fraser Health Authority			
Begin to plan postgraduate family medicine program reorganization	Outline plan for family medicine program reorganization	Distributed medical education for *IMG-BC Program* enabled Clinical teaching resources well identified, supported/trained, tightly scheduled Current medical education expansions continue to be successful and meet accreditation requirements Matrix model of management is efficient, effective, well understood and supported	Timely and sufficient financial resources may not be available Postgraduate medical education program is at capacity now and must reorganize to meet new demand of yet another expansion and further distribution.

Reporting Period: April 1, 2011 – March 31, 2012

Project Objective 1: Increase the number of residents training in family medicine. Practicing physicians/clinical-academic experiences will extend to those in underserved/rural communities, as much as possible.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 1, 2011- March 31, 2012, Fraser Health Authority			
Continue to set up program infrastructure for distributed family medicine in **Fraser Health**. Have site-specific: regional assistant program director; program administration support; clinical faculty engagement activities for teaching (with clinical placement liaison office); clinical faculty development for those working with IMGs	Continue to hire site personnel Continue to identify family physicians (clinical faculty) and their practices in underserved/rural communities for teaching residents Confirm at least 10 family physicians with CFPC certification who are willing to teach Conduct 2 training sessions to orient clinical faculty to teaching/working with IMGs	Distributed medical education for *IMG-BC Program* begins Academic enterprise begins to become part of physician culture in health authority/region Health authority medical director and physician recruitment office are aware of new entry-level positions for their region	Physician base for teaching in health authority/region may lack CFPC certification Physician community may choose to not engage in the academic program Physician community may become side tracked by other distracting interests/agendas that surface from time to time Timely and sufficient financial resources may not be available for postgraduate family medicine program reorganization
Change *IMG-BC Program* policy/practices to enable distributed medical education in health authority/region	Adjust existing policy/practices	Changes in *IMG-BC Program* policy/practice enable distributed medical in health authority/region	*IMG-BC Program* may resist shift from centralized to distributed program
Confirm evaluation framework for *IMG-BC Program* expansion and distribution Adjust postgraduate family medicine program data collection Plan and implement evaluation framework	Have complementary *IMG-BC Program* evaluation framework Draw baseline for project	Baseline information is collected within larger context of distributed medical education and research and analysis is possible, or underway	Timely and sufficient financial resources may not be available for ESU to hire personnel required to focus/drive *IMG-BC Program* evaluation

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
Collect baseline information			
Place 8 new entry-level positions in CaRMS match 2012 for family medicine training in **Fraser Health**, followed by two-year return of service in health authority/region, preferably in an underserved/rural community	Have 8 family practice residents start July 1, 2012 in **Fraser Health**	The number of IMG residents training in family medicine increases	IMGs may not choose this location for training in the first iteration of the match There may not be enough family physicians with CFPC certification/interest in teaching to support 8 new residency positions

Project Objective 2: Increase alignment of academic and primary health care services delivery. More residents will work with physicians engaged in integrated health networks (IHNs) or divisions of family practice.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 1, 2011- March 31, 2012, Fraser Health Authority			
Continue to align family medicine residency positions with health authority/region's IHN or division of family practice	Have CPLO facilitate a shift for family physicians who do not belong to an IHN or division of family practice, based on physician interest	Family medicine residencies are more closely linked with health authority's primary health care delivery	There may not be enough IHNs or divisions of family practice for physicians to align to More IHNs or divisions of family practice may need to be set up
Continue to engage more family physicians interested in the academic enterprise; train them to be effective clinical faculty, especially with IMGs	Have more clinical faculty in health authority/region engaged; trained	More practicing family physicians in health authority engage in the academic enterprise and agree to train residents	Clinical faculty require CFPC certification and may not have this

Project Objective 3: Increase access to primary health care for underserved communities. More residents (who are physicians providing service within a recognized training program, under the supervision of a fully licensed physician) will be offering primary health care services in a particular health region.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 1, 2011- March 31, 2012, Fraser Health Authority			
Set up Clinical Placement Liaison Office (CPLO)	Hire CPLO personnel	Family physician base with CFPC for teaching increases in health authority/region, through clinical placement liaison office	Timely and sufficient financial resources may not be available for a clinical placement liaison office
Continue to identify family physicians	Confirm at least 10 family physicians	More family residents are training and	There may not be enough family physicians with

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 1, 2011 - March 31, 2012, Fraser Health Authority			
(clinical faculty) serving underserved/rural communities who are interested in teaching residents	with CFPC certification who are willing to teach	providing primary care services in health authority/region, preferably in underserved/rural communities More residents are training in physicians' practices that belong to an IHN or division of family practice More family physicians are engaged in the academic enterprise which helps to strengthen primary health care delivery in health authority/region Physician culture changes	CFPC certification who want to teach IMGs may not choose health authority/region for training Timely and sufficient financial resources may not be available for postgraduate family medicine training program reorganization

Project Objective 4: Join together a physician's training with a return of service commitment. In total, physicians are looking at providing four years of service in a particular health region, thereby 'tipping' IMGs to relocate and engage, rather than commute.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 1, 2011 - March 31, 2012, Fraser Health Authority			
Adjust *Return of Service Program* policy/practices to enable the assignment of returning service to health authority/region in which IMG trains	Align residents training in physicians' offices with potential for returning service assignment in health authority/region, preferably in underserved/rural community	IMGs are training/practicing in a health region for four years More IMGs choose to relocate to the health region	There may not be enough family physicians with CFPC certification who want to teach IMGs may challenge return of service assignment
Change FoM/MoHS instructions to CaRMS, beginning in 2012. 8 new family medicine residency positions are attached to health authority/region, followed by two-year return of service, preferably in an underserved/rural community	Updated instructions to CaRMS are posted on CaRMS website, summer 2011 Have Health Match BC connect with successful IMGs and support them to identify an underserved/rural community in the health authority/region to return	Training and return of service are joined More IMGs choose to relocate to the health region	

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 1, 2011- March 31, 2012, Fraser Health Authority			
	services, as they train. Keep this connection live throughout their residency training		

Sect 13

Project Objective

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Project Objective 6: Restructure the postgraduate program for Family Medicine to better support clinical faculty and optimize clinical teaching resources.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 1, 2011- March 31, 2012, Fraser Health Authority			
Complete plan for postgraduate family medicine program reorganization	Introduce family medicine program reorganization	Distributed medical education for *IMG-BC Program* enabled Clinical teaching resources well identified, supported/trained, tightly scheduled Current medical education expansions continue to be successful and meet accreditation requirements Matrix model of management is efficient, effective, well understood and supported	Timely and sufficient financial resources may not be available Postgraduate medical education program is at capacity now and must reorganize to meet new demand of yet another expansion and further distribution.
Set up Clinical Placement Liaison Office (CPLO)	Refer to project objective 3	Distributed medical education for *IMG-BC Program* enabled	Timely and sufficient financial resources may not be available

Reporting Period: April 1, 2012 – March 31, 2013

Project Objective 1: Increase the number of residents training in family medicine. Practicing physicians/clinical-academic experiences will extend to those in underserved/rural communities, as much as possible.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 2012-March 2013, Vancouver Island			
Set up program infrastructure for distributed family medicine training site in **Vancouver Island**. Have site-specific: regional assistant program director; program administration support; clinical faculty engagement activities for teaching (with clinical placement liaison office); clinical faculty development for those working with IMGs	Hire site personnel Begin to identify family physicians (clinical faculty) and their practices in underserved/rural communities for teaching residents Confirm at least 10 family physicians with CFPC certification who are willing to teach Conduct 2 training sessions to orient clinical faculty to teaching/working with IMGs	Distributed medical education for *IMG-BC Program* begins Academic enterprise begins to become part of physician culture in health authority/region Health authority medical director and physician recruitment office are aware of new entry-level positions for their region	Physician base for teaching in health authority/region may lack CFPC certification Physician community may choose to not engage in the academic program Physician community may become side tracked by other distracting interests/agendas that surface from time to time Timely and sufficient financial resources may not be available for postgraduate family medicine program reorganization
Continue to collect data for evaluation framework for *IMG-BC Program* expansion and distribution	Collect, analyze, summarize date Prepare first draft evaluation report for review and discussion Assess relevance of recommendations (perhaps too early for this) Incorporate MoHS HR feedback into first report	Information is collected within larger context of distributed medical education and research and analysis is underway	Timely and sufficient financial resources may not be available for ESU to hire personnel required to focus/drive *IMG-BC Program* evaluation
Place 8 new entry-level positions in CaRMS match 2013 for family medicine training in **Vancouver Island**	Have 8 family practice residents start July 1, 2013 in **Vancouver Island Health**	The number of IMG residents training in family medicine increases	IMGs may not choose this location for training in the first iteration of the match

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
Health, followed by two-year return of service in health authority/region, preferably in an underserved/rural community			There may not be enough family physicians with CFPC certification/interest in teaching to support 8 new residency positions

Project Objective 2: Increase alignment of academic and primary health care services delivery. More residents will work with physicians engaged in integrated health networks (IHNs) or divisions of family practice.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 2012-March 2013, Vancouver Island			
Continue to align family medicine residency positions with health authority/region's IHN or division of family practice	Have CPLO facilitate a shift for family physicians who do not belong to an IHN or division of family practice, based on physician interest	Family medicine residencies are more closely linked with health authority's primary health care delivery	There may not be enough IHNs or divisions of family practice for physicians to align to More IHNs or divisions of family practice may need to be set up
Engage more family physicians interested in the academic enterprise; train them to be effective clinical faculty, especially with IMGs	Have more clinical faculty in health authority/region engaged; trained	More practicing family physicians in health authority engage in the academic enterprise and agree to train residents	Clinical faculty require CFPC certification and may not have this

Project Objective 3: Increase access to primary health care for underserved communities. More residents (who are physicians providing service within a recognized training program, under the supervision of a fully licensed physician) will be offering primary health care services in a particular health region.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 2012-March 2013, Vancouver Island			
Continue to identify family physicians (clinical faculty) serving underserved/rural communities who are interested in teaching residents	Confirm at least 10 family physicians with CFPC certification who are willing to teach	More family residents are training and providing primary care services in health authority/region, preferably in underserved/rural communities More residents are training in physicians' practices that belong to an IHN or division of family practice	There may not be enough family physicians with CFPC certification who want to teach IMGs may not choose health authority/region for training Timely and sufficient financial resources may not be available for postgraduate family medicine training program reorganization

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 2012-March 2013, Vancouver Island			
		More family physicians are engaged in the academic enterprise which helps to strengthen primary health care delivery in health authority/region Physician culture changes	

Project Objective 4: Join together a physician's training with a return of service commitment. In total, physicians are looking at providing four years of service in a particular health region, thereby 'tipping' them to relocate and engage, rather than commute.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 2012-March 2013, Vancouver Island			
Continue to adjust *Return of Service Program* policy/practices to enable the assignment of returning service to health authority/region in which IMG trains	Monitor for 'tipping' information from *IMG-BC Program* and Health Match BC	IMGs are training/practicing in a health region for four years More IMGs choose to relocate to the health region	There may not be enough family physicians with CFPC certification who want to teach IMGs may challenge return of service assignment
Change again, if required, FoM/MoHS instructions to CaRMS,	Have Health Match BC connect with successful IMGs and support them to identify an underserved/rural community in the health authority/region to return services, as they train. Keep this connection live throughout their residency training	More IMGs choose to relocate to the health region	

Sect 13

Project Objective 5

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Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 2012-March 2013, Vancouver Island			
			Sect 13

Project Objective 6: Restructure the postgraduate program for Family Medicine to better support clinical faculty and optimize clinical teaching resources.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 2012-March 2013, Vancouver Island			
Continue postgraduate family medicine program reorganization	Monitor and adjust implementation strategy for reorganization	Distributed medical education for *IMG-BC Program* enabled Clinical teaching resources well identified, supported/trained, tightly scheduled Current medical education expansions continue to be successful and meet accreditation requirements Matrix model of management is efficient, effective, well understood and supported	Timely and sufficient financial resources may not be available Postgraduate medical education program is at capacity now and must reorganize to meet new demand of yet another expansion and further distribution.
Rely on Clinical Placement Liaison Office (CPLO)	Refer to project objective 3	Distributed medical education for *IMG-BC Program* enabled	Timely and sufficient financial resources may not be available

Reporting Period: April 1, 2013 – March 31, 2014

Project Objective 1: Increase the number of residents training in family medicine. Practicing physicians/clinical-academic experiences will extend to those in underserved/rural communities, as much as possible.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 2013-March 2014, Interior Health			
Set up Program infrastructure for distributed family medicine training site in **Interior Health Authority**. Have site-specific: regional assistant program director; program administration support; clinical faculty engagement activities for teaching (with clinical placement liaison office); clinical faculty development for those working with IMGs	Hire site personnel Begin to identify family physicians (clinical faculty) and their practices in underserved/rural communities for teaching residents Confirm at least 10 family physicians with CFPC certification who are willing to teach Conduct 2 training sessions to orient clinical faculty to teaching/working with IMGs	Distributed medical education for *IMG-BC Program* begins Academic enterprise begins to become part of physician culture in health authority/region Health authority medical director and physician recruitment office are aware of new entry-level positions for their region	Physician base for teaching in health authority/region may lack CFPC certification Physician community may choose to not engage in the academic program Physician community may become side tracked by other distracting interests/agendas that surface from time to time Timely and sufficient financial resources may not be available for postgraduate family medicine program reorganization
Place 8 new entry-level positions in CaRMS match 2014 for family medicine training in **Interior Health**, followed by two-year return of service in health authority/region, preferably in an underserved/rural community	Have 8 family practice residents start July 1, 2014 in **Interior Health**	The number of IMG residents training in family medicine increases	IMGs may not choose this location for training in the first iteration of the match There may not be enough family physicians with CFPC certification/interest in teaching to support 8 new residency positions

Project Objective 2: Increase alignment of academic and primary health care services delivery. More residents will work with physicians engaged in integrated health networks (IHNs) or divisions of family practice.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 2013-March 2014, Interior Health			
n/a			

Project Objective 3: Increase access to primary health care for underserved communities. More residents (who are physicians providing service within a recognized training program, under the supervision of a fully licensed physician) will be offering primary health care services in a particular health region.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 2013-March 2014, Interior Health			
n/a			

Project Objective 4: Join together a physician's training with a return of service commitment. In total, physicians are looking at providing four years of service in a particular health region, thereby 'tipping' them to relocate and engage, rather than commute.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 2013-March 2014, Interior Health			
n/a			

Project Objective 5:] Sect 13

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 2013-March 2014, Interior Health			
n/a			

Project Objective 6: Restructure the postgraduate program for Family Medicine to better support clinical faculty and optimize clinical teaching resources.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 2013-March 2014, Interior Health			
n/a			

Reporting Period: April 1, 2014 – March 31, 2015

Project Objective 1: Increase the number of residents training in family medicine. Practicing physicians/clinical-academic experiences will extend to those in underserved/rural communities, as much as possible.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 2014-June 2015, Northern Health and second Fraser Health			
Set up Program infrastructure for distributed family medicine training site in **Northern Health**. Have site-specific: regional assistant program director; program administration support; clinical faculty engagement activities for teaching (with clinical placement liaison office); clinical faculty development for those working with IMGs Begin to set up infrastructure for second distributed family medicine training site in **Fraser Health.** Have site-specific: regional assistant program director	Hire site personnel Begin to identify family physicians (clinical faculty) and their practices in underserved/rural communities for teaching residents Confirm at least 10 family physicians with CFPC certification who are willing to teach Conduct 2 training sessions to orient clinical faculty to teaching/working with IMGs	Distributed medical education for *IMG-BC Program* begins Academic enterprise begins to become part of physician culture in health authority/region Health authority medical director and physician recruitment office are aware of new entry-level positions for their region	Physician base for teaching in health authority/region may lack CFPC certification Physician community may choose to not engage in the academic program Physician community may become side tracked by other distracting interests/agendas that surface from time to time Timely and sufficient financial resources may not be available for postgraduate family medicine program reorganization
Place 8 new entry-level positions in CaRMS match 2015 for family medicine training in **Northern Health**, followed by two-year return of service in health authority/region, preferably in an underserved/rural community	Have 8 family practice residents start July 1, 2015 in **Northern Health**	The number of IMG residents training in family medicine increases	IMGs may not choose this location for training in the first iteration of the match There may not be enough family physicians with CFPC certification/interest in teaching to support 8 new residency positions

Project Objective 2: Increase alignment of academic and primary health care services delivery. More residents will work with physicians engaged in integrated health networks (IHNs) or divisions of family practice.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 2014-June 2015, Northern Health and second Fraser Health			
n/a			

Project Objective 3: Increase access to primary health care for underserved communities. More residents (who are physicians providing service within a recognized training program, under the supervision of a fully licensed physician) will be offering primary health care services in a particular health region.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 2014-June 2015, Northern Health and second Fraser Health			
n/a			

Project Objective 4: Join together a physician's training with a return of service commitment. In total, physicians are looking at providing four years of service in a particular health region, thereby 'tipping' them to relocate and engage, rather than commute.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 2014-June 2015, Northern Health and second Fraser Health			
n/a			

Sect 13

Project Objective 5

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 2014-June 2015, Northern Health and second Fraser Health			
n/a			

Project Objective 6: Restructure the postgraduate program for Family Medicine to better support clinical faculty and optimize clinical teaching resources.

Planned Activities / Timeframes	Outputs	Outcomes	Anticipated Challenges
April 2014-June 2015, Northern Health and second Fraser Health			
n/a			

Appendix B

Budget

Note: The Recipient may reallocate, within a given Fiscal Year's budget, amounts among the approved broad budget categories, by no more than fifteen percent (15%), with the exception of the budget category for "Personnel" which may not be increased or decreased through a reallocation by more than five percent (5%). Where the amounts exceed 15% or 5%, the Recipient shall submit a written request to the Canada prior to making the transfer. Canada's written permission must be obtained before implementing the reallocation.
It is understood by the Parties that reimbursement for travel/accommodations and hospitality shall not exceed the amounts prescribed in the Treasury Board's policy.

Summary Budget	Contribution from Health Canada (Federal Fiscal Year = April 1 to March 31)					Total Budget
	January-March 2011	April 2011-March 2012	April 2012-March 2013	April 2013- March 2014	April 2014-March 2015	
Revenues						
Health Canada	$18,625	$1,695,304	$2,836,787	$711,554	$718,554	$5,980,824
Total Revenues	$18,625	$1,695,304	$2,836,787	$711,554	$718,554	$5,980,824
Expenditures						
Personnel salaries and benefits	$0	$1,396,304	$2,538,912	$711,554	$718,554	$5,347,949
Goods and services of contractual personnel	$8,750	$125,000	$125,000	0	0	$258,750
Travel and accommodations	$4,375	$70,000	$56,875	0	0	$131,250
Goods and services for meetings/conferences/workshops/ seminars/training/consultations	$1,500	$24,000	$36,000	0	0	$61,500
Materials and supplies	$1,250	$25,000	$25,000	0	0	$51,250
Audit	See note 2	See note 2	See note 2	0	0	0
Performance Measurement / Evaluation	See note 3	See note 3	See note 3	0	0	0
Communication and dissemination	See note 4	See note 4	See note 4	0	0	0
Rent and utilities	$1,500	$30,000	$30,000	0	0	$61,500
Equipment	$1,250	$25,000	$25,000	0	0	$51,250
Total Expenditures	$18,625	$1,695,304	$2,836,787	$711,554	$718,554	$5,980,824

BUDGET NARRATIVE

	January-March 2011	April 2011 – March 2012	April 2012- March 2013	April 2013 – March 2014	April 2014- March 2015	Total Budget
Revenues						
Health Canada	**$18,625**	**$1,695,304**	**$2,836,787**	**$711,554**	**$718,554**	**$5,980,824**
Personnel salaries and benefits [1]	**$0**	**$1,396,304**	**$2,538,912**	**$711,554**	**$718,554**	**$5,365,324**
Clinical Placement Liaison Office (CPLO)		▪ $56,000 – 0.4 FTE Faculty Director ▪ $70,000 – 1 FTE Database Admin ▪ $30,000 – 1 FTE Clerical Support	▪ $56,000 – 0.4 FTE Faculty Director ▪ $70,000 – 1 FTE Database Admin ▪ $30,000 – 1 FTE Clerical Support			
Sect 13		▪ $56,000 – 0.4 FTE Faculty Director ▪ $90,000 – 1 FTE	▪ $56,000 – 0.4 FTE Faculty Director ▪ $90,000 – 1 FTE			

		Assessment Specialist ▪ $30,000 – 1 FTE Clerical Support	Assessment Specialist ▪ $30,000 – 1 FTE Clerical Support			
Distribution of IMG-BC Program (per FP Site)		▪ $112,000 – 0.8 FTE Assistant Regional Director ▪ $70,000 – 1 FTE Program Coordinator ▪ $35,000 – 1 FTE Database Admin. ▪ $30,000 – 1 FTE Clerical Support	▪ $112,000 – 0.8 FTE Assistant Regional Director ▪ $70,000 – 1 FTE Program Coordinator ▪ $35,000 – 1 FTE Database Admin. ▪ $30,000 – 1 FTE Clerical Support	▪ $112,000 – 0.8 FTE Assistant Regional Director ▪ $28,250 – 0.4 FTE Program Coordinator	▪ $112,000 – 0.8 FTE Assistant Regional Director ▪ $35,250 – 0.5 FTE Program Coordinator	
Residents' salaries and benefits [2]		$571,304 for 8 residents FTEs	$1,713,912 for 24 resident FTEs	$571,304 for 8 resident FTEs	$571,304 for 8 resident FTEs	

Evaluation Studies Unit		▪ $56,000 – 0.4 FTE Faculty Director ▪ $90,000 – 1 FTE ▪ Evaluation Expert $70,000 Database Admin ▪ $30,000 – 1 FTE Clerical Support	▪ $56,000 – 0.4 FTE Faculty Director ▪ $90,000 – 1 FTE ▪ Evaluation Expert $70,000 Database Admin ▪ $30,000 – 1 FTE Clerical Support			
Goods and services of contractual personnel	**$8,750**	**$125,000**	**$125,000**			**$258,750**
Clinical Placement Liaison Office (CPLO)		$30,000 for database development contractor (120 days @ 250/day)	$30,000 for database development contractor (120 days @ $250/day)			
Sect 13		$30,000 for database development contractor (120 days@$250/day)	$30,000 for database development contractor (120 days@$250/day)			

Evaluation Studies Unit		$30,000 for database development contractor (120 days@ $250/day)	$30,000 for database development contractor (120 days@ $250/day)			
Audit	$4,400 for auditor (4.19 days @ $1,050/day) and $4,350 bookkeeper (10.4 days @$420/day)	$17,500 for auditor (16.7 days @ $1,050/day) and $17,500 bookkeeper (41.7 days @ $420/day)	$17,500 for auditor (16.7 days @ $1,050/day) and $17,500 bookkeeper (41.7 days @ $420/day)			
Travel and accommodations	**$4,375**	**$70,000**	**$56,857**			**$131,250**
Clinical Placement Liaison Office (CPLO)		$14,000 for 10 trips for director travel $800/return flight + Hotel (3 nights x $150), + $150 daily meals coverage, incidentals/cab/ transit costs (Considers TB guidelines)	$13,125 for 10 trips for director travel 700/return flight + Hotel (3 nights x $150), + $162.50 daily meals, incidentals, coverage, cab/transit costs (Considers TB guidelines)			

Sect 13		$14,000 for 8 trips for director travel $1100/return flight + Hotel (3 nights x $150) + $200 daily meals coverage, incidentals/ cab/transit costs	$4,375 for 2 trips for director travel $1300/return flight + Hotel (4 nights x $150) + 287.50 daily meals coverage, cab/transit costs				
Distribution of IMG-BC Program (per site)	$4,375 for 3 trips for director travel $900/return flight + Hotel (3 nights x $150), $108.33 daily meals coverage, incidentals/cab/ transit costs for 1 distributed site (Considers TB guidelines)	$28,000 for 20 trips for directors + residents $1000/return flight + Hotel (2 nights x $150) + $100 daily meals coverage, incidentals/ cab/transit costs for 2 distributed sites (Considers TB guidelines)	$39,375 for 30 trips for directors + residents $900/return flight + Hotel (2 nights x $150) + $112.50 daily meals coverage, incidentals/ cab/transit costs for 3 distributed sites (Considers TB guidelines)				

Evaluation Studies Unit		$14,000 for 10 trips for director $1100/return flight + Hotel (1 night x $150) + $150 daily meals coverage, incidentals/ cab/transit costs for 2 distributed sites					
Goods and services for meetings/conferences/workshops/ seminars/training/consultations	**$1,500**	**$24,000**	**$36,000**				**$61,500**
Clinical Placement Liaison Office (CPLO)		$4,800 for: 5 meetings- meeting room rental @ $150/day; hospitality- 40 physicians x $20.25/physician; hospitality	$6,000 for: 6 meetings- meeting room rental @ $150/day; hospitality- 60 physicians @ $14.17/physician;				
Sect 13		$4,800 for: 16 meetings- meeting room rental @ $150/day;	$6,000 for: 20 meetings- meeting room rental @ $150/day;				

		hospitality-5 people @ $30/person	hospitality-5 people @ $30/person				
Distribution of IMG-BC Program (per site)	$1,500 for: 5 meetings- meeting room rental @ $150/day; hospitality-5 people @ $30/person	$9,600 for: 32 meetings (16 per site)- meeting room rental @ $150/day; hospitality-5 people @ $30/person	$18,000 for: 60 meetings (20 per site)- meeting room rental @ $150/day; hospitality-5 people @ $30/person				
Evaluation Studies Unit		$4,800 for: 16 meetings- meeting room rental @ $150/day; hospitality-5 people @ $30/person	$6,000 for: 20 meetings- meeting room rental @ $150/day; hospitality-5 people @ $30/person				
Materials and supplies	**$1,250**	**$25,000**	**$25,000**				**$51,250**
Clinical Placement Liaison Office (CPLO)		$5,000 for materials and supplies, including toner, paper, teleconferences, etc	$5,000 for materials and supplies, including toner, paper, teleconferences, etc				

Sect 13		$5,000 for materials and supplies, including toner, paper, teleconferences etc	$5,000 for materials and supplies, including toner, paper, teleconferences etc				
Distribution of IMG-BC Program (per site)	$1,250 for materials and supplies, including toner, paper, teleconferences etc for 1 site	$10,000 for materials and supplies, including toner, paper, teleconferences etc for 2 sites	$15,000 for materials and supplies, including toner, paper, teleconferences etc supplies for 3 sites				
Evaluation Studies Unit		$5,000 for materials and supplies, including toner, paper, teleconferences etc					
Audit[3]	See note 2	See note 2	See note 2				
Performance Measurement / Evaluation[4]	See note 3	See note 3	See note 3				
Communication and dissemination[5]	See note 4	See note 4	See note 4				

Rent and utilities	**$1,500**	**$30,000**	**$30,000**				**$61,500**
Clinical Placement Liaison Office (CPLO)		$6,000 for 12 months office space rental; heating; electricity; telephone rental	$6,000 for 12 months office space rental; heating; electricity; telephone rental				
Sect 13		$6,000 for 12 months office space rental; heating; electricity; telephone rental	$6,000 for 12 months office space rental; heating; electricity; telephone rental				
Distribution of IMG-BC Program (per site)	$1,500 for 3 months office space rental; heating; electricity; telephone rental for 1 distributed site	$6,000 for 12 months office space rental; heating; electricity; telephone rental for 2 distributed sites	$6,000 for 12 months office space rental; heating; electricity; telephone rental for 3 distributed sites				
Evaluation Studies Unit		$6,000 for 12 months office space rental; heating; electricity; telephone rental					

Equipment	**$1,250**	**$25,000**	**$25,000**				**$51,250**
Clinical Placement Liaison Office (CPLO)		$5,000 for: 4 computers; 1 fax/photocopy machine; 1 printer	$5,000 for: 4 computers; 1 fax/photocopy machine; 1 printer				
Sect 13		$5,000 for: 4 computers; 1 fax/photocopy machine; 1 printer	$5,000 for: 4 computers; 1 fax/photocopy machine; 1 printer				
Distribution of IMG-BC Program (per site)	$1,250 for: 2 computers; 1 fax/photocopy machine; 1 printer	$10,000 for: 8 computers; 2 fax/photocopy machine; 2 printers (2 sites)	$15,000 for: 12 computers; 3 fax/photocopy machine; 3 printers (3 sites)				
Evaluation Studies Unit		$5,000 for: 4 computers; 1 fax/photocopy machine; 1 printer					
Total Expenditures[6]	**$18,625**	**$1,695,304**	**$2,836,787**	**$711,554**	**$718,554**		**$5,980,824**

Budget Matrix Footnotes:

1 Personnel salaries and benefits is the sum total of personnel costs to support the clinical placement office Sect 13 MG-BC distribution, residents, and the evaluation studies unit, identified in **bold** under 'budget calculations'. Costs in 2010/11 cover 3 months.

2 Residents' salaries and benefits are in place prior to the CaRMS match in order to secure the posting.

3 Annual cost of contracted audit and book keeping estimated at $35,000/year and included under contractual personnel.
4 Annual cost of evaluation ($306,000/year) is factored into other expenditures such as personnel salaries, as outlined under 'budget calculations' for the Evaluation Studies Unit.
5 These costs will be covered as services in kind through existing website linkages/or postings.
6 Expenditures do not include university overhead charges. UBC Faculty of Medicine and Ministry of Health Services have signed a 2006 memorandum of understanding about the postgraduate residency education program which assigns funding to the program based on the PGME funding formula. It does not recognize funding for university overhead charges.

Appendix C

Reporting Schedule

Reporting Schedule

1. **Progress Reports:** ***Recipient Reporting and Evaluation Template: Part 1*** **(Appendix E)**

2010-2011

January 2011 – March 2011	DUE: April 30, 2011

2011-2012

April 2011 to September 2011	DUE: October 31, 2011
October 2011 to March 2012	DUE: April 30, 2012

2012-2013

April 2012 to September 2012	DUE: October 31, 2012
October 2012 to March 2013	DUE: April 30, 2013

2013-2014

April 2013 to September 2013	DUE: October 31, 2013
October 2013 to March 2014	DUE: April 30, 2014

2014-2015

April 2014 to September 2014	DUE: October 31, 2014
October 2014 to March 2015	DUE: April 30, 2015

2. **Financial Reports**

2011-2012 through to 2014-2015 (Projection)

January 2011 - March 2011	DUE: upon signature of the agreement and before March 1 each subsequent year for the duration of the agreement.

2010-2011

January 2011 – March 2011	DUE: April 30, 2011

2011-2012

April 2011 to September 2011	DUE: October 31, 2011
October 2011 to March 2012	DUE: April 30, 2012

2012-2013

April 2012 to September 2012	DUE: October 31, 2012
October 2012 to March 2013	DUE: April 30, 2013

2013-2014

April 2013 to September 2013	DUE: October 31, 2013
October 2013 to March 2014	DUE: April 30, 2014

2014-2015

April 2014 to September 2014	DUE: October 31, 2014
October 2014 to March 2015	DUE: April 30, 2015

3. **Performance Measurement Reports:** ***Recipient Reporting and Evaluation Template: Part2*** **(Appendix E):**

2010-2011

January 2011 – March 2011	DUE: April 30, 2011

2011-2012

April 2011 to September 2011	DUE: October 31, 2011
October 2011 to March 2012	DUE: April 30, 2012

2012-2013

April 2012 to September 2012	DUE: October 31, 2012
October 2012 to March 2013	DUE: April 30, 2013

2013-2014

April 2013 to September 2013	DUE: October 31, 2013
October 2013 to March 2014	DUE: April 30, 2014

2014-2015

April 2014 to September 2014	DUE: October 31, 2014
October 2014 to March 2015	DUE: April 30, 2015

4. **Evaluation Report** — DUE: 60 calendar days after expiry of the agreement

5. **Report on Assets Acquired** (if applicable) — DUE: 60 calendar days after expiry of the agreement

6. **Notification of Rebate/Refund/Tax Credit** — DUE: 30 days after notification of any rebate, refund or tax credit (if applicable)

7. **Annual Audit Report** (if applicable) — DUE: 30 days upon its release.

Appendix D

Cashflow Forecast and Record of Expenditures

Insert Cashflow Statement

Please ensure that budget categories are added to the cashflow form as per the Approved Budget in Appendix B.

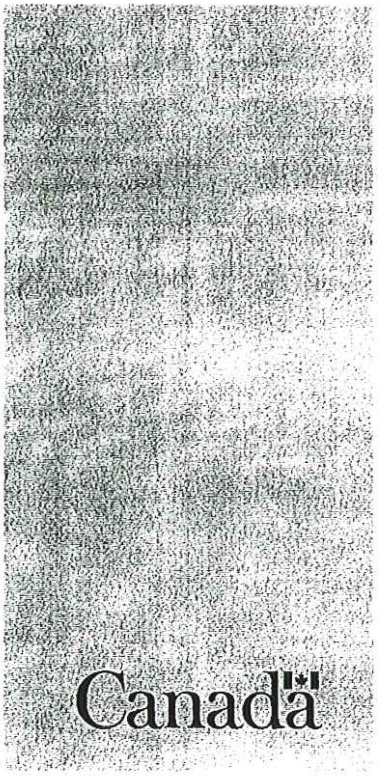
Appendix E

Recipient Reporting and Evaluation Template

Health Care Policy Contribution Program

Recipient Reporting and Evaluation Template

July 2010



INTRODUCTION

The Health Care Policy Contribution Program (HCPCP) is designed to support the Government of Canada's commitment to improving the health care system. This program enables the government to continue to: support knowledge development and transfer in key areas for advancing federal health policy goals; respond to emerging health policy priorities; establish partnerships with provincial and territorial governments to effect change on a pan-Canadian scale; and support organizations whose unique expertise can help with achievement of public policy goals.

To fulfill the program's accountability requirements, Health Canada has developed this Recipient Reporting and Evaluation Template. The template has a dual purpose: to assist recipients with their progress reporting, and to gather information to help assess the implementation, impact and effectiveness of the program.

The questions in this template specify the type of information and level of detail required, and capture information on activities, outputs and outcomes in a systematic way across all projects. This information will illustrate how the program contributes to improving the accessibility and sustainability of the health care system.

To streamline project reporting, in most cases recipients will complete only the template and will not need to conduct a separate evaluation of their project. There may be some exceptions depending on the nature and scope of the project so be certain to follow the terms and conditions specified in your contribution agreement. You may also choose to carry out a project evaluation to gather information about other valuable aspects of your project not captured by the template.

Please refer to *A User Guide for the Recipient Reporting and Evaluation Template* and follow the instructions when completing this template. The definitions provided in the user guide may be especially useful to you in clarifying the information requested. Your Health Canada contact will also be pleased to assist you.

Health Canada is collecting your personal information, i.e., funding recipient's contact information, under the authority of section 4 of the Canada Health Act, to ensure regular and consistent communication between the Health Care Policy Contribution Program and your organization. The Privacy Act provides you with the right to access your personal information held by the government and with protection of that information against unauthorized use and disclosure. Information on the Privacy Act and instructions for making requests pursuant to the Act are located in Info Source, which is available at www.infosource.gc.ca. A description of the personal information being collected by the Health Care Policy Contribution Program is found in Personal Information Bank (PIB) Number PSU 914.

Health Canada would like to acknowledge the Public Health Agency of Canada for permission to adapt its *Project Evaluation and Reporting Tool (PERT): Complete Questionnaire.*

INSTRUCTIONS

The Health Care Policy Contribution Program Recipient Reporting and Evaluation Template consists of two Parts: 1) Progress Reporting and 2) Performance Reporting.

Part 1 should be completed for EACH progress reporting period, as specified in your project's contribution agreement.

PART 1: Progress Reporting

1.1 General Information
1.2 Project Status
1.3 In-kind Resources
1.4 Collection of Performance Reporting Information
1.5 Audit

Part 2 should be completed according to the performance reporting requirements specified in your project contribution agreement.

PART 2: Performance Reporting

2.1 Project Outputs
- 2.1.1 Collaborative Working Arrangements
- 2.1.2 Identification of Barriers and Enablers
- 2.1.3 Knowledge Products and Dissemination Mechanisms

2.2 Project Outcomes
- 2.2.1 Awareness and Understanding
- 2.2.2 Application of Knowledge Products
- 2.2.3 Action on Policy and Practice
- 2.2.4 General Outcomes and Lessons Learned

2.3 Health Canada Support

Please note that you need answer **only** questions that pertain to your project activities. For example, if your project activities are focused only on enhancing collaboration, then it is not necessary to answer questions related to the other outputs. If there is no change from the previous reporting period, please check the box provided.

Once completed, please submit the template to your Health Canada contact via electronic mail. Ensure that you keep a copy for your records.

PART 1: Progress Reporting

1.1 GENERAL INFORMATION

The information below will be used to identify the project and the individual to contact if clarification is required. The contact person should be the project lead.

Please note that the questions under 'General Information' are mandatory and must be completed for each reporting period.

Today's date (month/day/year):
Project title:
Recipient organization:
Project number:
Program component:

- ☐ Health Human Resource Strategy
- ☐ Internationally Educated Health Professionals Initiative
- ☐ Health Care System Innovation

Project start date (month/year):
Reporting period: (check one)

- ☐ April 1 – June 30
- ☐ July 1 – September 30
- ☐ October 1 – December 31
- ☐ January 1 – March 31
- ☐ Semi-annual (time period:)
- ☐ Annual (time period:)
- ☐ Final project report

Project Lead Information

☐ No change from previous reporting period

Name and title:

Telephone number:

Facsimile number:

Email address:

☐ I confirm, as project lead, that the information provided in this Recipient Reporting and Evaluation Template is complete and accurate to the best of my knowledge (please check the box).

1.2 PROJECT STATUS

Question #1

1. For each project objective, please:

- state the planned activities listed in the approved work plan,
- provide the status on the planned activities for this reporting period, including any changes to the project activities and budget, and
- note any challenges encountered and actions taken to address them.

Note: Additional tables may be added, if needed.

Project Objective #1:		
Planned Activities	Status	Challenges and Actions to Address Them

Project Objective #2:		
Planned Activities	Status	Challenges and Actions to Address Them

Question #2

2. In the space below or on an attached sheet, please provide an executive summary of your project, including details on the status of your project that cannot be captured above.

1.3 IN-KIND RESOURCES

Question #3

In this section, please provide details on the in-kind contributions received for your project.

☐ No change from previous reporting period → go to section 1.4 Collection of Performance Reporting Information

3a. Has your project received in-kind contributions to support its activities?

☐ Yes ☐ No → go to section 1.4 Collection of Performance Reporting Information

3b. Please complete the following table. Estimate the monetary value of in-kind contributions where possible.

Check all that apply	Type of in-kind contribution	Name of organization providing contribution	Brief description of contribution (*for staff time, include number of hours contributed)
	Personnel, incl. staff time*		
	Travel and accommodations		
	Materials and supplies		
	Communication and dissemination		
	Rent and utilities, incl. telephone, internet		
	Equipment		
	Other (please specify)		

1.4 COLLECTION OF PERFORMANCE REPORTING INFORMATION

In your funding proposal, you provided a performance measurement plan for your project. Implementing this plan will enable you to gather the information needed to complete this template and so it is important to track your progress on data collection. It is strongly recommended that you begin to implement your performance measurement plan at the start of your project to avoid any difficulties in obtaining the information at a later date.

☐ No change from previous reporting period → go to section 1.5 Audit

Question #4

4a. Have you started collecting project performance reporting information?

☐ Yes ☐ No → go to section 1.5 Audit

4b. How often are you collecting this information? (check all that apply)

☐ Weekly
☐ Monthly
☐ Quarterly
☐ Semi-annually
☐ Annually
☐ Other (specify) :

1.5 AUDIT

☐ No change from previous reporting period → go to section 2.1 Project Outputs

Question #5

5a. Do you intend to complete a financial audit of this project?

☐ Yes ☐ No → go to section 2.1 Project Outputs

5b. When do you expect it to be completed? (month/year) :

PART 2: Performance Reporting

2.1 PROJECT OUTPUTS

Project outputs refer to the direct products or services stemming from the project activities. The program is designed to generate three broad categories of outputs: (1) collaborative working arrangements; (2) identified barriers and/or enablers; and (3) knowledge products and dissemination mechanisms.

2.1.1 COLLABORATIVE WORKING ARRANGEMENTS

Collaborative working relationships involve two or more groups/organizations working together to contribute to the achievement of the funded projects' objectives. Formal arrangements are those that specify legal obligations for each of the parties, e.g., contracts (excluding contractual agreements for goods/services), memoranda of understanding, tripartite agreements. Informal arrangements do not carry legal obligations, are usually more flexible and are typically developed casually between the parties.

☐ No change from previous reporting period → go to section 2.1.2 Identification of Barriers and Enablers

Question #6

6. Does your project involve any collaborative working arrangements?

☐ Yes ☐ No → go to section 2.1.2 Identification of Barriers and Enablers

Question #7

7. Were any collaborative working arrangements established *prior* to your project start date?

☐ Yes ☐ No

Question #8

8a. Were any collaborative working arrangements *newly established* during this reporting period?

☐ Yes → go to 8b. ☐ No → go to 9.

8b. Please complete the following table for each collaborative working arrangement established during this reporting period (repeat table for additional arrangements):

Name of organization with whom you are collaborating:											
Type of organization (check box that applies)		Level of the organization		Type of arrangement		Start date mm/yyyy	Organization's role in the arrangement (check all that apply)		Why was this arrangement important for the project's success?		
☐	Community/ NGO	☐	Local	☐	Formal		☐	Voting member			
		☐	Regional				☐	Provides funding			
		☐	P/T				☐	Provides in-kind resources			
☐	Education/ research	☐	National	☐	Informal		☐	Advisory			
☐	Government	☐	Pan-Canadian				☐	Provides access to policy process			
☐	Other:	☐	Other:				☐	Other:			

Question #9

9. For each collaborative working arrangement related to this project (including those established prior to, or during, the project), please specify which ones have been maintained, modified, or ended during this reporting period, and describe the changes in the table below.

(check all that apply)		Which one(s)?	Description of change(s)
	Maintained (i.e., no change)		N/A
	Modified		
	Ended		

2.1.2 IDENTIFICATION OF BARRIERS AND ENABLERS

The program seeks to identify barriers and enablers related to knowledge development, dissemination and use, as well as to achieving health care system innovations, in order to determine their impact(s) on program effectiveness. It is also important for projects to identify these barriers and enablers to understand how these factors may affect the achievement of project outputs and outcomes.

☐ No change from previous reporting period → go to 11a.

Question #10

10a. During this reporting period, did your project identify any barriers?

☐ Yes → go to 10b. ☐ No → go to 11a.

10b. Please provide details in the table below (repeat table for additional barriers).

Description of the barrier	How does the barrier affect the achievement of project results? (check all that apply)		Action taken to address the barrier	Impact of action taken
		Hinders the creation or modification of knowledge products		
		Hinders the dissemination of knowledge		
		Hinders the use or adoption of knowledge		
		Hinders innovations in the health care system		
		Other:		

Question #11

11a. During this reporting period, did your project identify any enablers?

☐ Yes → go to 11b.

☐ No → go to section 2.1.3 Knowledge Products and Dissemination Mechanisms

11b. Please provide details in the table below (repeat table for additional enablers).

Description of the enabler	How does the enabler affect the achievement of project results? (check all that apply)		Action taken to maximize effects of enabler	Impact of action taken
	☐	Supports the creation or modification of knowledge products		
	☐	Supports the dissemination of knowledge		
	☐	Supports the use or adoption of knowledge		
	☐	Supports innovations in the health care system		
	☐	Other:		

2.1.3 KNOWLEDGE PRODUCTS AND DISSEMINATION MECHANISMS

'Knowledge products' refer to all of the outputs and innovations created or modified by the project, including new and/or modified approaches, models and strategies. These also include the knowledge exchange/dissemination mechanisms developed to share information and to raise awareness and understanding among the target audiences.

'Target audience' is defined as people and/or organizations that you are trying to reach directly through your project activities.

☐ No change from previous reporting period → go to section 2.2 Project Outcomes

Question #12

12a. Did your project intend to create any knowledge products?

☐ Yes: (check all that apply)
- ☐ Still in progress
- ☐ Completed during this reporting period
- ☐ Created in previous reporting period

☐ No

12b. Did your project intend to disseminate knowledge products?

☐ Yes: (check all that apply)
- ☐ Not yet disseminated
- ☐ Disseminated during this reporting period
- ☐ Disseminated in a previous reporting period

☐ No

12c. If yes to 12a and/or 12b, provide details on the product(s) created and/or disseminated during this reporting period in the table below. Also attach a copy of the output(s) produced, if applicable. Do not report on outputs that are still in development.

Type of outputs	Description/ title	Number produced and estimated cost (% of budget)	Method of dissemination and estimated cost	Purpose of dissemination	Name of target audience(s) (specify type and level)
Research reports/ summaries					
Tools/ manuals					
Approaches/ models/ best practices					
Knowledge exchange mechanisms					
Other					

2.2 PROJECT OUTCOMES

Project outcomes refer to the results or changes that occur (at least in part) from your project activities and outputs. Outcomes are usually further qualified as being immediate, intermediate or long-term, depending on when they occur or where they fit in the logical chain of events. For example, immediate and intermediate outcomes must be realized before the long-term outcomes can occur.

This template is designed to capture information on three broad categories of outcomes: (1) increased awareness and understanding; (2) application of knowledge products; and (3) action on policy and practice. This template also gathers information on lessons learned and any the unintended outcomes of your project.

2.2.1 AWARENESS AND UNDERSTANDING

☐ No change from previous reporting period → go to section 2.2.2 Application of Knowledge Products

Question #13

13a. Did your project intend to raise your target audience's level of awareness of any of the knowledge products created, modified or disseminated by your project?

☐ Yes → go to 13b. ☐ No → go to 14a.

13b. During this reporting period, did your project assess your target audience's level of awareness of these knowledge products:

☐ Yes → go to 13c. ☐ No → go to 14a.

13c.

Which methods were used for the assessment? (add more rows if needed)	What were the main results? (attach copy of the report, if available)

Question #14

14a. Did your project intend to raise your target audience's level of understanding of health care system innovation issues?

☐ Yes → go to 14b. ☐ No → go to section 2.2.2. Application of Knowledge Products

14b. During this reporting period, did your project assess your target audience's level of understanding of health care system innovation issues:

☐ Yes → go to 14c. ☐ No → go to section 2.2.2. Application of Knowledge Products

14c.

Which methods were used for the assessment? (add more rows if needed)	What were the main results? (attach copy of the report, if available)

2.2.2 APPLICATION OF KNOWLEDGE PRODUCTS

☐ No change from previous reporting period → go to section 2.2.3 Action on Policy and Practice

Question #15

15. Did your project intend to create or disseminate new knowledge products?

☐ Yes ☐ No

Question #16

16. Did your project intend to expand or implement any pre-existing knowledge products?

☐ Yes ☐ No

Question #17

17a. If yes to questions 15 or 16 above, were any of these knowledge products used by your target audience(s)?

☐ Yes → go to 17b. ☐ No→ go to 18.

17b. Please complete the table below (repeat table for additional knowledge products).

Title or description of knowledge product	Who used it? (specify name of organization and level)	Setting where it was used? (check all that apply)		How it was used? (check all that apply)		Was an evaluation or assessment of the knowledge product conducted?	
		☐	practice environment	☐	to inform decision-making	☐	yes (attach copy, if available)
		☐	government	☐	implemented or adopted by the organization		
		☐	education /research institution	☐	to influence changes in policy	☐	in progress
		☐	community/NGO	☐	to influence changes in practice		
		☐	health authorities	☐	other (specify):	☐	no
		☐	other (specify):				

Question #18

18. Please explain why the knowledge product (s) was/were not used:

2.2.3 ACTION ON POLICY AND PRACTICE

We would like to know if your project has influenced policy development or implementation, has supported existing policies, or has influenced changes in practice. This information will help to document project capacity in, and action on, influencing and contributing to changes/improvements in the health care system through policy development and implementation, and/or changes/improvements in practice. If you have any questions or concerns about reporting activities in this area, please discuss these with your Health Canada contact.

☐ No change from previous reporting period → go to 2.2.4 General Outcomes

Question #19

19. Did your project intend to influence policy?

☐ Yes → go to 20. ☐ No → go to 22.

Question #20

20. Did your project influence change(s) in policy during this reporting period?

☐ Yes → go to 21. ☐ No → go to 22. ☐ Do not know → go to 22.

Question #21

21. Please describe the main policy(ies) or policy areas that your project did influence and describe how. Attach any relevant documentation.

Question #22

22. Describe how your project could influence changes in policy (i.e., what would the potential be for this project to influence changes in policy).

Question #23

23. Did your project intend to influence practice?

☐ Yes → go to 24. ☐ No → go to 26.

Question #24

24. Did your project influence change(s) in practice during this reporting period?

☐ Yes → go to 25. ☐ No → go to 26. ☐ Do not know → go to 26.

Question #25

25. Please describe the main practice(s) that was/were influenced and describe how. Attach any relevant documentation.

Question #26

26. Describe how your project could influence changes in practice (i.e., what would the potential be for this project to influence changes in practice).

2.2.4 GENERAL OUTCOMES AND LESSONS LEARNED

☐ No change from previous reporting period → go to section 2.3 Health Canada Support

Question #27

27. Did your project result in any unintended or unanticipated outcomes?

☐ Yes → go to 28. ☐ No → go to 29.

Question #28

28. Please explain what these unintended or unanticipated outcomes were:

Question #29

29. Do you anticipate that any aspect(s) of your project will continue after funding from the program ends?

☐ Yes ☐ No

Question #30

30. Do you anticipate that any new activities will emerge as a result of your project after funding from the program ends?

☐ Yes → go to 31. ☐ No → go to 32.

Question #31

31. Please describe what aspect(s) or activities are expected to continue or emerge, for what length of time, and whether any resources (e.g., funds, human resources) have been secured to support them.

Question #32

32. Health Canada may have the opportunity to follow up on the lasting effects and benefits from this funding program. May we follow up with your organization at a later date (2-3 years)?

☐ Yes ☐ No
If you wish, please explain:

Question #33

33. Please describe any overall lessons learned from your project, including but not limited to those related to: a) influencing policy, b) influencing practice, c) supporting existing policies or practices, or d) reaching your target audience(s).

2.3 HEALTH CANADA SUPPORT

At Health Canada, we recognize that the support we provide to our funding recipients is an important part of our role. As such, we are committed to improving our service to you and the quality of this reporting template.

Examples of support could include attendance at an event, assistance with finding information or publications, referral to other project staff, evaluation assistance, information on financial reporting, etc.

☐ No change from previous reporting period → template complete

Question #34

34. Have you received the support you needed from Health Canada staff over this reporting period? If you did not need support, please check 'N/A'.

☐ Yes ☐ No → go to 36. ☐ N/A → go to 36.

Question #35

35. What was most helpful?

Question #36

36. What type of support from Health Canada would be helpful?

Question #37

37. How useful was this template in terms of your project reporting activities?

☐ Useful ☐ Somewhat useful ☐ Not useful

Question #38

38. Please explain your rating above:

Question #39

39. Approximately how much time did it take to complete the template for this reporting period?

Question #40

40. Overall, do you have any suggestions to improve Health Canada support and/or this reporting template?

You have now completed the Recipient Reporting and Evaluation Template.
Thank you for taking the time to record this important and useful information.