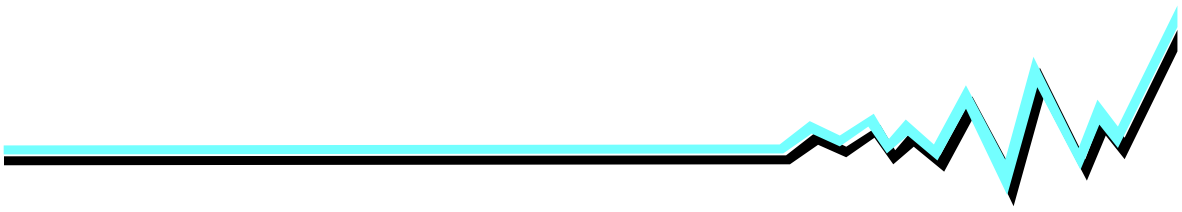
Veterans Affairs Canada | Anciens Combattants Canada

Long Term Care Community Facilities Audit

Final: February 2012



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Acknowledgements

The audit team would like to gratefully acknowledge the people in the Charlottetown, Saint John, Montreal, Mississauga and Vancouver District Offices, the Atlantic, Ontario and Western Regional Offices, Head Office and Medavie Blue Cross in Charlottetown and Moncton, whose contributions were essential to the audit.

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EXECUTIVE SUMMARY

The Long Term Care Program[1] works in cooperation with provinces/territories, health authorities and long term care facilities to financially support eligible Veterans in an appropriate long term care setting. Veterans Affairs Canada provides funding for qualified Veterans who occupy a contract bed or those in a community bed. As of March 31, 2011, there were 9,376 recipients of funding support from Veterans Affairs Canada in non-departmental institutions across Canada. 2,782 recipients were in contract beds and 6,594 were in community beds. These numbers are forecasted to decline between 2012 and 2020 when there will be a decline in demand for Long Term Care. Forecasts estimate that there will be 5,780 Veterans in long term care in five years (2016-2017).

The 2006 *Audit of the Residential Care Program - Ontario Region* and the 2010 *Audit of Residential Care, Camp Hill Veterans Memorial Building* identified significant weaknesses relating to the financial management of the Long Term Care Program. The 2006 audit also identified that further study was required for priority access beds where agreements were struck with local health authorities. All recommendations from the 2006 and 2010 Audits have been addressed with one remaining to be finalized. Veterans Affairs Canada's management of community beds has never been audited. Contract beds that fall under this type of arrangement, i.e. where the Department provides funding for operating costs or enhancements, were excluded from the audit scope.

The purpose of this audit was to provide assurance that the management control framework governing the Long Term Care Program is effective and the internal controls surrounding the program are adequate and functioning well. The scope included Long Term Care recipients in community beds and contract beds governed by a Memorandum of Understanding with provincial health authorities, from April 1, 2010 to March 31, 2011.

In addition to interviews, walkthroughs and documentation review, a statistically valid sample of 72 files and associated financial transactions was reviewed to verify compliance with financial and program regulations. Audit Planning commenced in February 2011 with the analysis completed in August 2011.

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[1] For the purposes of this audit, unless otherwise specified, Long Term Care refers to VIP Intermediate care under Part II of the VHCR and Long Term Care under Part III of the VHCR.

Audit Opinion

In the opinion of the audit team, the internal controls, governance and risk management framework relating to financial and program management require improvement.

The audit results identified weaknesses with the internal processes supporting account verification and program management. Sampling identified significant weaknesses in regards to the documentation supporting decisions (audit trail). In addition, the monitoring process was not sufficient to reduce the residual risks to an acceptable level.

Recommendations:

R1 It is recommended that the Director General, Service Delivery and Program Management Division, review and update the Long Term Care Strategy in the current departmental context and include a risk management strategy, measurable targets and operational plans. (Essential)		
Corrective action to be taken	**OPI (Office of Primary Interest)**	**Target date**
Consult with internal stakeholders: Treatment Benefits & Veterans Independence Program; Regional Staff; VAC Health Professionals.	SDPM – LTC Directorate	March 2012
Consult with the Departments' Accountability & Risks Unit and Program Performance Unit regarding the risk management strategy and measurable targets.	SDPM – LTC Directorate	June 2012
Update National Long Term Care Strategy.	SDPM – LTC Directorate	December 2012
Communicate Strategy and seek approvals.	SDPM – LTC Directorate	December 2012

R2 It is recommended that the Director General, Policy and Research Division, in consultation with the Director General, Service Delivery Management, revise the process for obtaining financial information for the calculation of the accommodations and meals charges. (Critical)		
Corrective action to be taken	**OPI (Office of Primary Interest)**	**Target date**
Clarify the terms for the existing exchange of data with HRSDC. It is anticipated that VAC's Legal Services unit will need to consult with HRSDC Legal Services unit.	Program Policy Directorate	November 2011
Depending on the outcome of the consultation with Justice, either: a) establish a working group to determine the most efficient means of obtaining the necessary financial information to determine the accommodation and meal charges; or b) establish a formal arrangement with HRSDC to enable utilization of the financial information to calculate accommodation and meal charges.	Program Policy Directorate	March 2012 September 2012

R3 It is recommended that the Director General, Service Delivery and Program Management Division, clarify the responsibilities and accountabilities of the Client Service Agent and District Nursing Officer in regards to the Long Term Care program. (Essential)

Corrective action to be taken	OPI (Office of Primary Interest)	Target date
Consult with National Medical Officer to determine appropriate responsibilities and associated administrative tasks.	SDPM – TBVIP / LTC Directorates	December 2011
Investigate need to change delegated authorities and associated policies and processes.	SDPM – TBVIP / LTC Directorates	December 2011
Review National Business Process: Intermediate and Long Term Care Application Process to reflect roles and responsibilities of DNO and CSA.	SDPM – TBVIP / LTC Directorates	March 2012
Review forms, and revise as necessary, (VAC 751 and 1305b) to ensure ongoing validity.	SDPM – TBVIP / LTC Directorates	March 2012
Communicate roles and responsibilities of DNO's and CSA's as related to the financial administration of LTC.	SDPM – TBVIP / LTC Directorates & National Medical Officer	June 2012

R4 It is recommended that the Director General, Service Delivery and Program Management Division, communicate the responsibilities and accountabilities of *Financial Administration Act* Section 34 Officers as they relate to decision making and preservation of the audit trail. (Critical)

Corrective action to be taken	OPI (Office of Primary Interest)	Target date
Distribute "Guidelines for the Account Verification of Health Care Facility Costs" document prepared by Finance to the Residential Care Program Section 34 Officers.	SDPM – LTC Directorate	December 2011
Communicate Subject 2-5 of the Financial Policy and Procedures Manual on account verification function to Residential Care Program Section 34 Officers.	SDPM - LTC Directorate	December 2011
Respond to questions from Residential Care Program Section 34 Officers regarding account verification.	SDPM – LTC Directorate & Finance Division	Ongoing

R5 It is recommended that the Director General, Service Delivery and Program Management Division, develop and implement a quality assurance process over the Long Term Care program focused on the adequacy of decision making and documentation of decisions (audit trail). (Critical)

Corrective action to be taken	OPI (Office of Primary Interest)	Target date
Review and update the steps for documentation within the National Business Process: Intermediate and Long Term Care Application Process.	SDPM – TBVIP / LTC Directorates	March 2012
Review and update the Long Term Care Decision Form (VAC 751) and the VIP contribution arrangement (1305b). The addition of a section to record rationale for decisions will be explored where required.	SDPM – TBVIP / LTC Directorates	March 2012
Investigate the need for a "How to complete" guide to accompany the Long Term Care Decision Form.	SDPM – TBVIP / LTC Directorates	June 2012
Provide training on completion and retention of documentation, where required.	SDPM – TBVIP / LTC Directorates & Regional Staff	June 2012
Implement a quality assurance process to ensure audit trail is captured.	SDPM – TBVIP / LTC Directorates & Regional Staff	September 2012

R6 It is recommended that the Director General, Service Delivery and Program Management Division, in consultation with the Director General, Finance Division, ensure that funds for Long Term Care are committed in accordance with the *Financial Administration Act* and Treasury Board Directives. (Critical)

Corrective action to be taken	OPI (Office of Primary Interest)	Target date
Director General, Service Delivery and Program Management will communicate with Regional Director Generals the directive to commit funds at the program level.	SDPM – LTC & TBVIP	March 2012
Effective April 1, 2012, funds for Long Term Care Program will be committed.	Finance	April 2012

R7 It is recommended that the Director General, Service Delivery and Program Management Division, implement system improvements to enhance controls and to preserve the audit trail for the Long Term Care Program. (Essential)		
Corrective action to be taken	**OPI (Office of Primary Interest)**	**Target date**
Review the feasibility and applicability to alter RCSS financial screen to a monthly rate rather than per diem rate.	SDPM – TBVIP / LTC Directorates and Corporate Information Applications	September 2012
Investigate the addition of system edits to data entry fields with cross-validation, to ensure there are no irregular or impossible data combinations entered.	SDPM – TBVIP / LTC Directorates and Corporate Information Applications	November 2012
Consult on the potential for expanded audit capability for facility (institution) information updates (i.e. logging of changes made and by whom to facility information screen).	SDPM – TBVIP / LTC Directorates and Corporate Information Applications	January 2013
Consult on the expanded audit capability for financial information (i.e. logging of changes made and by whom to financial information screen).	SDPM – TBVIP / LTC Directorates and Corporate Information Applications	January 2013
Investigate the ability to add an additional screen to RCSS to indicate payee and particulars of services to be provided and funded through VAC.	SDPM – TBVIP / LTC Directorates and Corporate Information Applications	March 2013

Statement of Assurance

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 policy, 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.

Chief Audit Executive's Signature

Original signed by *January 20, 2012*

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Don Love Date
Chief Audit Executive

The audit team consisted of the following persons:

Jonathan Adams, Audit Director

Karen Walsh, Audit Manager

Adrianne VanLunen Gallant, Senior Audit Officer

Lana Wright, Audit Officer

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1.0 BACKGROUND

Federal government involvement in the long term care (LTC) of injured and disabled Veterans began at the end of the First World War and expanded significantly after the end of the Second World War. The LTC program[2] works in cooperation with provinces/territories, health authorities and LTC facilities to financially support eligible Veterans in an appropriate LTC setting where their assessed health care needs are being met. Veterans Affairs Canada (VAC) provides funding for qualified Veterans who occupy a contract bed or a community bed.

Presently, VAC provides benefits through two main legislative authorities contained in the Veterans Health Care Regulations (VHCR):

- Part II, Veterans Independence Program (VIP) provides for funding in community facilities; and

- Part III, Long Term Care provides for funding in departmental, contract and community facilities.

There are the following three levels of care provided through LTC: adult residential care (Type I), intermediate care (Type II) and chronic care (Type III). The level of care is provided in the following three types of beds: contract beds, community beds and departmental beds. Eligibility for these care levels and bed types is complex and involves a determination of service eligibility and program eligibility. Eligibility for the program is determined by staff in the respective District Office (DO).

The 2006 *Audit of the Residential Care Program - Ontario Region* and the 2010 *Audit of Residential Care, Camp Hill Veterans Memorial Building* identified significant weaknesses relating to the financial management of the LTC Program. The 2006 audit also identified that further study was required for priority access beds[3] where agreements were struck with local health authorities. All recommendations from the 2006 and 2010 Audits have been addressed with one remaining to be finalized. The remaining recommendation relates to system improvements which are also referenced in this audit in Section 3.2.6. Additionally VAC's management of community beds has never been audited.

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[2] For the purposes of this audit, unless otherwise specified, Long Term Care refers to VIP Intermediate care under Part II of the VHCR and Long Term Care under Part III of the VHCR.

[3] Formerly described as "floater PABs". These are contract beds in facilities that were not a part of the transfer of departmental hospitals to the province, but rather agreements that were made to ensure priority access for Veterans in their own community.

As of March 31, 2011, there were 9,376 program recipients in non-departmental institutions across Canada, where 2,782 recipients were in contract beds and 6,594 were in community beds. Demand for LTC is forecasted to decline over the next five years to approximately 5,780 Veterans.

LTC beds are funded through Other Health Purchased Services (OHPS) or the Veterans Independence Program (VIP) contribution arrangement. Funding for contract beds must come out of OHPS, whereas funding for community beds can come out of either funding source (VIP or OHPS). Total actual program spending for LTC, excluding the departmental facility, in 2010-2011 was $276 million out of a total departmental spending of $3.1 billion. $218 million was spent for non-departmental institutions (OHPS) and $58 million was spent for non-departmental institutions (VIP).

Table 1: Number of inpatients by bed type

	2007-08	2008-09	2009-10	2010-11
Contract beds	2,866	2,852	2,832	2,782
Community beds	7,370	7,107	6,897	6,594
Total	10,236	9,959	9,729	9,376

Source: Statistics Directorate

Table 2: Average annual cost per bed type

	2007-08	2008-09	2009-10	2010-11
Contract beds	$57,103	$61,926	$61,961	$63,701
Community beds	$12,806	$12,937	$13,486	$14,482

Source: Statistics Directorate

2.0 ABOUT THE AUDIT

2.1 Audit Objectives

The objectives of the Long-Term Care Audit are as follows:

1. To assess the governance framework for Long Term Care;
2. To assess compliance with policies, regulations and procedures;
3. To determine if payments are accurate and in accordance with established terms and conditions; and
4. To assess the adequacy of internal controls governing expenditure initiation and payment verification.

2.2 Scope

The scope of the audit included intermediate care, under Part II of the VHCRs and LTC, under Part III of the VHCRs, including certain contract (priority access beds) in non-departmental institutions. Community beds (provincially and non-provincially insured) were also in scope for the audit. However, contract beds in facilities that received funding for operating costs or enhancements did not form part of the audit because the internal controls surrounding the management of those contract beds were included in previous audits in 2006 and 2010. Compliance with VIP policies and procedures was not in scope as it was part of the VIP Audit in 2010, however, the VIP payment verification process was included as part of this audit to address the adequacy of internal controls for payment verification.

Audit objectives relating to governance, compliance and internal controls covered current practices in 2011/12. The audit team conducted on-site audit tests in late spring/early summer 2011 at the Ontario Regional Office (RO), and the Charlottetown, Saint John, Mississauga, Vancouver, and Montreal district offices. On-site audit tests were also conducted at Medavie Blue Cross processing centers for VIP in Charlottetown and Moncton. The accuracy of payments was covered in a transaction sample drawn from 2010/11 that addressed the adequacy of internal controls for expenditure initiation and payment verification.

2.3 Methodology

The audit was conducted in accordance with the Institute of Internal Auditors' (IIA) Standards for the Professional Practice of Internal Auditing, as required under the Treasury Board Policy on Internal Audit. To achieve the audit's objectives, the following methodologies were used:

Interviews were held with employees in district, regional and head offices to determine the adequacy of internal controls, policies and procedures, governance framework, and to gain an understanding of expenditure initiation and payment verification process.

The Ontario Regional Office, five VAC district offices and two Medavie Blue Cross offices were visited to observe, consult and confirm payment processes.

The auditors performed participatory observation exercises with Client Service Agents (CSA) and/or District Administrative Services Officers (DASA) to obtain an understanding of the Residential Care Support System (RCSS) and to observe the expenditure initiation and account verification processes. Observation exercises were also held with Finance Officers to demonstrate the payment process.

A statistical sample of 72 files was reviewed. The sample was chosen from a population of 9,802 LTC recipients in a community or contract bed as described in Section 2.2 as of March 31, 2011. Files were randomly selected based on a 95% confidence level and a 5% margin of error. The purpose of the review was to determine if payments to facilities are accurate and in accordance with established terms and conditions. Transactions for testing were randomly chosen from the statistical file sample of 72, allowing for one transaction per file. The population of 9,802 included persons that died in fiscal year 2010/2011 and did not include persons that were in contract beds in facilities that received funding for operating costs or enhancements. Additionally, a review of controls described in policy manuals took place to ensure they were accurately and adequately applied (i.e. compliance).

A review of a judgmental sample of 40 files and payment transactions for chronic care and intermediate care community beds was conducted to determine if the expenditure initiation and payment verification processes were adequately applied. The sample was randomly selected based on higher risk transactions (Materiality, contract beds and non- provincially insured beds (i.e. private beds)).

The auditors reviewed supportive documentation to determine the adequacy of the governance framework of the LTC Program and compliance with regulations, policy and procedures. In addition, the audit team determined the adequacy of the documentation and business processes for expenditure initiation and payment verification.

The audit team analysed program statistics to obtain an understanding of the program environment and to select the district offices that formed the scope of the audit for testing.

2.4 Statement of assurance

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 policy, 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.

3.0 AUDIT RESULTS

3.1 Governance

3.1.1 Governance Structure

The IIA defines Governance as “the combination of processes and structures implemented by the board to inform, direct, manage and monitor the activities of the organization toward the achievement of its objectives.” The audit team examined the following aspects of the governance structure: accountabilities, responsibilities, authorities, risk management, legislative authority, quality assurance and policies, procedures and business processes. The audit findings for the governance structure are described further in this section of the report.

The structure of the LTC Program includes program management under the Long Term Care Directorate, located in Head Office (HO). The Directorate is responsible for the provision of functional direction to the Regional Directors of Quality Care and Regional Institutional Care Specialists (RICS), who, in turn, provide functional direction to the front line staff in the DOs. Though the role of the Regional Director Quality of Care varied across the country, their main focus was on the management of the contract facilities located in the regions. Due to the complexity of the LTC program, the DO staff rely heavily on the RICS for direction and clarification. The RICS play a critical role as subject matter experts and are essential in the management of the LTC program. A knowledge transfer strategy would mitigate the risk of knowledge loss due to potential turnover in the RICS position.

3.1.2 Risk Management

Objectives should be clearly defined and communicated because they provide direction for the program. At the same time, when objectives are set, risks and opportunities should be identified and assessed to ensure that threats to the achievement of the objectives are monitored and managed. Measurable targets should be established to determine achievement towards objectives and to indicate if there is a need for change. There should be operational plans to ensure achievement of program objectives.

The LTC program area has developed a LTC Strategy which sets out objectives for the future of the program. The strategy is dated 2008 and the environment at VAC has changed since that time. There are additional budgetary controls on OHPS; the population of program recipients is expected to decrease; the current environment is one of fiscal constraint; government initiatives have identified the need for change (e.g.

Auditable Financial Statements, Office of the Auditor General); therefore, the objectives of the strategy should be reviewed and updated regularly.

The LTC Strategy identifies risks, and the auditors would recommend a risk management strategy be developed to ensure change is managed effectively and to facilitate decision making. The auditors would also recommend that measurable targets be set, which would ensure the program area could determine progress towards objectives. Finally, the regional and head offices should develop operational plans on how they will implement the strategic LTC objectives of the Department. The strategy and operational plans should include timelines and measurable targets so that accountability is clearly defined and indicators of necessary changes are brought forward in a timely manner.

Recommendation 1

It is recommended that the Director General, Service Delivery and Program Management Division, review and update the Long Term Care Strategy in the current departmental context and include a risk management strategy, measurable targets and operational plans. (Essential)

Management Response

Management agrees with the recommendation to review and update LTC Strategy in the current departmental context, and include a risk management strategy, operational plans, with measurable targets.

Management Action Plan

Corrective action to be taken	Office of Primary Interest	Target date
Consult with internal stakeholders: Treatment Benefits & Veterans Independence Program; Regional Staff; VAC Health Professionals	SDPM – LTC Directorate	March 2012
Consult with the Departments' Accountability & Risks Unit and Program Performance Unit regarding the risk management strategy and measurable targets	SDPM – LTC Directorate	June 2012
Update National Long Term Care Strategy.	SDPM – LTC Directorate	December 2012
Communicate Strategy and seek approvals.	SDPM – LTC Directorate	December 2012

3.1.3 Accessing Income Information

As part of the LTC Program, most recipients are required to contribute to the cost of accommodations and meals (A&M). The calculation of the A&M is based on income, with some exemptions being granted for various items (e.g. comforts, spousal exemption). The auditors observed staff using the Human Resources and Skills Development Canada (HRSDC) database to access income information of program recipients for the calculation of the A&M charges. VAC has formalized agreements, as set out in the *Income Tax Act* and the *Old Age Security Act*, to access income information from the HRSDC database for the administration of income replacement programs through the *War Veterans Allowance* (WVA*) Act* and the *Canadian Forces Members and Veterans Re-establishment and Compensation Act* (CFMVRCA). The auditors were unable to identify a formalized arrangement for VAC to access this information for the LTC Program.

At the same time, the information contained in the HRSDC database is useful and provides VAC opportunities to gain efficiencies. Not only could VAC use the information in the calculation of A&M, but also to gain efficiencies in other programs, for example, reduce the need for annual submissions of income information for spouses in receipt of VIP, and reduce the amount of overpayments due to delayed death notifications.

Recommendation 2

It is recommended that the Director General, Policy and Research Division, in consultation with the Director General, Service Delivery Management, revise the process for obtaining financial information for the calculation of the accommodations and meals charges. (Critical)

Management Response

Management agrees that there is no formalized arrangement in place to permit the use of HRSDC information for any other purpose other than in relation to income replacement programs under the WVA and CFMVRCA. VAC will explore options for using HRSDC information to support the administration of its programs while respecting the current legal and policy framework. Management also recognizes that using the HRSDC information is an efficient means of obtaining the required financial information to calculate the applicable accommodation and meal charges.

Management Action Plan

Corrective action to be taken	Office of Primary Interest	Target date
Clarify the terms for the existing exchange of data with HRSDC. It is anticipated that VAC's Legal Services unit will need to consult with HRSDC Legal Services unit.	Program Policy Directorate	November 2011
Depending on the outcome of the consultation with Justice, either: a) establish a working group to determine the most efficient means of obtaining the necessary financial information to determine the accommodation and meal charges; or b) establish a formal arrangement with HRSDC to enable utilization of the financial information to calculate accommodation and meal charges.	Program Policy Directorate	March 2012 September 2012

3.1.4 Policies, procedures and guidelines

Policies, procedures and guidelines provide staff with the parameters within which they are allowed to act and provide direction on how the Department manages program risk, by clarifying legislation and providing staff with a clear direction on expectations.

The long term care program area has an established Residential Care Integrated Working Group (RCIWG) which is composed of both HO and RO LTC program staff. The RCIWG meets monthly and offers members the opportunity to review and provide input on new business processes, program directives and operational procedures. Despite the establishment of the RCIWG, there is a need for improved direction from HO in certain aspects of the LTC Program, as evidenced by the inventory of local tools developed at the regional level. There are variances within individual work practices, indicating a need for procedures and more oversight. While the program area has recently updated procedural guidance for A&M calculation and LTC application process, there continues to be gaps. Also, local procedures continue to exist, particularly in regards to eligibility, income verification, and funding private beds.

Eligibilities to LTC, in general, are complex. Eligibility charts exist at the national (Veterans Programs Policy Manuals) and local levels (ROs have their own). This could lead to inconsistencies in decision making if the charts are not accurate and appropriate

updates are not made. There is a need for a rules-based tool when determining eligibility.

The file review identified a lack of consistency in terms of what type of documentation is required for income verification. There were various types of source documents, for example, a notice of assessment, a tax return, a declaration, etc. There should be clarification provided as to what specifically is required from recipients in order to assess income and it should be applied consistently across the country. Otherwise, income is being assessed based on different income information and can lead to inconsistent calculations.

LTC recipients are not generally required to move outside their community in order to access provincially insured beds provided a comparable non-provincially insured bed is available at a reasonable cost. The policy manual leaves the interpretation of "community" and "reasonable cost" up to the regions to determine. There are various interpretations of "community" and "reasonable cost" and the auditors are of the opinion national involvement is required, due to the materiality and repercussions of admitting Veterans into non- provincially insured beds (they are less likely to be admitted to a lower cost, provincially insured bed because the province would consider their needs to be met). One region or DO might interpret community as 45 minutes driving time in urban areas and 50 kilometres in rural areas whereas another region would interpret it as within 100 kilometres. While each DO has its unique geographic and demographic elements, the decision making criteria on what is "reasonable cost" should be consistent across the country or there should be central oversight on funding for non-provincially insured beds.

3.1.5 Authority, responsibility and accountability

The Canadian Institute of Chartered Accountants provides the following guidance on authority, responsibility and accountability: "*Authority is the power to make certain decisions and/or perform certain tasks within defined limits. Responsibility is the duty to perform certain tasks. Accountability is the obligation to answer for the performance of responsibilities. An individual or group must be provided with the authority and responsibility for a task, output or outcome in order to be held accountable. The extent to which people recognize that they will be held accountable influences their decisions and actions. That is why authority, responsibility and accountability should be clearly defined and communicated…*"[4] The audit team identified some opportunities for improvement in regards to the clarity of authority, responsibility and accountability of the LTC Program, particularly as they related to financial administration.

[4] Canadian Institute of Chartered Accountants. (1995). Guidance on Control. Toronto: CICA.

Authority for expenditure initiation under Part II and Part III of the VHCR is granted to District Nursing Officers (DNO) from the Minister through the Delegated Authorities Manual and Terms and Conditions. The Client Service Agent (CSA) is responsible for determining eligibility for the program and collecting financial information, whereas the DNO is the final approval authority. Currently, the DNO does not have the expertise to navigate the eligibilities of the LTC program, nor do they have the expertise to provide oversight on the income assessment, both of which are factors in determining eligibility and entitlement to the LTC Program. The accountabilities and responsibilities need to be communicated to ensure that DNOs know what the expectation is and how their role interacts with the CSA's role.

Recommendation 3

It is recommended that the Director General, Service Delivery and Program Management Division, clarify the responsibilities and accountabilities of the Client Service Agent and District Nursing Officer in regards to the Long Term Care program. (Essential)

Management Response

Management agrees with the recommendation that some clarity of roles would be beneficial.

Management Action Plan

Corrective action to be taken	Office of Primary Interest	Target date
Consult with National Medical Officer to determine appropriate responsibilities and associated administrative tasks.	SDPM – TBVIP / LTC Directorates	December 2011
Investigate need to change delegated authorities and associated policies and processes.	SDPM – TBVIP / LTC Directorates	December 2011
Review National Business Process: Intermediate and Long Term Care Application Process to reflect roles and responsibilities of DNO and CSA.	SDPM – TBVIP / LTC Directorates	March 2012
Review forms, and revise as necessary, (VAC 751 and 1305b) to ensure ongoing validity.	SDPM – TBVIP / LTC Directorates	March 2012
Communicate roles and responsibilities of DNO's and CSA's as related to the financial administration of LTC.	SDPM – TBVIP / LTC Directorates & National Medical Officer	June 2012

The delegated authority for the *Financial Administration Act* (FAA) Section 34 approval for CSAs is unlimited; however, the practice is to return an invoice for management approval if the invoice is in excess of $5,000. The limit of $5,000 is questionable because a CSA could submit one invoice for two months at $5,000 and it would be returned if the manager did not sign; however, if the CSA were to submit two claims for $2,500, the claim would go through with CSA signature alone. The practice of requiring management signature for payment requests in excess of $5,000 leads to inefficiency and delayed payments. The practice should be reviewed to determine if the limit is appropriate or if a limit is in fact required.

Currently, the Regional Finance Office (RFO) is maintaining a system to ensure that duplicate payments do not occur; however, the RFO is the FAA Section 33 authority. The FAA Section 34 Officer is required to verify that the payment requested is not a duplicate. Indeed, the majority of FAA Section 34 Officers would be unable to identify duplicate payments because they do not have access to the payment system, FREEBALANCE. In addition, the FAA Section 34 Officer is required to ensure the coding is correct, the amount is correct, ineligible items have been removed, the calculations are correct and supporting documentation exists. As part of the FAA Section 33 process, RFO has implemented a 100% pre-payment audit due to the high number of errors identified on the requests for payments; however, the volume and nature of errors has not been quantified. The pre payment verification is limited to the accuracy of the payment and does not verify entitlement, which is reflected in the audit findings, where 29% of the files lack an adequate audit trail to support eligibility. The preservation of the audit trail is a FAA Section 34 responsibility. Finance Division in HO has developed guidelines and checklists for account verification and expenditure initiation. Communication of these documents to FAA Section 34 Officers would support the audit recommendation in this section of the report.

The RFO has an opportunity to improve accountability in the DO through their audits, but they should report on the errors and communicate them to those involved in the processing of LTC payments. Currently, errors are reported to the FAA Section 34 Officer, but there is no global reporting of errors. Global reporting would help identify and resolve systemic problems and would ensure all FAA Section 34 Officers are aware of common errors and ultimately reduce the error rate. Eventually, the RFO should consider a risk based audit process, once the reports have shown adequate improvement.

Recommendation 4

It is recommended that the Director General, Service Delivery and Program Management Division, communicate the responsibilities and accountabilities of *Financial Administration Act* Section 34 Officers as they relate to decision making and preservation of the audit trail. (Critical)

Management Response

Management agrees with this recommendation.

Management Action Plan

Corrective action to be taken	Office of Primary Interest	Target date
Distribute "Guidelines for the Account Verification of Health Care Facility Costs" document prepared by Finance to the Residential Care Program Section 34 Officers.	SDPM – LTC Directorate	December 2011
Communicate Subject 2-5 of the Financial Policy and Procedures Manual on account verification function to Residential Care Program Section 34 Officers.	SDPM - LTC Directorate	December 2011
Respond to questions from Residential Care Program Section 34 Officers regarding account verification.	SDPM – LTC Directorate & Finance Division	Ongoing

3.1.6 Monitoring and Performance Measures

A key component to quality care is improving the monitoring of all VAC recipients of facility-based care. The LTC Program Area has developed a Quality Assurance (QA) Framework for care outcomes, which includes a comprehensive assessment of quality of care in LTC facilities, a national LTC Quality Assurance Framework, national Client Satisfaction Questionnaires, initiatives to increase accreditation for LTC facilities where program recipients reside and monitoring of provincial compliance measures for LTC facilities. These enhanced QA activities are designed to support VAC in helping ensure LTC Program recipients are receiving quality care and that their needs are being met. In terms of monitoring and quality assurance with regards to quality of care, the audit team is of the opinion that the program area has implemented adequate controls and has mitigated the risks to recipient health outcomes to the extent that they are able.

While there is QA for quality of care, improvements could be made to QA over program management. There are some QA activities which are scheduled, including an annual review of the A&M calculations, and a cyclical review of data contained in the RCSS to ensure accuracy, however, there should be additional QA to ensure the consistency in decision making. HO did not demonstrate a formalized QA process for the management of the program. Regions have implemented ad hoc reviews of the LTC program but do not have a standardized QA process for these activities. Responsibility and expectations for QA are not clear. The district and regional office positions most directly involved in the LTC program include CSAs, DNOs and RICS, but their job descriptions make no reference to oversight or accountability of the management of the program.

The results of the file review indicate there is a poor audit trail and decision thread for LTC, where 29% of the files reviewed lack an adequate audit trail to support eligibility. It was difficult to determine the appropriateness of payments or expenditure initiation. Of particular concern were the transactions for exceptional payments and exceeding rates, where the justification was inadequate. There was a general lack of consistency in the documentation of the decisions, making it difficult to determine the appropriateness of a decision. Quality assurance would ensure consistency of application and management of the program, ensure compliance with regulations and policies and would ensure a good audit trail. Additional guidance on decision making and documenting should also be provided.

There are no set workload measures for LTC, nor targets set as there are for other programs. For example, VIP follow ups must occur on an annual basis, the number of outstanding follow ups is reported on, and work items are automatically generated for the employee to ensure they are aware of upcoming or outstanding follow ups. Because there are no measures for LTC and there are measures for other programs, the work related to other programs takes priority because staff are constantly reminded about what is required for those programs. The implementation of workload measures for LTC would be difficult because there is no system support for timelines and no application form; however, some of the benefits are improved timeliness and efficiency of service and reimbursement, a more accurate picture of workload, and skills maintenance because staff would be required to process more regularly, possibly leading to fewer errors.

Recommendation 5

It is recommended that the Director General, Service Delivery and Program Management Division, develop and implement a quality assurance process over the Long Term Care program focused on the adequacy of decision making and documentation of decisions (audit trail). (Critical)

Management Response

Management agrees with this recommendation. The quality assurance component of the Long Term Care Program is robust in regards to the services funded. Management agrees the quality assurance for the administration of the program can be improved upon i.e. adequacy of decision making and documentation of decisions.

Management Action Plan

Corrective action to be taken	Office of Primary Interest	Target date
Review and update the steps for documentation within the National Business Process: Intermediate and Long Term Care Application Process.	SDPM – TBVIP / LTC Directorates	March 2012
Review and update the Long Term Care Decision Form (VAC 751) and the VIP contribution arrangement (1305b). The addition of a section to record rationale for decisions will be explored where required.	SDPM – TBVIP / LTC Directorates	March 2012
Investigate the need for a “How to complete” guide to accompany the Long Term Care Decision Form.	SDPM – TBVIP / LTC Directorates	June 2012
Provide training on completion and retention of documentation, where required.	SDPM – TBVIP / LTC Directorates & Regional Staff	June 2012
Implement a quality assurance process to ensure audit trail is captured.	SDPM – TBVIP / LTC Directorates & Regional Staff	September 2012

3.2 Financial Management and Control

3.2.1 Budget and Commitments

Veterans Affairs Canada receives funding through annual Parliamentary appropriations based on the Main Estimates. Budget and forecasts for program costs are developed at a regional level and managers are required to manage within budget allocations. In terms of the forecast for program demand, the statistics unit at HO develops an annual Client and Expenditure Forecast which is used to determine cost for LTC. In addition the regional offices have developed monthly financial forecasts which are reviewed by HO. It is expected that the demand for beds will decrease in future and as the number of LTC recipients reduce, so should the expenditures.

The requirements for commitment control are described in Section 32 of the FAA, and Treasury Board Secretariats' (TBS) *Directive on Expenditure Initiation and Commitment Control*. Commitment authority is delegated in writing to departmental officials by the deputy head (or equivalent) for ensuring there is a sufficient unencumbered balance available before entering into a contract or other arrangement.

Currently funds for contract beds are being committed while funds for community beds are not. It is important to note that LTC is a quasi-statutory program which means it is a non-discretionary expenditure, recipient-related and demand-driven and has no expenditure ceiling. The amount of this funding is dependent upon the number of recipients who apply for benefits and their eligibility for programs. LTC is funded either through a contribution arrangement or a special purpose allotment, which in addition to the current budget controls, limits the risk of exceeding the appropriation. However, Section 32 of the FAA, and TBS's *Directive on Expenditure Initiation and Commitment Control*, require funds be committed for community beds being paid out of OHPS.

In addition, the auditors identified weaknesses in the contribution arrangement control out of VIP where the contribution arrangement amounts were not reviewed on an annual (or regular) basis and the estimated amount for the contribution arrangement was inconsistent in terms of what would be a reasonable amount. The amount entered in the contribution arrangement is the key control to ensure that overpayments are not made. Amounts entered in the contribution arrangements should be reviewed on a regular basis to ensure the expected spending from the contribution arrangement is still valid and not inflated. The amount assigned to the contribution arrangement acts as a type of control in ensuring allocated funds are not exceeded, much like commitment control.

Recommendation 6

It is recommended that the Director General, Service Delivery and Program Management Division, in consultation with the Director General, Finance Division, ensure that funds for Long Term Care are committed in accordance with the *Financial Administration Act* and Treasury Board Directives. (Critical)

Management Response

Management agrees with this recommendation. Long Term Care funding is a special purpose allotment; as such these funds cannot be used for other purposes.

The Department allocates funds for long term care on an annual basis, based on valid Client and Expenditures Forecast which takes into account number of program recipients by province in contract beds and community beds. These allocations of funds are communicated to each Regional Director General by the Assistant Deputy Minister, Service Delivery.

Committing funds in accordance with the *Financial Administration Act* and Treasury Board Directives will further enhance departmental controls over spending for long term care.

Management Action Plan

Corrective action to be taken	Office of Primary Interest	Target date
Director General, Service Delivery and Program Management will communicate with Regional Director Generals the directive to commit funds at the program level.	SDPM – LTC & TBVIP	March 2012
Effective April 1, 2012, funds for Long Term Care Program will be committed.	Finance	April 2012

3.2.2 Program Funding

Veterans have access to intermediate care (Type II) in a health facility under two programs, VIP (VHCR Part II) or LTC (VHCR Part III). Chronic care (Type III) is only available through LTC (VHCR Part III). VIP is a transfer payment and funding is provided to the Veteran on the basis of a contribution arrangement. LTC is paid through OHPS, a special purpose allotment. In terms of intermediate care, eligibility is confusing in that applicants are eligible for intermediate care under both Part II and Part III, whereas others are eligible for intermediate care under Part III and others are eligible for chronic but not intermediate care. The eligibility is further complicated by the type of bed the applicant is eligible for, whether a contract bed, a community bed, or both.

Although the audit team did not identify instances of duplicate payments, separate funding arrangements being paid out of separate financial systems place the Department at increased risk of duplicate payments. In addition, a contribution arrangement and an operating allocation carry different responsibilities for the Department. Whereas operating resources are appropriate for services directly delivered by the Department (such as contract or departmental facilities), contribution arrangements are appropriate for programs where an outside party is better equipped to deliver the program (such as provincially insured beds). However, the audit sample of payments made out of VIP or OHPS have similar profiles where 86% of VIP payments and 82% of OHPS payments were for provincially insured beds. There seems to be little difference in the funding sources other than contract beds must be paid out of OHPS.

In addition to the two funding sources, the payments are coming out of two different financial systems. These systems do not interact. However, there are controls in each system to ensure duplicate payments do not occur for a particular recipient in a particular month from that particular system. The Federal Health Claims Processing System (FHCPS) has system application controls, where as RFO has implemented manual controls in the form of a spreadsheet, due to a limitation in the accounts payable system. However, the audit team was not able to identify controls to ensure that facilities are not inadvertently charging both the Department and the recipient for the same service. An additional control could be the implementation of a payment notification system, solely reimbursing either the recipient or the facility, or periodically checking with the Power of Attorney (POA) to ensure duplicate invoicing is not occurring.

3.2.3 Appropriateness of payments

There were no set agreements for non-provincially insured beds between VAC and the facility. Therefore, the audit team determined the appropriateness of the transaction by looking at provincially set budgets or industry pricing information. Of particular concern were the beds in Nova Scotia (NS) as these beds were costing more than elsewhere. However, all six transactions reviewed for NS complied with the provincially set facility budgets. The transactions for other provinces were within the limits set in the industry pricing and 100% of the invoices (72/72) reviewed were within a "reasonable" rate based on industry pricing information. However, there are opportunities for cost savings if VAC were to eliminate or reduce funding for non-provincially insured. The audit population of 9802 contained 624 non-provincially insured beds or 6% of the population.

In addition to the statistical sample, the audit team undertook judgmental sampling of higher risk transactions – i.e. contract beds (20 transactions) and non-provincially insured beds (20 transactions). As with the statistical sample, there are issues with the adequacy of the audit trail for files in the judgmental sample where 35% did not have adequate information to support eligibility (compared to 29% in the random sample).

Additionally the audit team noted that, the practice of admitting recipients to non-provincially insured beds is costly and since the recipients needs are being met, they most likely would not be moved to a less costly, provincially insured bed (because they would not fit provincial placement guidelines – their needs are being met, they are most likely stable and in an environment that can care for them). The admission to non-provincially insured beds varies from region to region.

In terms of the contract beds that formed the scope of the audit, the province of most concern was Ontario because for the other provinces, the agreement with the provincial health authorities did not have an additional charge for priority access. Five of the transactions reviewed were for contract beds in Ontario and they all complied with the Memorandum of Understanding (MOU) with the Ministry of Health (MOH), although the MOU is expired. The audit team is of the opinion that there is an issue with separation of duties for the MOH invoices in Ontario. The two parties involved were RFO and the MOH. Another party could play a role in the invoicing. This would ensure the party verifying the payment is not the same party that is processing the payment.

VAC cannot ensure that recipients are getting priority access to these beds because they are not managing the placement of recipients in the beds– placements are determined by provincial representatives. There are weaknesses in how VAC monitors these beds to determine if recipients have moved to a less costly, provincially insured bed because the onus is left on the province or facility to apprise the Department of a change in status. Also, the province determines whether to place a Veteran in a priority

access bed. Section 24(1) of the VHCRs, indicates that if health needs are similar, then there is a priority of admission for contract beds, but VAC is not managing this priority.

No recommendation is made for this section because the quality assurance activity will address the control weaknesses in regards to decision making.

3.2.4 Standardized Invoicing

Basic accounting principles outline many standardizations that assist in processing day to day accounting transactions. One such aspect is the vehicle used for source documentation when an invoice is submitted for payment. Standardized invoicing has become common practice and the Department would benefit from impressing on vendors to standardize invoicing for payment processing. Standardized invoicing information should include the following:

- Unique invoice number
- Date
- Facility
- Recipient Name and file number
- Date of service
- Type of service
- Cost per unit (i.e. per diem, monthly rent, etc.)
- Amount

Payment processing of standardized invoices would improve efficiency for processing and would help to identify errors or possible duplicates. A movement toward processing standardized invoices would also help to ensure the Department is in a better position for the future when more electronic invoices may be submitted for payment. Payment processing of electronic invoices improves the quality of invoice data and streamlines business processes. Over time, invoice data will create an inventory of business intelligence for VAC payables, enhance oversight capabilities, and improve financial controls.

The Regional Director Finance has taken steps to address invoicing anomalies by communicating with facilities to ensure they are aware of the necessary information on the invoice. However, there continues to be varied payment instruments submitted for processing. The audit team identified that 25% of the payments sampled from FREEBALANCE and FHCPS had inadequate source documentation. Inadequate

documentation included paying from a statement of account, reimbursing the facility from a receipt, and reimbursing a recipient from a facility invoice. These are inadequate because it creates an opportunity for errors, duplicates, and administrative burden leading to untimely payments. Receipt of a standardized invoice from a vendor to process for payment would help improve efficiency for staff processing the claims and possibly identify errors and duplicates.

Medavie Blue Cross has a standard template that is to be filled out and attached to the service providers' submitted invoice. It helps to standardize the information submitted for processing but uptake on the use of the template has been low. CSAs also fill in various templates for payments, but it is overly administrative and time consuming. Ideally, the onus would be placed on the vendor requesting reimbursement to fill in the necessary information rather than have VAC staff re-package the information on the invoice.

3.2.5 Vendor Management

In looking for transactions for LTC in FREEBALANCE, it was difficult to determine the appropriate vendor. Although the current naming convention is a unique identifier for the vendor, which is either the Veteran file number or the first three letters in the facility name followed by the postal code, the vendor descriptions are quite similar. There is segregation of duties in that a separate section adds the vendors to the system, i.e. the section requesting payment to the vendor is not the same section as the one that is adding a vendor. Also, the system does not allow for duplicate vendor codes to be entered, but will allow duplicate names.

Examples of vendor descriptions include the following:

- Assiniboine Regional Health, Assiniboine RHA, Assiniboine Regional Health AU, Assiniboine R.H.A., Assiniboine Regional.
- C.S.S.S DE TROIS-RIVI+RES, C.S.S.S DE TROIS-RIVIERES
- John Smith, Smith, John

The existence of numerous, active, similar vendors in FREEBALANCE increases the risk of the Department processing payments to the incorrect vendor. The auditors would have expected a single vendor with multiple pay sites, but the payment system does not allow for this functionality. RFO detects duplicate payments from a spreadsheet and it is a control that mitigates the risk of duplicate payments. The spreadsheet has been implemented to manage the payment system limitations.

3.2.6 Financial and Information System Controls

Financial and information systems are a vital component in the delivery of government programs and services. When managed effectively, the systems improve service to the public, enhance productivity and reduce costs. It is necessary to ensure proper controls are in place within those systems to mitigate business risks. RCSS is not a financial system, but is being used as one (e.g. for account verification).

The information in RCSS on the facility rate does not allow for monthly rent and the calculation from the per diem rate is not accurate (based on a 30 day period). Improvements should be made to allow for either a per diem or a monthly facility rate in the financial screen of RCSS and this information should be shared with FHCPS to avoid unnecessary contact with the DO for clarification. The financial screen in RCSS should also be enhanced to provide the PAYEE and details of the agreement. This would ensure a clear audit trail, improve processing time and also would ensure that others could fill in for the CSA with relative ease.

Determination of LTC eligibility is complicated. RCSS could be enhanced with an implementation of rule based logic for the determination of LTC eligibility for Veterans. The DO needs to ascertain the correct eligibility because each eligibility criteria may have access to different parts of LTC. For example, one group of Veterans may have access to VIP community beds, whereas another group may not. Assistance of a tool for eligibility would help ensure consistent and the best decisions are made in the interest of Veterans.

The current design of RCSS is an information tool only with access to some historical data (income/A&M letters). There should be authority levels for data changes in RCSS. Data additions/changes/deletions should be tracked in RCSS to ensure a proper audit trail.

The facility screen in RCSS does not have rules/logic behind assigning bed type. For example, a recipient could be assigned to a contract bed in a facility without contract beds. Reporting from RCSS will also be inaccurate and could lead to inaccurate billing.

FHCPS keeps a history of A&M rates and if a change is made mid-year, it will continue to display the erroneous rate for the period that the error was present in RCSS. FHCPS does not identify facility rate only the A&M rate. Therefore the third party contractor must contact the DO to establish the rate to be paid. The facility rate should also be displayed in FHCPS along with VAC rate because the absence of the rate could lead to inaccurate payments and inefficiencies because the analyst must research to find the rate.

RCSS/FHCPS/CSDN (Client Service Delivery Network) currently have appropriate system access controls. Requests for access are managed by VAC Information Technology Division and also on a divisional basis to ensure access to the systems are on a work related and need to know basis.

A change in the system may not be cost effective and therefore a change in the process would be required to ensure the audit trail is preserved.

Recommendation 7

It is recommended that the Director General, Service Delivery and Program Management Division, implement system improvements to enhance controls and to preserve the audit trail for the Long Term Care Program. (Essential)

Management Response

Management agrees to analyse the feasibility (including the resources, risks, and benefits) of implementing system improvements to enhance controls and to preserve the audit trail for the Long Term Care and Veterans Independence Programs.

Management also recognizes the system related implications of the transformation agenda as top priority for the department. Assessing the capacity to implement these proposed changes, prior to delivering on the transformation agenda priorities, will be challenging, if at all possible.

Management Action Plan

Corrective action to be taken	Office of Primary Interest	Target date
Review the feasibility and applicability to alter RCSS financial screen to a monthly rate rather than per diem rate.	SDPM – TBVIP / LTC Directorates and Corporate Information Applications	September 2012
Investigate the addition of system edits to data entry fields with cross-validation, to ensure there are no irregular or impossible data combinations entered.	SDPM – TBVIP / LTC Directorates and Corporate Information Applications	November 2012

Consult on the potential for expanded audit capability for facility (institution) information updates (i.e. logging of changes made and by whom to facility information screen).	SDPM – TBVIP / LTC Directorates and Corporate Information Applications	January 2013
Consult on the expanded audit capability for financial information (i.e. logging of changes made and by whom to financial information screen).	SDPM – TBVIP / LTC Directorates and Corporate Information Applications	January 2013
Investigate the ability to add an additional screen to RCSS to indicate payee and particulars of services to be provided and funded through VAC.	SDPM – TBVIP / LTC Directorates and Corporate Information Applications	March 2013

3.3 Opportunities for improvement

The Audit Team indentified the following opportunities for service delivery improvement for management consideration:

- The same information provided by the recipient and gathered by the CSA must be entered in multiple systems. Under the VIP Program, the DVA1305 must be filled out, and RCSS decision form must be filled out, and then the information has to be manually inputted into FHCPS, CSDN and RCSS as there is no auto-population of systems, other than certain tombstone data. The lack of system integration is administratively time consuming and also leaves room for error.

- The A&M contribution required from recipients increases each October. In order to notify recipients of the yearly increase in contribution, letters are mailed to each recipient or POA. These letters are individually produced and mailed out by the DO. This task is occurring on an annual basis and requires time and resources for the DO to complete and certain aspects could be automated, as is currently being done with batch letters for other programs.

- Some DOs requested that invoices be sent to them prior to the third party contractor for payment. This is not a requirement, is inefficient and slows down payments.

- Invoices for LTC services in Ontario were being sent to the RO as they were received. Sending documentation on its own rather than in batches can increase

the risk of lost documentation because there is no record of what was being requested for payment and no record to determine if all the information was received on the other end. Invoices arrive and are completed by the DO on a regular basis and batching them together to be sent to the RO would be beneficial.

- There are insufficient form letters available to CSAs for LTC. Therefore each DO or CSA is developing their own letters to be sent to the recipient regarding LTC services. This results in letters written differently, containing varying levels of information and inconsistent information being provided to recipients. Improvements are required to the national standardized letters to improve usability.

3.4 Audit Opinion

In the opinion of the audit team, the internal controls, governance and risk management framework relating to financial and program management require improvement.

The audit results identified weaknesses with the internal processes supporting account verification and program management. Sampling identified significant weaknesses in regards to the documentation supporting decisions (audit trail). 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
Departmental Audit Committee Members
Assistant Deputy Minister, Policy, Communications and Commemoration
Assistant Deputy Minister, Service Delivery
Assistant Deputy Minister, Corporate Services
Director General, Finance
Director General, Service Delivery and Program Management
Director General, Policy and Research
Director, Long Term Care
Director, Program Policy
Director, Statistics
Director, Treatment Benefits & Veterans Independence Programs
Director, Outreach, Consultation and Engagement
General Counsel, Legal Services Unit
National Manager, Residential Care Program
National Manager, Veterans Independence Program
Manager, Health Care Policy
Regional Directors General
Area Directors
Senior Communications Advisor
Executive Advisors to the Deputy Minister
Office of the Comptroller General (Internal Audit Registrar)
Office of the Auditor General

Appendix 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.

Appendix B – Audit Criteria

Objective	Criteria	Result
To assess the governance framework for Long Term Care	The organization has in place operational plans and objectives aimed at achieving its strategic objectives.	Partially Met
	External and internal environments are monitored to obtain information that may signal a need to re-evaluate the organization's objectives, policies and/or control environment.	Met
	Management identifies the risks that may preclude the achievement of its objectives. Management identifies and assesses the existing controls that are in place to manage its risks. Management assesses the risks it has identified.	Partially Met
	Authority, responsibility and accountability are clear and communicated.	Partially met
To assess compliance with policies, regulations and procedures;	Compliance with policy and financial management laws, policies and authorities is monitored regularly.	Partially Met
	Controls described in policy manuals are actually applied and are applied the way that they're supposed to be (COSO).	Not Met
	Financial and program management policies and authorities are established and communicated.	Partially Met
	Financial management policies and authorities are reviewed regularly and revised, as required.	Partially met
	Policies flow from regulation and adequate business processes exist to provide necessary procedural guidance.	Partially Met
	Decisions are adequately documented to ensure a sound rationale for exceptional payments.	Not met

To determine if payments to facilities are accurate and in accordance with established terms and conditions with local and/or provincial health authorities;	VAC only accepts items that meet agreement specifications.	Partially Met
	Pay appropriate prices.	Partially Met
	Payments are issued in a timely manner.	Partially Met
To assess the adequacy of the process for payment verification.	Forecasts are monitored on a regular basis.	Partially Met
	Supervisory personnel review the functioning of controls.	Met
	Appropriate system application controls exist.	Partially met
	Effective process exists to rectify incorrect payments	Partially met
	Payments are in compliance with directive on account verification.	Not met
	Reviews are conducted to analyze, compare and explain financial variances between actual and plan.	Not met

Appendix C – Overview of File Review

Objective

The following sampling plan was applied in assessing the controls governing the application of administrative and financial responsibilities in respect to the provision of intermediate and chronic health care in community health care facilities.

Definition of the population and sampling unit

The assessment will be based on a sample of the total population of program recipients identified in VAC's Residential Care Support System (RCSS) during the 2010/2011 fiscal year.

Sampling Technique

The statistical sampling methodology to be used will be weighted attribute sampling. In profiling the Long Term Care program, characteristics of the population, as well as, the level of risk associated with payment process was evaluated. To ensure the sample reflects the population characteristics, the sample will be weighted by bed type (i.e. certain contract beds, provincially insured, and non-provincially insured).

Attributes to be tested:

1. Was the recipient's eligibility properly established?

2. Was accommodation and meals properly calculated and applied?

3. Was Treasury Board's Directive on Account Verification adhered to?

    - Audit trail
    - Verification of payment accuracy
    - Verification of entitlement
    - Payment in accordance with agreements
    - Evidence FAA Section 34 was adequately done
    - Lawful charge
    - Adequate funds to support charge

Testing Standards

The following testing standards will be used in determining the number of transactions to be sampled from the RCSS database.

Confidence Level:	**95 %**
Maximum Expected Error Rate:	**5%**
Margin of error:	**± 5%**
Population	**9802**

Maximum Expected Error Rate is based on the latest results from the Finance Division's quality assurance reviews of the FAA Section 34 process.

Sample Size

Based on the above statistical criteria, 72 files were randomly selected for review. Additional judgmental sampling was conducted in the higher risk transactions to gather sufficient evidence on the adequacy of internal controls over the LTC Program.

The following table provides population and sample statistics of bed types for participants in the Long Term Care Program during fiscal year 2010-2011.

Bed Type	Random Sample	Population
Contract Beds	4	464
Non-Provincially Insured	8	1,102
Provincially Insured	60	8,236
Total	**72**	**9,802**

The following table provides sampling for the judgmental sample. A selection of transactions was randomly selected for the higher risk transactions (contract beds and non-provincially insured).

Bed Type	Judgmental Sample	Population
Contract Beds	20	464
Non-Provincially Insured	20	1,102
Total	**40**	**1,566**

Overview Results

In terms of entitlement to the program, the file review identified 1% (1/72) cases where there was no evidence to support the recipient's entitlement to the program.

The audit trail to support eligibility was inadequate in 29% (21/72) of the cases. While the audit team were able to determine eligibility by looking at the war service records on file, the remaining key elements to support LTC eligibility were missing, whether it be a nursing assessment, the RCSS Decision Form or VAC 1305 (if applicable).

35% (25/72) of recipients in the sample were entitled to LTC, but did not have documentation on file to support the eligibility under Part II or Part III of VHCR (e.g. eligible for contract bed but in a community bed – 68% (17/25) due to misalignment of policy and regulations.)

Appendix D - Acronym List

Accommodations and meals (A&M)

Canadian Forces Members and Veterans Re-establishment and Compensation Act (CFMVRCA)

Client Service Agent (CSA)

Client Service Delivery Network (CSDN)

District Administrative Services Officer (DASA)

District Nursing Officer (DNO)

District Office (DO)

Federal Health Claims Processing System (FHCPS)

Financial Administration Act (FAA)

Head Office (HO)

Human Resources and Skills Development Canada (HRSDC)

Institute of Internal Auditors (IIA)

Long Term Care (LTC)

Memorandum of Understanding (MOU)

Ministry of Health (MOH)

Nova Scotia (NS)

Old Age Security (OAS)

Other Health Purchased Services (OHPS)

Power of Attorney (POA)

Quality Assurance (QA)

Regional Finance Office (RFO)

Regional Institutional Care Specialist (RICS)

Regional Office (RO)

Residential Care Integrated Working Group (RCIWG)

Residential Care Support System (RCSS)

Service Delivery Program Management (SDPM)

Treasury Board Secretariat (TBS)

Treatment Benefits Veterans Independence Program – TBVIP

Veterans Affairs Canada (VAC)

Veterans Health Care Regulations (VHCR)

Veterans Independence Program (VIP)

War Veterans Allowance (WVA)