Veterans Affairs Canada | Anciens Combattants Canada

Evaluation of the Intermediate and Long Term Care Programs

Final: January 2014

Audit and Evaluation Division

Canada

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EXECUTIVE SUMMARY

Background

This evaluation of the Intermediate and Long Term Care Programs was conducted in accordance with the approved Veterans Affairs Canada Multi-Year Risk-Based Evaluation Plan 2012-2017.

The Veterans Independence Program Intermediate Care (VIP IC) Program and the Long Term Care (LTC) Program, herein after referred to as "the Programs", support eligible Veterans and other individuals who require facility-based long term care. There are two types of beds under the Programs: community beds and contract beds. Community beds are beds in a facility operated by health authorities, private and not-for-profit sectors. Contract beds are beds that are set aside in a community facility pursuant to a contractual arrangement between the facility and VAC. Eligibility for these bed types varies. Community beds fall under both the VIP IC Program and the LTC Program, while Contract beds fall solely under the mandate of the LTC Program.

The evaluation examined the relevance and performance of the Programs, and was conducted in accordance with Treasury Board policy requirements and guidance material. The evaluation findings and conclusions are based on the analysis of multiple lines of qualitative and quantitative evidence.

Overall Results

Relevance

The Programs are aligned with the priorities of the Government of Canada, as well as the strategic plans of the Department. While the evaluation confirms a continuing need for the Programs for the foreseeable future, the Programs' recipients are steadily declining. The number of recipients eligible for contract beds is limited and as the population ages, the need for those beds will decline.

Achievement of Expected Outcomes

The effectiveness and success of a program are generally measured through the use of performance measurement strategies that include performance measures and three intended program outcomes. The outcomes of the Programs are as follows:

- Immediate: *Eligible Veterans have access to long term care services*;
- Intermediate: *Eligible Veterans feel their care needs are being met*; and
- Ultimate: *Eligible Veterans physical, mental and social needs are met in a long term care facility*.

At the time of the evaluation, data against the ultimate outcome was not being collected. In addition, other key information was not available (e.g., the number of applicants to the Programs, the number of unfavourable decisions). Furthermore, the Department does not track how many Veterans apply for these Programs.

In addition, the intended outcomes for the Programs should be revised as they were not appropriate for both the VIP IC and LTC Programs. For example, the immediate outcome is that Veterans have access to long term care services. While appropriate for the LTC Program, it is inappropriate for the VIP IC Program as the province determines access to a community bed. The ultimate outcome is that Veterans needs are met in a long term care setting. Once again, this outcome is largely dependent on service offered by the provinces, and is not linked to Program design which requires VAC to provide funding.

Demonstration of Efficiency and Economy

The evaluation identified efficiencies that can be realized through addressing the overlap within the Programs. More specifically, VAC should align the management structure for the two Programs, use a single payment system and payment office. In addition, VAC should continue to consider the appropriate mix of community and contract beds, as the demographics of the Veteran population shifts.

These findings resulted in the following recommendations:

R1 (Essential): It is recommended that the Assistant Deputy Minister of Service Delivery review and revise (if necessary) the outcomes of the VIP IC and LTC Programs and develop measurable program-specific performance indicators.

R2 (Critical): It is recommended that the Assistant Deputy Minister of Service Delivery develop a system to track applications and decisions for the VIP IC and LTC Programs.

R3 (Essential): With regard to community beds, it is recommended that the Assistant Deputy Minister of Service Delivery, in collaboration with the Assistant Deputy Minister of Human Resources and Corporate Services, address the administrative overlap in the VIP IC and LTC Programs by considering the following:

- **merging the management structure for VIP IC and LTC Programs;**
- **implementing a single payment system; and**
- **creating/designating a single payment office.**

1. INTRODUCTION

This report is about the Evaluation of the VIP IC and the LTC Programs. The purpose of the Programs is to support eligible Veterans and other individuals, such as Allied Veterans and Canadian Armed Forces Veterans, who require facility-based long term care.

In 1915, the Government of Canada began building hospitals to treat injured and disabled Veterans of the First World War. As the years went on, there was a growing number of Veterans with chronic service-related injuries who needed more care as they aged. To respond to the needs of the aging First World War Veterans requiring long term care, VAC instituted programs and created Veterans' facilities. VAC adapted its programs over time as the needs of Veterans changed and as the provinces began offering more services to their citizens.

In 1948, the federal government introduced a series of National Health Grants to directly provide funds to the provinces for hospital construction, professional training and public health.

In 1963, the Glassco Commission recommended that VAC transfer responsibility for the VAC hospitals to the provinces. As a provision of the transfer agreements, a fixed number of beds (contract beds) in each of these facilities were reserved for Veterans.

In 1966, the *Medical Care Act* was introduced. It established the formula by which the federal government transfers funds for hospital and health services provided by the provinces. This framework evolved in 1977 and again in 1984 into what is now called the *Canada Health Act.*

Today, there are a fixed number of beds reserved for Veterans in certain facilities. The Programs evolved further in response to Veterans' desire to remain in their communities by extending funding to Veterans for long term care in community beds. The Department works in cooperation with provinces, health authorities and long term care facilities and provides financial support to eligible Veterans in community and contract beds.

Community and contract beds are offered by VAC either through its VIP IC or LTC Programs. Community beds fall under both VIP IC and LTC, whereas contract beds fall under LTC alone. In addition, VIP IC covers intermediate type care only, whereas LTC covers both intermediate and chronic types of care.[1] Table 1 provides an overview of each bed type and key differences between each.

[1] **Intermediate Type Care** is defined as a service provided in a health care facility to meet the need of a person for personal care on a continuing basis under the supervision of a health professional, where the person has a functional disability, has reached the apparent limit of recovery and has little need for diagnostic or therapeutic services.

Chronic Type Care is defined as a service provided in a health care facility to meet the need of a person for personal care and for diagnostic, nursing and therapeutic services provided by a health professional on a continuing basis, where the person is chronically ill or has a functional disability and the acute phase of the illness or disability has ended, whether or not the status of the illness or disability is unstable.

Table 1: Overview of the Programs by bed type as of 2011-2012

Type	Community beds		Contract beds	
Definition	beds in facilities operated by health authorities, private and not-for-profit sectors		beds that are set aside in a community facility pursuant to a contractual arrangement entered into by the Minister for the intermediate or chronic care of eligible Veterans	
VAC's Activities	provide funding to eligible Veterans placed in long term care		provide funding to a health authority, and/or facility to cover the costs of administering long term care for eligible Veterans, which can include funding for enhanced services[2]	
Program Legislative Authorities	benefits provided through: a) Part II of *Veterans Health Care Regulations* (VHCR) – VIP, and b) Part III of VHCR – LTC Program		benefits provided through: Part III of *Veterans Health Care Regulations* (VHCR) – LTC Program	
Funding	funded through: a) VIP contribution program and b) through a special purpose allotment – Other Health Purchased Services (OHPS[3])		funded through: a special purpose allotment – Other Health Purchased Services (OHPS)	
Overall Cost	The Programs' expenditures are approximately 8% of the total 2011-2012 VAC expenditures spent on all VAC programs[4]			
Average cost by Bed Type[5]	$14,882/yr		$62,747/yr	
Number of Program Recipients as of March 31, 2012[6]	6,178		2,659	
	VIP Intermediate Care 3,429	LTC 2,749	VIP Intermediate Care N/A	LTC 2,659
Recipient Forecast	Forecasted decline to 1,443 Veterans in VIP IC and LTC by 2026[7]			
Pros of Each Delivery Model According to Interviewees	• Veterans can remain in their communities • Veterans are able to co-locate with their spouses • Beds are less costly to VAC		• Veterans receive priority access to beds • Veterans are co-located with other Veterans • Veterans can receive additional services and more specialized care than are generally available in most other facilities	

2 VAC provides additional funding for "enhanced services". Examples of enhanced services include: additional registered practical nurses and activity aides; recreation therapy and creative arts programs; pastoral and chaplaincy services; and an enhanced dining program.

3 OHPS is a special purpose allotment, meaning that it is money provided to VAC with the intention that the money will be spent on a specific initiative or item.

4 Source: VAC Finance Division, 2011-2012. VAC expenditures include costs associated with Ste. Anne's Hospital.

5 Source: VAC Statistics Directorate. Note: The average costs vary due to the varying agreements. Contract beds cost more on average because generally VAC pays for operating costs, more nursing hours of care, and enhanced services. The provinces subsidize community beds at a different rate than contract beds.

6 Source: VAC Statistics Directorate. Note: These numbers include four Adult Residential Care (ARC) recipients who were excluded from the scope of the evaluation. ARC was initiated to support lower level care recipients living in retirement type housing. ARC was eliminated in 1993, with those in receipt at the time grand-fathered in.

7 Source: VAC Statistics Directorate, Bed Demand Forecast, 2012.

2. METHODOLOGY AND SCOPE

The evaluation assessed program practices as they occurred from April to December 2012. The evaluation excluded aspects of facility-based care such as the care provided at VAC's only departmentally owned hospital (Ste. Anne's Hospital).

In line with the Treasury Board *Directive on the Evaluation Function*, this evaluation examined five issues under relevance and performance, namely:

Relevance

1. the continued need for the program;
2. alignment with government priorities;
3. alignment with federal roles and responsibilities;

Performance

4. achievement of expected outcomes; and
5. demonstration of efficiency and economy.

2.1 Multiple Lines of Evidence

The lines of evidence used to evaluate the Programs' relevance and performance were:

- **Statistical analysis**
  - Data provided by VAC Finance Division and the Program Performance Unit.
  - Review and analysis of data to gain an understanding of and draw conclusions on the Programs.

- **File review**
  - A statistically valid sample from a population of 71,501 transactions from VIP and Other Health Purchased Services (OHPS) up to March 31, 2012.
  - 426 transactions randomly selected - 95% confidence level and 5% margin of error.
  - Stratified by the two payment systems used by VAC, namely the Federal Health Claims Processing System and FreeBalance.

- **Interviews**

  72 interviews were conducted:
  - Internal stakeholders – VAC staff in Halifax, Saint John, Ottawa, London, Regina and Winnipeg offices, and Head Office (48 interviews).
  - External stakeholder interviews - facility and provincial representatives (24 interviews).

- **Review of literature**
  - Internal sources (research studies, surveys, reports and policies)
  - External sources (media scan, studies and web search)

2.2 Limitations and Analytical Challenges

The following limitations were identified during the evaluation:

- Certain performance data (e.g., the number of applicants to the Programs, the number of unfavourable decisions) was not readily available so alternate methodologies such as a file review, literature reviews, and statistical computations, were used to gather the information.
- The evaluation team did not speak directly with program recipients. The evaluation relied on recipient satisfaction questionnaires, existing internal and external studies and interviews with VAC and provincial representatives who deal directly with Veterans and their families to gauge the needs and views of program recipients.
- As the quality of care in facilities and its impact on Veterans was not assessed as part of the evaluation (e.g., the impact of enhanced services, additional nursing hours of care), the evaluators undertook a literature review to assess the achievement of the ultimate outcome.

These limitations should be considered when reading the evaluation findings.

3. EVALUATION FINDINGS

The findings of the evaluation are presented by the core issues of relevance and performance.

3.1 Relevance

There is a continued need for VAC's VIP IC and LTC Programs for the foreseeable future.

The proportion of Veterans accessing VIP IC and LTC is in line with the percentage of the general population in long term care in Canada. Of the approximately 188,000[8] Veterans eligible to apply for VIP IC and LTC, 13,226[9] Veterans (or 7%) accessed the Programs from April 1, 2011 – March 31, 2012. Similarly, national statistics in Canada state that 7% of the total population of seniors are living in a collective dwelling[10] that focuses on special care to seniors.

Eligibility for VIP IC and LTC Programs comprises mostly of two main groups: War Service Veterans and Canadian Armed Forces Veterans[11]. Most War Service Veterans are eligible for both contract beds and community beds, whereas Canadian Armed

8 Source: VAC Statistics Directorate. Note: This number includes all Veterans who served in Canada, of which only a portion would meet the eligibility requirement of low income.

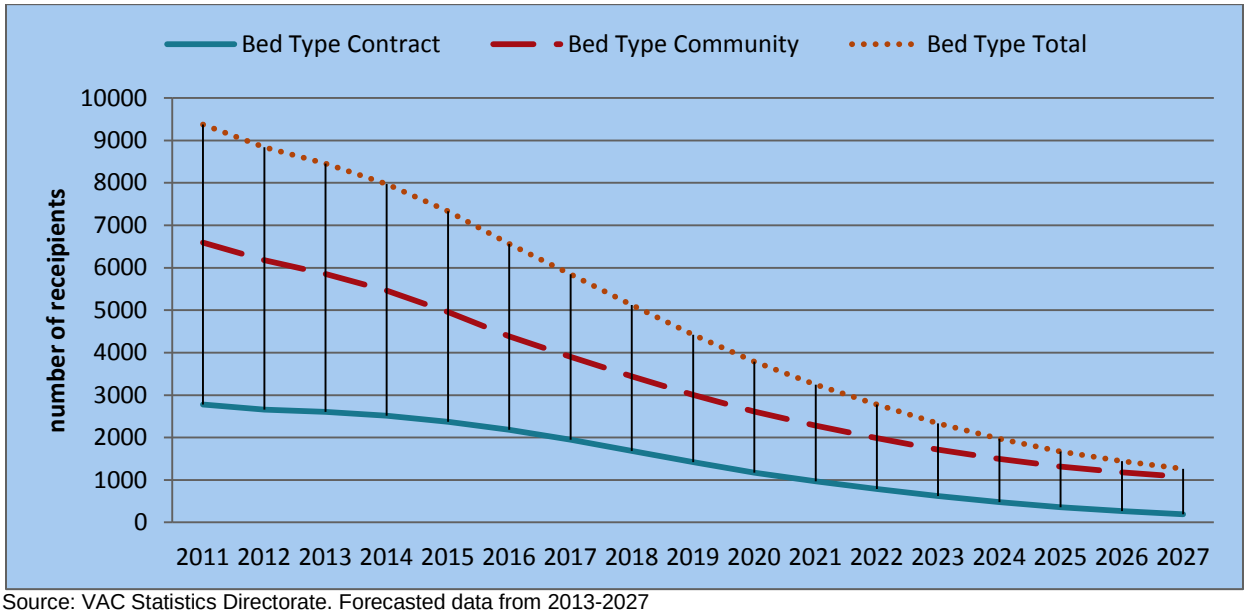
9 Source: VAC Statistics Directorate.

10 Source: *"Living Arrangements for Seniors",* Date accessed January 22,2013 < http://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-312-x/98-312-x2011003_4-eng.cfm#bx2> Persons in collective dwellings refer to the population in a dwelling of a commercial, institutional or communal nature, such as nursing homes or hospitals.

11 Certain types of civilians are also eligible. For example, certain civilians with a disability pension.

Forces Veterans are eligible for community beds alone. In recent years, Canadian Armed Forces Veterans have started to access community beds in increasing numbers, however, they still do not represent as significant a proportion of the Programs' population as War Service Veterans. The number of participants in the Programs will decline as the population ages. Figure 1 shows the projected decline in the Programs' recipients by bed type up to 2027.

Figure 1: Projected Program Recipients by Bed Type.



Source: VAC Statistics Directorate. Forecasted data from 2013-2027

Departmental forecasts indicate an ongoing future demand for the Programs out to 2018. For 2011-2012 fiscal year, 3,200[12] recipients were new to the Programs which represented approximately 25% of Veterans who accessed the Programs that year. The Department's approach to the declining Veteran population is further elaborated in Section 3.2.2 of this report.

The Programs align with government priorities.

The VIP IC and LTC Programs are aligned with the Government of Canada's priorities as outlined in the *2011 Speech from the Throne*, which affirmed the government's commitment to recognize and support all Veterans, and the *2010 Speech from the Throne,* which indicated that the government will contribute to the improvement of the health of Canadians.

The VIP IC and LTC Programs also align with the Department's strategic outcome of "*Financial, physical and mental well-being of eligible Veterans*". The Programs support eligible Veterans including Allied Veterans and Canadian Armed Forces Veterans, who require long term care.

[12] Source: VAC Statistics Directorate.

The Programs align with federal roles and responsibilities.

Provincial and territorial governments are responsible for the management, organization and delivery of health services for their residents. With the exception of Ste. Anne's Hospital, VAC does not deliver, manage, or organize long term care services for Veterans. Instead, VAC is a financial contributor to Veterans towards the costs of VIP IC and LTC for community beds. For contract beds, VAC provides funding to provinces, health authorities and Long Term Care facilities for priority access and/or enhanced services and ensures the funding is utilized in line with agreements. VAC's mandate and legislative requirement for VIP IC and LTC are outlined in the *Department of Veterans Affairs Act* and under Parts II and III, respectively, of the *Veterans Health Care Regulations*.

There are no other federal or provincial programs that provide Veteran-specific programming for Veterans in long term care.

3.2 Performance

3.2.1 Program Efficiencies

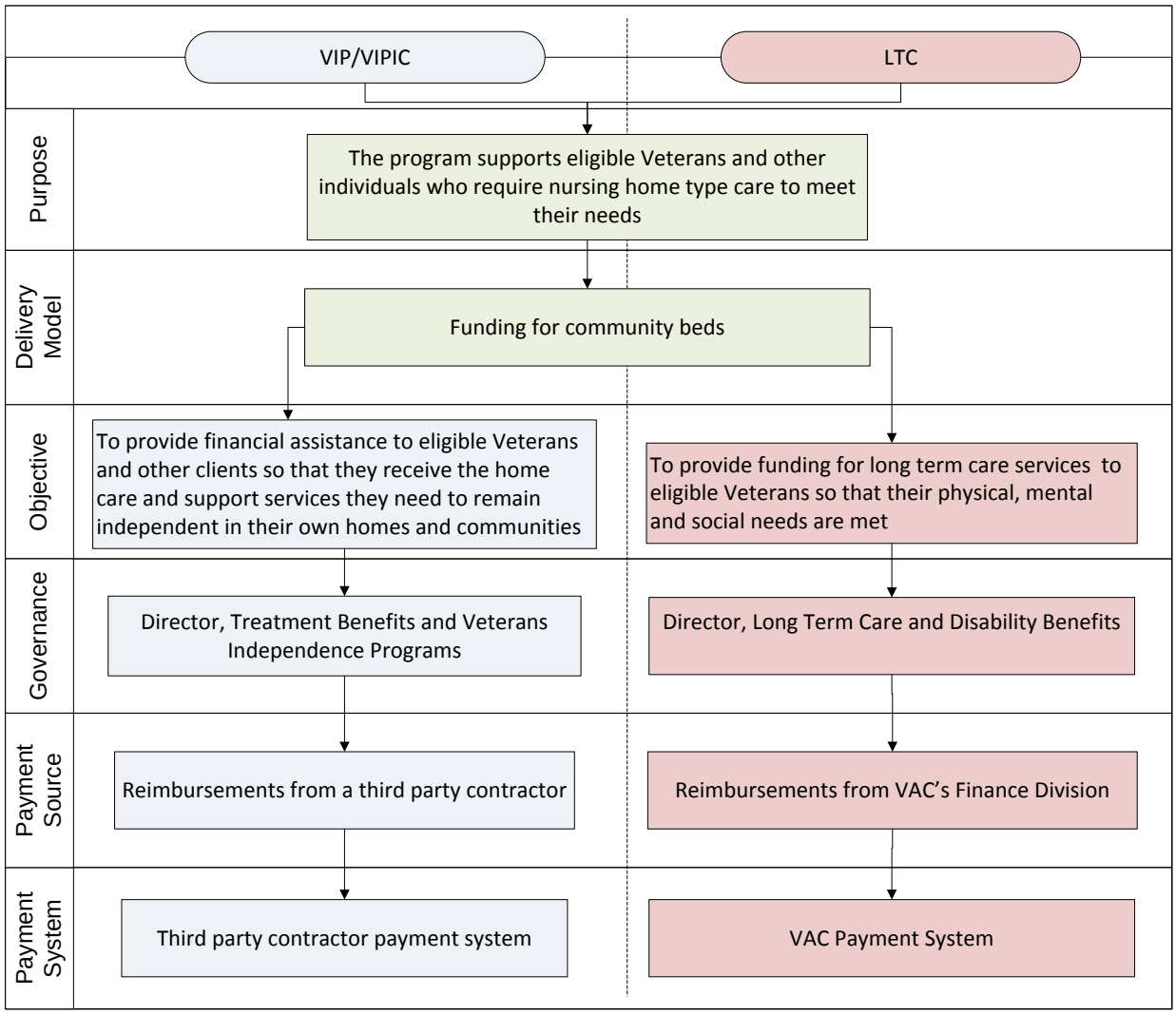
There is overlap between the Programs as they relate to community beds.

In terms of LTC, the two Programs share the same purpose and provide the same level of financial assistance to Veterans for community beds. The only difference between the VIP IC and LTC, as they relate to community beds, is program eligibility.

Veterans who access contract beds are funded through one program, the Long Term Care Program. However, eligible Veterans who access community beds can get financial assistance through one of two VAC programs (VIP IC and LTC). Having two programs providing financial assistance for the same service is sub-optimal. Likewise, so too is having two different VAC management structures, processing centres, and payment systems.

Figure 2 depicts the overlaps between the VIP IC and LTC Programs for community beds.

Figure 2: Community Beds - Overlap within the VIP IC and LTC Programs[13]



Having two distinct programs for the same benefit results in the following:

- Split accountabilities and additional approvals delayed decision making at the program management level.
- Redundant systems and systems upkeep increased risk of duplicate payments.
- Confusion among facility administrative staff or Veterans when sending requests for reimbursements.

VAC staff, Veterans and facilities would benefit from addressing the overlap in the Programs which would:

- improve service to recipients and the interface with service providers;

[13] The purpose of the Programs was taken from the draft 2013-2014 Program Alignment Architecture for VAC. The objective for the Programs was taken from the draft performance measurement strategies for the VIP and LTC programs. These performance measurement strategies were not finalized at the time of fieldwork.

- clarify responsibilities;
- simplify accountabilities; and
- improve reporting structures.

Additional program information would support future program decisions.

When a Veteran approaches the Department for long term care, VAC must determine if the Veteran is eligible. Determining eligibility for VIP IC and LTC is based on the following:

- the type of long term care the Veteran requires (intermediate or chronic care); and
- the kind of military service, level of income, health care need the Veteran has and/or the link between service-related disability and the need for long term care.

Program eligibilities are complex. They are defined within the *Veterans Health Care Regulations* by multiple sub-types of eligibilities. The eligibilities reference various sections of six separate Acts, which add another level of complexity. Further, the business processes and tools departmental staff use to determine eligibility were found to be inconsistent and incomplete which increases the risk that errors may occur.

While eligibilities are complex, the evaluation team could not identify if efficiencies could be gained by simplifying eligibilities because of insufficient information regarding application requests. This is because VAC does not have an application tracking system in place to count how many Veterans apply or how many are denied. VAC program management is working on developing an application form which will assist in tracking applications and decisions.

By collecting key information on applications VAC would be able to:

- track the types of applicants requesting assistance, which would in turn help determine if program eligibility changes are necessary;
- allow quality assurance on unfavourable eligibility decisions for VIP IC and LTC; and
- determine the actual volume of requests processed in each area office, so as to identify inconsistencies and opportunities for streamlining.

3.2.2 Efficiencies Currently in Place

Evaluations must assess not only a program's relevance and results achieved but also the resources the program utilizes. Administrative costs and actual program expenditures for the Programs for the past two years are provided in Table 2.

Table 2: Program and Administrative Expenditures for the Programs

Fiscal Year	Salary, Operating and Maintenance	Program	Total Expenditures
2011-2012	$21,300,000	$268,000,000	$289,300,000
2010-2011	$14,400,000	$278,100,000	$292,500,000

Source: VAC Statistics Directorate

Overall total expenditures between 2010-2011 and 2011-2012 have decreased marginally. The Program expenditures have decreased slightly, which is consistent with the decline in Program recipients due to mortality.

The difference between 2010-2011 and 2011-2012 is mainly due to the results of collective bargaining that concluded in 2011-12, including one-time payments totalling $4.6 M for employee severance benefits[14], retroactive salary and related increases in employee benefits. The remainder of the increase includes on-going costs of $0.9 M from the collective bargaining salary increase, and a $1.4 M increase due to a requirement to report health professional salaries and contract medical services against the Programs.

The level of effort required to manage the Programs remains relatively the same as previous years.

The Department has developed an approach to rationalize contract bed expenditures.

VAC has a variety of arrangements for contract beds. In some instances, VAC funds priority access to contract beds in certain facilities for a fixed number of beds whether the bed is occupied or not. In other instances, VAC pays only when a bed is occupied.

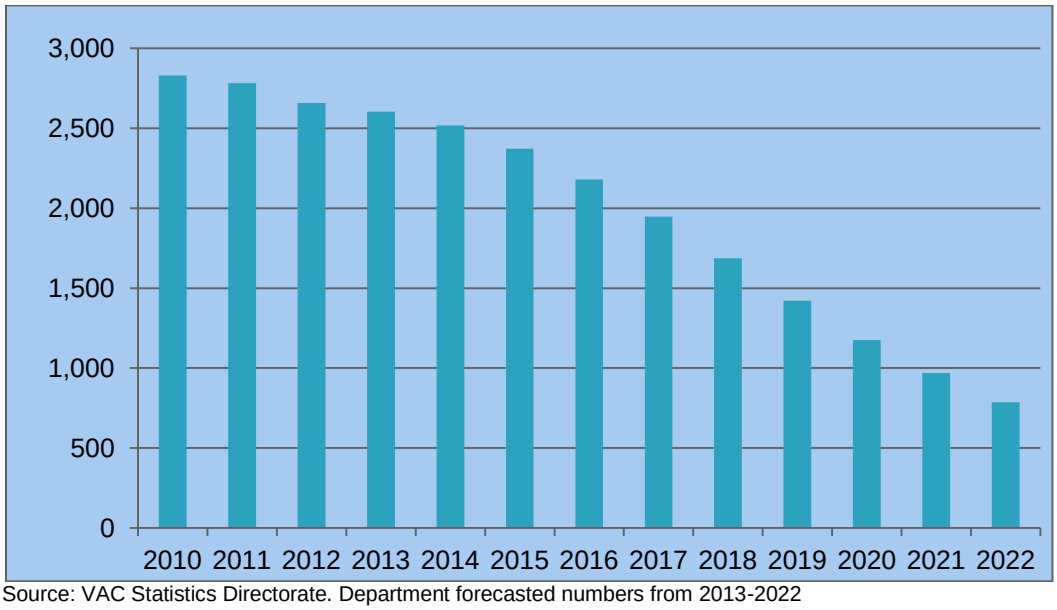
On average, contract beds cost about four times as much as community beds. The average bed cost per year for community beds is $14,882 compared to contract beds at $62,747[15]. Figure 3.1 depicts the projected decline in Veterans occupying contract

[14] Certain employee groups, as a result of collective bargaining negotiations, were given the option of an immediate payout (full or partial) of their severance benefits, or payment upon departure/retirement from the Public Service.

[15] Source: VAC Statistics Directorate. Note: The average costs vary due to the varying agreements. Contract beds cost more on average because generally VAC pays for operating costs, more nursing hours of care, and enhanced services whereas, the provinces subsidize community beds at a different rate than contract beds.

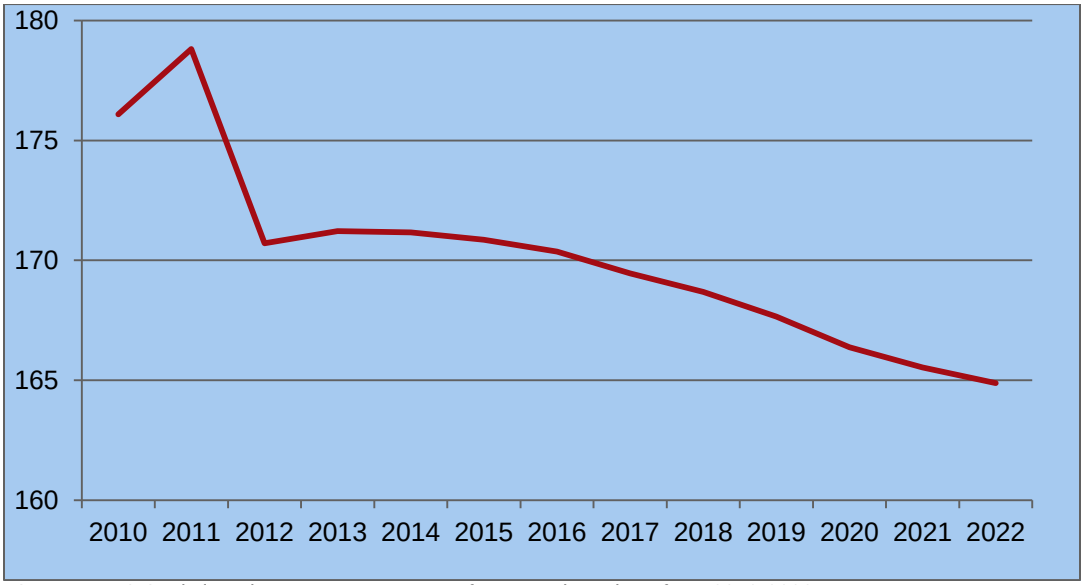
beds, while Figure 3.2 depicts the relatively constant decline in expenditures which will occur in future years should the current contract bed arrangements stay in place. From 2012 to 2022, eligibility for contract beds is expected to decrease by 70%, while the expenditures will remain relatively constant at a 3% decrease, indicating the need for program re-design.

Figure 3.1: Forecast of Contract Beds



Source: VAC Statistics Directorate. Department forecasted numbers from 2013-2022

Figure 3.2: Forecast of Expenditures (Millions)



Source: VAC Statistics Directorate. Department forecasted numbers from 2013-2022

Contract bed expenditures will remain relatively constant because the majority (approximately 90%) are paid to facilities regardless of whether the bed is occupied or not. While demand for contract beds to 2016 is expected to remain high, post-2016 demand is expected to fall sharply.

Funding agreements are being reviewed and adjusted as waitlists/demand drops and provincial need for civilian beds increases.

3.2.3 Effectiveness - Progress Toward Expected Outcomes

A program outcome is defined as the degree of change resulting from program activities and outputs. Outcomes can be further qualified as immediate, intermediate, or ultimate.

The immediate outcome of "*Eligible Veterans have access to long term care services"* should be based on accessibility to VAC's Programs.

This outcome lends itself more to the contract bed model where the Department pays for priority access. Under the community bed model, Veterans must meet the provincial criteria for admissions and are not given priority over other provincial citizens. This outcome should therefore be reviewed, as VAC does not control access to long term care services in the province. A more relevant immediate outcome would take into consideration accessibility to VAC's Programs rather than an individual's access to provincial beds. In order to measure accessibility, VAC must begin tracking applications and resulting eligibility decisions.

VAC is achieving the intermediate outcome of *"Veterans feel their needs are being met"* for those Veterans in receipt of VIP IC or LTC.

VAC measures progress towards the intermediate outcome through a survey of VAC VIP IC and LTC Program recipients in long term care beds. In 2009-2010, the survey was administered to recipients in both contract and community beds. At that time, overall satisfaction was relatively the same regardless of bed type (97% for community beds versus 99% for contract beds[16]).

Progress toward achieving the ultimate outcome of "*Veterans' needs are ultimately met in a long term care setting*" cannot be clearly attributed to VAC (for community beds).

As VAC performance measures for this outcome were not collected at the time of the evaluation, the team could not determine the Programs' progress towards the ultimate outcome. Performance measures for the ultimate outcome should be collected to help inform the effectiveness of the Programs.

Furthermore, the ultimate outcome cannot be clearly attributed to VAC. The Department provides funding toward the costs of care and does not provide care itself. The ultimate outcome must be achieved in collaboration with the provincial governments. The

[16] Source: VAC Long Term Care Directorate.

Veterans' needs in community beds are met to the extent the provinces are able to meet the needs of any provincial resident requiring long term care. The achievement of the ultimate outcome for community beds is largely outside of VAC's control. The evaluators cannot clearly attribute VAC's involvement to the achievement of this outcome.

4. CONCLUSIONS AND RECOMMENDATIONS

In summary, the VIP IC and LTC Programs are relevant. The evaluation found that the number of Veterans benefitting from the Programs is in line with the number of Canadians accessing long term care. There continues to be new recipients entering the Programs annually. Forecasts indicate a need for the Programs but at a declining rate. The Programs align with federal government priorities and departmental strategic outcomes. The Programs are administered as per VAC's legislative mandate.

Current performance measures need to continue to improve to allow for more refined measures and enhanced management of the Programs. A review of the performance measurement strategy would be beneficial to the Programs as the immediate and ultimate outcomes regarding the use of community beds do not fall within VAC's purview. In addition, data was not being captured on the achievement of the ultimate outcome.

Gathering additional program information would facilitate and assist in future program decisions. VAC is unable to determine if applicants are being correctly approved or denied for the Programs because there is no system in place to track this information. The Department is therefore unable to establish the types of applicants applying for assistance, accepted or declined, and as a result, is unable to determine what Program changes are necessary.

Finally, the Programs would benefit from addressing the overlap between VIP IC and LTC. This would include:

- merging the management structure for VIP IC and LTC Programs;
- implementing a single payment system; and
- creating/designating a single payment office.

4.1 Management Response and Action Plan

Recommendations	Management Response and Planned Action	Office of Primary Interest (OPI)	Action Completion Date
Recommendation 1 (Essential): **It is recommended that the Assistant Deputy Minister of Service Delivery review and revise (if necessary) the outcomes of the VIP IC and LTC Programs and develop measurable program specific performance indicators.**	Management agrees with this recommendation. The performance measurement strategy and performance indicators in the performance measurement plan have been reviewed. Changes recommended to be made are in the approval process. The changes will ensure the Department's ability to effectively measure VIP IC and LTC program results starting in March 2014.		
	1.1 Review, by Service Delivery Branch, the performance measurement strategy including performance indicators in the performance measurement plan.	DG Service Delivery and Program Management	Completed
	1.2 Revise and approve the performance measurement strategy including performance indicators in the performance measurement plan.	DG Service Delivery and Program Management	February 2014
	1.3 Communicate revisions, internally, as appropriate.	DG Service Delivery and Program Management	March 2014
Recommendation 2 (Critical): **It is recommended that the Assistant Deputy Minister of Service Delivery develop a system to track applications and decisions for the VIP IC and LTC Programs.**	Management agrees with this recommendation. An application form has been developed with a view to implement it by December 2013. Similarly, work to develop standardized national decision letters to support consistent, plain language communication with recipients has been completed. These processes will be integrated within existing systems to allow for tracking and monitoring on VIP IC and LTC Programs' applications and decisions.		
	2.1 Develop a single application form for VIP IC and LTC Programs.	DG Service Delivery and Program Management	Completed
	2.2 Implement the application form for VIP IC and LTC Programs.	DG Service Delivery and Program Management	Completed
	2.3 Develop standardized letters to advise applicants of departmental decisions regarding VAC support for long term care.	DG Service Delivery and Program Management	Completed
	2.4 Implement standardized letters.	DG Service Delivery and Program Management	Completed
	2.5 Monitor quarterly performance reports to determine trends (e.g., number of applications, number of applications processed).	DG Service Delivery and Program Management	April 2014 & ongoing

Recommendations	Management Response and Planned Action	Office of Primary Interest (OPI)	Action Completion Date
Recommendation 3 (Essential): **With regard to community beds, it is recommended that the Assistant Deputy Minister of Service Delivery, in collaboration with the Assistant Deputy Minister of Human Resources and Corporate Services, address the administrative overlap in the VIP IC and LTC Programs by considering the following:** • **merging the management structure for VIP IC and LTC Programs;** • **implementing a single payment system; and** • **creating/designating a single payment office.**	Management agrees with the recommendation. Effective April 2013, the former regional management positions responsible for long term care began reporting to the Director, Long Term Care and Disability Benefits. By April 2014, management will determine what, if any, additional merging of responsibilities under a single management structure might be beneficial. By June 2014, any changes will be communicated to VAC staff and managers. The ability to process/reimburse long term care payments has been identified in the statement of requirements to solicit bids for third party administration of health claims. This will address the single payment system and central payment office issues.		
	3.1 Consider what, if any, merging of management structures for the VIP IC and LTC Programs might be warranted.	DG Service Delivery and Program Management	April 2014
	3.2 Implement and communicate any changes made to Head Office and Field Operations staff.	DG Service Delivery and Program Management	June 2014
	3.3 Processing of all VIP IC and LTC Program payments through new FHCPS System.	DG Service Delivery and Program Management	August 2015
	3.4 Communicate new process to Head Office and Field Operations staff.	DG Service Delivery and Program Management	August 2015

5. DISTRIBUTION

Deputy Minister
Associate Deputy Minister
Assistant Deputy Minister, Policy, Communications and Commemoration
Assistant Deputy Minister, Service Delivery
Assistant Deputy Minister, Human Resources and Corporate Services
Executive Director and Chief Pensions Advocate, Bureau of Pensions Advocates
Director General, Field Operations
Area Directors (12)
Director General, Strategic Coordination & Liaison and Transformation
Director, Access to Information and Privacy
Treasury Board Secretariat Centre of Excellence for Evaluation