Veterans Affairs Canada

Anciens Combattants Canada

EVALUATION OF THE HEALTH CARE BENEFITS (TREATMENT BENEFITS) PROGRAM MANAGEMENT FUNCTION

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Audit and Evaluation Division

Canada

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EXECUTIVE SUMMARY

Program Profile

The Health Care Benefits Program (commonly referred to as the Treatment Benefits Program) provides eligible Veterans and other qualified recipients with funding to access necessary health care benefits. The Program is complex and is comprised of fourteen categories of benefits/services which include hundreds of benefits and services to meet a variety of needs. In 2016-17, program expenditures totaled approximately $308 Million and there were almost 80,000 Veterans accessing benefits. The Program is administered by Veterans Affairs Canada (VAC) field office staff and through a third-party health care processor with support from numerous areas within VAC. The Treatment Benefits Program Management Unit is responsible for the management of the Program.

Evaluation Purpose & Background

The Evaluation of the Health Care Benefits (Treatment Benefits) Program Management Function was conducted between June 2017 and January 2018. The purpose of the evaluation was to assess the operational efficiency of the Treatment Benefits Program Management Function and to provide opportunities for improvement. The scope period for the evaluation was April 2014 to September 2017. The evaluation approach was formative in nature and was a process and utilization-focused evaluation. Multiple lines of evidence were used as part of the evaluation methodologies, primarily: document review, interviews, data analysis, and site visits/work observation. The main limitation of the evaluation was that limited management data was available to support an assessment of activities and outputs and the reliance on self-reported workload.

Defining Program Management

Based on a review of numerous sources, program management is considered to be the management of interrelated program components in order to achieve synergies and keep components on track to deliver expected objectives and outcomes. Program management requires emphasis on strategic thinking, analysis, and relationship building.

Evaluation Findings

The evaluation team found that there are opportunities to improve the Treatment Benefits program management governance structure. As a result of requirements to focus on operational activities, recent turnovers in staff, changes in organizational structures, and a continually evolving health care environment, there is a need to refocus the program management function and determine objectives, priorities, and associated roles and responsibilities required to achieve desired program results. A roles and responsibilities document had not been updated since approximately 2010 and priorities, lessons learned, and risk areas were being informally documented/discussed.

The Benefits Review Committee is another key component of the Program's governance structure. This committee provides a fundamental function for benefit and service discussions and changes, and provides an opportunity for transparent and evidence based decision making by stakeholders. There have been ongoing discussions regarding the committee's terms of reference for a number of months and there has not been an official committee meeting with the whole quorum of members since 2016. The evaluation team also noted opportunities where the

committee could be capitalized on to inform potential issue areas and to drive data/trend analysis for the Program.

At the time of the evaluation, the Treatment Benefits Program Management Unit had seen a significant departure in knowledgeable and experienced staff, and operational work was taking precedent over strategic management work (issues affecting Veterans are considered highest priority). Due to the focus on operational requirements and a turnover in staff, there has been limited data and trend analysis conducted by the Treatment Benefits Program Management Unit. Ongoing monitoring and reporting would support program performance measurement and help identify issues and trends that could improve program delivery and management.

The benefit grids are the basis of rules which directly support the delivery of benefits and services to Veterans. The last official review of the grids was completed between 2008 and 2010. In an ever-evolving health care environment, there is a need for more frequent reviews of the eligible treatment benefits and services and the supporting approval requirements.

Evaluation results suggest that short-term additional staffing could allow the Treatment Benefits Program Management Unit to analyze potential issues/risk areas, work on a medium to long-term plan, and therefore improve program management and delivery.

Conclusions

The governance structure of the Treatment Benefits Program Management Unit would benefit from updates to better support effective and efficient program management. A Treatment Benefits Program roles and responsibilities document requires updates. Ongoing discussions regarding the Benefit Review Committee's purpose and membership roles, unsettled terms of reference, and a lack of regular meetings are also impacting the efficient and effective delivery of the Program.

More focus on strategic areas would benefit Veterans and VAC staff by updating guidance documents and supporting tools (such as the benefit grids) and therefore reducing the number of escalated enquiries.

Due to a lack of management information, the evaluation team is unable to confirm that additional resources would fix all issues, or that resources would be required on a long-term basis; however, the evaluation results suggest that the Treatment Benefits Program Management Unit would benefit from short-term staffing. The Unit first needs to formalize its governance structure, and then determine resources required to meet the established goals and priorities of the Program.

Recommendations

The evaluation findings and conclusions resulted in the following recommendations:

Recommendation 1:

It is recommended that the Director General, Service Delivery and Program Management improve the Program governance structure by:

- Updating the Treatment Benefits Roles and Responsibilities document to reflect changes in the organizational structure, roles and responsibilities

of non-program unit staff and relevant committees, program unit objectives, key activities and outputs, and priorities;
- Producing a mid to long-term strategic and operational plan for the Treatment Benefits Program Management Unit, including resource needs, timelines, goals and linkages to Treatment Benefit Program priorities; and
- Sharing the above noted documents with departmental staff and third-party health claims processing staff.

Recommendation 2:

It is recommended that the Assistant Deputy Minister, Service Delivery finalize the Benefits Review Committee Terms of Reference (including membership roles and committee purpose), communicate the document with departmental staff and third-party health claims processing staff, and ensure that regular meetings occur on a go-forward basis.

Recommendation 3:

It is recommended that the Assistant Deputy Minister, Service Delivery work in collaboration with relevant areas across the department to strengthen the collection and analysis of data to support the management of the Treatment Benefits Program (such as performance measurement, risk areas, trend analysis, and regular monitoring of benefit specific data).

Recommendation 4:

It is recommended that the Director General, Service Delivery and Program Management implement a cycle of benefit reviews to ensure they are updated on a continuous and efficient basis.

1.0 Introduction

The Health Care Benefits Program, commonly referred to as the Treatment Benefits Program, provides eligible Veterans and other qualified individuals with financial support to access health care benefits to meet their identified needs. Support is provided under the authority of the Veterans Health Care Regulations, Part One. Veterans Affairs Canada's (VAC's) Program Inventory[1] identifies the Health Care Benefits Program under Core Responsibility 1: Benefits, Services and Support.

The Treatment Benefits Program (herein referred to as the Program) established during World War II is one of the Department's flagship programs. It is generally seen as stable, with continual updates to benefits/services offered and some changes to program delivery in recent years. There have been no recent changes to the program design structure and the majority of program decision making and transactions are straightforward, with efficient reimbursement to providers/program recipients. Although the 2017 VAC National Veteran Survey does not have a question relating to the prioritization of VAC programs based on need, recipients highly ranked their understanding of the Program benefits and services available (77%), number of service providers available (91%), and that the Program meets their health care needs (84%).

1.1 Program Overview

The Program is complex with fourteen separate Programs of Choice (POCs). These groupings of benefits together contain hundreds of individual benefits and services to meet a variety of eligible health care needs. A brief overview of the benefits and services provided through each of the POCs is included in Appendix A.

As of March 31, 2017, there were just under 80,000 Veterans accessing the Program[2]. The overall number of Program recipients has been declining each year since 2005-06. This decline is the result of a mortality rate that is higher for war service Veterans than the rate of Canadian Armed Forces (CAF) Veterans joining the program. However the rate of decline slowed in 2015-16, as more CAF are coming to Veterans Affairs Canada (VAC). VAC is now forecasting slight increases in Treatment Benefit recipients for the next five years.[3]

Program expenditures totalled $308 million in 2016-17. Three POCs account for approximately 80% of program expenditures: Prescription Drugs (POC 10), Related Health Services (POC 12) (for example: occupational therapy, physiotherapy, massage therapy) and Audio Services (POC 3). These same three POCs are also the most frequently used benefits/services by Veterans. Table 1 details the number of program recipients, benefit authorizations[4], transactions[5] and expenditures by POC for the fiscal year 2016-17.

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1 A department's Program Inventory identifies all of the department's programs and describes how resources are organized to contribute to the department's Core Responsibilities and Results.

2 VAC Client and Expenditure Forecast 2018-19. March 2017.

3 Client and Expenditure Forecast for 2017-18 (March 2016) and Facts and Figures Book (March 2017).

4 Authorizations are actions completed to support health care benefit/service transactions. Some authorizations are required prior to a benefit or service being administered by a health care provider, and some authorizations occur at the time of transactions. One authorization may have multiple transactions attached to it. For example, one authorization may be for up to fifteen occurrences of massage in one calendar year.

5 Transactions are the processing point for health care benefits and services. Each time that a claim is processed or adjusted, a transaction occurs.

Table 1 – Treatment Benefits Program Data by Program of Choice for 2016-17

POC	Program Recipients	Total Benefit Authorizations[6]	Total Benefit Transactions[7]	Total Expenditures[8]
1	6,957	13,584	30,235	$1,731,000
2	5,108	66,420	605,463	$1,365,000[9]
3	39,816	116,939	304,628	$45,012,000
4	13,738	Not Available	122,770	$11,397,000
5	1,535	3,336	15,086	$10,795,000
6	2,024	3,835	19,927	$3,101,000
7	8,652	32,922	80,355	$5,091,000
8	15,714	66,556	103,010	$7,560,000
9	1,401	2,593	10,510	$2,012,000
10	46,081	Not Available	4,673,960	$135,038,000[10]
11	3,692	4,655	7,686	$3,666,000
12	29,127	270,180	695,846	$59,097,000
13	13,362	76,788	144,395	$20,844,000
14	7,658	15,666	23,802	$3,619,000
	79,964[11]	**673,474**	**6,837,673**	**$308,033,000[12]**

Note: supplementary coverage for Health Related Travel (described in Appendix A) accounted for another $18 million in program expenditures in 2016-17.

1.2 Program Eligibility

The Program does not have a separate application process. Eligibility is based on receipt of other VAC programs/services. Veterans and other qualified individuals may qualify to receive financial support for treatment benefits if they are in receipt of services or supports of the following VAC programs:

- Disability Benefits;
- Veterans Independence Program;
- Long Term Care Program; and/or
- War Veterans Allowance.

Benefits and services under the Program are provided to eligible recipients in two situations:

- For the treatment of service related disabilities; and/or

6 Health Care Benefits Program – Program Management Performance Snapshot. Fiscal Year 2016-17. Service Delivery Branch.

7 Ibid. Transactions include payments, adjustments, rejections and special transactions.

8 VAC Client and Expenditure Forecast 2018-19. March 2017.

9 Does not include Health Related Travel.

10 Includes cannabis for medical purposes.

11 Total number of unique recipients. Some recipients utilize multiple POCs.

12 The expenditure column will not add up to the stated total expenditure line, as the total expenditure includes adjustments (e.g., late payments or credits made to the account which are incurred in the fiscal year but reported later). Adjustments are required to balance end of year VAC financial reporting with the monthly FHCPS data.

- As supplementary coverage when the required benefits or services are not provided under provincial health programs.

Additionally, participants of the Rehabilitation Program may qualify for financial support for treatment benefits related to their rehabilitation plan.

1.3 Program Delivery

VAC provides funding for recipients to receive benefits and services from health care providers. The Program is administered by VAC field staff in over thirty VAC area offices across the country and by a third-party health claims processor. Benefits and services are administered through the Federal Health Care Processing System (FHCPS) using VAC policies, processes, and rules established in individual benefit grids[13]. Oversight of the Program is provided by VAC's Head Office Service Delivery and Program Management Division. The delivery of the Program is also supported by other divisions within VAC, including the following:

- Health Professionals;
- Field Operations;
- Policy and Research;
- Contract Administration;
- Central Operations;
- Finance; and
- Service Delivery Advisory Team (SDAT)[14].

At the time of the evaluation, the Program's Performance Information Profile continued to be updated. The program objective and logic model had received minimal updates since the last evaluation in 2013. The logic model can be found in Appendix B.

[13] The benefit grids include a comprehensive list of most eligible treatment benefits and services, along with dollar and frequency limits, and approval requirements for each POC.

[14] SDAT is a single point of contact for all points of service at VAC to help with complex issues when business processes or policies are not clear or if there are questions regarding operational issues.

2.0 Scope and Methodology

The evaluation was conducted in accordance with VAC's 2017-2022 Risk-Based Audit and Evaluation Plan, and in compliance with the directive and standards specified in the Treasury Board of Canada's 2016 *Policy on Results*.

The evaluation focused on an assessment of operational efficiency of the Treatment Benefits program management function (as described in section 3.2). It should be noted that the management of cannabis for medical purposes was considered to be out of scope as it is managed by a separate unit. Additionally, the evaluation did not assess the delivery of the Program itself or the FHCPS contract.

The time period covered by the evaluation was April 1, 2014 to September 30, 2017. Appendix C outlines the evaluation issues/questions assessed.

In support of developing the scope for the evaluation, a risk/calibration assessment was completed as informed by preliminary interviews, a document review, and data analysis. Based on the risk assessment results, as well as the identified need by the program area, it was agreed that the evaluation would focus on an assessment of operational efficiency of the program management function.

2.1 Multiple Lines of Evidence

The evaluation was formative[15] in nature and was a process and utilization-focused evaluation[16].

The research methodology incorporated multiple lines of evidence, ensuring reliability of collected information and reported results. The lines of evidence used to evaluate the operational efficiency of the Program's management function are shown in Table 2.

Table 2 - List of Methodologies

Methodology	Source
Departmental Documentation and Secondary Research Review	The following Departmental documents/information were reviewed to understand the Program objectives/intent, their authorities and requirements, complexity, context and any key issue areas: planning documents, previous audits and evaluations, strategic documents, performance reports, research papers, and survey results. Various program management unit documents were reviewed to understand the governance structure, workload, and key issue areas: policies, business processes, organizational chart, records of decisions/meeting minutes, and performance reports.

[15] Formative evaluations focus on program improvement. Formative evaluations typically assess program implementation, or specific aspects of a program, and try to understand why a program works or doesn't, and if there are any impacting factors at play.

[16] Process evaluation is a method of assessing how a program is being implemented and focuses on the program's operations, implementation, and service delivery. A utilization evaluation looks at program operation & implementation.

Methodology	Source
Non-Departmental Document Reviews	Various non-departmental documents such as: program literature from other federal department and other countries, and published journals and/or articles relating to process evaluations and program management were reviewed. Parliament reports, Budget Speeches, Speeches from the Throne were also reviewed for context purposes.
Interviews	Over 70 interviews were conducted with VAC senior management, VAC staff involved in the management and operations of the programs (including field staff), and other subject matter experts. Interviews were also conducted with staff from the third-party health claims processor who play a role in the delivery of the program. Interviews with other federal and provincial government department program management units were conducted to understand resource models and potential best practices.
Data Analysis	Financial and operational data collected for fiscal years 2014-15 to 2017-18 was analyzed, where available.
Work Observation / Site Visits	Site visits and work observations with the third-party health claims processor took place to observe processes and practices in place regarding the Treatment Benefits Program since the adoption of the new FHCPS contract.
Logic Model	A logic model with program management inputs, activities and outputs was created to assist in understanding the workload, priorities and roles and responsibilities of the Treatment Benefits Program Management Unit and unit staff.
File Review	A small review of 37 enquiries received by the Treatment Benefits Program Management Unit was conducted to better understand the types of enquiries incoming, the length of time required to respond, and if there were any key trends or issues.
Process Map	A map of the escalation enquiry process was created to assist in understanding the workflow steps and key parties involved in the process.

2.2 Limitations and Considerations

The limitations and considerations noted below should be considered when reviewing the evaluation findings.

- Limited program performance measurement information has been collected and monitored for the past two years. The Program (as well as all other programs within VAC) is currently undergoing a process to revise all performance measurement strategies to align with the 2016 *Policy on Results* requirement for Performance Information Profiles[17].

[17] A Performance Information Profile identifies the performance information for each Program from a department's Program Inventory.

- There was limited management data available regarding outputs and activities completed by the Treatment Benefits Program Management Unit. To mitigate this risk, the evaluation worked closely with program staff to understand and document inputs, activities, and outputs of the unit. During the evaluation examination phase, it was clarified that the new tracking tool was measuring enquiries received (as opposed to completed enquiries) by the Treatment Benefits Program Management Unit and that not all activities/outputs were being tracked. Additionally the information was self-reported and manually tracked, therefore there is a risk of errors. The evaluation team considered conducting an activity-based assessment however due to the varying nature of the enquiries received it was difficult to obtain an adequate depiction of workload within the evaluation timeline.

- Significant Treatment Benefits Program Management Unit staff turnover occurred during the scope period of the evaluation which impacted workload as staff were learning new roles and responsibilities, and being trained by senior staff.

- Individual perceptions of workload may influence opinions from staff on efficiency. In order to mitigate personal bias the evaluation team conducted interviews with multiple staff members, including the manager, and reviewed a sample of enquiry files.

3.0 Program Management Background

In order to establish an understanding and definition of what encompasses 'program management' the evaluation team conducted a document review and interviews.

3.1 Definition

Based on a review of numerous sources, including Government of Canada policies, the Project Management Institute (PMI), the International Organization for Standardization (ISO), and various industry articles the evaluation team established the following definition of program management:

Program management is the management of several interrelated projects, or program components, managed together to achieve an organizational or operational objective(s) and outcome(s). Program management is about keeping all the components on track to deliver the expected results. Unlike project management, which focuses on completing specific project plan tasks on time, program management requires more emphasis on strategic thinking, analysis and relationship building.

The evaluation's document review highlighted the following key concepts/characteristics of program management[18]:

- Program components are interdependent/interrelated (with opportunities for synergies/efficiencies by co-managing components);
- Program management plan/framework is in place (including governance structure, alignment to organizational/strategic objectives, benefits to be realized by managing the program, roles and responsibilities, and necessary resources);
- Resources are coordinated and prioritized across program components;
- Costs, scope, quality and risks are managed;
- Deliverables are aligned to program outcomes;
- Program is managed to achieve objectives and outcomes;
- Organizational capability and capacity are optimized; and
- Stakeholder interests are identified and managed.

Potential differences of program management in the public sector versus the private sector to consider include:

- Many government programs are permanent ongoing programs/funded long-term (versus project oriented programs that are shorter in time); and
- Government programs are designed to provide benefits to program recipients and meet their needs but must also adhere to federal government regulations and legislation, and potential budgetary limitations (versus specific

[18] International Organization for Standardization. Project, programme and portfolio management — Guidance on programme management. Reference number ISO 21503:2017(E). 2017.

Zein, O. (2010). Roles, responsibilities, and skills in program management. Paper presented at PMI® Global Congress 2010—EMEA, Milan, Italy. Newtown Square, PA: Project Management Institute.

Moore, Thomas J. An evolving program management maturity model integrating program and project management Conference Paper. Program Management. 2000.

requirements and costs being provided by clients in requests for proposals in the private sector).

Additional information regarding typical roles and responsibilities surrounding program management can be found in Appendix D.

3.2 Structure of Program Management at VAC

The Treatment Benefits Program Management Unit (herein referred to as the Treatment Benefits Unit) is responsible for the management and operations of the Program. During the scope of the evaluation, the Treatment Benefits Unit was part of VAC's Health Care and Rehabilitation Programs Directorate[19].

As of September 2017, the Treatment Benefits Unit consisted of one Program Manager (who is also responsible for the Veterans Independence Program), three senior analysts, two junior analysts, two administrative positions, and one student for a total of nine staff.

There have been some internal and external changes related to the delivery of the Program in the past number of years:

- Head Office organizational re-structuring occurred in 2011 (amalgamating the program management and service delivery functions into one division);
- Department led initiatives seeking improved efficiencies and streamlined processes occurred from 2011 through 2013;
- New FHCPS contract was awarded in 2015 to a third-party health claims processor which included additional components of administering the Program being transferred from VAC over to the contractor;
- Changes to Canadian legislation around cannabis for medical purposes in 2014-15;
- Treatment Benefits Unit experienced a significant turnover in staff between 2013 and 2017;
- Office of the Auditor General's (OAG) office released their report titled *Drug Benefits—Veterans Affairs Canada* in April 2016 with findings and recommendations linked to the drug benefits portion of the Program which resulted in updates to VAC's drug formulary and its governance structure; and
- VAC cannabis for medical purposes policy established in November 2016 and a separate unit was created to manage this area using some staff from Treatment Benefits Unit.

Appendix E, Timeline of Events further highlights key program milestones.

[19] In January 2018 the management of the Program was consolidated into one health care directorate with the Veterans Independence Program and the Long Term Care Program – the Health Care Programs Directorate.

4.0 Findings

4.1 To what extent are the outputs delivered by the Treatment Benefits Program Management Unit in line with the original intent of the unit, and linked to program objectives?

The intended outputs of the Treatment Benefits Unit support the Program objective. However, the documented objectives and outputs of the unit are in need of updates. There have been a number of program-related changes, and although the unit priorities are informally documented, these priorities are not linked to the majority of current unit outputs.

4.1.1 Program Objectives

As highlighted in the Program's logic model, the overall program objective is: "to provide funding for health care benefits so that eligible Veterans' and other program recipients' health care needs are met." The Program objectives are documented in various sources: VAC Departmental Plan 2017-18, Performance Measurement Strategy/Performance Information Profile, VAC external website, and an internal Treatment Benefit Program Roles and Responsibilities document. The objectives listed within the documents are described and detailed at varying levels and the documents are not easily accessible to Head Office and/or Area Office staff.

4.1.2 Program Management Unit Roles and Responsibilities

When asking interviewees from both VAC Head Office and Field Operations what the expected roles and responsibilities for the Treatment Benefits Unit would be, the top three categories could be classified as:

1. Providing clear guidance and direction to field staff;
2. Providing timely and thorough communications; and
3. Overseeing and reviewing program components to improve efficiency and effectiveness (e.g. business processes and benefit grids).

The Treatment Benefits Unit provided a copy of their roles and responsibilities for the Program which was created in response to a recommendation within VAC's 2009 *Programs of Choice Analysis Audit*. The document highlights the overall program intent/objective as well as roles and responsibilities of various sections of VAC in the delivery of the Program. According to the document, the Treatment Benefits Unit is responsible for:

- setting program objectives and providing strategic direction for the program;
- maintaining the benefit grids, including working with VAC systems and the third-party health claims processor to ensure that the products, services and prices on the grids are a fair representation of current market conditions and adequately address the needs of VAC clients while adhering to VAC regulations and policy;
- identifying program trends and responding to program related concerns;

- participating with the Federal Healthcare Partnership (FHP) in negotiating various provider agreements with provider associations from across Canada[20];
- investigating, interpreting and resolving systemic issues within the Treatment Benefits Program;
- participating on the Formulary Review Committee (FRC)[21], Benefit Review Committee (BRC)[22] and the Treatment Benefits Integrated Network (TBIN)[23] to ensure that the Treatment Benefits program continues to adapt to the changing conditions of delivering health care benefits and services in Canada; and
- working in conjunction with the Policy and Research Division to ensure VAC policies are current and reflective of the goals of the Treatment Benefits Program and VAC.

The document has not been updated since the completion of the action plan from the audit recommendation in approximately 2010 and it is currently out-of-date. As stated in section 3.2, there have been numerous program-related changes since 2010, including modifications to the program management structure and program delivery structure. In its current form, the document does not clearly define the objectives and outputs of the Treatment Benefits Unit or the role of key internal and external partners (e.g., VAC Health Care Professionals Division, VAC Contract Administration Directorate, and the third-party health claims processor).

Further supporting the need for consistency and availability of program objectives, of the field staff interviewed, many had limited knowledge of the Program roles and responsibilities performed by the third-party health claims processor and by Head Office. The 2016 *VAC Service Delivery Review*[24] had a similar finding and an associated recommendation[25] to address this concern. As of February 2018, these actions were still outstanding. An internal departmental review in 2016 also proposed developing a strategic overview for each VAC program area to clarify program intent, direction and performance expectations.

4.1.3 Program Management Priorities

The priorities for the Treatment Benefits Unit are informally documented and discussed but are not formally distributed. The priorities identified include:

- Benefits Review Committee;
- Drug Formulary Review Committee;
- Multi-Disciplinary Clinics (POC 5);

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[20] Note: The Federal Healthcare Partnership is no longer in existence.

[21] The FRC reviews, maintains, and revises the list of drugs on VAC's Drug Benefit List. The committee provides recommendations and guidance to the Program in order to maintain and improve the services provided to Veterans.

[22] BRC is described and further discussed in Section 4.2.3

[23] The Treatment Benefits Integrated Network is an internal body comprised of VAC Head Office staff and Field Operations staff that meets on a regular basis to discuss health care benefit and services issues, concerns and trends.

[24] In the fall 2015, VAC conducted a comprehensive review of its four service delivery channels—online, telephone, in-person and mail—seeking better ways of working internally as well as more effective means to collaborate with external service providers to improve service to Veterans and their families.

[25] Establish an ongoing process to provide regular refreshers for staff on third-party contractor processes and turnaround times, and on their roles and responsibilities related to the contract.

- Health Related Travel (POC 2);
- Benefit Grids; and
- Business Processes/Guidelines.

While the Treatment Benefits Unit priorities were found to align with the roles and responsibilities of the unit, they are not aligned with the majority of work completed by unit staff (as discussed further in the following sections).

4.1.4 Program Management Outputs

The intended outputs of the Treatment Benefits Unit, as self-identified by unit staff, were found to be linked to the overall program objective. Staff identified the following outputs relating to Treatment Benefits:

- Enquiry responses/guidance on individual cases and general topics (VAC field staff and contract staff, Issues Resolution Officers[26], Ombudsman's Office, VAC senior management, Access to Information, media, and parliamentary questions);
- Business guidelines, rules and directives;
- Forms and letters;
- Benefit grid updates;
- CSDN updates;
- Memorandums of Understanding, Agreements, and drug Product Listing Agreements;
- Committee/meeting packages, attendance, and records of decision;
- Ad-hoc initiatives and reviews (including departmental working group membership);
- Training packages for VAC field staff and third-party health claims processing staff;
- Stakeholder presentations and meetings; and
- Action plans responding to internal and external audit and evaluation reports.

The evaluation team found that the outputs produced by the Treatment Benefits Unit support the activities and outputs in the program's logic model (benefit authorizations, appeal decisions, payments, health care identification card processing) as seen in Appendix B.

According to interviews, observation, and self-reported activity data, the majority of staff time is spent responding to benefits-related enquiries. These enquiries range from simple clarifications to in-depth matters involving policy interpretation and consultations with other VAC staff. The level of effort expended on enquiries will be further elaborated on in section 4.2.3.

[26] Inquiries Resolution Officers investigate, respond to, and make recommendations to resolve client issues, liaising as necessary with staff from any unit/branch within the department or escalate it directly to senior management when outside their scope of resolution.

4.2 To what extent is the Treatment Benefits Program Management Unit optimizing its use of resources and producing the required outputs?

The evaluation team was unable to fully assess the optimization of resources due to a lack of information on outputs and numerous shifts in resources over the evaluation scope timeline. As of 2017-18, the Treatment Benefits Unit resources had declined while the number of SDAT enquiries received by the unit have increased, and the number of business processes and benefit grids requiring updates continues to grow.

4.2.1 Resources (Inputs)

Inputs are the human, financial, or infrastructure resources needed to administer a program. The key inputs of the Treatment Benefits Unit are human and financial resources, regulations and policies, and the FHCPS and CSDN systems.

As mentioned in the introductory section 1.0, there have been a number of changes impacting the Program in recent years. As noted in Table 3, these changes include a loss (-3.4) of full-time equivalents (FTEs). Compounding the loss of these resources, there has been a significant departure of corporate knowledge within the Treatment Benefits Unit. In recent fiscal years, some indeterminate positions have been backfilled with non-permanent employees and/or employees new to the business area. As can be seen in Table 3, in 2013-14 100% of Treatment Benefits Unit FTEs were indeterminate, compared to 62% as of September 2017. New staff require training and time to learn the complex program benefit policies, processes, and intricacies.

Table 3 – Human Resources for the Treatment Benefits Unit from April 2013 to September 2017[27]

Fiscal Year	Total FTEs	Indeterminate FTEs	Casual/Term FTEs
2013-14	12.9	12.9	0.0
2014-15	10.6	10.6	0.0
2015-16	9.6	9.6	0.0
2016-17	9.2	8.25	0.95
2017-18 (YTD)	9.5	5.9	3.6
Changes	***-3.4***	***-7.0***	***+3.6***

Note: During the examination phase of the evaluation, the Treatment Benefits Unit lost an additional experienced analyst.

The great majority of Head Office interviewees noted that the Treatment Benefits Unit did not have sufficient resources to appropriately manage the program. Though not specific to only Treatment Benefits, a 2016 internal review indicated that there were too many staff enquiries and not enough functional direction expertise available.

[27] Based on internal reporting of Capital Budgeting and Human Capital for the Health Care Benefits and Rehabilitation Directorate.

4.2.2 Activities and Outputs

Activities are processes or operations that an organization completes using available inputs. Outputs are the direct products or services resulting from the activities.

According to interviews and self-reported tracking, the majority of the Treatment Benefits Unit resource effort is spent on operational items. Enquiries and escalations affecting Veterans are considered highest priority for the Treatment Benefits Unit. This focus is directly linked to departmental priorities of Veteran centricity, including the well-being of Veterans and service excellence, as well as program objectives.

When issues or risk areas are recognized Treatment Benefits Unit resources are assigned to work on these areas; however, the effort often cannot be fully dedicated as staff are also assisting in addressing enquiries.

Enquiry Escalation Process

Enquiries received by the Treatment Benefits Unit can be based on individual Veteran cases, provider specific issues, or related to general treatment benefit topics. Enquiries are received by the Treatment Benefits Unit from multiple avenues:

- SDAT system;
- Direct from field office and third-party health claims processing staff;
- VAC senior management;
- Issue Resolutions Officers; and
- Ombudsman's office.

Interview results from third-party health claims processor staff and VAC field staff noted varying methods of enquiry escalation, and did not always include the Treatment Benefits Unit (e.g., local supervisors, Standards Training and Evaluation Officers[28], SDAT, or direct to the Treatment Benefits Unit). There is limited documentation available for VAC field staff regarding when or how to escalate treatment benefit issues and requests for guidance. Current SDAT processes indicate that staff follow 'local practices in place' after which a supervisor submits a request through SDAT if they are unable to resolve the issue. The electronic SDAT system is used to submit, log, and track enquiries. The SDAT team distributes questions to the appropriate areas within VAC for action. (e.g., Treatment Benefits questions are directed to the Treatment Benefits Unit). SDAT enquiries received by the Treatment Benefits Unit are triaged by one central unit staff member. For a visual representation of the escalation process refer to Appendix F.

Interview results and program management activity tracking report that a number of enquiries (100-150 per month) are sent directly to Treatment Benefits Unit staff, including items considered of higher risk. The limited documented direction regarding the escalation process for treatment benefit issues can cause confusion for field staff leading to irregularities in the process and an inconsistent enquiry tracking method for the Treatment Benefits Unit.

[28] As part of their role, STEOs provide interpretation, guidance and coaching on the application of all program legislation, regulations, policy, business processes and decision making to field office staff as well as guidance on program and service issues.

Enquiries Received

The Program has seen an increase in the number of SDAT enquiries received in the last three fiscal years. There has been a 51% (226) increase in total SDAT enquiries between 2014-15 and 2017-18 YTD (January 2018). Estimates based on a review of 2016-17 data indicate that total 2017-18 SDAT enquiries are on track to match or exceed the previous fiscal year. The most recent year-over-year change in total SDAT enquiries (2015-16 to 2016-17) shows an increase of 40% (229), with enquiries from both VAC and the third-party health claims processor increasing. Table 4 highlights incidents logged from 2014-15 to 2017-18.

Table 4 – Treatment Benefit SDAT Incidents Logged

Fiscal Year	Incidents logged by third-party health claims processor	Incidents logged by VAC	Total incidents logged
2014-15	154	293	447
2015-16	354	224	578
2016-17	537	270	807
2017-18 (Forecast)*	500	308	808

*The 2017-18 forecast data is based on data as of January 31, 2018 plus estimates for the last two months of 2017-18 based on previous fiscal year activity.

Based on interviews and an analysis of SDAT incident data from April 2014 to January 2018, there is an indication that the move in treatment authorizations from VAC Treatment Authorization Centres[29] to the third-party health claims processor during 2014-15 and 2015-16 has resulted in additional enquiries to the Treatment Benefits Unit. There has been an increasing trend in the number of SDAT enquiries received from April 2014 to March 2017[30] from the contractor (383 or 249%). There are a number factors that could be reasonably attributed to the rise in enquiries:

- Overall increase in treatment benefit authorizations (560,702 in 2014-15 to 673,474 in 2016-17, an increase of 20%);
- Experience/knowledge of new benefits/services takes time to build (plus the third-party health claims processor had to hire additional staff, which would be an added learning curve regarding Veterans and general VAC policies and processes);
- Business rules and benefit grids in need of review could be contributing to the increasing enquiries; and
- Third-party health claims processor does not have the same level of discretionary decision making that VAC staff do, and therefore if business rules are not clear to make decisions they are left escalating issues or enquiries to the Treatment Benefits Unit.

Interestingly, an internal review of the benefit grids completed in 2010 predicted that if TAC processing work shifted to the third-party health claims processor and VAC's processes were not refined and streamlined, there was a risk that increasing volumes of work would be gradually pushed back to VAC. Based on the evidence reviewed, the evaluators are not able to

[29] Treatment Authorization Centres were regional VAC operational centers responsible for authorizing a variety of health care benefits and services prior to 2014.

[30] 2016-17 data was used as at the time of the evaluation, there was not a full fiscal year.

definitively conclude if this prediction has been realized, however evaluation findings do indicate that the shift in work has contributed to additional work for the Treatment Benefits Unit.

Generally, third-party health claims processing staff and VAC field staff interviewed indicated that they have the support they need to deliver the Treatment Benefits Program and are able to resolve the majority of their requests locally without additional clarification or involvement from Head Office. As noted previously, there is no documented process for escalating issues/questions.

As many of the Treatment Benefits Unit Analysts do not have an extensive background in health care, it is important that consultations occur with subject matter experts. At present, there is limited documentation in place highlighting when Treatment Benefits Unit staff should consult with non-program area staff (e.g. health professionals or policy) and consultations are not typically documented within CSDN[31]. Based on interviews and a small review of SDAT enquiries (37 files), informal and ad-hoc consultations appear to be occurring with non-program area staff.

Activity Tracking Tool

To assist in gathering a full representation of workload, a new activity tracking tool was implemented in October 2017 for the Treatment Benefits Unit. The evaluation team had four months of information to assess as the evaluation progressed. During the four months (October 2017 to January 2018) 1,778 reported activities were recorded.

Enquiry-based work was the primary focus of capturing information, with little to no information recorded regarding strategic work. The evaluation team found limited evidence that the information gathered is used to help manage the Treatment Benefits Unit workload and/or to inform management decision-making.

The evaluation team determined that the current tracking tool could be enhanced to maximize electronic capabilities and to better inform trends and issues, as well as program management decision making. The tool would benefit from additional information being captured such as: enquiry responses, turnaround times, types of enquiries (e.g. by POC or health care provider type), and other work being completed by Treatment Benefits Unit staff (e.g. business process updates, BRC, and internal ad-hoc reviews).

4.2.3 Assessing Optimization of Resources

Due to the unavailability of past output information and organizational changes the evaluation was unable to accurately attain information regarding all Treatment Benefits Unit outputs for the evaluation scope period. During the evaluation examination phase, it was clarified that the new tracking tool was measuring enquiries received (not completed) by the Treatment Benefits Unit and that not all activities/outputs were being tracked. Therefore it is difficult to comment on improved production of outputs.

In order to facilitate knowledge growth and retention for the Treatment Benefits Unit, the Program Manager began moving from a POC specialist model to a model where unit analysts are more generalist in 2017. Interviews with Treatment Benefits Unit staff noted that weekly team meetings are also used as a forum for sharing information and case discussions.

[31] Client Service Delivery Network – VAC's internal computer system of record for Veteran's files.

Industry Comparators

The evaluation team identified the following federal government departments with similar federally funded health care programs:

- Canadian Armed Forces (CAF) [health coverage for CAF members];
- Royal Canadian Mounted Police (RCMP) [health coverage for RCMP members];
- Treasury Board of Canada [Public Service Health Care Plan (PSHCP) offers health plan for federal public servants and retirees, as well as a few other groups]; and
- Health Canada [Non-Insured Health Benefits Program (NIHB) for First Nations and Inuit.

Program delivery and management/organizational structures of the above programs were assessed through a document review, internet search and interviews with program staff. Each program has its own intricacies (e.g. CAF provides health care directly to CAF members and NIHB has more regional administration), with varying 'client' base size (e.g. NIHB and PSHCP serve a much larger population). In the end, there was no clear comparison structure for the management of the VAC Treatment Benefits Program.

The evaluation did not conduct comparisons with private insurance plans due to key differences in the program design and delivery structure, primarily that recipients of private plans co-pay portions of benefit coverage, eligibility is not linked to conditions (like pensioned conditions), coverage is the same for all members, and cost containment is a major driving factor.

Benefits Review Committee (BRC)

The BRC is an official VAC body which is meant to offer a forum for discussion, consultation, and recommendations regarding new and emerging health care interventions and benefits, and the related health professional groups. The committee membership includes many key subject matter experts within VAC (e.g. Health Professionals, Appeals, Case Management, Rehabilitation, Policy, etc.). Since January 2016, the entire BRC quorum has not formally met. One meeting was held in September 2017 but not all members were present.

In 2017, the Terms of Reference for the BRC were reviewed to align more closely with the newly enacted VAC drug Formulary Review Committee (FRC) Terms of Reference. The FRC was revamped in response to a recent OAG audit report, and interviews indicate that the committee is functioning more efficiently and effectively based on these changes. At the writing of the evaluation report, the BRC Terms of Reference had been in progress since July 2016 and were not yet finalized. There continues to be discussions between the Service Delivery and Program Management Division and the Health Professionals Division regarding membership composition and roles and responsibilities of members.

Interviewees agree that the committee is needed and there are a list of items awaiting discussion and review. This statement is further supported by the 2016 OAG Drug Audit and the 2017 internal *Audit of VAC's Governance*, which both highlighted the importance of clear roles and responsibilities and documentation of decisions.

Based on a review of documentation and interview results, the evaluators determined that ongoing membership discussions, irregular meetings, and the lack of a finalized Terms of Reference are impeding efficient decision making for treatment benefits and services. The evaluation team also identified areas where the BRC could be further maximized including:

- Reviewing/driving treatment benefit trend and risk analysis;

- Acting as an advisory panel for special projects and ad-hoc reviews; and
- Incorporating a representative from VAC's clientele group to ensure more stakeholder consultation is occurring.

4.2.4 Opportunities for Improvement

Due to the many staffing changes and insufficient tracking information, the evaluation is not able to definitively confirm that additional resources would fix the issues currently being experienced by the Treatment Benefits Unit or if the additional resources would be required on a long-term basis. Short-term additional staffing could allow the Treatment Benefits Unit to analyze potential issue/risk areas, better support program management, and improve program delivery. For example, updating business processes/rules and providing more attention to key areas such as benefit grid reviews, multi-disciplinary clinic issues, health related travel, updating drug product listing agreements, creating a repository of enquiry responses, and other potential areas of efficiency.

The Treatment Benefits Unit tracking tool is a good basis for a more in-depth product and, as such, there are improvements which could enhance its purpose and value. There are clear benefits of tracking activities/outputs of the Treatment Benefits Unit: justification of current resources and workload limitations, informing and aligning future resource needs, and monitoring of trend/issue areas that require further analysis.

Evaluation findings suggest a lack of awareness of roles and responsibilities regarding the Treatment Benefits Unit as well as inconsistencies in the current treatment benefit enquiry escalation process. Since there is limited documentation available for VAC field staff regarding when or how to escalate issues and requests for guidance, there is an opportunity to augment awareness and knowledge with field staff in these areas.

4.3 Are there any opportunities to improve efficiencies in the management of the Treatment Benefits Program?

Over the past number of years, the Program has been seeking processing efficiencies. There are opportunities to apply various practices within the Treatment Benefits Unit to better support program management and help determine further areas where efficiencies could be gained.

4.3.1 Performance Measurement

In July 2016, the *Policy on Results* was enacted, replacing the previous *Policy on Evaluation*. Under the new policy suite, there is additional emphasis placed on monitoring and reporting of performance measurement for federal government departments, including requirements for reporting and consultation with Treasury Board Secretariat on program performance outcomes, indicators, and outputs.

Performance measurement is a key function that aides in effective program management. Performance measurement is generally described as the regular measurement of indicators and outputs established to track progress towards achieving the intended outcomes of a program.

This information is used to assess the effectiveness and efficiency of programs and to inform day-to-day decision making in program management.

The 2014 *VAC Health Care Benefits and Services Program Evaluation* noted challenges regarding performance measurement. At the time of the current evaluation's commencement, program performance measurement was two years in arrears. As such, there is no evidence of performance measurement being regularly collected, reported, or monitored by program management and used to support decisions made by the Treatment Benefits Unit.

4.3.2 Risk Management

Another important aspect of program management involves the identification, assessment, and prioritization of risks followed by an application of resources to mitigate the impact of negative events and to maximize possible opportunities. Risk management's objective is to ensure that uncertainty does not hinder an organization from reaching its goals.

At present, informal priorities and risks are informally discussed by management and the Treatment Benefits Unit staff but they are not formally documented. Additionally, there is no evidence of formal trend or risk analysis being completed on the enquiries received by the Treatment Benefits Unit. It is expected that the BRC will provide a forum to discuss risks, however this role is not clear as the BRC's Terms of Reference has not been finalized and an official BRC meeting did not take place during the evaluation project timeline (June 2017 to March 2018).

4.3.3 Data Analysis

The Program is large and there is much data available, however there has been limited analysis conducted in the last number of years. Ongoing monitoring and reporting of data would support program performance measurement and help identify issues/trends that could help improve the program delivery and management and therefore improve service for Veterans.

Though the evaluation did not assess authorization or transaction data at the POC or recipient type level, the evaluation team did note some areas of concern regarding consistency, integrity, and use of data to inform decision making. For example:

- Until requested by the evaluation team, the program performance snapshot was not generated for two years;
- Interviews with Treatment Benefits Unit staff supported that there has been little use of program data to manage the Program in the last few years; and
- Once analyzed by the evaluation team, the program performance snapshot data indicated that VAC was processing 65-75% of transactions, which is an error, the third-party claims processor actually processes nearly all Program transactions. The error had been ongoing for a number of years, indicating that this information is not regularly reviewed.

4.3.4 Stakeholder Engagement

Collaborating with stakeholder groups enables program managers to identify needs, issues and perspectives. Stakeholders can include: program recipients, internal and external partners, support teams, providers, and other organizations/groups affected by a program. As previously stated in section 1.0, results from the 2017 *VAC National Veteran Survey* indicate that program recipients are highly satisfied with the Program.

According to interviews with Treatment Benefits Unit staff and third-party health claims processing staff, some collaboration/discussions occur with various health care provider associations/groups. Some interviews noted a need for more focus on provider issue management. In fact, prior to 2014 the Treatment Benefits Unit had a staff member dedicated to this function. As discussed in section 4.2.3, there is also potential to include stakeholder representation on the BRC.

4.3.5 Lessons Learned

Lessons learned are experiences (positive or negative) gained from previous cases/projects. The purpose of identifying, documenting and sharing lessons learned is to apply knowledge derived from experience. The Treatment Benefits Unit meets weekly to discuss ongoing cases and to share information among the team. There is limited evidence that previously answered enquiries are used to inform future enquiries on similar topics. Ad-hoc and informal consultations among the Treatment Benefits Unit staff happen but there is no formal database to track previously completed enquiries. A concerted effort needs to be placed on gathering and analyzing this information as there has also been a significant turnover in staff in the Treatment Benefits Unit and this may assist in training and educating staff, and ensuring consistency in enquiry responses.

4.3.6 Other Report Findings

The *2016 Spring Reports of the Auditor General of Canada Report 4—Drug Benefits—Veterans Affairs Canada* noted the following gaps in relation to POC 10, but which could be applied to the entire Program:

- Adequate process for making evidence-based decisions related to benefits
- Monitoring for trends of exceptional decisions (non-benefit grid items routinely approved)
- Trend utilization that could inform program management; and
- Applying cost-effective strategies.

Similarly, an internal departmental review of the benefit grids in 2010 found that there was no clear process for determining the parameters contained within the grids and that processes for assessing and making changes should be standard, well-understood, and hold up to financial and legal scrutiny. The review also recommended that a regular data reporting regime be established to help identify trends and issues.

4.3.7 Efficiency Initiatives Underway/Realized

Although it was not within the scope of the evaluation to assess whether efficiencies regarding the delivery of the program were being realized, the evaluators did note that several efficiency seeking initiatives occurred since the last evaluation examination phase (autumn 2012) or were underway:

- In 2013, a project intended to streamline business processes regarding benefit/service authorizations was completed. The project close-out report indicates that subsequent pre-authorizations were greatly reduced (over 80% of claims are being processed without VAC interaction) and internal and external websites were enhanced for easier navigation of information. The evaluation team did not find sufficient evidence to validate that the

authorization reductions occurred as reported. This further supports the evaluation report's finding regarding the need to improve data/trend analysis function for the program.

- In an effort to optimize client service and delegate authorities to decision makers, VAC area office staff received additional delegated authorities for the Treatment Benefits Program in 2014. The evaluation team did not assess whether the intended goals were achieved.

- As part of the new FHCPS contract, authorization work previously completed by various VAC Treatment Authorization Centres was consolidated with the third-party health claims processor in 2014-15 in order to gain processing consistencies and efficiencies. The efficiency of the FHCPS contract was outside of scope, however there is an increasing amount of treatment benefit enquiries from the third-party health claims processor, as well business rules and benefit grids in need of review, suggesting that there are opportunities for improvement.

- In 2012, a mapping exercise was completed to ensure appropriate linking of medical conditions to benefits. The exercise resulted in a 'stop-light' tool in 2015 which is used as a reference guide for decision making/consultation. Interviews with third-party health claims processing staff indicate the tool is helpful.

- During the evaluation the Program launched a review of Health Related Travel claims processing. The goal of the review is to streamline processes to reduce administrative burden, reduce error rates, and meet the needs of Veterans. The review was too early in the process for the evaluation to comment on results.

- During the evaluation reporting phase, the Treatment Benefits Unit was also undertaking a review of 20+ program-related letters and forms for the purposes of clarifying information, streamlining processes, and enhancing user experiences. These letters/forms were considered priority due to their high usage through FHCPS.

5.0 Conclusions

The Treatment Benefits Unit has realized significant changes in its organizational structure and knowledge capacity in the past number of years which has had an impact on the ability to respond to the numerous enquiries and priorities that continue to emerge in the complex and evolving health care environment in Canada.

There is a need for a concrete governance structure for the Program. Having documentation in place highlighting the objectives, roles and responsibilities, and priorities of the Treatment Benefits Unit would provide direction and ensure that all parties clearly understand their core business. Additionally, ongoing BRC membership discussions and a lack of meetings are creating roadblocks to efficient decision making for treatment benefits and services.

Operational items take precedent over strategic management within the Treatment Benefits Unit. Enquiries/escalations affecting Veterans are considered the highest priority which is

directly linked to Departmental priorities; however, there is a strong likelihood that the lack of updates to the benefit grid rates and guidance documents are contributing to the increase in enquiries which the Treatment Benefits Unit has been realizing. If more focus is not spent on managing overarching issues and addressing the root causes, it can reasonably be expected that the Treatment Benefits Unit workload will remain high/continue to grow in these areas while other issues remain unaddressed.

Additionally, focusing on strategic areas would benefit Veterans and VAC staff, by enabling more efficient and effective benefit delivery. Furthermore, if the above issues are not rectified and the disability benefits application/review backlog is resolved, workload for the Treatment Benefits Unit has the potential to increase as new Program recipients begin accessing health care benefits and services.

There has been limited data analysis conducted in the last number of years on treatment benefits by the Treatment Benefits Unit. Ongoing monitoring and reporting of data would support program performance measurement and help identify issues/trends that could help improve the program delivery and management.

6.0 Recommendations

RECOMMENDATION 1:

It is recommended that the Director General, Service Delivery and Program Management improve the Program governance structure by:

- Updating the Treatment Benefits Roles and Responsibilities document to reflect changes in the organizational structure, roles and responsibilities of non-program unit staff and relevant committees, program unit objectives, key activities and outputs, and priorities;
- Producing a mid to long-term strategic and operational plan for the Treatment Benefits Program Management Unit, including resource needs, timelines, goals and linkages to Treatment Benefit Program priorities; and
- Sharing the above noted documents with departmental staff and third-party health claims processing staff.

Management Response:

Management agrees with this recommendation.

Management Action Plan:

Corrective Action to be taken	Office of Primary Interest (OPI)	Target Completion Date
Given the re-organization of the program management function for all Health Care Programs under a single Director effective January 22, 2018, the roles, responsibilities, objectives, priorities, and key activities/outputs associated with the program management of Treatment Benefits will be	Director General, Service Delivery and Program Management	30-June-2018

Corrective Action to be taken	Office of Primary Interest (OPI)	Target Completion Date
reviewed and updated with a view to ensuring a clear understanding by VAC staff and external partners. Develop a strategic and operational plan addressing resource needs, timelines, goals and linkages to priorities. This plan will be developed in consultation/collaboration with key players. This plan will identify mid to long term actions and will be driven by the updated roles and responsibilities of the Treatment Benefits Program noted above. Distribute the updated roles and responsibilities document and the strategic and operational plan to VAC staff, third-party health claims processing staff and other stakeholders as applicable.		30-November-2018 31-December-2018

RECOMMENDATION 2:

It is recommended that the Assistant Deputy Minister, Service Delivery finalize the Benefits Review Committee Terms of Reference (including membership roles and committee purpose), communicate the document with departmental staff and third-party health claims processing staff, and ensure that regular meetings occur on a go-forward basis.

Management Response:

Management agrees with this recommendation.

Management Action Plan:

Corrective Action to be taken	Office of Primary Interest (OPI)	Target Completion Date
Convene a meeting of the Benefits Review Committee based on the interim Terms of Reference.	Assistant Deputy Minister, Service Delivery	31-May-2018
Collaborate with the Health Professionals Division to finalize the Terms of Reference to ensure membership, roles, meeting frequency and committee purpose are established.	Director General, Service Delivery and Program Management	30-September-2018
Distribute finalized BRC Terms of Reference to VAC and third-party health claims processing staff, as applicable.	Director General, Health Professionals & Chief Medical Officer	31-October-2018
Ensure Committee meetings occur on a regular basis, as agreed upon in the Terms of Reference.		31-December-2018

RECOMMENDATION 3:

It is recommended that the Assistant Deputy Minister, Service Delivery work in collaboration with relevant areas across the department to strengthen the collection and analysis of data to support the management of the Treatment Benefits Program (such as performance measurement, risk areas, trend analysis, and regular monitoring of benefit specific data).

Management Response:

Management agrees with this recommendation. However, the nature, scope and timing of implementation will be subject to the availability and allocation of resources as well as any direction to focus attention on higher order Departmental priorities.

Management Action Plan:

Corrective Action to be taken	Office of Primary Interest (OPI)	Target Completion Date
Review and compile collection of currently available data.	Assistant Deputy Minister, Service Delivery	30-June-2018
Strengthen the collection of relevant data to support the Treatment Benefits Program by working in collaboration with the Performance Monitoring Unit, Contract Unit, third-party health claims processing staff, and Corporate Statistics to develop and implement a framework to enhance reporting and tracking tools to better enable data/trend analysis.	In conjunction with Assistant Deputy Minister, Chief Financial Officer and Corporate Services	30-September-2018
Perform trend analysis.	Director General, Service Delivery and Program Management	30-November-2018
Monitor relevant data and trend analysis on a regular basis to identify areas of risk.		31-March-2019

RECOMMENDATION 4:

It is recommended that the Director General, Service Delivery and Program Management implement a cycle of benefit reviews to ensure they are updated on a continuous and efficient basis.

Management Response:

Management agrees with this recommendation.

Management Action Plan:

Corrective Action to be taken	Office of Primary Interest (OPI)	Target Completion Date
Develop an approach for a cyclical review of treatment benefits and services and build this approach into mid- and long-term activities identified in the strategic and operational plan.	Director General, Service Delivery and Program Management	30-November-2018
Implement a review cycle for treatment benefits and services.		31-December-2018
Ensure benefits and services are updated on a continuous and efficient basis.		31-March-2019
Explore options for streamlining the assessment/approval process for some treatment benefits and services (e.g., low-risk items) and for further delegating authority to appropriate staff.		31 December 2018

Appendix A – Overview of the Programs of Choice (POCs)[32]

1. Aids for Daily Living - devices and accessories designed to assist in the activities with everyday tasks, such as walking and bathroom aids. The costs of necessary repairs to this equipment are also covered.

2. Ambulance Services and Health Related Travel - ambulance services required for an emergency situation or a specified medical condition. The program also includes coverage for costs related to travel when receiving treatment benefits.

3. Audio (Hearing) Services - equipment and accessories related to hearing impairment, such as hearing aids, telephone amplifiers, infrared devices, hearing aid accessories and dispensing/fitting fees.

4. Dental Services - basic dental care and some pre-authorized comprehensive dental services. Examples of eligible services and benefits are exams, fillings and dentures.

5. Hospital Services - treatment services in an acute care, chronic care or rehabilitative care hospital. As these services are generally a provincial responsibility, costs for these services are normally covered by VAC only if they relate to a condition for which a client holds disability entitlement.

6. Medical Services - services provided by a licensed physician for a condition for which a recipient holds disability entitlement. It also covers the cost of medical examinations, treatment or reports specifically requested by VAC. For most VAC recipients, physician services are the responsibility of the provincial health care insurance programs.

7. Medical Supplies - medical and surgical equipment and supplies normally used by an individual in a non-hospital setting. Examples of eligible benefits include bandages and incontinence supplies.

8. Nursing Services - services provided by a registered nurse or a qualified licensed/certified nursing assistant. Examples of eligible services include foot care, the administration of medications, application of dressings and counselling Veterans or caregivers in the use of medical supplies.

9. Oxygen Therapy (Respiratory Equipment) - oxygen and accessories, including the rental or purchase of respiratory supplies and equipment.

10. Prescription Drugs - drug products and other pharmaceutical benefits to those who have demonstrated a medical need and have a prescription from a health professional authorized to write a prescription in that province. Standard benefits and special authorization benefits are included in this program.

[32] Veterans Affairs Canada Programs of Choice.

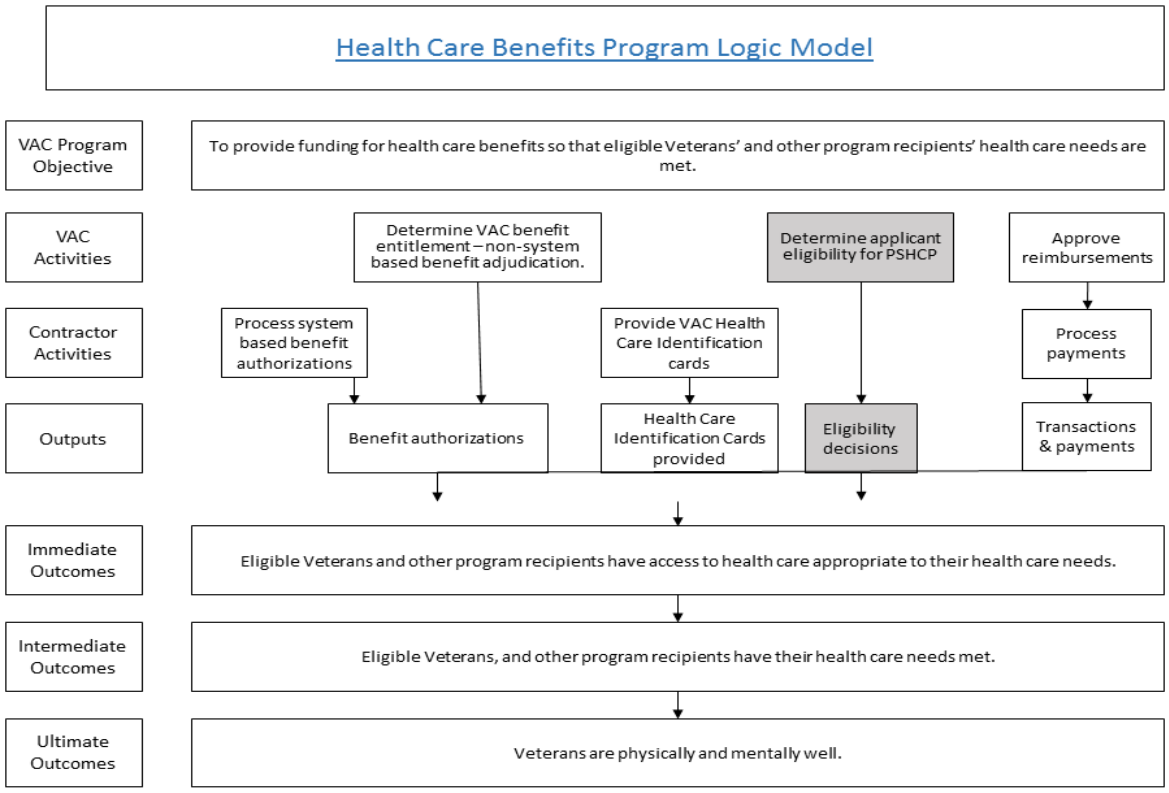
11. Prosthetics and Orthotics - prostheses, orthoses, and other related accessories. Repairs to equipment are obtained under this program.

12. Related Health Services - services provided by licensed health professionals. In many cases, the service must be prescribed by a physician in order to be approved by VAC. Examples of eligible services include occupational therapy, physiotherapy, and massage therapy.

13. Special Equipment - special equipment required for the care and treatment for eligible recipients. Benefits must be prescribed by a doctor, and in many cases supported by the recommendation of another health professional. VAC may also provide coverage for home adaptations or modifications (i.e., wheelchair ramps, door widening) to accommodate the use of the special equipment in the home. Examples of eligible equipment include hospital beds, wheelchairs and lifts.

14. Vision (Eye) Care - eye examinations, lenses, frames and accessories to correct sight impairments as well as low-vision aids.

Appendix B – Health Care Benefits Program Logic Model



Appendix C – Evaluation Issues/Questions

Issues / Questions	Indicators	Collection Methods	Data Sources
Relevance			
1. To what extent are the outputs delivered by the Treatment Benefits Program Management Unit in line with the original intent of the unit, and linked to program objectives?	• Objectives and outputs of the directorate are clearly defined • Activities and outputs of the directorate are directly linked to the purpose/objectives of the Program • Activities and outputs of the directorate are directly linked to the purpose/objectives of the unit • Program Management accountabilities and roles are clearly defined and understood • Management incentives align with goals/program objectives	• Document Review • Interviews / Observations	• Legislation, policies, processes and procedures • Program documents • Program Management staff + senior management • Briefing notes • Emails • Direction from senior management
Efficiency			
2. To what extent is the Treatment Benefits Program Management Unit optimizing its use of resources and producing the required outputs?	• Activities/information requests are effectively triaged based on risk/priority • The directorate staffing level and expertise are appropriate to meet the output demands • Limited overlap or duplication of duties exist • Non-directorate staff are appropriately engaged / consulted with when producing directorate outputs (e.g. health professionals, Policy, Field Ops, Contractor staff) • Use of tools and technology is maximized to help manage work appropriately • The key outputs produced by the directorate are appropriate in terms of quality and quantity. • Events/changes to program management/delivery have improved production of directorate outputs • Appropriate support is provided to program delivery staff • Ratio of inputs to outputs produced • Planned output production is achieved or surpassed • Ratio of inputs to outputs is comparable to similar federal government program management directorates • Comparable resource compliment/structure and processes are used by similar federal government programs	• Document review • Data analysis • Emails • Interviews • Observation / Focus Group(s)	• Program management documents • Policies, processes and procedures • Process maps • Committee/meeting minutes (BRC and TBIN) • Program directives / SDAT messages • Previous evaluations/Management Response and Action Plans (MRAPs) • Organizational Chart • Finance salary and O & M • SDAT, Issue Resolution Officer, Ministerial and OVO requests received • Program management, other HO staff, field operations and contractor staff input • Review of available comparison program management structures (e.g. DND [Department of National Defence], INAC [Indigenous and Northern Affairs Canada]/Health Canada)

Issues / Questions	Indicators	Collection Methods	Data Sources
3. Are there any opportunities to improve efficiencies in the management[33] of the Treatment Benefits Program?	• Performance measurement information is collected, reported, monitored and used to support program decision making • Key risks impacting program delivery are documented and disseminated to Treatment Benefits Program Management Unit • Appropriate consultation with other areas of the department occurs • Directorate uses lessons learned as opportunities for future program improvements • Have efficiencies been realized since the previous evaluations MRAPs	• Document review • Data analysis • Emails • Interviews	• Regular performance monitoring reports • Divisional workload tracking • Policies, processes and procedures • Committee/meeting minutes (BRC and TBIN) • Program directives / SDAT messages • HO, field operations and contractor staff • Review of available comparison program management structures (e.g. DND, INAC) • Previous Evaluations/MRAPs

[33] In the context of this question, management is defined as the activities and outputs conducted by the Treatment Benefits Program Management Unit.

Appendix D – Key Roles and Responsibilities of Program Management

The evaluation's document review highlighted the following roles and responsibilities of Program Managers[34]:

- Acting on direction of management;
- Ensuring program benefits are achieved and aligned with the organization's strategic plan;
- Monitoring program progress/success (including any key milestones);
- Managing program resources and costs;
- Managing risk and issues (resolving, mitigating or escalating where appropriate);
- Managing stakeholder relations; and
- Providing status updates to management.

Additionally, the following roles and responsibilities of Senior Management (referred to as Executive Leadership and Programme Sponsors in the literature) were highlighted:

- Establishing organization's strategic direction and business plan;
- Ensuring effective governance structure throughout organization;
- Ensuring alignment of program(s) with organization's strategic direction;
- Sponsoring deployment of programs and any change management required;
- Supporting stakeholder engagement;
- Ensuring ongoing program management capability;
- Providing sufficient funding to support program management;
- Delegating authorities to program management; and
- Resolving issues that cannot be addressed by program management.

[34] International Organization for Standardization. Project, programme and portfolio management — Guidance on programme management. Reference number ISO 21503:2017(E). 2017

An evolving program management maturity model integrating program and project management Conference Paper I Program Management I 2000. By Moore, Thomas J.

Appendix E – Timeline of Events

- 2008-2010 – Benefit Grid review is conducted and grids updated
- July 21, 2010 – SDAT is introduced as single point of contact for district, regional and Head Office staff to help with complex issues when business processes or policies are not clear
- 2011 – VAC Program Management and Service Delivery branches at Head Office are amalgamated
- 2011-12 – Benefit Code to Medical Pension Code mapping process conducted and linkages updated
- April 2012 – Budget 2012 focuses on reductions in departmental spending (Deficit Reduction Action Plan), impacting resources dollars
- June 2013 – new Health Canada Medical Marijuana Regulations enacted
- 2013-14 – Treatment Benefits Program Management Unit reduced by 4 FTEs
- 2014-2015 - In order to gain efficiencies, work previously conducted by VAC Treatment Authorizations Centres is included in the third-party contract award for the Federal Health Claims Processing System. Work is transferred to the third-party health claims processor in a phased approach (by POC/line of work) between October 2014 and April 2015.
- 2013-16 – The Medical Pension Code to Benefit Code Tool is created to simplify the eligibility/approval process for authorizations by the third-party health claims processor. The tool is implemented in phases by POC between November 2013 and November 2016.
- 2014-15 – Canadian Medical Marijuana regulations are updated by Health Canada, with changes to licensed provider requirements, price regulations, growing personal plants, and access to types of marijuana.
- February 16, 2015 – all calls from providers requesting authorizations, except POC 10, to the toll free Treatment Authorization Center number will be responded to by the third-party health claims processor.
- 2015-16 – OAG Drug Audit work is conducted (scope timeframe April 2013 to March 2015)
- April 2016 – OAG Drug Audit report is published with findings and recommendations linked to Drug Formulary Review Committee decision-framework, documentation of evidence supporting decisions, drug utilization monitoring and cost-effective strategies.
- November 2016 – new VAC Cannabis for Medical Purposes Policy is established.

Appendix F – Enquiry Escalation Process

Escalation Work Flow

As documented/directed by Head Office