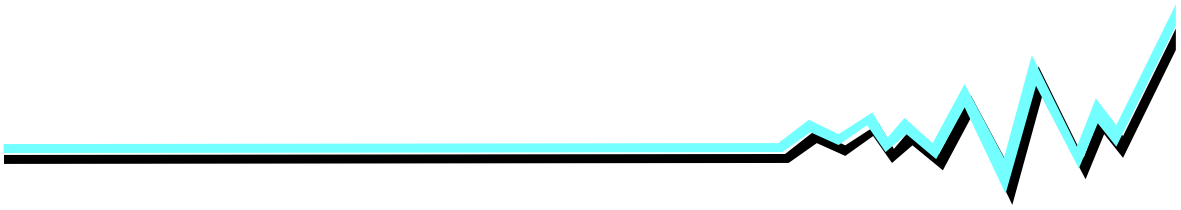
Veterans Affairs Canada | Anciens Combattants Canada

Responsibility Centre Phase II Audit

Final - April 2011



Canada

This report was prepared by the Audit and Evaluation Division

Acknowledgements

The audit team would like to gratefully acknowledge the people at the Halifax and Edmonton District Offices and the Atlantic and Western Regional Offices, whose contributions were essential to the audit.

Contents

EXECUTIVE SUMMARY

Veterans Affairs Canada has 60 points of service or responsibility centres, including regional and district offices that provide a wide range of services and programs. District offices provide direct service for programs, with regional offices providing functional direction and oversight. The three largest points of direct service are the Quebec, Halifax and Edmonton district offices which combined serve almost one-third of participants in the Rehabilitation Program. All three District Offices have approximately three client service teams and a varied mix of program participants.

This audit was the second of two phases and was developed at the request of senior management to assess the internal controls surrounding the delegated authorities, the adequacy of the management control framework and to identify opportunities to improve efficiency. The first phase of the cyclical audit which was completed October 2010, focussed on operations in the Quebec District Office. This site was chosen because new delegated authorities were being piloted there. The audit team used the results from the Quebec audit to focus and inform the planning for the second phase, which focussed on operations in the Halifax and Edmonton district offices.

In addition to interviews and documentation review, 245 case plans were reviewed to determine the adequacy of case management practices and participatory observation was conducted to assess the adequacy of case management practices. Audit planning began in August 2010 with the analysis completed in December 2010.

In support of the Department's transformation planning, regular briefing updates of preliminary findings and recommendations were shared with management throughout fieldwork. As a result, management action plans are directly linked to the Department's transformation plan and progress has already been made with several of the recommendations.

Audit Opinion

The findings for the second phase of the Responsibility Centre Audit reflect similar findings to the first phase of the audit which was focussed in the Quebec District Office. In the opinion of the audit team, the internal controls, governance and risk management framework relating to delegated authorities, management practices and service delivery require improvement.

The audit results identified significant weaknesses with the internal processes supporting service delivery. Sampling identified significant weaknesses in regards to the documentation supporting decisions and case plans. In addition, the monitoring process was not sufficient to reduce the residual risks to an acceptable level.

Recommendations:

R1 It is recommended that the Assistant Deputy Minister, Service Delivery clearly document and communicate management's vision and expectations of case management. (Essential)		
Corrective action to be taken	**OPI (Office of Primary Interest)**	**Target date**
ADM, SD and Senior Managers including National Manager, Case Management to present expectations of case management to the regional Management teams.	Service Delivery and Program Management	February 2011
Approval of case management foundation documents including Case Management Guiding Principles and Code of Conduct.	Service Delivery and Program Management	February 2011
Disseminate case management foundation documents.	Service Delivery and Program Management	March 2011

R2 It is recommended that the Director General, Service Delivery Management Division revisit and clarify the roles and responsibilities of District staff and regional experts and communicate the results to applicable staff. (Essential)		
Corrective action to be taken	**OPI (Office of Primary Interest)**	**Target date**
Approval of the report "Contracting for Health Professionals".	Service Delivery and Program Management - Contract Management	February 2011
Update the Roles and Responsibilities of Health Professional contractors.	Service Delivery and Program Management – Contract Management	March 2011
Review National/Regional and District core functions including roles, responsibilities (including Health Professionals).	Service Delivery and Program Management – Program Management/National Medical Officer	June 2011
Disseminate National/Regional and District core functions to applicable staff.	Service Delivery and Program Management	June 2011

R3 It is recommended that the Director General, Service Delivery Management Division provide training to applicable staff in regards to the new case planning tool, how to document decisions, how to write a clear rationale and how to communicate results. (Essential)

Corrective action to be taken	OPI (Office of Primary Interest)	Target date
Deliver Train the Trainers: Phase I Decision-making training.	Service Delivery and Program Management	November 2010
Deliver Phase I Decision-making training to field staff.	Service Delivery and Program Management	March 2011
Develop new case planning guidelines.	Service Delivery and Program Management	May 2011
Disseminate and provide information sessions on new case planning guidelines.	Service Delivery and Program Management	October 2011

R4 It is recommended that the Director General, Service Delivery Management Division review and revise the Client Service Agent performance measures to ensure they are relevant and appropriate in regards to workload, efficiency, effectiveness and productivity. (Essential)

Corrective action to be taken	OPI (Office of Primary Interest)	Target date
Review workload and revise Client Service Agent performance measures.	Service Delivery and Program Management	December 2011
Distribute Client Service Agent performance measures to field.	Service Delivery and Program Management	February 2012

R5 It is recommended that the Director General, Service Delivery Management Division clarify the guidelines for when case management should occur and when case management should cease and communicate the results to district staff. (Essential)

Corrective action to be taken	OPI (Office of Primary Interest)	Target date
Develop new case planning guidelines where the process and steps of disengagement will be clearly explained.	Service Delivery and Program Management	May 2011
Disseminate and provide information sessions on new case planning guidelines.	Service Delivery and Program Management	October 2011

R6 It is recommended that the Director General, Service Delivery Management Division clarify the definition of "direct client contact" and communicate the results to applicable staff and implement a quality control practice to ensure compliance. (Essential)

Corrective action to be taken	OPI (Office of Primary Interest)	Target date
Develop new case planning guidelines wherein the process and steps of direct client contact will be clearly explained.	Service Delivery and Program Management	May 2011
Develop a clear quality control practice for direct client contact to ensure compliance.	Service Delivery and Program Management	June 2011
Implement Case Management Performance tools.	Service Delivery and Program Management	September 2011
Disseminate and provide information sessions on new case planning guidelines.	Service Delivery and Program Management	October 2011

R7 It is recommended that the Director General, Service Delivery Management Division develop and implement a quality review process encompassing the new delegated authorities and case planning to ensure sufficient documentation and appropriate case management. (Critical)

Corrective action to be taken	OPI (Office of Primary Interest)	Target date
Develop a framework for the quality review of program decisions.	Service Delivery and Program Management	March 2011
Pilot quality review processes for rehabilitation decisions.	Service Delivery and Program Management	June 2011
Complete and monitor the implementation of quality review processes for program decisions made at the District Office level (VIP, Rehabilitation, Health Care Benefits/Treatment).	Service Delivery and Program Management	October 2011
Completion and dissemination of Case Planning Guidelines for Case Managers.	Service Delivery and Program Management	March 2011

R8 It is recommended that the area directors in the Halifax and Edmonton districts offices develop and document a local risk management strategy to properly identify, document and effectively manage the risks their offices face. These strategies should inform regional and national strategies, and ensure that senior management is aware of the risks the district offices face. (Essential)

Corrective action to be taken	OPI (Office of Primary Interest)	Target date
Consult with HO on Departmentally approved Risk Management approach/methodology/template to use.	HO/Region- Atlantic & Western/HFX/Edmonton DOs	February 2011
Examine, evaluate and document the risks facing the DO.	Halifax/Edmonton DOs	May 2011
Document and produce a progress report.	Halifax/Edmonton DOs	June 2011
Present the progress report to the Regional Director General (RDG) (make requested changes thereafter).	Halifax/Edmonton Dos	July 2011
Communicate the risk management strategy to employees.	Halifax/Edmonton DOs	September 2011

Assurance Statement

In the professional judgment of the Chief Audit Executive, sufficient and appropriate audit procedures have been conducted and evidence gathered to support with a high level of assurance the accuracy of the audit opinion provided in this report. This audit opinion is based on a comparison of the situation at the time of the audit and the pre-established audit criteria that were agreed on with management. The audit opinion is only applicable to the entity, process and system examined. The evidence was gathered in compliance with Treasury Board policies, directives, and standards on internal audit and the procedures used meet the professional standards of the Institute of Internal Auditors. The evidence has been gathered to be sufficient to provide senior management with a high level of assurance on the audit opinion.

Original signed by *April 6, 2011*

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Orlanda Drebit Date
Chief Audit Executive

The audit team consisted of the following members:

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1.0 BACKGROUND

Veteran's Affairs Canada (VAC) has 60 points of service or responsibility centres, including regional and district offices (DO) that provide a wide range of services and benefits to VAC program recipients. DOs provide direct service for participants in VAC programs, with regional offices (ROs) providing functional direction and oversight for the DOs. The ROs also have specialists who provide functional direction in standards, training, and education as well as rehabilitation and mental health.

This cyclical audit was developed at the request of senior management to assess the internal controls surrounding the delegated authorities, the adequacy of the management control framework and to identify opportunities to improve efficiency. The Quebec DO was the focus of the first phase, completed in October 2010. The Quebec DO was chosen at the request of senior management because of a new delegated authorities initiative being piloted and due to the large number of Canadian Forces (CF) Veterans being served at the DO. The audit team used the results from that audit to focus and inform the planning for the second phase of the audit, where the Halifax and Edmonton DOs were chosen by senior management.

This audit supports the annual opinion of VAC's Chief Audit Executive (CAE) on the risk management, control, and governance processes at the Department.

1.1 Profile of the Halifax District Office

There are approximately 60 employees separated into three client service teams (CST) in the Halifax DO. A CST consists of client service team managers (CSTM), case managers (CM), client service agents (CSA), and health care professionals to help provide an interdisciplinary perspective to decision making in the DO. One CST is partially located at Canadian Forces Base (CFB) Halifax while the remainder of the CST and other two CSTs are located at the main office in downtown Halifax.

The Halifax DO has the highest number of CF related program recipients of any DO in the country, 7,333 as of September 2010, or 50% of the total program participants in the Halifax DO. Although Halifax has a high percentage of CF related program recipients, the DO also has a high population of War Service Veterans (WSV) and survivors (6,667 as of September 2010). In addition, as demonstrated in Table 1 below, the overall client population for the DO continues to climb.

1.2 Profile of the Edmonton District Office

There are approximately 65 employees separated into three CSTs. One CST is located at CFB Edmonton Garrison while the other two are located at the DO. In addition, a VAC presence is maintained at CFB Cold Lake and CFB Wainwright in Alberta as well as in the Northwest Territories.

Edmonton DO has the fifth largest number of CF related program recipients in the country, 5,198 as of September 2010, or 50% of the total program participants in the Edmonton DO. Similar to Halifax, the number of WSV's and survivors in the district is also high at 4,486 as of September 2010.

1.3 Profile of the Quebec District Office

The Quebec DO has its main office located at Saint-Foy, with three CSTs. One CST is also located at the Valcartier Garrison and a small team in a service point at 3 Wing Bagotville. A CST consists of approximately 14 employees, including health care professionals and provides an interdisciplinary perspective to decision making in the DO.

Quebec DO has the third largest number of CF related program recipients in the country, 5,292 as of September 2010, or 65% of the total program recipients for the Quebec DO and is the second highest proportion of CF related program recipients in the country.

Table 1: Number of Recipients in the Halifax, Quebec, and Edmonton District Offices from March 2008 to September 2010

	March 08	Sept 08	March 09	Sept 09	March 10	Sept 10
Halifax DO	12,714	14,120	14,203	14,332	14,426	14,558
Quebec DO	10,519	10,920	10,966	11,021	11,091	10,417
Edmonton DO	8,334	8.624	8,607	8,025	8,091	8,123

Source: Statistics Unit

2.0 ABOUT THE AUDIT

2.1 Audit Objectives

The mandate of this audit was given to the Audit and Evaluation Division (AED) by VAC senior management under the 2009 Internal Audit Plan. It is part of a broader mandate of the Department's senior management to ensure the effectiveness of internal controls and the quality and effectiveness of managing and delivering programs in the DOs and other VAC centres of responsibility.

The objectives of the Responsibility Centre Audit were as follows:

1. Examine the implementation of the new delegated authorities to CM for the Rehabilitation Program;

2. Determine the effectiveness of management practices;

3. Examine the efficiency of service delivery provided by CMs and CSAs in the DO.

The detailed audit criteria are presented in Annex B and were discussed with management prior to the commencement of the audit.

2.2 Scope

The audit examined the delegated authorities as they relate to Subsection 15(1) of the *Canadian Forces Members and Veterans Re-Establishment and Compensation Regulations* (CFMVRCR) and the increased authority to case managers for medical and psychosocial rehabilitation components of the case plan and did not examine the delegation of Program of Choice 13 under the *Veterans Health Care Regulations*.

The scope of the audit was the implementation of the new delegation of authority, the effectiveness of management practices and the efficiency of service delivery in the Halifax and Edmonton DOs. Comparisons were also made to the Quebec DO based on the audit conducted in the spring 2010 with an additional file review for the Quebec DO completed in the context of this audit. Audit planning began in August 2010 with the analysis completed in December 2010.

A key aspect of service delivery is case conferencing (criteria 3.3 in Annex B). However, it should be noted that due to privacy constraints, the audit team did not assess the effectiveness of case conferencing.

2.3 Methodology

This audit was conducted in accordance with the Institute of Internal Auditors' (IIA) *Standards for the Professional Practice of Internal Auditing*, as required under Treasury Board Policy on Internal Audit. Audit procedures consisted of:

- A review of policies, authorities and other documentation pertaining to the new delegated authorities and the management and service delivery practices to verify their efficiency and effectiveness, and to assess the adequacy of management control framework within each DO audited;

- Interviews with employees in the Halifax and Edmonton DOs, the Atlantic and Western ROs and Head Office (HO) to determine the adequacy of management practices and the efficiency and effectiveness of the delivery of services and benefits in the respective DO, including the new delegated authorities to CMs;

- Walkthroughs/participatory observations with CMs and CSAs to assess workload management practices and to determine if there are areas of their

service delivery practices where efficiency and effectiveness could be improved;

- An analysis of workload and program statistics to obtain an understanding of the DOs that form the scope of this audit and to support workload related observations.

- An in-depth review of 245 active rehabilitation files (as of September 20, 2010) from the Halifax (75 files), Edmonton (84 files) and Quebec[1] (86 files) DOs. Files were selected randomly using a confidence level of 90%, a margin of error rate of 7%, and a 30% estimated error rate. The purpose of the review was to assess the adequacy and quality of new case plans, the adequacy of documentation of decisions, and the quality of desired outcomes defined by CMs. The file review was conducted between September 22 and November 3, 2010. The audit team sought the help of a subject matter expert to help in the file review.

2.4 Statement of Assurance

In the professional judgment of the CAE, sufficient and appropriate audit procedures have been conducted and evidence gathered to support with a high level of assurance the accuracy of the audit opinion provided in this report. This audit opinion is based on a comparison of the situation at the time of the audit and the pre-established audit criteria that were agreed on with management. The audit opinion is only applicable to the entity, process and system examined. The evidence was gathered in compliance with Treasury Board policy, directives, and standards on internal audit and the procedures used meet the professional standards of the IIA. The evidence has been gathered to be sufficient to provide senior management with a high level of assurance on the audit opinion.

3.0 AUDIT RESULTS

3.1 Observations, Recommendations and Management Action Plans

3.1.1 Change initiatives (New Delegated Authority)

The Department is undergoing a time of change and managing these changes adequately is important. Timely information must be provided to the people who are expected to implement changes for the Department, with effective communication delivered to end users affected directly by the new change initiative. It is important to get buy-in to ensure that gaps or deficiencies have been identified.

[1] A file review was conducted as part of phase one of the RC Audit in the Quebec DO, but the results of that file review were not directly comparable to the file review for phase two due to a different population sampling.

The most recent change initiative that is being implemented is the change to delegated authority. The purpose of the new delegation of authority is to give more discretionary and decision making power to front-line decision makers and to allow them to make decisions and respond more quickly and effectively to the needs of participants in the Rehabilitation Program. The implementation of the delegated authority is a two-phased approach, where the first phase has been fully implemented (increased authority for medical, psycho-social, vocational rehab and home adaptations). The second phase will include changes to the approval of exceptional benefits and increased delegation to CM's, CSA's, and District Nursing Officer's (DNO).

The auditors are of the opinion that insufficient time is provided to managers in the DO and RO to implement changes. For example, an email was sent to CSTM's and Treatment Authorization Centre (TAC) Managers on May 6, 2010 with direction to implement the first phase of the new delegated authorities as of May 10, 2010. This does not seem to be adequate time to implement the change. The issue of untimely communication was also identified in the Quebec DO, where CSTM's were provided limited time to dedicate resources to convert case plans into a new case planning tool. As a result, there was inadequate conversion of old case plans into the new case plans for all three DO's.

The Department has been responsive to some of the issues identified by front line workers. There is a 1-877 number and a general email address where staff can direct questions and the contact information is provided when initiatives are communicated to staff. However, turn-around-times (TAT's) for responses to questions can vary. In particular, regional staff expressed frustration with waiting for a response from these support lines and the audit team encountered the same difficulties.

Without sufficient advance notice to implement change, staff are not adequately prepared, which creates a risk of poor or incorrect decisions and/or a delay in decisions. As VAC continues to implement the new delegated authorities there should be an implementation strategy on how to efficiently and effectively implement and manage change. More specifically, VAC should ensure that the information is provided to all levels of the organization in a timely manner and allow enough time and dedicated resources to implement the process.

3.1.2 Clarity of expectations for case management

A clear management vision establishes the expectations for an organization and enables employees to take responsibility for their decisions.

Documentation review and interviews with staff identified that the expectations for case management at VAC are not clear and CMs require a clearly defined set of expectations and guidelines. CMs are held accountable for decisions made in regards to case management without a clear understanding of VAC's expectations, making them hesitant to make an unfavourable decision because it may be overturned in the regional or head office.

The lack of clarity on expectations for case management has led to uncertainty in the decision making processes for case management and inconsistency in delivery of case management services. A lack of clearly defined expectations could lead to inappropriate case management or incorrect decisions.

R1 It is recommended that the Assistant Deputy Minister, Service Delivery clearly document and communicate management's vision and expectations of case management. (Essential)

Management Response

Management agrees with this recommendation.

This action has been identified within the Transformation Case Management Plan and is a priority deliverable.

Management Action Plan

Corrective action to be taken	OPI (Office of Primary Interest)	Target date
ADM, SD and Senior Managers including National Manager, Case Management to present expectations of case management to the regional Management teams.	Service Delivery and Program Management	February 2011
Approval of case management foundation documents including Case Management Guiding Principles and Code of Conduct.	Service Delivery and Program Management	February 2011
Disseminate case management foundation documents.	Service Delivery and Program Management	March 2011

3.1.3 Clarity of roles and responsibilities

The roles and responsibilities of the CSTM in regards to expectations and how their role relates to the role of regional specialists are not clear. The roles and responsibilities outlined in the CSTM work description appeared to overlap with the role of the regional specialists. For example, one of the key activities of the CSTM is to monitor, advise and assist CST members in determining appropriate interventions. Some CSTMs were interpreting this as interventions related to the case plan, but this could also link to the regional specialist role of providing functional direction on case plans for rehabilitation program participants.

In addition, the Quebec DO had a clinical care specialist position which provided support to case managers on case planning and case managing. The staff in the Quebec DO found the clinical care position to be helpful. These positions have not yet been implemented in the Halifax and Edmonton DO's, but some CSTM's felt that it was

their role to provide this type of direction, and questioned the role of clinical care specialists.

The role of the CSTM and the role of the regional specialists should be clarified to ensure the proper use of CSTM and regional specialist resources. Additionally, there should be some type of guidance or triggers for referral to a regional specialist to help CMs determine when to consult the regional specialist.

Traditionally, CMs worked in conjunction with a CSA to deliver services and benefits to recipients on the CM's case load. There has been a change in philosophy where the CSA's and CM's work autonomously with separate case loads – CMs on case management work, and CSA's on non-case management work. The shift to separate case loads has left ambiguity as to the role of the CM versus the role of the CSA and has led to CM's performing administrative duties, taking away from direct service.

The role of the District Administrative Services Agent (DASA) is equally unclear. The work description for the staff in the DO is generic and the DASA's work description includes contacting participants and/or health professionals to gather, clarify and/or verify information in order to provide support to VAC programs, etc. It is not clear what the role of the DASA is versus the role of the CSA. The work description is broad in terms of the responsibilities of the DASA, and there should be clarification on individual roles and responsibilities at the DO level.

Roles and responsibilities need to be clearly defined and communicated to those who are responsible for the achievement of the organization's objectives. When roles and responsibilities are clear, employees are aware of their limits and know where to seek the expertise required when making decisions. Lack of clarity in roles and responsibilities can lead to uninformed decisions, ineffective use of resources, and inadequate control.

R2 It is recommended that the Director General, Service Delivery Management revisit and clarify the roles and responsibilities of District staff and regional experts and communicate the results to applicable staff. (Essential)

Management Response

Management agrees with this recommendation.

This action has been identified within the Transformation Case Management Plan and is a priority deliverable.

A report on contracting for Health Professionals has been completed and recommendations include a revision of the roles and responsibilities. Phase II of this project will begin in the Fourth Quarter of 2010/11.

Management Action Plan

Corrective action to be taken	OPI (Office of Primary Interest)	Target date
Approval of the report "Contracting for Health Professionals".	Service Delivery and Program Management - Contract Management	February 2011
Update the Roles and Responsibilities of Health Professional contractors.	Service Delivery and Program Management – Contract Management	March 2011
Review National/Regional and District core functions including roles, responsibilities (including Health Professionals).	Service Delivery and Program Management – Program Management/National Medical Officer	June 2011
Disseminate National/Regional and District core functions to applicable staff.	Service Delivery and Program Management	June 2011

3.1.4 Adequacy of policies, procedures and guidelines

The Canadian Institute of Chartered Accountants' *Guidance on Control* provides the following guidance:

> *Policies designed to support the achievement of an organization's objectives and the management of its risks should be established, communicated and practised so that people understand what is expected of them and the scope of their freedom to act.*
>
> *Policies prescribe how things should be done and prohibit inappropriate action, thus providing the limits of acceptable action. If people are to exercise their judgment and creativity in the interests of the organization, they must understand these limits and be free to act within them…*
>
> *Understandable policies, communicated throughout the organization and translated into specific practices, provide direction on how operations are to be conducted and reflect a judgment as to which risks are deemed acceptable…*

Employees in the DO indicated that policies, procedures, and business processes were not consistent and did not provide clear direction. It is difficult for staff to ascertain what the appropriate course of action is, particularly when the policy, business process and/or operational directive do not provide the same direction. In the absence of clear direction, staff indicated that they rely on each other's experiences for clarification.

Business processes were not revised to include recent updates. For example, the business process identifies the CSTM as the approval authority for exceeding limits, but

this has changed to the CM as per the new delegated authorities. If staff were not privy to prior correspondence, they would not be aware of new changes, as the inaccurate business processes remain online as the point of reference. As detailed in Appendix D, business processes cite employee names as contacts regardless of whether these employees are still in the position. In addition, business processes have not been updated to reflect organizational changes.

Weaknesses were found in the dissemination of information, in particular business processes, policies, and directives, to those who need it. Staff indicated that they want to take the proper course of action but find conflicting information between policies, procedures and directives. Information was sent via several mechanisms and originates from several areas. There should be a communication strategy for information going to the field.

Because of the inaccurate and conflicting information provided, staff have lost confidence in the accuracy of information being provided to them by HO and the information posted on the Intranet. Untimely or inaccessible information has led to staff relying on each other when seeking answers to questions. This can lead to misinterpretation and incorrect decisions. Staff require easy access to policies and clarification in order to ensure they are aware of and understand their freedom to act.

The issues identified in this section of the report have also been identified in previous audit and evaluation reports. The Audit of the Quebec District Office, October 2010, made a recommendation to address these findings.

Appendix D provides a detailed list of some of the updates required to policies and procedures.

3.1.5 Adequacy of tools and training

In order to ensure that staff are working efficiently and that controls are effective, there must be sufficient tools and training. The audit team has identified areas for improvement to the case plan tool as well as training gaps.

A new case planning tool was implemented in April 2010 and is intended to support case management. Staff were supportive of the new tool and found it to be an improvement over the previous tool. However, staff are not using the tool to its full potential and were not appropriately filling in the fields leading to inadequate case plans and inefficiency. For example, the file review identified instances of double documenting in the new tool and also in Client Service Delivery Networks (CSDN) client notes because staff were unsure of where to document the information. Additional training is required on the tool to ensure staff are using the tool to its full capability.

The quality of the case plans with completed rationale for the decisions varied and did not always contain all the information required to form a good decision. The *Documentation and Practice Guidelines for Case Planning* (April 9 2010) indicates for

CMs to complete the rationale section, but does not outline what components to include to ensure the rationale is complete.

File review results identified the quality of case plan documentation in the Quebec DO was generally better than in the Edmonton and Halifax DOs. The difference being the Quebec DO was a pilot site for the implementation and had developed a defined template and method for documenting decisions which helped improve the quality of the rationale being entered into the resource screen. In addition, Quebec DO completed two quality control exercises and was subject to an internal audit that commenced in January 2010.

In terms of improvements to the tool, a filter or search function on the progress notes and a method to link the desired outcome to the progress notes and action steps would be useful. A filter on the progress notes should be considered because as the case plans develop, there will be a large number of progress notes and an employee would have to review the entire list of notes to find the desired information. Not linking the desired outcome to action steps and progress notes makes it difficult to determine which action steps are designed to address which desired outcome and it would be difficult to determine if the participant has been successful in meeting the case plan objectives. Linking the steps would add clarity to the progress on the case plan.

Desired outcomes identified in the case plan are expected to be SMART (see Appendix C for definition of “SMART”). The review found 5% of desired outcomes were SMART. However, the guidance on SMART is ambiguous, where Attainable and Realistic are both defined as “doable”. The new tool could be improved to support the SMART desired outcome by using a template approach rather than the free field that is currently used in the system.

Finally, the case plan tool could be improved to ensure the administrative burden is minimized. In particular, the CMs are required to type in the service providers name, address, benefit codes, etc. each time a service is approved. For the Rehabilitation Program there could be several service providers entered for one program participant. A drop down list of registered service providers, which could be sorted by province and/or Program of Choice (POC) and/or benefit code would ensure a more efficient use of time and more accurate information.

In terms of delegated authorities, employees were hesitant to make decisions as they had not received sufficient training to feel confident in their decisions and they indicated the rushed implementation lends itself to issues and gaps in the process. Employees felt a need to consult with the Interdisciplinary Team (IDT) or CSTM. No training had been provided to staff for the new delegated authorities because training was going to be provided as part of the second phase of the implementation of the delegated authority; however, training had not yet been provided to DO staff over the course of the audit.

It is clear that there is a need for training for the current authorities in order to ensure staff are empowered to make decisions and that decisions are adequate and accurately documented. At the same time, there is a need to understand the ramifications of decisions and what supports are in place for CM's for decisions made under the new delegated authority.

The DO's would benefit from a training strategy, which would complement a national training strategy. This strategy should include the list of competencies required to do the job, identify gaps and a plan of how to address those gaps. The Audit of the Quebec District Office also identified areas where staff required clarification or training.

R3 It is recommended that the Director General, Service Delivery Management Division provide training to applicable staff in regards to the new case planning tool, how to document decisions, how to write a clear rationale and how to communicate results. (Essential)

Management Response

Management agrees with this recommendation.

This action has been identified within the Transformation Case Management Plan and is a priority deliverable. Electronic case planning tool will be adjusted and information sessions will be held.

Management Action Plan

Corrective action to be taken	OPI (Office of Primary Interest)	Target date
Deliver Train the Trainers: Phase I Decision-making training.	Service Delivery and Program Management	November 2010
Deliver Phase I Decision-making training to field staff.	Service Delivery and Program Management	March 2011
Develop new case planning guidelines.	Service Delivery and Program Management	May 2011
Disseminate and provide information sessions on new case planning guidelines.	Service Delivery and Program Management	October 2011

3.1.6 Performance monitoring

Monitoring performance is important to determine if objectives are being attained and also to develop benchmark information to help ascertain if interventions have had the intended impact. Persons monitoring performance measures need access to reliable information on operating results. At the same time, if objectives or expectations for performance change, the measures might also need to change.

VAC has a set of performance measures and service standards which are tracked and reported on through reports posted in the Reporting Database (RDB), an electronic information system. CSTMs and Area Directors consult the RDB to monitor performance of staff in the DO, and to monitor and manage workload.

As described below, the audit team identified deficiencies in both the performance measures for CSA's, CMs workload measurement and monitoring of contact with program participants.

Performance measures for CSA's

The role of the CSA is to be the first line of contact for non-case managed recipients and also to coordinate non-case managed services and benefits. The performance measures for CSAs include the number of low risk Veterans Independence Program (VIP) follow ups, screening and transition interviews, but CSAs also do other work that is not captured in these performance measures (for example, Long-Term Care and POC 13 work). Based on their workload and the priorities the CSA sets for themselves, the measures are not necessarily meaningful for CSAs.

The objectives of the Department may not coincide with the performance measures placed on CSAs because of the changing objectives of the Department. When the Department monitors a standard, such as annual low risk follow up, versus admittance to palliative care, they are sending a message to CSAs that low risk VIP follow ups are more important (because those are the measures they are being held accountable for). Also, as mentioned above, when expectations for performance change, performance measures may also need to change.

Although the evidence supports a review of CSA performance measures, the Department may wish to equally review the performance measures for CMs to determine if the measures are providing adequate information to monitor workload, efficiency, effectiveness, and productivity.

R4 It is recommended that the Director General, Service Delivery Management Division review and revise the CSA performance measures to ensure they are relevant and appropriate in regards to workload, efficiency, effectiveness and productivity. (Essential)

Management Response

Management agrees with this recommendation and submits the following management action plan.

Management Action Plan

Corrective action to be taken	OPI (Office of Primary Interest)	Target date
Review workload and revise Client Service Agent performance measures.	Service Delivery and Program Management	December 2011
Distribute Client Service Agent performance measures to field.	Service Delivery and Program Management	February 2012

Case management guidelines

CMs must open a case plan for rehab participants, but for non-rehab participants the decision to open a case plan is largely left to the discretion of the CM. Some CMs are not creating case plans for participants, but are delivering services and benefits to these participants. Essentially, the CM is providing case management-like services and has the participant on their case load, but because they are not opening up a case plan, the work they are doing for this participant is not being captured in their workload. The practice of determining when to open case plans varied and there are no clear indicators of when to open a case plan for a participant. For example, the practice in some offices was to open a case plan primarily for participants in the Rehabilitation Program, whereas in other areas, the case manager would make the determination based on their own assessment.

The skewed workload for CMs has led to inconsistent representation of workload across the country and also would affect the funding of Full Time Equivalents (FTE) for certain areas because they can be based on the number of case managed participants.

R5 It is recommended that the Director General, Service Delivery Management Division clarify the guidelines for when case management should occur and when case management should cease and communicate the results to district staff. (Essential)

Management Response

Management agrees with this recommendation.

This action has been identified within the Transformation Case Management Plan and is a priority deliverable.

Management Action Plan

Corrective action to be taken	OPI (Office of Primary Interest)	Target date
Develop new case planning guidelines where the process and steps of disengagement will be clearly explained.	Service Delivery and Program Management	May 2011
Disseminate and provide information sessions on new case planning guidelines.	Service Delivery and Program Management	October 2011

Monitoring of "direct client contact"

The TAT for "direct client contact" is captured in the information system based on the CM identifying that "direct client contact" was made. The date of the contact is used to determine the service standard (i.e. the need to be contacted every 90 days). The date is also used to provide the CM an automated work item to remind them that they need to follow up with a particular participant on a particular date. The audit team reviewed 245 case plans and examined the most recent occurrence where the radio button "direct client contact" was "yes". It was questionable whether "direct client contact" was made in approximately 14% of the cases, as some examples of "direct client contact" included the following: left message, contact made with a third party service provider, forms mailed out.

The *Documentation and Practice Guidelines for Case Planning* are not clear on the definition of "direct client contact". The lack of clarity on the definition of "direct client contact" and the lack of monitoring to ensure it is accurately captured has led to the Department not having an accurate picture of whether or not VAC is meeting the service standard of contacting case managed participants every 90 days. Additionally, participants may not be followed up on a regular basis; no reminder would be given to CMs or CSTMs (i.e. no work item generated); and CSTM would not be aware because the reports would indicate that the service standard had been met.

R6 It is recommended that the Director General, Service Delivery Management Division clarify the definition of "direct client contact" and communicate the results to applicable staff and implement a quality control practice to ensure compliance. (Essential)

Management Response

Management agrees with this recommendation.

This action has been identified within the Transformation Case Management Plan and is a priority deliverable.

Management Action Plan

Corrective action to be taken	OPI (Office of Primary Interest)	Target date
Develop new case planning guidelines wherein the process and steps of direct client contact will be clearly explained.	Service Delivery and Program Management	May 2011
Develop a clear quality control practice for direct client contact to ensure compliance.	Service Delivery and Program Management	June 2011
Implement Case Management Performance tools.	Service Delivery and Program Management	September 2011
Disseminate and provide information sessions on new case planning guidelines.	Service Delivery and Program Management	October 2011

3.1.7 *Quality Reviews*

A quality review process ensures that organizations are obtaining their standards and identifying areas for improvements. At the same time, a quality review process ensures that when changes are implemented, they are done adequately and appropriately.

CMs approve resources for participants in the rehab program through the resource tab of the case plan. The rationale for the decision must be clearly documented; however, this has not been the case as evidenced by the file review of 87 rationales, which found that 45% of rationales were not adequate to provide a clear justification for the decision.

According to the Rehabilitation Decision Making Guide, each approved resource must also have official communication to the recipient by letter. A review of 87 decisions from the Halifax, Edmonton and Quebec DOs found that 43% of the cases did not have a decision letter on file. Decisions must be clearly documented and communicated in order to ensure appeal rights are communicated and decisions are clearly documented.

A review of the 245 case plans indicated that approximately 5% of open case plans (or 12 case plans) could have been closed (disengaged). One potential explanation for this provided to the auditors by interviewees is that CM's who choose not to disengage are less likely to be assigned a new participant. There could also be confusion on when to disengage and when to deem a participant as Total and Permanent Incapacity (TPI)[2]. In addition, 25% of the case plans did not have evidence of regular contact with participants over the last year (regular contact is defined as contact with the participant at a minimum of every three months on average in the last year).

[2] "Total and Permanent Incapacity" means, in relation to a Veteran, that the Veteran is incapacitated by a permanent physical or mental health problem that prevents the Veteran from performing any occupation that would be considered to be suitable gainful employment.

There were weaknesses found in the rationale for decision making as well as the new case plan tool. Although there was quality control being completed on the part of CSTM's, there was a breakdown in the process, as evidenced by the audit team's results where 45% of the 87 rationales reviewed were not adequately documented.

The lack of follow up has led to some inappropriate case plans and several files with inadequate documentation of decisions. A follow up process when changes are made would ensure staff understand their responsibilities and would help the organization identify areas for improvement.

A quality review process should be implemented in all instances where a change has occurred to ensure changes are adequately and appropriately implemented and to ensure staff understand and are complying with policies and procedures. This will be particularly important when implementing the next phases of delegated authorities.

R7 It is recommended that the Director General, Service Delivery Management Division develop and implement a quality review process encompassing the new delegated authorities and case planning to ensure sufficient documentation and appropriate case management. (Critical)

Management Response

Management agrees with this recommendation.

This action has been identified within the Transformation Case Management Plan and is a priority deliverable.

Management Action Plan

Corrective action to be taken	OPI (Office of Primary Interest)	Target date
Develop a framework for the quality review of program decisions.	Service Delivery and Program Management	March 2011
Pilot quality review processes for rehabilitation decisions.	Service Delivery and Program Management	June 2011
Complete and monitor the implementation of quality review processes for program decisions made at the District Office level (VIP, Rehabilitation, Health Care Benefits/Treatment).	Service Delivery and Program Management	October 2011
Completion and dissemination of Case Planning Guidelines for Case Managers.	Service Delivery and Program Management	March 2011

3.1.8 Risk Management

The Treasury Board Secretariat (TBS) Policy on *Risk Management* stipulates that effective risk management practices ensure the continuity of government operations. Because risks are present in all government operations, proper management of a departmental activity such as the delivery of VAC programs and services in a DO is contingent upon the adoption of an effective and documented risk management strategy, including the assessment and identification of risks pertaining to the activity, and the development of proper risk mitigation strategies.

According to Treasury Board directives, an integrated risk management strategy is a continuous, proactive, and systematic process to manage and communicate risk from an organization-wide perspective. It is about making strategic decisions that contribute to the achievement of an organization's overall corporate objectives.

At the time of the audit, no documented risk management strategy existed for the Edmonton or Halifax DOs. While the Integrated Human Resources and Business Plan identified some risks to the achievement of organizational objectives, the plan was regionally based and not specific to the DO. The Edmonton and Halifax DOs have risks that are unique to their organizations. A risk assessment should be documented and should serve to inform the regional and HO risk management processes. The local risk management strategy would contribute to the national risk management strategy to ensure a coordinated approach. It is not enough for an organization to attain its objectives at a local level, they must also work together on a national level. Conversely, the districts need to know what the risk appetite of the Department is in order to ensure they are working within the tolerable limits.

While the audit scope was limited to the Halifax and Edmonton district offices, the auditors suspect that the situation is similar in other areas of the Department. The Department is moving towards a more robust risk management approach and is taking steps to improve the risk management regime at VAC.

R8 It is recommended that the area directors in the Halifax and Edmonton districts offices develop and document a local risk management strategy to properly identify, document and effectively manage the risks their offices face. These strategies should inform regional and national strategies, and ensure that senior management is aware of the risks the district offices face. (Essential)

Management Response

Management agrees that developing and documenting a local risk management strategy specific to client service delivery is required. However, we believe that this risk management strategy must be developed based on the regional and national strategies. Atlantic Management Team only received training/guidance on this Risk Management philosophy on January 19, 2011, long after the Audit and Evaluation review of Halifax DO. Western Management Team will receive training/guidance on Risk Management in

March 2011. Management agrees that this report must be based on Treasury Board risk management principles.

Management Action Plan

Corrective action to be taken	OPI (Office of Primary Interest)	Target date
Consult with HO on Departmentally approved Risk Management approach/methodology/template to use.	HO/Region- Atlantic & Western/HFX/Edmonton DOs	February 2011
Examine, evaluate and document the risks facing the DO.	Halifax/Edmonton DOs	May 2011
Document and produce a progress report.	Halifax/Edmonton DOs	June 2011
Present the progress report to the Regional Director General (RDG) (make requested changes thereafter).	Halifax/Edmonton DOs	July 2011
Communicate the risk management strategy to employees.	Halifax/Edmonton DOs	September 2011

3.2 Audit Opinion

The findings for the second phase of the Responsibility Centre Audit reflect similar findings to the first phase of the audit which was focussed in the Quebec DO. In the opinion of the audit team, the internal controls, governance and risk management framework relating to delegated authorities, management practices and service delivery require improvement.

The audit results identified significant weaknesses with the internal processes supporting service delivery. Sampling identified significant weaknesses in regards to the documentation supporting decisions and case plans. In addition, the monitoring process was not sufficient to reduce the residual risks to an acceptable level.

4.0 DISTRIBUTION

Deputy Minister
Associate Deputy Minister
Veterans Ombudsman
Chief of Staff to the Minister
Departmental Audit Committee Members
Assistant Deputy Minister, Policy, Communications and Commemoration
Assistant Deputy Minister, Service Delivery
Assistant Deputy Minister, Corporate Services
Director General, Service Delivery Management
Regional Director Generals
Director General, Communications
Director General, Departmental Secretariat and Policy Coordination
Director General, Policy and Research
General Counsel, Legal Service Unit
Executive Director, Transformation
Executive Director and Chief Pensions Advocates
Executive Director, Ste. Anne's Hospital
Director, Strategic & Enabling Initiatives
Director, Briefing, Coordination and Liaison
Area Directors
Executive Advisors to the Deputy Minister
Office of the Comptroller General (Internal Audit Registrar)
Office of the Auditor General

Annex A – Risk Ranking of Recommendations and Audit Opinion

The following definitions are used to classify the ranking of recommendations and the audit opinion presented in this report.

Audit Recommendations	
Critical	Relates to one or more significant weaknesses for which no adequate compensating controls exist. The weakness results in a high level of risk.
Essential	Relates to one or more significant weaknesses for which no adequate compensating controls exist. The weakness results in a moderate level of risk.

Audit Opinion	
Well Controlled	Only insignificant weaknesses relating to the control objectives or sound management of the audited activity are identified.
Generally Acceptable	Identified weaknesses when taken individually or together are not significant or compensating mechanisms are in place. The control objectives or sound management of the audited activity are not compromised.
Requires Improvement	Identified weaknesses, when taken individually or together, are significant and may compromise the control objectives or sound management of the audited activity.
Unsatisfactory	The resources allocated to the audited activity are managed without due regard to most of the criteria for efficiency, effectiveness and economy.

Annex B – Audit Criteria

Objective 1 - New Delegated Authorities		
Criteria	**Sub-Criteria**	**Result**
1.1 The organization has processes and practices to ensure change initiatives are properly implemented.	a. Management provides functional direction and oversight of new delegated authorities. b. Training and/or documented guidance is provided to employees to ensure they have the functional direction they need.	Partially Met
1.2 Change initiatives are well communicated.	a. Significant change initiatives and management actions are communicated to the appropriate people on a timely basis. b. Staff has the support in place to answer questions they may have.	Partially Met
1.3 The new delegated authorities for CMs is clearly defined, understood and applied adequately and effectively in the DO.	a. CMs comply with the directive on new delegated authorities and the decision making guide. b. Employees are aware of their new delegated authorities. c. Employees have accepted their new authorities. d. Decision making is clearly documented and decisions are made in compliance with VAC's policies and regulations.	Partially Met

Objective 2 - Effectiveness of Management Practices in the DO		
Criteria	**Sub-Criteria**	**Result**
2.1 A risk management framework is established and documented.		Partially Met
2.2 The Organization provides employees with the necessary training, tools, resources and information in support of the discharge of their responsibilities.	a. A suitably comprehensive training and development plan exists. b. Employees have access to sufficient tools, such as software, equipment, work methodologies and standard operating procedures. c. Key positions and activities have been identified and sufficient back-up exists. d. Training and development plans are resourced and actioned. e. An information-sharing process exists to support the efficient and targeted dissemination of relevant and reliable information to those that need it.	Partially Met
2.3 The organization has in place a formal system of rewards and sanctions.	a. Incentives and rewards that aim to motivate appropriate behavior in employees are documented, communicated and applied. b. Training and/or documented guidance is provided to managers to assist with disciplinary action that will be taken if policies or rules are violated.	Partially Met

Objective 2 - Effectiveness of Management Practices in the DO		
Criteria	**Sub-Criteria**	**Result**
2.4 Authority, responsibility and accountability are clear and communicated.	a. Authority is formally delegated and delegated authority is aligned with individuals' responsibilities; b. Responsibilities and performance expectations to which managers and supervisors are held accountable are formally defined and clearly communicated. Work descriptions and/or performance agreements should exist for this purpose and be up-to-date. c. Roles and responsibilities of IDT's are clearly communicated (cues for referral, Terms of Reference exists for IDT, staff understand when to present to IDT)	Partially Met
2.5 Employees formally acknowledge their understanding and acceptance of their accountability.	a. Regular performance discussions and/or employees periodically review of work descriptions to ensure clear understanding of responsibilities and accountabilities. b. Supervisory personnel meet periodically with employees to review job performance and suggestions for improvement.	Partially Met
2.6 There is an effective oversight body in place that ensures proper delivery of services and its mandate is clearly understood by staff.		Partially Met
2.7 Management monitors actual performance against planned results and adjusts course as needed.		Partially Met

Objective 3 - Efficiency of Service Delivery provided by Case Managers and Client Service Agents in the DO		
Criteria	**Sub-Criteria**	**Result**
3.1 Open and effective channels of communication exist.		Partially Met
3.2 Management has identified appropriate performance measures linked to planned results.	a. Planned results are achievable and measurable. b. Performance measurement strategies are in place and are applied for new or renewed policies, programs or initiatives. c. Performance measures are reviewed on a periodic basis and updated as required.	Partially Met
3.3 Effective use of case conferencing.	Scope limitation see Section 2.2	
3.4 Appropriate use of regional specialists.		Partially Met
3.5 Policies, procedures and guidelines surrounding the work of case managers and client service agents are clear and understood by staff.		Partially Met
3.6 Workload is managed appropriately.	a. Staff work assignments are equitable and appropriate. b. Case managers and Client Service Agents manage their workload appropriately. c. Management oversight over caseload occurs on a frequent basis. d. Staff is able to access functional direction, when required.	Met

Appendix C - Detailed definition of S.M.A.R.T. criteria used in the file review

(S) Specific: A desired outcome is deemed specific if it identifies who is involved, what exactly needs to be accomplished (specific change or goal to be achieved), and why exactly (reasons, purpose, benefits) it is important to achieve the goal and/or objective stated.

(M) Measurable: A desired outcome is deemed measurable if it quantifies the amount of change to be achieved in such a way that we know exactly what the participant is intending to achieve or accomplish (How much? How many? In comparison to what? Milestones, benchmarks, difference, frequency, percentage, rating, ratio, score, etc.); it is also stated in a way that enable the participant and the CM to chart and document the progress accomplished toward the targeted goal.

(A) Attainable and realistic: A desired outcome is deemed attainable and realistic if, with a reasonable amount of effort, it is do-able and can be achieved given the time frame established (if applicable) and given the participant's history (personal capacity and limitations) and the resources and systems available.

(R) Relevant and/or Related: A desired outcome is deemed relevant if it is directly related to an issue or a barrier that the participant is trying to overcome in his rehabilitation process and/or plan.

(T) Time Limited: A desired outcome is deemed time limited if it is stated in such a way that it is clear as to when – in time – the change or goal is to be achieved.

Appendix D – Examples of Policies and Processes

Examples:

Business Process - Rehabilitation - Referral to Head Office for Exceptional Medical and/or Psycho-social Rehabilitation Services or Benefits (June 2007)

Issues:

Contains many areas of work and positions which no longer exist:

- National Operations Division
- Client Services and Quality Management Directorate
- Area Counsellor
- Re-establishment and Compensation Programs
- Program Policy Directorate

Contains employee's name.

Linkages:

- Business Process does not direct employees to the new Directive on the intranet or the Interim Policy released in August 2009

Business Process - How to Process VAC Rehabilitation Program Medical and Psycho-social Rehabilitation Service and Benefit Costs (June 2007)

Issues:

No mention of recent Directive in the Business Process.

The authorities are no longer correct:

Exceeding Frequency Limits for Rehabilitation Clients

- The CSTM is the approval authority for any recommended medical and psycho- social rehabilitation services and benefits which exceed the Non-Pharmacy System (NPS) Benefit Grid frequency limit(s).

Exceeding Cost (Dollar) Limits to a maximum of 20% for Rehabilitation Clients

- The CSTM is the approval authority for any recommended medical and psycho-social rehabilitation services and benefits which exceed maximum cost limit(s) to a maximum of 20% as indicated in the NPS Benefit Grids.

Contains areas of works and positions which no longer exist:

- National Operations Division
- Area Counsellor
- Re-establishment and Compensation Programs

Business Process - How to Determine a Client Totally and Permanently Incapacitated (TPI) for the VAC Rehabilitation Program (June 2007) and the Guidelines For Determining Total and Permanent Incapacity

Issues:

No link to the *Guidelines For Determining Total and Permanent Incapacity* from the Business Process.

It is unclear who needs to be involved in the determination of TPI based on the checklist and it is unclear when consultation is required.

Directive - For the Medical/Psychosocial Rehabilitation Program, Case Managers will have the authority as of May 10, 2010 to approve components of the case plans including medical and psycho-social benefits that:

- **meet or exceed dollar limits to a maximum of 20% above Federal Health Claims Processing System Benefit Grids limits (excluding provider rates);**
- **meet or exceed frequency limits; and**
- **require Clinical Care Manager extensions over 180 units and extensions of inpatient treatment.**

Issues:

As it reads now, staff have unlimited authority to exceed the frequency limits. Also, it is not clear if the authority is on a transactional basis, a recipient basis, or an annual basis.

Linkages:

The Directive contains no links to the Policy or Business Processes.

Directive - All approvals for home adaptations and special equipment under the Veterans Health Care Benefit Program will take place at the District/Regional Office level beginning on May 10, 2010. The authority levels are as follows:

- **Client Service Agent/Case Manager Up to $5,000**
- **Client Service Team Manager $5,001 to $20,000**
- **Regional Director Client Services $20,001 and above**

Issues:

The Directive does not acknowledge the Benefit Grid limits. It is unclear as to whether the Business Processes for Exceptional Benefits or the new Directive are to be used.

Linkages:

The Directive contains no links to the Policy or Business Processes.

Directive - As of May 10, 2010, this directive gives Case Managers the authority to approve items on the Individual Vocational Rehabilitation Plan (IVRP) up to the dollar limits stated in section 15(1) of the *Canadian Forces Members and Veterans Re-establishment and Compensation (CFMVRC) Regulations.*

Linkages:

The Directive contains no links to the Policy or Business Processes.