



Veterans Affairs  
Canada

Anciens Combattants  
Canada

# **EVALUATION OF THE VETERANS INDEPENDENCE PROGRAM (VIP)**

**FINAL: JULY 2011**



Canada 

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The evaluation team consisted of the following people:  
Orlanda Drebit, Director General, Audit and Evaluation Division  
Kevin Edgecombe, Director, Audit and Evaluation  
Lisle Clarke, Audit & Evaluation Manager  
Stephen Ogden, Evaluation Manager  
Shauna Cheverie, Audit & Evaluation Officer

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## **EXECUTIVE SUMMARY**

### **Introduction**

The Veterans Independence Program (VIP) was introduced in 1981 to respond to an aging demographic Veteran population and to help reduce long-term care (LTC) bed waitlists by providing care to Veterans at home. The national Veterans Affairs Canada (VAC) home care program assists qualified Veterans, still-serving Canadian Forces (CF) disability pensioners, surviving spouses/primary caregivers, and certain civilians to maintain their health, quality of life and independence in their own home for as long as possible. At the point where care in the home is no longer possible, the VIP will assist in providing care in long-term care facilities in the community of the Veteran.

The VIP is not intended to duplicate or replace existing provincial/territorial or community services, but complements these programs to best meet the needs of Veterans. Under the VIP, a recipient may receive funds to help pay for:

- ambulatory health care services (e.g., adult day programs);
- access to nutrition (e.g., Meals on Wheels);
- health and support services (e.g., nurses, occupational therapists);
- personal care (e.g., bathing and dressing);
- housekeeping (e.g., laundry, vacuuming, meal preparation);
- grounds maintenance (e.g., grass cutting, snow removal);
- social transportation (e.g., to activities, shopping, banking)
- home adaptations; and
- nursing home intermediate care.

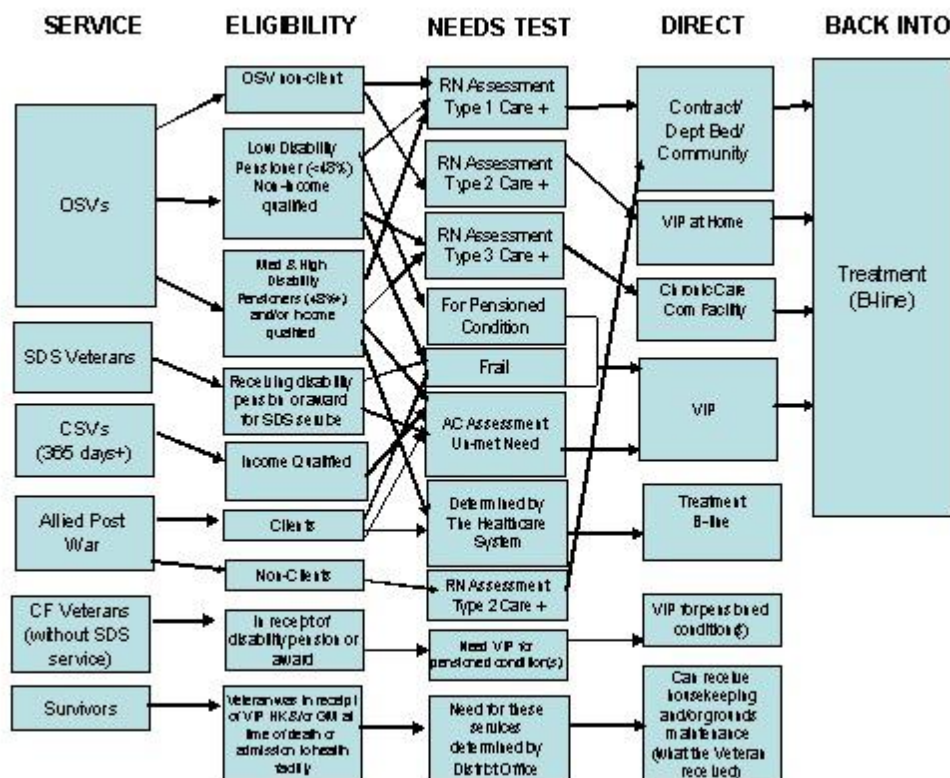
There are two electronic systems used to capture information and to deliver the VIP: (1) Program delivery - the VAC Client Service Delivery Network (CSDN); and (2) Payment processing - the Federal Health Claims Processing System (FHPCS) through a third-party contract with Medavie Blue Cross.

### **Eligibility to the Program**

Since 1981 the program recipient profile has changed dramatically. War Service Veterans have aged and their needs have increased, while the program has also created additional eligibilities for individuals such as spouses/primary caregivers.

The total War Service Veteran (WSV) population is 155,700 of whom 55,600 are VIP recipients. This group has an age-related mortality rate of approximately 2,000 per month. As can be seen in Figure 1 below, there are numerous eligibilities for this recipient group as well as numerous gateways to the VIP. Eligibility to VIP itself also provides access or enhanced eligibility to VAC treatment benefits.

**Figure 1, VIP Eligibilities**



Source: MacLean, MB. VAC Health Services Review: Client and Expenditure Impact of Proposals. Figure 6: Entitlement Based Eligibility for Health Services . May 21, 2008.

There are approximately 314,200 Canadian Regular Force Veterans (CFV) and 279,600 Canadian Forces Reserve Veterans in Canada<sup>1</sup>. Some still-serving CF members may also be eligible for VIP, if they are not entitled to such services under the Department of National Defence (DND) program. As of March 2009, there were an estimated 94,000 still-serving CF personnel living in Canada, bringing the total CF Veteran and non-Veteran population (potential future VIP recipients) to approximately 686,000<sup>2</sup>. Of that population, just under 18,000 are recipients of the VIP.

When a Veteran recipient dies, or is admitted to a LTC facility, the surviving spouse or primary caregiver<sup>3</sup> is often eligible to receive VIP housekeeping and/or grounds maintenance support. There are two types of eligibilities under the VIP for surviving spouses/primary caregivers: (1) primary caregiver eligibility (mainly spouses) which is a

<sup>1</sup> VAC Quarterly Fact Sheet. Table 1. VAC Statistics Directorate. March 2010.

<sup>2</sup> MacLean MB, Van Til L, Thompson JM, Pedlar D, Poirier A, Adams J, Hartigan S, Sudom K. *Life After Service Study: Data Collection Methodology for The Income Study and The Transition to Civilian Life Survey*. Veterans Affairs Canada Research Directorate Technical Report, April 29, 2010: p79.

<sup>3</sup> Under the primary caregiver eligibility, the individual is only entitled to that which the Veteran was receiving and under the survivor expansion eligibility, the spouse is entitled to both elements, however only up to a \$2,540 maximum limit (2010 rate).

continuation of VIP services in place at the time of the Veterans death/admittance to a facility; and (2) survivor expansion for survivors of Veteran spouses who did not have VIP at their time of death/admittance to a facility. The number of VIP primary caregiver recipients has been steadily growing since the eligibility was added in 2005 (approximately 45 percent increase). In 2009-2010, spouses/primary caregivers accounted for 32 percent (34,465) of the VIP recipient population. Forecasted recipient populations for future years show that the spousal/primary caregiver recipients will outnumber War Service Veterans (WSV) in 2015.

## **Program Costing**

The program has expanded significantly since its inception, with approximately 108,000 recipients assisted by the program in 2009-2010. Between 2007-2008 and 2009-2010 the number of VIP recipients has increased by approximately 4,700 and program costs have increased by almost \$35 million to \$338 million, while administration costs have risen by a little over one million dollars for a total of \$32 million. The increase in recipients and administration cost was mostly caused by the expansion of eligibility criteria to include frail pensioners (2003), primary caregivers (2005), surviving spouses (2008) and Allied Veterans (2010). The expansion in eligibility to the program resulted in more recipients entering the program, and therefore increased program, contract and administration costs. Intensity of use of the VIP by WSV also increased during the same time period due to their increased needs and higher levels of risk, adding to the program costs.

## **Methodologies**

A goal of the evaluation was to provide timely and value added information to assist management and serve as a basis for decision-making regarding future program direction and design. The VIP evaluation team used multiple lines of evidence, including: statistical data, a literature review, research studies, survey results, file reviews, internal analysis reports, key informant interviews and peer reviews.

The evaluation team encountered limitations and successes which are outlined in detail in Annex G. Successes included dovetailing the evaluation with a concurrent major departmental transformation initiative, access to a substantial body of recent research and analysis of VIP, home care and the data from the 2010 National Survey of all recipients of VAC programs. Limitations were mainly caused by a lack of performance data and the ongoing changes being made to VIP during the evaluation. The impact of the limitations on the report included finding alternate data collection approaches due to missing and inadequate data, creating significant challenges meeting deadlines and scheduling resources.

## **Concurrent Departmental Work**

The VIP is currently part of a program-wide Transformation agenda, with the goal of improving the quality, timeliness and efficiency of services to VAC recipients. The Transformation is focussing on:

- reducing complexity;
- overhauling service delivery;
- strengthening partnerships;
- delivering on the New Veterans Charter; and
- aligning the organization with demographics.

The VIP evaluation will serve as a solid foundation for transforming and improving design and delivery of the VIP.

## **Program Relevance**

The VIP is aligned with the priorities and objectives of the federal government as well as VAC's, and with the strategic outcomes identified by the Department.

The VIP is very relevant to the needs of elderly Veterans, their surviving spouses/primary caregivers and injured/disabled Veterans and members. File reviews, data analysis and recipient surveys indicate that the majority of WSV would not be able to remain in their own homes without the help of the VIP. However, it appears that there are some CF Veterans/members who are in receipt of VIP services and may not need them (30 percent), while there are other groups of CF Veterans, who appear to need VIP, but are not in receipt (10 percent). A specific CFV home care and support strategy is needed to consistently and appropriately administer services and supports to CF members and Veterans as some may only require short term supports.

Though there are some older CFVs who have needs similar to the WSVs, there is a cohort of younger CFVs who have different home support needs, and are not necessarily at risk of institutionalization. The VIP does not sufficiently meet the needs of these CFV recipients. CFVs in particular, but not exclusively, could benefit from modified and/or additional supports such as child care/family respite and home repair.

Home care elements are meeting the needs of VIP recipients, however some of the smaller elements (social transportation, ambulatory care, and home adaptations) should be reviewed to consider their fit in future programming. The Department should consider expanding the eligibility and/or inclusion of additional support under these elements to better meet the needs of Veterans and their spouses/families (child care/respite, social/mental health). These changes could help address the growing and emerging needs of CFV.

As people age, there is often a decline in functional mobility and an increased risk of social isolation. Social transportation is one support mechanism to help reduce this risk and meet the need for social interaction and transportation, and also to meet the needs of some younger CF who face barriers with reintegrating into civilian life. The 2010 National Client Survey showed that 44 percent of recipients self-reported needing help getting to/from appointments, running errands, shopping, etc. The average expenditure for the social transportation element was \$612 in 2009-2010, with only a small number of users.



Ambulatory health care services can be very appropriate for Veterans wishing to participate in adult day programs and for caregivers who require some assistance with respite care. Field staff interviewed during the VIP evaluation also identified a potential need for respite-like services for younger CF members with families, for example respite in the form of child care/family support. Therefore, there may be a potential unmet need for recipients and their families in terms of what can be included under the element. As well, due to the maximum rate payable, the element may not be sufficient support to allow for consistent participation in adult day programs.

There is a potential risk that elderly Veterans and their spouses are not receiving proper nutrition because of limitations on the access to nutrition element under VIP. As there was insufficient evidence to support this observation, the evaluation was unable to support a recommendation. The Department may wish to further investigate this issue to determine the level of risk and degree of impact.

The evaluation team has determined that there is a degree of VAC programming duplication between the VIP and the Treatment Benefits program as well as between the VIP and the LTC Program. The ability to analyze the potential of dual-VAC program overlap was limited due to the fact that VIP elements do not have sub-benefit codes. Intermediate care, which was initially added to VIP to address a gap in services, is no longer a best fit under the VIP. Intermediate care is more appropriate for the LTC program, as it is care provided in a facility and already has many similarities with the evolved LTC program. The team also found that current documentation is unclear and inadequate to guide staff in delivering VIP health and support services and VIP home adaptations in comparison to similar Programs of Choice (POC 1 and POC 8). Inclusion of supports and services needs to be better defined and communicated to staff to ensure these elements are meeting the full potential of addressing relevant recipient needs.

The VIP is the Department's flag ship program and continues to meet the needs of most eligible recipients. The program however faces a number of challenges: an aging demographic with increased health care needs who will be requiring more assistance, as well as their surviving spouses/primary caregivers; an increasing number of CFV recipients presenting with significantly different needs from the previous majority recipients (at this stage in their lives); a program structure and purpose not set up to meet the different needs of younger CF Veterans, and as recent media events demonstrate, more articulate and dissatisfied recipients.

There is a need for a continuum of care approach as opposed to the health care maintenance approach of the current VIP. Overall, the WSV eligibility criteria are too complex and therefore VIP is not effectively meeting the needs of some Veterans and spouses/primary caregivers. It was suggested by a majority of field staff interviewed, and supported by the Gerontological Advisory Council and Dr. Hollander, that once service is established for older recipients, only needs-based criteria should be applied.

Though the VIP appropriately tops-up and complements other government home care programs and services, there do appear to be some instances where the

authority/responsibility for providing home care is not clear. A closer relationship with provincial home care staff could help VAC better serve dual-recipients.

## **Program Success**

The Department has been actively involved in performance measurement however a perennial problem has been difficulty in obtaining the necessary performance information for reporting on outcomes and to assist program management decision making. As noted in the first annual report on VAC's program performance, "The overall departmental capacity in performance measurement is simply not adequate at present"<sup>4</sup>.

The evaluation team assessed VAC's VIP Performance Measurement Plan and found that the indicators have been clearly defined and are appropriate to support decision-making. However, there are major deficiencies in reporting on performance-related information necessary to properly manage and evaluate the VIP. Although there has been progress and effort in improving VAC's state of performance measurement and reporting, the evaluation team agrees that the lack of performance information related to outcomes still represents a significant challenge for evaluation reporting purposes. The risk/impact of not capturing sufficient performance information is high. Other performance indicators/targets to capture on an ongoing basis to aid in the measurement of outcomes and performance targets suggested by the evaluation team include:

- average recipient duration on VIP/LTC ;
- number of VIP recipients who would require care in a facility if not for VIP;
- trend of VIP recipients requesting VIP and then applying for other VAC programming gateways (e.g. Disability Pensions);
- functional assessment score trends of VIP recipients from home care through the different levels of facility care (continuum of care profile);
- program use and attrition trends for short-term periods/acute use of the VIP;
- track the impact (e.g. health change/maintenance) of providing VIP for those overseas Veterans who qualify for home care while on a waitlist for a long-term care bed; and
- average age of entry to LTC of non-VIP home care users compared to VIP home care users.

## **Immediate Outcome – Eligible Veterans and other recipients have access to home care and support services**

The VIP has overall just under half of the total VAC population accessing program services and supports, with the majority being War Service Veterans and their surviving spouses/primary caregivers. According to the 2010 National Client Survey, 85 percent of recipients indicated they were able to find people to help with their VIP services and

<sup>4</sup>

Drebit, O. *Performance Measurement within Veterans Affairs Canada: The First Annual Report to the Departmental Evaluation Committee on the State of Performance Measurement of Programs in Support of Evaluation within Veterans Affairs Canada (VAC)*. Head of Evaluation, Veterans Affairs Canada. October 2010.

only 5 percent of registered VIP recipients in 2009-2010 did not have a VIP claim transaction. There can be accessibility issues for those living in rural or remote areas; however the self-directed nature of the VIP helps mitigate this issue by allowing neighbours and some family members to provide VIP services and supports. Due to the self-directed nature of the program and a lack of turnaround time data available, there is a limitation in measuring timeliness of access to care. The majority of feedback from the field is that generally there are no wait times for VIP services and supports.

As discussed, there appear to be recipients receiving services which they may not need, but the evaluation team is not able to confirm this due to a lack of ongoing monitoring and file documentation<sup>5</sup>. Based on possible inappropriate long term use of the program it is the opinion of many field staff that the VIP may be creating some dependencies, thus impacting the programs progress towards expected outcomes.

### **Intermediate outcome– Eligible Veterans’ needs for home care and support are met**

The intermediate outcome ties in strongly to the relevance of the program as both relate to meeting the needs of recipients. The satisfaction level for the WSV group is high, with more CFVs disagreeing that VIP meets their needs (Almost 10 percent compared to 4 percent of WSV). Overall, 86 percent of VIP recipients agree that VIP meets their needs. Although VIP provides support for physical ADLs and IADLs<sup>6</sup>, there is a lack of mental and social focus, which are both important components of overall health and well-being, and a relevant aspect for the younger CFVs who are trying to reintegrate into society. Based on the assessment of program relevance to recipient needs, there are unmet needs for home care and support services among the younger CFV population (including VAC recipients and non-VAC recipients) and therefore the program is not achieving the optimum level of performance for this recipient group.

This intermediate care component of VIP does not necessarily fit with this outcome. In fact, intermediate care is mainly measured through the LTC program performance measurement plan. The VIP should focus on in-home outcomes to be consistent with the original program objective.

### **Ultimate outcome– Eligible Veterans and other recipients are able to remain in their own homes and communities**

As this is the ultimate outcome of the program, several other factors also influence this outcome (e.g. provincial support and informal caregiver support), which creates challenges in linking VIP directly to the outcome. However, there is significant evidence that the provision of VIP enables recipients to remain in their own home and communities, for example:

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<sup>5</sup> MacLean MB, Poirier A & Sweet J. *Veterans Independence Program Need - Indicators from the Survey on Transition to Civilian Life*. Life After Service Studies (LASS) Secondary Analysis (2011 Series – Release 1). Research Directorate, Veterans Affairs Canada. February 14, 2011.

<sup>6</sup> Aids to Daily Living (ADLs) include such activities as dressing, bathing, eating and ambulation while Instrumental Aids to Daily Living (IADLs) are other activities such as housework, meal preparation, and assistance with shopping/errands and finances.

- majority of VIP recipients (91 percent) self-reported that VIP enables them to remain at home. ;
- only 4 percent of VIP recipients were admitted to nursing homes in 2009-2010;
- corporate statistics for those receiving their first intermediate care payment between 2007-2008 and 2009-2010 show that the majority of recipients (84 percent) began VIP with home care elements, and had on average a two year delay in institutionalization compared to their counterparts who enter VIP directly through intermediate care;
- average VIP recipient duration in intermediate care since 2000 is just under two years, indicating recipients are staying at home for as long as possible; and
- provision of VIP to overseas Veterans on a wait-list for a facility bed showed positive results as individuals prefer to remain at home, and it is more cost-effective.

The evaluation team found that even though they have the same desired program outcomes, the actual results achieved are different for the spouse/primary caregiver recipient groups as they do not have access to the whole spectrum of VIP benefits and services.

## **Program Efficiency and Effectiveness**

In order to evaluate the efficiency and effectiveness of the program, the evaluation team considered whether the outcomes of the program were being efficiently achieved in relation to the resources utilized and whether the results demonstrated that the program was achieving its objective effectively from a cost and outcome achievement perspective.

### **Efficiency**

Since the program was first implemented it has seen many changes in terms of the eligibility to Veterans and other recipients, the scope, services offered, the delivery of the program and the processing of payments. With many recent and ongoing organizational and program changes, the team determined that there continues to be some perceived confusion of roles and responsibilities, specifically at the Head Office level between program management, operations, and performance measurement and from the regional and district office staff in terms of who to contact with questions.

The program has a centralized policy, procedures and monitoring mechanism in place, however to date there have been issues with consistency in communication and application. The policy/program areas are making great strides to streamline policies, program directives and processes and the communication of information with one voice to all staff. All VIP policies, program directives and processes are expected to be updated and distributed to the field along with communication and training plans by the spring/summer of 2011.

The Transformation work is also conducting several streamlining initiatives. Some initiatives have been implemented as recently as April 2011 (e.g. direct deposit and new

delegated authorities), therefore the evaluation team was not able to assess the impact on the program; however, the team believes they should impact positively on efficiency. Specific findings on areas of the program that could improve on efficiency include:

- VIP is not appropriately supporting short-term access to the program due to lack of program processes for staff to support the delivery of services and a lack of system features to facilitate appropriately tracking contribution periods for fewer than twelve months;
- there appear to be inefficiencies with regard to processing pended VIP claims and there is also a lack of tracking data for these pended claims that would provide additional information regarding potential process inefficiencies;
- there is room for the Department to expand on its communication and information sharing with both the Department of National Defence and the provinces in order to more efficiently and effectively serve dual recipients;
- streamlining eligibilities and access to program elements would provide additional efficiencies and avoid unnecessary applications to gateway programs; and
- re-aligning VIP design as a home care approach versus a mix of home care and facility care would enable the program to focus its attention and demonstrate progress towards outcomes more efficiently and effectively.

## **Effectiveness**

Through VIP the Department is aiding in achieving substantial health care expenditure savings and other societal benefits for Canada as many VIP recipients would not be at home if not for VIP. There is compelling evidence, as documented throughout the report, that VIP contributes to allowing recipients to stay in their home for as long as possible and thereby preventing the cost of substantially more expensive care delivered in a facility setting. When comparing the average cost of VIP per recipient to that of care in the facility, there is clear cost-effectiveness evident. The VIP also provides support to informal caregivers and families, helping avoid caregiver burnout and potential institutionalization.

Since there was an absence of sufficient performance information to fully evaluate the ability of the VIP to achieve its expected outcomes the evaluation team had some limitations associated with measuring cost-effectiveness of delivering the VIP. Overwhelming evidence shows that the resources expended on the VIP are minimal when compared to the value of outcomes achieved:

- Continuing Care Research project findings show the overall average total societal savings of providing care to an individual in the home rather than in facility ranges from \$50,000 to \$80,000 per year;
- in 2009-2010, the average per recipient expenditure of VIP at home was only \$2,716 compared to \$9,483 for intermediate care and \$13,486 for LTC community care;

- average total VIP contribution arrangement in 2009-2010 for those in receipt of personal care at home was \$7,027 (almost \$2,500 under the average intermediate care cost per recipient);
- less than 3 percent of VIP recipients at home in 2009-2010 actually claimed over \$9,000, indicating that VAC is spending well below the point of cost-effective care at home compared to care in a facility;
- high satisfaction level self-reported by recipients that VIP meets their needs (86 percent) and enables them to remain in their homes (91 percent) shows that VIP is effectively meeting needs;
- considering 92 percent of WSV self-report the need for VIP to remain at home, the estimated savings of VIP at home compared to care in an intermediate care facility is approximately \$320 million; and
- data analysis of VIP recipients' first intermediate care transaction shows the majority (84%) were first recipients of VIP home care, and on average entered the facility two years later than those starting VIP directly through intermediate care; this translates into estimate cost savings of approximately \$32 million annually (\$6,283 per recipient).

Since 2007-2008 the efficiency of the program has increased (increase of \$1 million in salary and operation/management costs is more than offset by a 5,000 increase in recipients and a recognized increase in age related needs and program consumption), allowing the program to be more effective in its delivery. In order to minimize the use of resources in achieving results, the Department has made several changes such as: transferred delegation of authorities downward; adjusted program delivery; outsourced contracted assessments and payment processing; limited access to program to very restrictive Veteran categories. Although VIP efficiency has improved over the years, there is room for increased efficiency in program delivery and in better meeting program outcomes that would therefore improve cost-effectiveness:

- new recipients that are younger and potentially not in need of VIP for their entire life appear to continue to receive VIP. Cost savings could be realized by promoting more independence and monitoring health improvements more diligently;
- data and system limitations restricted the evaluation team's ability to comment on overall cost-effectiveness of the VIP and to quantify the extent to which the program is exceeding the outcomes;
- Department does not track administration costs by program area;
- Continuing Care Research project findings indicate potential to obtain systems level efficiencies by substituting lower cost home care or supportive housing services for long-term care facility services (when appropriate); and
- forecasting for new program expansions has been a challenge given the limited history from which to base the forecast; in some program areas, this has resulted in an over-estimation of the planned expenditures (e.g. Survivor Expansion

estimates) as actual recipient numbers and associated program spending have been much lower than estimated<sup>7 8</sup>.

There does not appear to be an alternative design and delivery approach that would be more efficient and still provide value for money; however, within the existing program design and delivery approach, efficiency gains could be realized.

In conclusion, the VIP is a relevant, successful, efficient and effective program, although there were issues and possible improvements identified by the evaluation team within each of the evaluated areas. The evaluation was a strategic analysis of the VIP as a whole, with a view to providing a solid foundation for ongoing and future transformation of the program, especially with regard to responding to the changing demographic realities.

### **Recommendations:**

- R1 It is recommended that the ADM, Service Delivery provide field staff with clear direction for delivering VIP services and supports to recipients who may not require assistance for a long term period. The goal of the strategy should be to: (1) ensure that VIP is delivered to only those in need, (2) provide direction on monitoring for continued need, and (3) encouraging independence in day-to-day activities. (Essential)**
- R2 To ensure the differing objectives and outcomes of the VIP and the Treatment Benefits Program are met, it is recommended that the ADM, Policy, Communications and Commemoration: (Important)**
- 2.1 Review element coverage under VIP Home Adaptations for the possibility of including low-dollar home modifications such as grab bars and differentiate the purpose and definition from POC 1 Aids To Daily Living.**
- 2.2 Clearly define and communicate the definition and element coverage of VIP Health and Support Services and VIP Home Adaptations to staff.**
- R3 As part of a re-designed health program it is recommended that the ADM, Policy, Communications and Commemoration, analyze: (Essential)**
- 3.1 the feasibility of modifying current supports and/or adding new supports (for example respite/child care and minor home repair) to meet the needs of younger Canadian Forces Veterans.**
- 3.2 the feasibility of broadening current eligibilities and element coverage for smaller VIP elements (social transportation and ambulatory care) to enable improved relevance to all Veterans.**

<sup>7</sup>

It should be noted that these forecasts do not speak to the capabilities and expertise of internal VAC forecasting as the estimates were provided by the Department of Finance.

<sup>8</sup>

MacLean MB. *VAC Health Services Review Client and Expenditure Impact of Proposals*. Appendix E: Independent Review of the Cost Estimates. Veterans' Health Services Review. May 21, 2008.

- 3.3 whether or not the VIP intermediate care element should continue to be part of the VIP or form part of a new program for LTC.
  - 3.4 the viability of streamlining eligibilities for the War Service Veterans to allow for a needs-based approach of delivering the VIP or a renewed health program.
- R4 It is recommended that the ADM, Service Delivery: (Essential)**
- 4.1 Encourage a regular forum for VAC and provincial home care staff to jointly discuss issues, best practices, and build a relationship to help better co-serve Veterans.
  - 4.2 Ensure clear understanding by provincial health authorities of VIP eligibilities, improve collaboration and identify opportunities for partnership.
  - 4.3 Create a brochure/fact sheet to be shared with provincial and community providers illustrating program coverage and eligibilities to Veterans and other individuals.
- R5 It is recommended that the ADM, Service Delivery: (Critical)**
- 5.1 Make adjustments in processes, systems and capacity (HR and data capture) so that the necessary information is available to manage and evaluate the VIP on an ongoing basis;
  - 5.2 Implement a tracking process in the FHCPS system to report on pends generated and their results;
  - 5.3 Institute ongoing measurement of utilization of resources for the VIP; and
  - 5.4 Put in place a system edit and/or an internal quality control check to improve the data integrity of the Canadian Forces Still-Serving eligibility field.

## **SIGNIFICANCE OF RECOMMENDATIONS:**

To assist management in determining the impact of the observations, the following definitions are used to classify recommendations presented in this report.

- Critical:** Relates to one or more significant weaknesses/gaps. These weaknesses/gaps could impact on the achievement of goals at the departmental level.
- Essential:** Relates to one or more significant weaknesses/gaps. These weaknesses/gaps could impact on the achievement of goals at the branch/program level.
- Important:** Relates to one or more significant weaknesses/gaps. These weaknesses/gaps could impact on the achievement of goals at the sub-program level.



## 1.0 INTRODUCTION

### Program Profile

The Veterans Independence Program (VIP) was introduced in 1981 to respond to an aging demographic group and to help reduce long-term care (LTC) bed waitlists by providing care to Veterans at home. The national Veterans Affairs Canada (VAC) home care program assists qualified Veterans, still-serving Canadian Forces (CF) disability pensioners and certain civilians to maintain their health, quality of life and independence in their own home for as long as possible. At the point where care in the home is no longer possible, the VIP will assist in providing care in long-term care facilities in the community of the Veteran.

The program objectives of the VIP are to<sup>9</sup>:

- offer supportive service and intervene only to the extent that health needs cannot be met through personal and family support, or through provincial and community programs;
- recognize the right and responsibility of the individual to remain at home for as long as it is reasonable, safe and practical to receive VIP services;
- promote personal independence as well as personal and family responsibility in planning and providing care appropriate to the Veteran's health needs;
- encourage an independent lifestyle to whatever degree possible; and
- meet the health needs of Veterans in a cost-effective manner.

Under the VIP, a Veteran may receive funds to help pay for:

- ambulatory health care services (e.g., adult day programs);
- access to nutrition (e.g., Meals on Wheels);
- health and support services (e.g., nurses, occupational therapists);
- personal care (e.g., bathing and dressing);
- housekeeping (e.g., laundry, vacuuming, meal preparation);
- grounds maintenance (e.g., grass cutting, snow removal);
- social transportation (e.g., to activities, shopping, banking)
- home adaptations; and
- nursing home intermediate care.

The VIP is one of the Department's largest and most widely accessed programs. The top three most used program elements by both the war service and CF Veterans are housekeeping, grounds maintenance and access to nutrition. There has also been an increasing use of Nursing Home Intermediate Care (NHIC) in the last number of years, from 2,996 in 2000 compared to 6,276 in 2009, as a significant portion of the VIP population ages. VIP is not intended to duplicate or replace existing provincial/territorial

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<sup>9</sup>

Annex K-3: Terms and Conditions for the Veterans Independence Program. 2009.

or community services, but complements these programs as a payer of last resort to best meet the needs of Veterans to ensure a cost-efficient choice of service is available and avoidance of any duplication of service delivery.

There are two electronic systems used to capture information and to deliver the VIP:

- Program delivery - the VAC Client Service Delivery Network (CSDN) and Payment processing - the Federal Health Claims Processing System (FHPCS) through a Third-party contract with Medavie Blue Cross.

## **Eligibilities**

Since 1981 the program recipient profile has changed dramatically. Traditional Veterans have aged and their needs have increased, while the program has also created additional eligibilities, such as spousal continuations. Annex D, shows the total number of recipients by service type from fiscal years 2007-2008 through 2009-2010.

### War Service Veterans (WSV)

The overall war service population is 155,700, with an age-related mortality rate of approximately 2,000 per month. Just over 35 percent of the estimated total WSV population are VAC recipients, of which 81 percent (55,600) are VIP recipients. There are numerous eligibilities for this recipient group as well as numerous gateways to the VIP, for example income qualified and disability pensions. Eligibility to VIP itself also provides access or enhanced eligibility to VAC treatment benefits.

### Canadian Forces Veterans (CFV) and Members

As of March 2010, VAC estimates there are approximately 314,200 Canadian Regular Force Veterans and 279,600 Canadian Forces Reserve Veterans in Canada (total of 593,700)<sup>10</sup>. Of that population, just under 63,000 are recipients of one or more VAC programs and supports<sup>11</sup> and just under 18,000 (3 percent of total CFV population) are recipients of the VIP. The *Life After Service Study* (LASS) conducted in 2010, estimates that as of March 2009 there were an estimated 94,000 still-serving CF personnel living in Canada, bringing the total CF Veteran and non-Veteran population (potential future VIP recipients) to an approximate 686,000<sup>12</sup>.

Canadian Forces recipients are only entitled to receive VIP to address pension-related needs, unless they are deemed frail, and would therefore have access to all VIP elements for unrelated pensioned needs. Some still-serving CF members may also be eligible for VIP, if they are not entitled to such services under the Department of National Defence (DND) program. It is important to note that there is a wide range of ages and needs included under the CF group; there are some older CFVs who have similar health maintenance needs as the aging WSVs, but there are also younger CFVs who are trying to reintegrate into civilian life and are not necessarily at risk of institutionalization. Approximately 44 percent of all CFV VIP recipients are under 65 years old.

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<sup>10</sup> VAC Quarterly Fact Sheet. Statistics Directorate. March 2010.

<sup>11</sup> Ibid.

<sup>12</sup> Ibid footnote 2.

### Spouses/Primary Caregivers

When a Veteran recipient dies, or is admitted to a LTC facility, the surviving spouse (or primary caregiver) is often eligible to receive VIP housekeeping and grounds maintenance support<sup>13</sup>. There are several complex criteria which determine the extent of access to these VIP elements for surviving spouses. The number of VIP primary caregiver recipients has been steadily growing since the eligibility was added in 2005 (approximately 45 percent increase). However the participation rate for the surviving spousal expansion is dramatically lower than forecast, possibly due to lack of awareness and/or complicated eligibility criteria. In 2009-2010, spouses/primary caregivers accounted for 32 percent (34,465) of the VIP recipient population. Forecasted recipient populations for future years show that these groups will outnumber the WSVs in 2015.

To summarize, there are very complex eligibility criteria to meet very straightforward and predictable needs

### **Program Costing**

The program has expanded significantly since its inception, with approximately 108,000 recipients assisted by the program in 2009-2010. Between 2007-2008 and 2009-2010 the number of VIP recipients has increased by approximately 4,700 and program costs have increased by almost \$35 million to \$338 million, while administration costs have risen by a little over one million dollars for a total of \$32 million. The increase in recipients and administration cost was mostly caused by the expansion of eligibility criteria to include frail pensioners (2003), primary caregivers (2005), surviving spouses (2008) and Allied Veterans (2010). The expansion in eligibility to the program resulted in more recipients entering the program, and therefore increased program, contract and administration costs. Intensity of use of the VIP by War Service Veterans also increased during the same time period due to their increased needs and higher levels of risk, adding to the program costs.

### **Stakeholder Opinions**

VIP is considered a best practice by academics and researchers<sup>14</sup> in the health care and home care domains and has been emulated in many other jurisdictions. VIP is very well-regarded both by individual Veterans and by Veterans Organizations, as evidenced by correspondence from Veterans and their families and by resolutions and agenda items at Veterans Organization conventions.

### **Past Departmental Work**

There have been several, relatively recent research studies both internal and external about the impacts of VIP. In addition, several reports are available internally that have analyses and information about the success of the VIP. All of these documents provide information and analysis about certain aspects of VIP and progress towards expected

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<sup>13</sup> Ibid footnote 3.

<sup>14</sup> For example Dr. Marcus Hollander, Dr. David Pedlar, the Gerontological Advisory Council, Australia DVA, etc.

outcomes. Section 8.0, References, provides a comprehensive list of documents reviewed.

## **Concurrent Departmental Work**

The VIP is currently part of a program-wide transformation agenda, with the goal of improving the quality, timeliness and efficiency of services to VAC recipients. The transformation will focus on:

- reducing complexity;
- overhauling service delivery;
- strengthening partnerships;
- delivering on the New Veterans Charter; and
- aligning the organization with demographics.

Currently the Department is focussing on maintaining and/or improving services for existing war Veteran recipients and other existing recipients (CF and spouses/primary caregivers) while addressing issues of relevance, program design and service delivery approach for new CF recipients and their families.<sup>15</sup> The evaluation team and the VIP transformation team representatives communicated frequently throughout the evaluation to share research, findings and potential action plans for the program.

The consolidated body of knowledge gained as a result of the evaluation will assist as the transformation team moves forward in streamlining and researching new options to develop and evolve the VIP in-line with recipient demographics. It is anticipated that the evaluation will serve as a solid foundation for transforming and improving design and delivery of the VIP.

The VIP has been used by other jurisdictions as a benchmark and influential component of implementing services and supports for aging populations and Veterans. The Aging Veterans Program, the predecessor to the VIP, was a pioneer in national home care programs. Annex E, provides a brief overview of home care trends at the national and international level.

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<sup>15</sup> VIP Re-Engineering project initiation document. August 23, 2010.

## **2.0 SCOPE**

The evaluation of the VIP is required prior to the renewal of the Terms and Conditions for the program by November 2011.

The VIP evaluation did not specifically cover the following topic areas: case management; an assessment of informal caregivers to Veterans at home; the transition process for releasing CF members from DND to VAC; Allied Veterans receiving VIP (there is little data on usage and needs as this is a new recipient group as of January 2010); hospitalization rates/frequency of VIP recipients (acute care); and linkage between the New Veterans Charter and VIP, for those recipients under both programs.

The VIP includes institutional care (intermediate care element). The evaluation team assessed the relevance and success of the VIP for those recipients in an intermediate care facility bed. However, the scope of the evaluation does not include an analysis of the entire long-term care program. Long-term care is a separate program and will be the subject of another distinct evaluation.

### **Evaluation Objectives**

This evaluation examined the five core objectives set by Treasury Board in the 2009 Evaluation Directive:

- to assess the extent to which the VIP continues to address a demonstrable need and responds to the needs of Veterans;
- to assess the linkages between the objectives of the VIP and (i) federal government priorities and (ii) departmental strategic outcomes;
- to assess VAC roles and responsibilities in delivering the VIP;
- to assess progress toward expected outcomes of the VIP (including immediate, intermediate and ultimate outcomes) with reference to performance targets and program reach, program design, including the linkage and contribution of outputs to outcomes; and
- to assess VIP resource utilization in relation to the production of outputs and progress toward expected outcomes.

### 3.0 METHODOLOGIES

A goal of the evaluation was to provide timely and value added information to assist management and serve as a basis for decision-making regarding future program direction and design. The VIP Evaluation used multiple lines of evidence, including:

- statistical data collection and analysis (internal and external);
- external and internal literature review, including studies by subject matter experts and organizations (e.g., Dr. Marcus Hollander, Gerontological Advisory Council (GAC), Canadian Home Care Association, etc.) as well as home care reports from Canada, Australia, and the United States;
- departmental literature review (research studies, survey results, file reviews, internal analysis and other documents);
- statistically valid representative recipient file review of approximately 136 Veteran files (90 percent confidence level and an assumed 7 percent margin of error<sup>16</sup>);
- key informant interviews (82) with field (Charlottetown, Montreal, Ottawa and Winnipeg) and Head Office staff. A list of interviews is attached in Annex F; and
- peer reviews.

The evaluation team encountered limitations and successes, both are outlined in Annex G, Evaluation Successes and Limitations. The impacts of the limitations on the report are as follows:

- (1) The evaluation team had to find alternate methodologies to capture certain statistical data originally planned.
- (2) Delay in data receipt created a major challenge with project plan and report delivery.
- (3) Opportunity cost of spending more time than planned to provide analysis of missing or inadequate data areas.

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<sup>16</sup>

Also replicates Program Performance Unit file review sample methodology for non-intermediate care VIP recipients conducted during the same time period of the evaluation.

## 4.0 PROGRAM RELEVANCE

### 4.1 Role of VAC and Government of Canada in serving Veterans

#### **Alignment to Federal Government Priorities**

The Government of Canada's Speech from the Throne identifies the federal government's priorities for the upcoming year. While the federal government priorities are reviewed each year, several common themes such as improving the health of Canadians, keeping Canadians safe, supporting Canadian families, and making government more effective and efficient have been included in the speeches over the years. In 2010, the Speech included the area of '*Standing up for those that helped build Canada*'; this particular priority speaks specifically to supporting Veterans and recognizing their sacrifices<sup>17</sup>.

The VIP is aligned with these federal government priorities by:

- (1) Contributing to improvement of the health of Canadians through providing Veterans access to home care services and support such as personal care, nursing services, access to nutrition, and ambulatory care that aim to help Veterans remain healthy and independent in their own homes and communities.
- (2) Helping to keep Canadians safe by providing Veterans access to services and supports such as home adaptations, housekeeping, grounds maintenance and social transportation to aid Veterans in everyday household tasks that they may no longer be able to complete safely on their own.
- (3) Supporting Canadian families of Veterans through its support of caregivers.
  - a. The suite of programs aid families and caregivers of Veterans by offering assistance determined by the Veterans eligibility and needs.
  - b. Housekeeping and/or grounds maintenance services aid eligible primary caregivers and spouses of Veterans who have entered a long-term care facility, or have passed away, to remain healthy and independent in their own homes.

The Prime Minister of Canada has identified five priorities for his government, one of which is "Delivering the health care Canadians need, when they need it, by addressing the fiscal imbalance and establishing a patient wait-times guarantee with the provinces"<sup>18</sup>. VIP helps address this priority by providing services to Veterans on provincial waitlists (e.g., personal care) and by offering services that help them remain in their homes until facility beds become available (e.g., Overseas Veterans [OSV] waitlist initiative).

#### **Alignment to VAC's Strategic Outcomes**

A statement reflecting VAC's *raison d'être* is that '*Veterans Affairs exists to repay the nation's debt of gratitude toward those whose legacy is the peace and security we enjoy as Canadians*'<sup>19</sup>. The intent of the program is to help recipients remain healthy and

<sup>17</sup> Speech from the Throne 2010. 3 March 2010. Ottawa, Ontario. <http://www.speech.gc.ca/eng/media.asp?id=1388>

<sup>18</sup> Prime Minister of Canada website. Five Priorities. <http://pm.gc.ca/eng/feature.asp?pagelid=40>

<sup>19</sup> Veterans Affairs 2009-2010 Departmental Performance Report.

independent in their own homes or communities. Thus, the VIP directly supports the Department's 2009-2010 strategic outcome that *'Eligible Veterans and other recipients achieve their optimum level of well-being through programs and services which support their care, treatment, independence and re-establishment'*.

### **Alignment to VAC's mandate**

The purpose of the VIP, as stated in the Terms and Conditions is *'to provide support to help recipients remain healthy and independent in their homes and communities'*.

VAC has a two-fold approach to the Department's 'raison d'être', as indicated above: 1) through recipient benefits and services that respond to recipient needs; and (2) through remembrance activities to foster the memory of Canada's Veterans.

Research studies and reports<sup>20</sup> agree that the VIP is exercising the Department's mandate by fulfilling its purpose of delivering benefits and services to Veterans and families of Veterans at home and in their community to help them remain healthy and independent. VAC has been recognizing and supporting Veterans for their efforts and sacrifices since 1919 when the Board of Pension Commissioners for Canada was established and began providing disability pensions to injured soldiers.

### **Conclusion**

The VIP is aligned with the priorities and objectives of the federal government as well as the Department, and with the strategic outcomes identified by VAC.

## **4.2 Program Relevance to Recipient Needs**

In order to determine relevance of the program to recipients need, there is a requirement to assess the recipient population's needs. There are numerous eligibility types within the VIP (see Annex H); however, VIP recipients can be summed up into three categories: War Service Veterans (WSV), Canadian Forces members/Veterans (CFV), and spouses/primary caregivers.

### **General Canadian Population Home Care Trends**

The 2006 Statistics Canada health report, *Chronic Pain in Canadian Seniors*, states that 27 percent of seniors living in private households reported chronic pain, in comparison to 16 percent of those between 18 and 64 years old. In fact, over half of seniors living at home reported two or more chronic conditions<sup>21</sup>, with a significant proportion of this population also reporting chronic pain (36 percent). Such chronic conditions are often linked to loss of independence, as people habitually become more dependent on assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)<sup>22</sup> as they age and become ill.<sup>23</sup> The ability or inability to conduct ADLs is a common measurement used to assess an individual's ability to function

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<sup>20</sup> VAC Strategic Review, Health Care Services Review and others.

<sup>21</sup> In *Keeping the Promise* (2008 Gerontological Advisory Council), the report outlines that less than 40 percent of people 85 years and older reported no disabilities, compared to 80 percent of people between the ages of 65 and 70.

<sup>22</sup> Ibid footnote 6.

<sup>23</sup> Gerontological Advisory Council to Veterans Affairs Canada. *Keeping the Promise: The Future of Health Benefits for Canada's War Veterans*. April 2006.



independently. The inability to conduct IADLs, though not as fundamental to remaining at home, can limit a person's independence and interactions in their community.

According to a 2006 Statistics Canada report<sup>24</sup>, approximately 6 percent of senior men and 7 percent of senior women needed help with ADLs, and 15 percent of men and 29 percent of women needed help with IADLs. Results from the 2010 National Client Survey for the Department indicate that there is a significant number of WSV VAC recipients who need help with various ADLs and IADLs, as can be seen in Table 1, VIP Recipients Identified Needs.

### **Differing life stages of VIP Recipients**

The average age of War Service Veterans (WSV) is 87 years old<sup>25</sup>. The WSV are at the stage in their lives where they are typically living on their own or with their spouse/adult children, realizing declining functional ability and deteriorating overall health status.<sup>26</sup>

The needs of Canadian Forces Veterans (CFV) are quite different from those of the traditional War Service Veterans (WSV). As well as a significant cohort of aging CFV, there are also a younger group who, unlike the older Veterans, often have dependent children and spouses who work outside the home. The CFV is typically younger (average age 57<sup>27</sup>) trying to reintegrate into society after serving in the Canadian Forces and hoping to continue with a previous line of work, start a new career and/or improve education/skills training.

#### **4.2.1 Meeting Recipient Needs**

Responses from the 2010 National Client Survey show that 80 percent of VIP recipients feel their health limits them to some extent in their day-to-day activities<sup>28</sup>. More specifically, the following table breaks out responses by VIP recipient type in regards to the type of limitations they experience because of their condition:

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<sup>24</sup> Gilmour, H and Park, J. *Dependency, chronic conditions and pain in seniors*. Supplement to Health Reports, Volume 16. Statistics Canada. Catalogue 82-003. Ottawa. February 2006.

<sup>25</sup> VAC Quarterly Fact Sheet. Table 2. VAC Statistics Directorate. March 2010.

<sup>26</sup> VAC Program Performance Unit file review. 2010.

<sup>27</sup> VAC Quarterly Fact Sheet. Table 2. VAC Statistics Directorate. March 2010.

<sup>28</sup> VAC National Client Survey. Table 2.5a. 2010.

**Table 1: VIP Recipients Identified Needs**

	Overall VIP (weighted <sup>29</sup> percent)	By VIP recipient type (percent)		
	VIP	CFV	WSV	Spouse/ Primary Caregiver
Preparing meals	32	35	44	20
Getting to appointments, running errands, shopping, etc.	44	40	47	46
Doing every day housework	65	75	64	63
Personal care such as washing, dressing, eating or taking medication	14	17	18	10
Moving about inside the house	10	9	14	10
With finances e.g. paying bills	23	17	28	24

Source: 2010 NCS, Table 2.11 "Because of any physical condition or mental condition or health problem, I need the help of another person with the following"

Survey results indicate that there is a significant portion of the population with needs associated with transportation (44 percent). Also, the CFV report greater need for everyday housework assistance than the WSV (75 percent compared to 64 percent). An explanation for this may be that the CFV are in general greater users of grounds maintenance than the WSV (74 percent of CFV are users compared to 51 percent of WSV). This could be for different reasons: CFV have greater link to recent injuries/disabilities for grounds maintenance and WSV are living in apartments/condos and facilities. It should be noted that although these self-identified needs are from regular/reserve force pensioners in receipt of VIP, the need may not necessarily be related to the individual's service, which is a requirement of the VIP. There is potential bias for over-reporting or adjusting identified needs reported by the CFV to retain the supports in place. As would be expected by their average age, WSV indicated greater needs with regard to mobility, preparing meals, and with finances.

Health Canada and the World Health Organization use a life course model regarding the pathways to aging. The model highlights 11 indicators of health, including: income and social status, social support networks, education and literacy, employment and working conditions, social environments, physical environments, personal health practices and coping skills, genetic endowment, health services, gender and culture. The VIP uses many categories of need such as these as well as those noted above in Table 1. Once service eligibility is determined, a VAC representative conducts an assessment of recipient needs based on these indicators.

The Gerontological Advisory Council also discusses impact of income on health; those with higher incomes through life are likely to have better health than those with lower income status. The VIP also uses income as an indicator of need with low income one of the qualifying criteria for VIP. War Veterans Allowance (WVA) is designed to

<sup>29</sup> The 2010 NCS used a weighted average technique to provide statistically accurate data responses by overall recipient groups and benefits/assistance programs. Results were weighted based on the distribution of recipients within the recipient groups and within the benefits/assistance programs, e.g. VIP. In total, 913 survey respondents were VIP recipients (189 CFV, 320 WSV, and 404 Survivors).

supplement the income of qualified Veterans. As of March 2010, VAC had over 5,000 WVA recipients (majority of WVA recipients to date are survivors)<sup>30</sup>. Lack of income (as well as other factors), is directly linked to challenges in maintaining independence for the elderly.

Generally, the WSV tend to be the most likely to indicate that VIP is meeting their needs. The 2010 National Client Survey (NCS) results show that the WSV most strongly agree that their needs are met through the VIP, followed by spouses/ primary caregivers, and finally CFV. Interviews with field staff for the evaluation corroborate these findings, with the field staff rating, on average, WSV needs being met as 4.5/5, spouse/primary caregiver needs being met at 4/5 and CFV needs being met at 3/5.<sup>31</sup>

**Table 2: 2010 National Client Survey Results, “Overall, VIP meets my needs”**

	<b>By VIP Recipient Eligibility Group (percent)</b>			
	<b>CFV</b>	<b>WSV</b>	<b>Spouse/ Primary caregivers</b>	<b>VIP OVERALL (weighted percent)</b>
<b>Strongly Agree</b>	25	24	25	<b>25</b>
<b>Agree</b>	57	63	60	<b>61</b>
<b>Neither agree nor disagree</b>	6	3	4	<b>4</b>
<b>Disagree</b>	9	4	6	<b>5</b>
<b>Strongly disagree</b>	1	1	0	<b>1</b>
<b>No response</b>	3	4	5	<b>4</b>

Results from the Survey show little difference among the recipient groups in terms of ‘strongly agreeing’; however, there is a difference between those that agree, and those that disagree among the recipient groups. Almost 10 percent of CFVs disagree that VIP is meeting their needs, compared to only 4 percent of WSV and 6 percent of surviving spouses/primary caregivers.

Overall, 86 percent of VIP recipients strongly agree/agree that in general VAC programs and services that they have received meet their basic needs (89 percent of VIP WSV respondents and 82 percent of VIP CFV respondents). Also, 91 percent of VIP WSV recipients surveyed indicated they were satisfied/very satisfied with VAC programs and services offered, while only 73 percent of VIP CFV recipients felt the same way. These results show higher satisfaction levels for the VIP CFV (82 percent) compared to the overall CFV VAC population (69 percent) that their needs are met through VAC

<sup>30</sup> VAC Quarterly Fact Sheet. Table 11. VAC Statistics Directorate. March 2010.

<sup>31</sup> Evaluation team used a scaling methodology for some evaluation questions.

programs. More research would be required to determine the cause for the satisfaction discrepancies<sup>32</sup>.

The VIP statistics from the 2010 National Client Survey do not inform whether those deemed ineligible for VIP due to service eligibility criteria feel their home care needs are met. The survey does not speak specifically to unmet needs of non-recipients, or to those in receipt of VIP who may not be in need of services and supports. Little is known about the health status of those Veterans who are not recipients of VAC benefits or services.

### **War Service Veterans (WSV)**

In 2006, the Gerontological Advisory Council (GAC)<sup>33</sup> provided VAC with a report centered on the WSV demographic, focussing on how the Department could better target the aging Veterans' needs. The report highlighted that as people age they become more vulnerable to life events that can lead to frailty, and loss of health or independence. An external study by Bergman et al. conducted for the Canadian Initiative on Frailty and Aging, quoted in the 2006 GAC report, found that about 10 to 20 percent of older people are frail. Both international and national studies examined for the GAC study determined a trend that Veterans generally have poorer health than those who did not serve in the military.<sup>34</sup>

The goal of VIP for this aging group is to help maintain their health and independence at home, and thereby mitigate their chances of falls and/or injuries that could lead to hospitalizations or admittance to a long-term care facility. Various recipient surveys, file reviews and recipient assessments conducted have shown that the WSV tend to be happier, and less likely than their younger counterparts to report a need for assistance.

For most of the WSV, as well as the majority of their surviving spouse/ primary caregiver (average age of 83 years old)<sup>35</sup>, it is the general consensus of VAC staff and stakeholders, that VIP benefits and services are very relevant to their needs. In fact, 92 percent of WSV and 90 percent of spouses/primary caregivers indicate they rely on VIP to remain at home<sup>36</sup>. A supporting Departmental file review conducted on VIP recipients produced more striking results, with 98 percent indicating that they require the VIP service(s) they receive due to a health need and to assist in remaining independent in their home and community. From interviews with field and Head Office staff, and through a literature review, it appears that for most of the WSV population, and their surviving spouses/primary caregivers, needs are being met by the program – if they are eligible for services. Complex eligibility of the VIP will be further elaborated under section 5.5 of the report, Relevance of Program Eligibility Criteria.

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<sup>32</sup> The Program Performance Unit (responsible for the survey contract) does plan to conduct secondary analysis, however due to high priority duties, this has not occurred yet.

<sup>33</sup> The Gerontological Advisory Council was formed by VAC in 1997 to advise the Department on policies, programs, services and trends impacting Canada's aging veteran population. Fourteen of Canada's most distinguished experts on aging, seniors' and Veterans' issues sit on the council. Many of the Council's recommendations to-date have been implemented. ([www.veterans.gc.ca](http://www.veterans.gc.ca))

<sup>34</sup> Multiple studies listed in the *Keeping the Promise* report.

<sup>35</sup> VAC Quarterly Fact Sheet. Table 2. VAC Statistics Directorate. March 2010.

<sup>36</sup> VAC National Client Survey. Table 4.1a. 2010.



## **Canadian Forces Veterans (CFV)/Canadian Forces Still-Serving**

Many CFV have suffered injuries during service sometimes resulting in chronic conditions and/or disabilities. Recent research indicates that there is a profound need for VAC programming to address the needs of seriously injured CF Veterans and their families.<sup>37</sup> Prior to this research, there was little information available regarding Veterans and personnel who are not recipients of VAC programs.

Through the work done in the *2010 Survey on Transition to Civilian Life (STCL)*,<sup>38</sup> VAC was able to capture some data on CF members released during the period covered by the survey, including health and life status and potential needs. For example, of those non-VAC recipients indicating chronic conditions, between 58 percent to 83 percent indicated they felt this condition was attributable to their military service.<sup>39</sup> If these conditions are in fact service related, this indicates potential unmet needs and raises questions as to why these individuals are not VAC recipients. The LASS study notes that it is not certain whether the VAC participation rate represents all who could be eligible, or whether the VAC programs (not specific to VIP), are not reaching the full target population.

Individual respondents of the STCL averaged forty-six years old and approximately three quarters were married or common-law. The survey reviewed indicators of health, disability and determinants of health, including questions about activity limitations and need for help with activities of daily living, which are indicators of VIP-like needs. Though the survey results cannot be generalized to all Veterans as the sample frame included Regular Force Veterans released between 1998 and 2007, the results are a strong indicator of feedback, use of and need for the VIP for recipients, and non-recipients.

Following the analysis of the survey data, the VAC Research Directorate conducted various secondary analyses, including a further investigation on use of the VIP.<sup>40</sup> The specific secondary analysis questions targeted were:

- (1) How many VIP Veteran recipients appear not to have a need for VIP? and
- (2) Is VIP reaching Veterans in need?

Of the sample of respondents, 11 percent were VIP recipients as of March 2009, with the remaining being non-VIP VAC recipients (22 percent) and non-VAC recipients (66 percent).

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<sup>37</sup> Fast J, Yacyshyn A, and Keating N. *Wounded Veterans, Wounded Families*. Hidden Costs/Invisible Contributions. Department of Human Ecology, University of Alberta. February 2008.

<sup>38</sup> The STCL was one component of the LASS program of research conducting in conjunction by VAC, DND/CF, and Statistics Canada. The study population consisted of 32,015 Veterans. In addition to the transition survey, LASS also includes an income study. The LASS Survey on Transition to Civilian Life respondents were CF Regular Forces Veterans released from service between January 1, 1998 and December 31, 2007.

<sup>39</sup> The self-reported attribution to military service of chronic health conditions in table 14 of the STCL report (except for high blood pressure which was 24 percent).

<sup>40</sup> MB MacLean, A Poirier & J Sweet. *Veterans Independence Program Need - Indicators from the Survey on Transition to Civilian Life LASS Secondary Analysis: 2011 Series – Release 1*. February 14, 2011.

**Table 3: Survey of Transition to Civilian Life Results**

	VIP Recipients	VAC Recipients (Non-VIP)	Non-VAC Recipients	Total
<b>Sample Size</b>	622	1,173	1,359	3,154
<b>Weighted percent of population</b>	11	22	66	100
<b>Participation and activity limitation</b> (95 percent confidence level)	98	90	38	56
<b>Needs help with tasks</b> (95 percent confidence level)	70	26	5	17
<b>Needs help but not a VIP recipient</b> (95 percent confidence level)	-	-	-	10

Source: LASS Secondary Analysis: 2011 Series – Release 1

Findings of the secondary analysis suggest potential unmet needs and VIP program reach issues, as well as receipt of benefits with no apparent need for VIP.<sup>41</sup> The majority of VIP recipients reported activity limitations; however, only 70 percent reported needing help with tasks. Most of the non-VIP VAC recipients also reported activity limitations and approximately one quarter reported needing help with tasks. Fewer non-VAC recipients reported activity limitations and only 5 percent reported needing assistance. Together these figures show that 10 percent of the population may have a need for VIP but are not in receipt of the program and that 3 percent of the total sample population (and 30 percent of the VIP recipients of the sample population) may not need the VIP support they are receiving<sup>42</sup>.

This finding was supported by interviews in the field with many of the staff interviewed reporting that the VIP was actually creating dependencies among some of the CF recipients, as opposed to creating a sense of independence. The field staff reported that no directive or guidance from Head Office has been received to help in dealing with recipients who may not need VIP for a long-term period. While the VIP may be appropriate for injured or functionally declined members of the CF group, it may not necessarily be appropriate for all CF recipients. This area will be further explored in section 6.0 of the report, Program Success.

Mental health, operational stress injuries, and post-traumatic stress disorder (PTSD) are a major concern for the CF population. Results from the STCL show 43 percent of New Veterans Charter recipients and 25 percent of Disability Pension recipients self-report PTSD conditions, while 51 percent of New Veterans Charter recipients and 35 percent

<sup>41</sup> It should be noted that the report is based on a point in time snapshot of post-release health status of personnel, therefore findings cannot be used to prove cause and effect relationship between military service and health after release or outcomes of VAC programs.

<sup>42</sup> MB MacLean, A Poirier & J Sweet. *Veterans Independence Program Need - Indicators from the Survey on Transition to Civilian Life LASS Secondary Analysis: 2011 Series – Release 1*. February 14, 2011.

of Disability Pension recipients also self-report depression or anxiety conditions<sup>43</sup>. As part of the *New Veterans Charter Phase III Evaluation*, a file review conducted provided some information on the health status of individuals; the file review noted at least half of the sample self-reported a significant mental health issue and a high stress level. Also, between April 2007 and March 2010 just under 40 percent of the Department's rehabilitation program recipients were also recipients of the VIP<sup>44</sup>.

VAC recently implemented a Mental Health Strategy, which includes a departmental health and wellness framework highlighting five determinates of health (personal factors, social environment, economic environment, physical environment, and health services environment) that relate to social patterns and structures that assist individuals well-being<sup>45</sup>. Under the framework, specific determinates of health that relate to the VIP are the social and physical environment factors: (1) strengthen the social environment of recipients (e.g. through support for families and awareness of community supports); and (2) contribute to a supportive physical environment through home and residential programs.

### **Spouses/Primary Caregivers**

The primary caregiver and surviving spouse VIP eligibility groups are limited to VIP housekeeping and/or grounds maintenance. Also, the primary caregiver group is eligible only for the element(s) that the Veteran was in receipt of at their time of institutionalization or death, while the survivor group is entitled to both VIP elements, up to a maximum of \$2,540. Significant growth of the population raises questions about the continued relevance of the program as they do not have access to the whole program. This will be further explored in the complex eligibility section as well as the outcome section of the report. Spouses have the same desired program outcomes as Veteran recipients, but have limited eligibility.

### **Expert opinions**

A finding from the 2008 *Continuing Care Research Project* (CCRP) led by Dr. Hollander illustrated the importance of home care and relevance of the needs of the individuals as stated in the following quote: "*the critical role that home support services, and unpaid caregivers, play in allowing people to remain in the community and maximize their independence for as long as possible*" (p. 65)<sup>46</sup>. Hollander found this to be similar to that of previous studies; however CCRP also built on the evidence gathered to support the benefits of long-term home care and home support services.

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<sup>43</sup> Thompson JM, MacLean MB, Van Til L, Sudom K, Sweet J, Poirier A, Adams J, Horton V, Campbell C, Pedlar D. *Survey on Transition to Civilian Life: Report on Regular Force Veterans*. Research Directorate, Veterans Affairs Canada, Charlottetown, and Director General Military Personnel Research and Analysis, Department of National Defence, Ottawa. 04 January 2011:103 p. Table 14: Self-reported attribution to military service of chronic health conditions.

<sup>44</sup> FHCPS data.

<sup>45</sup> VAC Mental Health Program Framework. [www.veterans.gc.ca](http://www.veterans.gc.ca).

<sup>46</sup> Hollander M, Miller J, & MacAdam M. *The Continuing Care Research Project*. Synthesis Report conducted for Veterans Affairs Canada and the Government of Ontario. April 2008.



The Gerontological Advisory Council report<sup>47</sup> identified several weaknesses of VAC services, including: complex eligibility restricting access to services; services are often reactive; limited senior housing choices as well as restricted choice of health promotion services. It is the conclusion of the Gerontological Advisory Council, that there is a group of marginalized seniors who tend to live by themselves, or as part of close-knit couple, and lack community networks and interactions, who can be a risk as they age and become more vulnerable. Several positive points about VAC (and the VIP) were also noted, including the fact that VAC has been a leader in services for seniors that assist Veterans to remain in their homes, providing a falls prevention program and adapting its health and social programs to meet the changing needs of Veterans.

The report<sup>48</sup> stated the following: *“When asked about their health needs, Veterans said they wanted more emphasis on health promotion and disease prevention, more community-based care and more flexible services to meet their needs and help them delay or avoid the need for long-term care.”* The Gerontological Advisory Council also recommended streamlining VAC’s Health Care programs to provide a single entry system and that VAC should use needs as the only eligibility criteria for the provision of benefits.

#### **4.2.2 Unmet needs**

A recent Statistics Canada report<sup>49</sup> states that there are general unmet home care needs for seniors in Canada. The study found many seniors reporting heavy household chore needs and assistance moving around the house were not receiving home care. In fact, almost 20 percent of seniors receiving a combination of formal and informal home support reported unmet needs. According to VAC’s Departmental Corporate Information System (CIS) demographic report<sup>50</sup> of senior Veteran population, approximately 30 percent of all Canadian senior males 80 years and older are WSV. This means that a significant proportion of the Veteran population in Canada could have home care needs that VIP could be helping to address. By addressing the needs of the Veteran cohort, VAC is providing a considerable societal benefit to Canada’s elderly and the health care system.

#### **War Service Veterans (WSV)**

The WSV will continue to require more frequent and additional supports and services as they age. Also, the general public in Canada is aging and requiring more home care supports and services. This demand could impact the level and frequency of support required by VAC to Veterans and their surviving spouses/primary caregivers, as provinces may continue to ‘off load’.

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<sup>47</sup> Gerontological Advisory Council to Veterans Affairs Canada. *Keeping the Promise: The Future of Health Benefits for Canada’s War Veterans*. April 2006.

<sup>48</sup> Ibid.

<sup>49</sup> Statistics Canada. Seniors’ use of home care health report. Statistics Canada Health Report. (2006)

<sup>50</sup> VAC Corporate Information System. Demographic Senior Veteran Population. Retrieved March 5, 2011.

Most field staff interviewed, and supported by the Gerontological Advisory Council report<sup>51</sup> and internal VAC reports, conclude that there is no doubt VIP helps Veterans at home. However they indicated that, as there are unmet needs among this group the Department should be doing more by focussing the VIP as a needs-based program rather than a service entitlement program.

### **CF Veterans (CFV)**

There was a strong consensus among the majority of field and Head Office staff interviewed, and supported by other internal report findings, that many CF recipients (especially the younger members) need different types of supports than WSV. The VIP was designed and targeted for an aging population at risk of institutionalization, which is not an appropriate target for all modern day Veterans. Several staff interviewed felt strongly that additional benefits are needed for the CFV under the VIP. Of those benefits suggested, the following were the most frequently identified: child care/family support; exercise programs/grants to facilitate rehabilitation (e.g., gym memberships or fitness fund); and home repair/maintenance (this was actually indicated as a gap for all recipient groups). Two recent major research studies also confirm that there are significant unmet needs among the CFV group<sup>52</sup>.

### **Spouses/Primary Caregivers**

There are some unmet needs within the surviving spouse/primary caregiver groups, which are similar to those of the WSV. However, the current eligibility criteria restrict access to VIP by these groups.

### **Miscellaneous**

National Contact Centre Network<sup>53</sup> staff interviewed mentioned that one of the main complaints from recipients is the request for direct deposit. Many Veterans have mobility issues, so it can be hard to get to the bank. Having direct deposit would eliminate cheque wait times. For the 2009-2010 fiscal year, there were almost 40,000 (almost one quarter of the total) complaints to the NCCN regarding cheque inquiries. The Transformation Agenda is responding to this need by initiating direct deposit for VIP beginning April 2011.

## **4.2.3 Conclusions**

- The VIP is very relevant to the needs of elderly Veterans, their spouses/primary caregivers and injured or disabled Veterans and members. File reviews, data analysis and recipient surveys indicates that the majority of WSV would not be able to remain in their own homes without the help of the VIP.
- It appears that there are some CF Veterans/members who are in receipt of VIP services and may not need them (30 percent), while there are other groups of CF Veterans, who appear to need VIP, but are not in receipt (10 percent). (This

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<sup>51</sup> Gerontological Advisory Council to Veterans Affairs Canada. *Keeping the Promise: The Future of Health Benefits for Canada's War Veterans*. April 2006.

<sup>52</sup> *Wounded Veterans, Wounded Families and Life After Service Studies* (including the *Survey of Transition to Civilian Life*).

<sup>53</sup> The National Contact Centre Network (NCCN) is VAC's national toll-free telecommunications network which provides one point of contact. NCCN staff respond, and re-direct, recipient inquiries and requests for service.

conclusion ties into the Transformation theme of overhauling service delivery to make programs and services more accessible).

- The VIP does not sufficiently meet the needs of some CFV recipients. CFVs in particular, but not exclusively, could benefit from care supports such as child care/family support and minor home repair. (This conclusion supports the Transformation theme of reducing complexity).
- A specific CFV home care and support strategy is needed to consistently and appropriately administer services and supports to CF members and Veterans. Such a strategy should help recipients understand the goals and objectives of the VIP, thereby ensuring monitoring of ongoing need for long-term program entitlement. (This conclusion also relates to the Transformation theme of overhauling service delivery, including focusing on modifying delivery methods in line with Veterans' needs).

**R1 It is recommended that the ADM, Service Delivery provide field staff with clear direction for delivering VIP services and supports to recipients who may not require assistance for a long term period. The goal of the strategy should be to: (1) ensure that VIP is delivered to only those in need, (2) provide direction on monitoring for continued need, and (3) encouraging independence in day-to-day activities. (Essential)**

#### **Management Response:**

Management agrees with this recommendation. The program directive 'Requirements for Decision Making and Determination of Need' was developed by VIP Program Management and released to field staff April 1, 2011. This directive provides clear direction on ensuring that recipient needs are properly identified and that the appropriate level of VIP services are delivered. The directive speaks to the need to not only increase services as recipients age but also to reduce or remove them should a recipient's situation improve.

A business case for 'Electronic Tracking Functionality for the Veterans Independence Program' was prepared by Service Delivery in March 2011. This initiative has been developed to allow VIP adjudication transactions to be tracked within the CSDN. As well the system will prompt VAC agents to follow-up with a recipient whose needs are expected to change in less than a one year time line. This will aid VAC agents in managing their workloads and removing the need for more manual bring forward systems. In the interim period Program Management will be working with Contract Administration to determine methods of using FHCPs to track contribution arrangements of less than one year.

Many VIP policies have been recently revised by Program Policy and Program Directives have been developed by VIP Program Management to provide clear direction to field staff on program delivery and adjudication practices. Further updated Policies and supporting Program Directives will be released in the coming months providing more support and direction to field staff. VIP Program Management changed delegations of

authority for VIP effective April 1, 2011. Training on the new authorities is in the process of being rolled out nationally.

VIP Program Management, in consultation with Case Management, will develop a further training module to support the delegation of authority for approving VIP services to client service agents (CSAs) based on the feedback received during this roll-out to support the transition. A portion of this training will be dedicated to this issue. Delivery of this learning is planned for October 2011. Once delivered, the success of the training will be evaluated on an ongoing basis based on feedback and recommendations. Adjustments and future learning will be determined by this process.

### **Management Action Plan:**

<b>Corrective Action to be taken</b>	<b>OPI (Office of Primary Interest)</b>	<b>Target Date</b>
1.1 Requirements for Decision Making and Determination of Need program directive	DG SDPM	April 1, 2011 (Complete)
1.2 Revised policies and program directives to be released	DG PRD & DG SDPM	June 2011
1.3 Develop training module	DG SDPM	October 2011
1.4 Determine if FHCPS can track Contribution Arrangements less than one year	DG SDPM	December 2011

## **4.3 The Program Coverage**

While VIP eligibility has expanded and widened (with over twenty amendments<sup>54</sup>) since its inception in 1981, the program design itself has changed little over the years. The VIP's responsiveness to the needs of recipients often varies by recipient type as there are different levels of access to program elements depending on the individual's service and eligibility criteria. While the Department has expanded VIP eligibility to meet political demands, the necessary assessment of individual sub-groups' needs has not always occurred in order to determine the fit of the existing VIP supports for the new expansion groups (for example younger CFV). Therefore, the relevance of program elements also varies depending on the recipient's stage of life, as discussed in section 4.2. During the interview process, the evaluation team was provided with a good analogy of the VIP: the house [VIP] was designed for a specific purpose [aging Veterans], and as rooms [eligibilities] have been added here and there over the years the foundation [relevance] of the house is no longer adequate to support all of the additions. The Department is now at a critical point where it is aware VIP is not a one-size fits all program for all recipients and it must determine what renovations it will do.

The VIP consists of three main categories of services and supports: (1) home care elements, (2) intermediate care (community facility care), and (3) other care elements.

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See Annex K for a Program Chronology.

### 4.3.1 VIP Home Care Elements

Housekeeping and grounds maintenance are often seen as the foundation elements of the VIP; they are well used and well liked, and often the most requested VIP elements according to district staff. Based on a profile review of WSV needs, as well as the general senior population in Canada, and home care facts and figures presented earlier in the report, the evaluation team found there was definite evidence that these two elements are highly relevant to aiding Veterans and their families. The basic assistance provided around the home such as laundry, meal preparation, tidying, vacuuming, clearing snow/ice, grass cutting, etc. can provide significant assistance to maintaining an individual in their own home.

Several field staff, as well as Head Office staff, indicated that there may be a gap in VIP home support. The Department provides housekeeping and grounds maintenance services, but no support for minor home repair and maintenance. A minority of staff stated that it did not make sense to provide housekeeping and enable recipients to remain at home and home adaptations, but not help maintain the safety of the home. For example, amputees and mobility impaired Veterans are physically unable to complete some of the most routine home repairs (e.g., changing light bulbs) and therefore may be at increased risk. In the mid 1990's a VIP element existed called 'heavy housekeeping' which may have addressed this need. This element was dropped as a cost-cutting measure as part of a government-wide Program Review in 1994. Under the CF Mobility Program offered through DND, there is support for home assistance including minor house repair<sup>55</sup>.

Other VIP elements included under the home care cache of supports are: personal care, access to nutrition, and health and support services. Spouses/primary caregivers are not eligible for these home care supports.

Personal care is a common inclusion under any home care program, including provincial Canadian jurisdictions and international programs. Personal care provides direct support to recipients through assistance of ADLs such as bathing, dressing, toileting, etc. which are all critical aspects of maintaining independence and health at home. Personal care is often provided to Veterans as a top-up to other supports that are provided in tandem with VIP, usually through provincial home care, informal caregivers, and/or private providers. In 2009-2010, 6,938 VIP recipients (6 percent) accessed personal care. This element is more relevant to the WSV (11 percent usage rate) than to the CFV (3 percent usage rate).

Access to nutrition provides basic financial support to aid recipients in accessing meals. A potential risk voiced by a minority of field staff interviewed was that if a Veteran is in need of support to access nutrition, and he/she has a spouse at home, there may not be the capability to prepare a meal. It was indicated that in some cases, the couple are splitting the meals and each may not be receiving adequate nutrition. Although not

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<sup>55</sup> Chapter 211.03: Sick or Injured Officers and Non-Commissioned Members – Home Assistance. Mobility Assistance for Sick and Injured Members of the Canadian Forces. Compensation and Benefits Instructions. Department of National Defence. May 15 2008.

investigated in depth by the evaluation team, this issue should be further assessed by the Department to determine risk and impact as this element is the third most used element for Veterans. In the 2010 National Client Survey, just under half of all WSV VIP recipients indicated a need for assistance preparing meals.

The Health and Support Services VIP element has been used to a lesser extent; however, in the past two years there has been increasing use (from 68 people in 2007-2008 to 183 in 2009-2010). In fact, between 2008-2009 and 2009-2010 usage almost doubled. One reason for the jump in use may be a recent discovery by field staff of how the element can be used for services such as foot care. There is not a clear definition of this element; the *Veterans Health Care Regulations* define the element as “*health and support services by a health professional, such as nursing care, therapy and personal care*” while the Veterans Programs Policy Manuals describe it as “*health assessment and diagnostic services, care, maintenance and related personal care provided by health professionals*”. This finding indicates inconsistent definitions between regulations and policies. There are also indications that this previously low-used element may be more relevant than originally thought and that a lack of communication/knowledge sharing of the element exists in some regional areas.

#### **4.3.2 VIP Intermediate Care**

The VIP does offer support in the community, outside of the Veterans home, if the care level of the Veteran progresses to the extent that their needs cannot be met at home. Nursing Home Intermediate Care (NHIC) was first introduced to fill a gap in facility care for war Veterans under the establishment of the VIP in the 1980s. At the time, the VAC LTC program was only offering beds in department facilities, and with growing demand for beds, the Department decided to initiate community beds under the VIP. By initiating community beds, Veterans were then able to remain in their community and close to family, friends and neighbours. Community beds (non-contract) are also less expensive than contract beds. Since then, LTC has expanded to include intermediate care in community beds for some eligible recipients and is progressing away from departmental<sup>56</sup> and contract facilities towards community facilities for chronic care beds as well. Table 4 below shows the VAC LTC facility bed breakdown by type and Table 10 provides a comparison of VAC LTC bed costs.

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<sup>56</sup> VAC only has one remaining departmental facility, Ste. Anne's Hospital, which is currently under negotiations for transfer to the province of Québec.

**Table 4: VAC LTC bed breakdown as of March 31**

	2008	2009	2010
<b>Non-contract LTC</b>	3,292	3,176	2,901
<b>Contract LTC</b>	2,866	2,852	2,832
<b>VIP Intermediate Care</b>	4,078	3,931	3,996
<b>Departmental</b>	408	405	404
<b>Total</b>	<b>10,644</b>	<b>10,364</b>	<b>10,133</b>

During the interview process, there was almost 100 percent consensus among VAC staff that the VIP intermediate care component and LTC programs should be combined. Staff also agreed that streamlining the two programs into one LTC program makes sense as NHIC is care in a facility, and not at home. Though care in a facility is relative to the needs of Veterans, this type of care is not necessarily a best fit for the VIP, which is meant to provide care in the home and help avoid institutionalization. This issue also relates to potential programming overlap and efficiencies, and will be further discussed later in the report.

Under the VIP, there is also Adult Residential Care (ARC) which 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. As of March 2010, there were 21 individuals in receipt of the element, with an average annual cost of \$7,939 per person. ARC recipients are slowly decreasing, by 2020 it is expected that there will be no recipients under this element. However, it appears that demand for ARC-like needs is growing in the elderly population as a whole. In response to changing trends in housing options, VAC has recently amended its policies to include assisted living facilities or supportive housing under the definition of 'principal residence'.

#### **4.3.3 Other VIP elements**

The 'other' VIP elements account for the smallest percentage of program use and expenditures. These elements include social transportation, ambulatory care, and home adaptations. The smaller elements tend to be the least used, yet appropriate and meaningful to certain recipients, in certain situations. The VIP is not a 'one size fits all' type of program, therefore the flexibility to provide other relevant services and supports to recipients who need them is an important aspect of the program. Unfortunately, as stated by some field staff, due to eligibility restrictions and low maximum rates payable, these program elements may not be adequately meeting recipients' needs.

Social transportation is limited to Veterans who are income-eligible. Though relevant to the needs of this group, there may be others who are not income eligible that would benefit from transportation assistance to social activities. Over 40 percent surveyed

indicated a need<sup>57</sup> while less than 4 percent of the VIP population accessed the element in 2009-2010. Also, some field staff discussed that providing transportation to an event or activity is positive, but if the individual is low-income, they may not be able to afford to access the social event or activities. An example provided to the evaluation team was that of a Veteran receiving VIP transportation assistance to the bowling alley, but without enough money to bowl. Therefore, there may be unmet needs within the social transportation in terms of limitations of eligible access as well as the element itself. The 2009 maximum rate payable for the social transportation element was \$1,271. The average expenditure by recipient for the 2009-2010 period was \$612<sup>58</sup>. Overall expenditures for the element accounted for less than one percent of total program expenditures for the same year.

Expansion of the coverage and definition of this element to be less restrictive to transportation only (include social activities) would enable the Department to focus on meeting social needs of recipients. As indicated by the 2010 National Client Survey, almost half of VIP recipients identified needs with assistance getting to appointments, running errands, shopping, etc. Lifting the restriction on access from low-income Veterans to all Veterans would enable the Department to better meet the needs of all recipients, especially with regards to unmet mental/social needs of the CFV mentioned earlier in the report.

Ambulatory health care services can be very appropriate for Veterans wishing to participate in adult day programs and for caregivers who require some assistance with respite care. The current VIP mandate limits coverage to Veterans only, so the manner with which the program can support the caregiver with respite is mainly through adult day programs for Veterans (with some limitations). The 2009 maximum rate payable for the ambulatory care element was \$1,059. The average expenditure by recipient for the 2009-2010 was \$804<sup>59</sup>. Respite has become a well known topic of discussion as a support method to informal caregivers. The 2009 Dementia Care Evaluation noted that the average cost for adult day programs ranges from \$25-\$40 per day (transportation may also be required in excess of the fee). Based on the maximum rate payable, this allows for only 26-42 days per year. The study stated that "Day programs can be beneficial for the caregiver because it offers them respite from their caregiving responsibilities. It has been shown that day programs can delay institutionalization, reduce family stress and improve caregiver's psychological well-being."<sup>60</sup>

Field staff interviewed during the VIP evaluation also identified a potential need for respite-like services for younger CF members with families, for example respite in the form of child care/family support. Therefore, there may be a potential unmet need for recipients and their families in terms of what can be included under the element. As well, due to the maximum rate payable, the element may not be sufficient support to allow for consistent participation in adult day programs. Ambulatory care through the VIP could be an effective method of addressing this need.

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<sup>57</sup> VAC National Client Survey. 2010.

<sup>58</sup> VIP Program Profile. VAC Program Performance Unit. 2009-10.

<sup>59</sup> Ibid.

<sup>60</sup> Dementia Care Evaluation. VAC Audit and Evaluation Division. July 2009.



The VIP element called home adaptations offers financial support to modify a principal residence to aid the individual in carrying out their daily activities. However, this VIP element is seldom used; many staff interviewed said they rarely used it. One of main reasons for non-use centered around the constraints on delegated authorities and maximum rate payable by case managers and CSAs who only have the authority to approve \$500 (limits are currently under review) for a home modification under this element. The impact of this restriction is that staff may bypass the VIP route if the recipient is eligible for non-pensioned related needs under the VAC Treatment Benefits Program. The POC 13 Treatment Benefit provides coverage of home adaptations specifically for special equipment. The two VAC applications of home adaptations will be discussed in the next section, Potential VAC program overlap.

#### **4.3.4 Conclusions**

- While the program elements meet the needs of many elderly and injured Veterans and their spouses, there is a need to consider what/how VAC should address the different needs of the younger Veterans and their families.
- Home Care elements are meeting the needs of VIP recipients, however some of the smaller elements (social transportation, ambulatory care, and home adaptations) should be reviewed to consider their fit in future programming. The Department should consider expanding the eligibility and/or inclusion of additional support under these elements to better meet the needs of Veterans and their spouses/families (child care/respite, social/mental health). These changes could help address the growing and emerging needs of CFV. (This conclusion supports the Transformation theme of reducing complexity).
- As people age, there is often a decline in functional mobility and an increased risk of social isolation. Social transportation is one support mechanism to help reduce this risk and meet the need for social interaction and transportation.
- There is a potential risk that elderly Veterans and their spouses are not receiving proper nutrition because of limitations on the Access to Nutrition element under VIP. As there was insufficient evidence to support this observation, the evaluation was unable support a recommendation. The Department may wish to further investigate this issue to determine the level of risk and degree of impact.
- Health and Support Services inclusion of supports and services needs to be better communicated to staff to ensure the element is meeting its full potential of addressing relevant recipient needs.
- Intermediate care, which was initially added to VIP to address a gap in services, is no longer a best fit under the VIP. It is more appropriate for the LTC program, as it is care provided in a facility and has many similarities already with the LTC program. (This conclusion also ties into the Transformation theme of reducing complexity).

#### **4.4 Potential overlap/duplication of VIP and other VAC Services**

The VIP is one pillar of VAC Health Care Programs. Some of these programs provide gateways to other program pillars, such as Treatment Benefits. Various VAC programs offer recipients services and supports with similar outputs and outcomes, but require

different eligibility criteria and have different maximum rates payable and delegated authorities. This section will address specific examples of other programs which appear to overlap with VIP, such as the NHIC and LTC program example, discussed above under Program Relevance. For a full comparison of each area, please reference Annex I.

#### **4.4.1 VIP Home Adaptations and Treatment Benefits**

There do not appear to be any potential 'double-dippers' between VIP home adaptations and the POC 13 home adaptations benefit codes. However, the evidence does show that there may be inconsistent use, or inappropriate use, due to restrictions in delegated authorities. During the analysis phase of the evaluation, the Transformation team announced an amended delegated authorities table for the VIP which included amending the authority level for case managers for home adaptations to the maximum rate payable (\$5,000). This change should sufficiently address the potential for misusing POC 13 adaptations for VIP needs due to lack of authority. The purpose of the element would lend itself to the inclusion of 'adjustments' (home adaptations) to a household that would aid individuals in mobility around the house – i.e. aids to daily living such as grab bars (similar to POC 1 Aids to Daily Living). If such adjustments (home modifications) are eligible under the VIP home adaptation element, the program area should clarify and communicate this to staff as it does not seem to be known.

Based on FHCPs transaction data reviewed, over half of all VIP Home Adaptation recipients are also recipients under the POC 1 program. However, it is the evaluation team's belief that some supports provided under the POC 1 benefit could in fact be provided under the VIP home adaptation element.

A limitation of the evaluation, and the ability to analyze this issue, is that the specifics of the home adaptations supports provided under VIP are unknown as, unlike the POCs, the VIP elements do not have sub-benefit codes for items.

#### **4.4.2 Health and Support Services and Treatment Benefits**

After a review of policies, benefit descriptions and some feedback from field staff, the evaluation team believed there was potential of some 'double-dipping' of similar POCs (POC 12, related health services and POC 8, nursing services) and VIP health and support services. However, as with the comparison of POC 13 home adaptations and VIP home adaptations highlighted above, the data analysis of FHCPs transaction data did not prove conclusively that there is overlap occurring. The evaluation team was again faced with a limitation regarding the unknown specifics of the health and support services provided under the VIP (e.g., occupational therapy assessments, foot care, etc.) as there are no specific benefit codes within the VIP elements and a lack of documentation regarding element coverage. The evaluation team concluded that overlap in services exists, however the risk and impact are deemed to be minimal (equates to only 28 individuals).

#### 4.4.3 VIP Nursing Home Intermediate Care and the Long-term Care (LTC) Program

The VIP intermediate care is meant to meet the needs of lower care individuals (Federal Type II<sup>61</sup>) while LTC is meant to take on the higher/chronic needs of individuals (Federal Type III). However, as introduced earlier in the report, the LTC program has evolved with recipient demand to include intermediate care in community beds thus the two programs have become somewhat intertwined in their offerings. However, the strategy, outcome and performance measures are much different.

It was indicated through the evaluation team's file review, and corroborated through interviews, that there are some recipients receiving care through VIP intermediate care that are beyond Type II care needs. Due to the fact that VAC care levels and provincial care levels may differ, as well as the fact that LTC contract beds are more costly, two recipients could be in the same facility, under two different VAC programs, at two different rates receiving the same level of care.

The only disadvantage of a program merger mentioned by the field was from one interviewee who flagged a potential negative impact on resourcing; however, the Residential Care Directorate indicated that there would be little to no impact from a management perspective at Head Office, and field staff administering the programs identified no disadvantages. In fact, field staff highlighted many advantages, including the fact that one LTC program would simplify processes and free up time. For a list of additional advantages as well as required steps to change the program, please refer to Annex I.

Recent work completed internally for the Department in response to '*The Report of the Independent Blue Ribbon Panel on Grants and Contributions*<sup>62</sup>', also recommended that the two programs should be streamlined into one program.

It is the evaluation team's belief that an opportunity exists for VAC to streamline and align its programs and policies to better meet demographic needs. The VIP intermediate care element is not a good fit for VIP, which is primarily home care; merging the LTC program and VIP intermediate care element would create efficiencies, ensure alignment with program objectives, and to streamline the delivery of both programs.

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<sup>61</sup> Federal Type II care means 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, while Federal Type III care means that therapeutic services are required, in addition to daily supervisions, nursing and personal care.

<sup>62</sup> The 2008 Blue Ribbon report suggested that the government needs to simplify administration of programs while strengthening accountability. Two specific recommendations related to this issue that were identified by the report are: (1) horizontal coordination in program administration should be improved and (2) the process should be simplified and made more transparent.

#### 4.4.4 Conclusions

- Intermediate care is not a fit for the VIP, which is focused on home care. The evaluation team did not assess the cost impacts of altering the current approach.
- The ability to analyze the potential of dual-VAC program overlap was limited due to the fact that VIP elements do not have benefit codes.
- Current documentation is unclear and inadequate to guide staff in delivering VIP Health and Support Services and VIP Home Adaptations in comparison to similar Programs of Choice (POC 1 and POC 8).

**R2 To ensure the differing objectives and outcomes of the VIP and the Treatment Benefits Program are met, it is recommended that the ADM, Policy, Communications and Commemoration (Important):**

- 2.1 Review element coverage under VIP Home Adaptations for the possibility of including low-dollar home modifications such as grab bars and differentiate the purpose and definition from POC 1 Aids To Daily Living.**
- 2.2 Clearly define and communicate the definition and element coverage of VIP Health and Support Services and VIP Home Adaptations to staff.**

#### **Management Response:**

- 2.1 Management agrees with this recommendation. In early 2011, a new Home Adaptations policy (VPPM II - 2.3.10) was released and provides policy direction for both the Treatment Benefits Program and the Veterans Independence Program. The policy clearly differentiates when home modifications are available through Treatment Benefits or the Veterans Independence Program. Low dollar modifications to a bathroom are an eligible expense under the current policy. However, additional direction will be added to the policy to indicate that where Veterans have eligibility for Treatment Benefits - in this case POC 1 specifically - that reimbursement will first be considered under the policies and procedures of the Treatment Benefits program. This policy will be revised and released in July.
- 2.2 Management agrees with this recommendation. The new Home Care Services policy (VPPM II - 3.2) which is currently awaiting release, will be revised to direct that when a Veteran is eligible for both Treatment Benefits and for the Veterans Independence Program, that health and support services will first be considered under the policies and procedures of the Treatment Benefits program. This policy is planned to be released in July.

## **Management Action Plan:**

Corrective Action to be taken	OPI (Office of Primary Interest)	Target Date
2.1 Review and revise applicable policies	PCC	July, 2011
2.2 Communicate to staff	PCC	July, 2011

### **4.5 Relevance of Program Eligibility Criteria**

It is evident from the usage data that there continues to be a high demand for the VIP. However, as mentioned previously there are some elements that are used less frequently than others. This should not be interpreted as a lack of need for these under-used elements, but rather the outcome of restrictive eligibility criteria and element inclusions/coverage.

The 2006 and 2008 RMAF/RBAF<sup>63</sup> discusses complex eligibility and how the Department has tried to meet the challenge of better responding to evolving recipient needs by modifying the program and providing additional eligibilities; unfortunately the result has led to a 'patchwork' of eligibilities. The 2006 RMAF/RBAF went so far as to say that this approach is no longer the best way to address Veterans needs in a fiscally responsible way. The patchwork still leaves some recipients with limited or no access, and therefore unmet needs.

Specifically among the older WSV recipients there are some unmet needs caused mostly by the excess of conflicting and complex eligibility criteria. The Department is not able to determine how many recipients really 'fall through the cracks' because there is a lack of data captured on VIP inquiries that do not lead to an application. This information may be captured but is not searchable within the Client Service Delivery Network. VAC currently records the number of applicants who are deemed eligible for VIP, as well as the frequency of appealed rulings (less than 20 between November 2009 and March 2010)<sup>64</sup>. The remainder of VIP applicants are 'counselled out' by staff after an initial assessment indicates that the recipient does not meet the service eligibility criteria. As reported by field staff, the recipient may have presented with a bonafide need, but did not meet the eligibility criteria therefore may be directed to other potential services and supports in their communities.

Some recipients may only need limited assistance in their home, for example 'just a little housekeeping', to help with their day-to-day activities and keeping them safe and healthy in the home. However, because of the complex eligibility criteria in some cases individuals are required to apply for other VAC programs, (e.g. Disability Pension Program) which can take four to six months from application to decision. This creates artificial demand on the pension process. If successful, the individual may qualify for

<sup>63</sup> The Results-Management Accountability Framework (RMAF) and Results Based Accountability Framework (RBAF) are past documents used in support of Treasury Board submissions that outline the program profile and performance.

<sup>64</sup> Only a five month period coverage was available due to organizational changes in responsibility for processing 2<sup>nd</sup> level of appeals.

VIP and a 'B' card, which could offer more services than the individual needs. Other individuals then may need treatment benefit support through the POCs, but they may not qualify as a 'B' recipient, so they apply for VIP which gives them access to the POCs. The 2010 Evaluation of Disability Pensions and Awards conducted found that the rate for favourable disability pensions was increasing, from 67 percent in 2006-2007, to 85 percent in 2008-2009. According to 2009-2010 data received from the Service Delivery Area, this trend is continuing with an 87 percent favourable rate for the WSV group<sup>65</sup>.

If the individual does not qualify for VIP through the income assessment or through the pension program, there may be pressure to apply for the Long-term Care Program as this is their only option of support available from VAC. This may cause increased resource demands on nursing assessments to determine the individuals level of care requirements and if qualified for LTC support. If placed on a bed wait list, some Veterans (Overseas Veterans) would then qualify for VIP while awaiting admission. Still another eligibility-related impact on the program utilization is the means-test applied to qualify for the social transportation element. There can be a significant hardship created when the income-testing is used to determine eligibility of elderly recipients.

It is important to note the patchwork nature of eligibilities reflects the expense and fiscal realities associated with expanding to comprehensively address all unmet needs. The program's patchwork of eligibilities has lead to unequal access for certain groups. These individuals may have potential VIP-like needs but were deemed ineligible due to their service and/or other eligibility requirements:

- Primary caregivers as they are generally only entitled to receive housekeeping and grounds maintenance that the Veteran was receiving at the time of death or admission to a LTC.
- Overseas Veterans (OSVs) as they are only entitled to VIP once they are deemed Federal Type II and on a waitlist for a Priority Access Bed (PAB) under the LTC Program.
- WSVs who are deemed Federal Type I and do not have a pensioned condition that can be linked to their need but would benefit from minimal assistance around the home to help them maintain their generally good health.
- Canada Service Veterans (CSVs) who do not meet the 365 day service requirement;
- CSVs who meet the age and service requirements, and for whom the cost of the required VIP service does not reduce their income below the applicable WVA ceiling.

These observations are supported by the evaluation's literature review and interview results. Several studies have been conducted to investigate program eligibility and access (e.g., Veterans Health Care Review and Continuing Care Research Project). Through such comprehensive research and analysis, VAC has identified program gaps. However, the Department has been constrained fiscally to implement program and

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<sup>65</sup> War Service Veterans - First Pension Application Decisions Favourable Rates 2009-2010. Service Delivery Management Activity Report. Source: Disability Completed Cube 2009-2010. Received March 18, 2011.

system changes that would eliminate the gaps. One internal departmental document stated the following regarding eliminating access to program barriers: *“Not all Veterans have access to VAC support to the full continuum of care available; rather the benefits they receive depend upon their entitlements and eligibility.”*

The Department’s current mechanisms for responding to the unmet recipient needs has been to expand VIP eligibility to one marginalized group at a time. This has resulted in further complicating the program’s eligibility criteria and creating program ‘stove pipes’. Eligibility add-ons can also frustrate Veterans and other recipients who are not included, or have limited program eligibility, and complicates program administration while not addressing the identified needs of Veterans and their families.

The discrepancy between identified need and program uptake appears to be a result of service eligibility requirements, and in the case of social transportation, the means-testing requirements. It was suggested by a majority of field staff interviewed, and supported by the Gerontological Advisory Council and Dr. Hollander, that once service is established for older recipients, only needs-based criteria should be applied. A constraint in the evaluation team’s assessment of the needs-based approach is that the team did not complete a comprehensive cost analysis to determine the viability of this approach. The CCRP as well as an internal study did however find such an approach would lead to more effectively aligning resources to higher needs recipients, and away from low needs recipients (on which the studies found VAC was focussing too many resources).

The overall conclusion is that current VIP eligibility is a patchwork of complex and confusing eligibilities (mainly for the WSV). This patchwork is a result of fiscal realities limiting the extent to which eligibilities could be expanded to address the needs of various Veteran and survivor/primary caregiver sub-groups. Streamlining and simplifying VAC programs is also part of the Transformation agenda.

- R3 As part of a re-designed health program it is recommended that the ADM, Policy, Communications and Commemoration, analyze: (Essential)**
- 3.1 The feasibility of modifying current supports and/or adding new supports (for example respite/child care and minor home repair) to meet the needs of younger Canadian Forces Veterans.**
  - 3.2 The feasibility of broadening current eligibilities and element coverage for smaller VIP elements (social transportation and ambulatory care) to enable improved relevance to all Veterans.**
  - 3.3 Whether or not the VIP intermediate care element should continue to be part of the VIP or form part of a new program for LTC.**
  - 3.4 The viability of streamlining eligibilities for the War Service Veterans to allow for a needs-based approach of delivering the VIP or a renewed health program.**

### **Management Response:**

Management agrees with this recommendation.

The work associated with the modernization of VAC's health care programs will consider these recommendations as it advances research, analysis and re-design work of the Department's health care program.

The Department has a mandate to ensure that essential care is provided to Veterans injured in military service. The changing demographics of the Veteran population have given rise to a major transformation initiative, with the objective being to improve service delivery, reduce complexity of programs and services and over the longer-term, modernize its health care program. While the initial steps in the transformation primarily involve improvement to service delivery, the policy basis of key services need to be reconsidered. Work to modernize the health care program is one of several foundation policy pieces.

Health care programs are provided to Veterans under authority of the *Veterans Health Care Regulations* (VHCRs). Benefits include home care services, treatment benefits, such as prescription drug and dental coverage, mental health counselling and long-term facility care. Despite these benefits, there are gaps in the assistance the Department can provide. Programs have evolved over decades to meet the changing needs of aging War Service Veterans, resulting in a patchwork of eligibilities and complicated rules to access programs.

While the VHCRs serve the needs of an older War Service Veteran population, programs and services are not fully aligned with current realities or the needs and challenges facing younger Veterans. To ensure that VAC's programs are responsive to the needs of all Veterans, including the younger generation of Veterans, the Department has just recently begun a review of its health care program. This work is expected to culminate in recommendations and options for Government consideration.

#### **Management Action Plan:**

<b>Corrective Action to be taken</b>	<b>OPI (Office of Primary Interest)</b>	<b>Target Date</b>
3.1 Initial discussion at / direction from DG Policy Committee	DG, PRD	Spring/Summer 2011
3.2 Confirmation of proposed approach / general parameters from SMPPC	DG, PRD	Summer 2011
3.3 Research, analysis, and consultation	DG, PRD	2011-2012
3.4 Program design and policy development	DG, PRD	2012- Fall 2013
3.5 Recommendations and options for Government consideration	DG, PRD	September 2013

#### **4.6 Potential overlap or duplication of other government services**

In order to determine the extent to which other similar government programs or services exist, the evaluation team compared home care services and supports offered by other



federal government departments to the general population, as well as specific subsets of the population. The review found that three other federal departments of government are also charged with home care responsibilities for defined recipients. The departments include the Department of National Defence (DND), Health Canada, and Indian and Northern Affairs Canada (INAC). The evaluation team also reviewed provincial governments home care services and supports available to provincial citizens based on differing criterion. This section will summarize the evaluation team's findings. For a review of the comparison departments please reference Annex J.

#### **4.6.1 Federal Government Departments**

While INAC, Health Canada and DND offer a form of home care services and supports, the evaluation team concludes that there is insignificant potential for overlap or duplication of services due to the number and qualifications of those eligible for the services.

The departments of INAC and Health Canada provide some home and community based health-related services to First Nations and Inuit people including: home care for those with disabilities and persistent or acute illnesses, as well as the elderly. However, the estimated number of VIP recipients that are identified First Nation's is minimal (less than 1 percent of the total VIP population) therefore the potential risk is low for dual program use. Also, INAC does not offer all of the same elements as the VIP.

As part of the 1984 *Canada Health Act*, Canadian Force members are specifically excluded from the definition of 'insured persons'. DND has its own health care system, the Canadian Forces Health Services (CFHS) system. For the fiscal year 2009-2010, DND reports that the number of CF members accessing the DND Home Care Program for Nursing Services is 184 and 120 for Personal Support/Home Maker Services. Some still-serving CF members are eligible for VIP, but in order to receive VIP they must not be eligible for such supports through the CF health care program.

In April 2009, DND also implemented a program for sick and injured Canadian Forces members. The Mobility Assistance for Sick and Injured Members of the Canadian Forces program offers assistance to members who require home/vehicle adaptations or home assistance due to their sickness or injury<sup>66</sup>. As per DND statistics for fiscal year 2009-2010, 81 CF members accessed the Home Adaptations portion of the Mobility Assistance Program and 65 members accessed the Home Assistance (snow removal and grounds maintenance) portion of the program. The DND program was created to address the gap between the recipient's immediate need, and the application for and confirmation of eligibility for VAC programs. The program policy clearly identifies that to qualify for the home assistance; the member cannot be eligible for benefits under the VIP. Information from key departmental policy management corroborates this statement.

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<sup>66</sup> Chapter 211. Mobility Assistance for Sick and Injured Members of the Canadian Forces. Compensation and Benefits Instructions. Department of National Defence. May 15 2008.

## 4.6.2 Provincial Government

There are varying legislations and provisions for home care across Canada. Extended health services (including home care) are not part of the *Canada Health Act*, therefore there is no set standard for home care requirements and each province is responsible for establishing its own home and community care support services. For an overview of home care benefits and supports in Canada and a breakdown by province please refer to Annex J. The provincial home care table in Annex J should be interpreted carefully as even within a province there may be varying provisions as well as funding and eligibility limitations. For example, some jurisdictions have income testing, maximum hours provided/frequency of home visits, long waitlists, etc. for certain home care services. Since the VIP is provided as a top-up to provincial home care supports, the level and degree of VIP provided across the country also varies.

The 2006 *Evaluation of the Veterans Independence Program* found that the program is designed so that it is neither redundant nor duplicative of any other federal, provincial, local or private level of services offered.<sup>67</sup> Both the 2010 Hollander report and the 2008 CHCA report, echo the fact that the VIP does not duplicate services offered by the provinces, but rather complements or tops-up already existing services for Veterans.

Of the VAC staff interviewed during the field visits, the majority stated that, based on their experience with the VIP and the respective provincial programs, that there is no overlap between the provincial home care services and the VIP. Within this group, many agreed strongly that the two levels of government home care programs complement each other. An issue reported by almost half of respondents was that once the province knows the individual is a Veteran, they are referred to VAC, and VAC is requested to become the provider of first resort rather than a top-up to provincial contributions. This comment came from both sides; those stating VIP is a complementary program, as well as those saying there is overlap.

During the fieldwork a few interviews with provincial home care representatives occurred. The issue of possible overlap or duplication was also discussed from their perspective and there was general consensus that while some jurisdictions offer somewhat similar programs, there is no overlap with VIP services.

It was also suggested that better working relationships and the capacity to exchange common recipient information would improve service delivery to recipients and eliminate any possibility of overlap or recipients falling through the cracks. While in some regions and districts field staff have good relationships with provincial home care, this is not the case in all areas. It should be noted that many VAC staff commented on the fact that the Department used to be better at communicating with provincial home care counterparts; however, this practice seems to have diminished in the last few years.

Complex Veteran eligibility for departmental programs appears to create some confusion for provincial home care representatives and results in VAC being the first payer, rather than payer of last resort. An increasing elderly population in Canada

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<sup>67</sup> Evaluation of the Veterans Independence Program (VIP). VAC Audit and Evaluation Division. December 2006.

combined with all governments pulling back on their expenditures for health care and home care services, is resulting in more Veterans being caught between the responsibilities of federal and provincial domains. VAC will experience the financial and administrative impact of this reality more and more in the next few years. Actual program recipients peaked in 2009-2010, with the total number of program recipients equaling 107,798. However, even as recipient numbers decline, the program expenditures will not peak until 2011-2012 at approximately \$343 million.<sup>68</sup>

#### **4.6.3 Conclusions**

In conclusion, the team found that overall the VIP tops-up and complements other government home care programs and services. There do appear to be some instances where the authority/responsibility for providing home care is not clear. With a growing elderly population in Canada in combination with provinces pulling back in their amount of home care services, VAC will feel the impact of this pressure more and more in the next few years. In today's environment of changing roles, changing recipient demographics and needs, and staff turnover, VAC field staff seem to have little time for more 'supplementary activities' such as relationship building with provincial home care staff. However, as it is shown in some regions, a close relationship with provincial home care staff can help VAC better serve dual-recipients. While this is happening to some degree, in some areas, there is no consistent approach. This finding could be applied across all departmental program areas, and aligns with the Transformation theme of strengthening partnerships.

#### **R4 It is recommended that the ADM, Service Delivery: (Essential)**

- 4.1 Encourage a regular forum for VAC and provincial home care staff to jointly discuss issues, best practices, and build a relationship to help better co-serve Veterans.**
- 4.2 Ensure clear understanding by provincial health authorities of VIP eligibilities, improve collaboration and identify opportunities for partnership.**
- 4.3 Create a brochure/fact sheet to be shared with provincial and community providers illustrating program coverage and eligibilities to Veterans and other individuals.**

#### **Management Response:**

- 4.1 Management agrees with the intent of this recommendation on a national level, VIP Program Management will continue to work with the groups and partners of the Federal Health Care Partnerships to ensure that it remains fully aware of the Home Care initiatives of both the RCMP and the Canadian Forces.

Program Management will also develop and provide strengthened guidelines and direction to service delivery staff to ensure stronger relationships and partnerships with provinces and health authorities regarding common recipients.

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<sup>68</sup>

VAC Statistics Directorate forecasted figures. Received October 2010.

- 4.2 Management agrees with this recommendation. The program directive “Requirements for Decision Making and Determination of Need” leverages provincial assessments as proxies to VAC assessments that encourages collaboration between VAC and provinces. Program Management, as noted in 7.1, will develop and provide strengthened guidelines and direction to service delivery staff to ensure stronger relationships and partnerships with provinces and health authorities regarding common recipients.
- 4.3 Management agrees with this recommendation. Program Management and Communications will work together to strengthen communications related to the VIP (including electronic and paper based).

#### **Management Action Plan:**

<b>Corrective Action to be taken</b>	<b>OPI (Office of Primary Interest)</b>	<b>Target Date</b>
4.1 (a) VIP Program Management will seek to integrate with the current Federal Health Partnerships	DG SDPM	June 2011
(b) Program Management will also develop and provide strengthened guidelines for field staff	DG SDPM	October 2011
4.2 (a) Release Program directive “Requirements for Decision Making and Determination of Need”	DG SDPM	April 1, 2011 (Completed)
(b) Program Management will also develop and provide strengthened guidelines for field staff	DG SDPM	October 2011
4.3 Strengthen communications related to the VIP	DG SDPM and DG Communications	October 2011

#### **4.7 Overall Relevance Conclusions**

- VIP is the Department’s flag ship program and continues to meet the needs of most eligible recipients. The program however faces a number of challenges: an aging demographic with increased health care needs who will be requiring more assistance, as well as their surviving spouses; an increasing number of CFV recipients presenting with significantly different needs from the previous majority recipients (at this stage in their lives); a program structure and purpose not set up to meet the different needs of younger CF Veterans, and as recent media events demonstrate, more articulate and dissatisfied recipients.
- The Department’s attempts to adjust to the changing demands by adding narrow bands of eligibility to selected groups has addressed some recipients’ needs, but has also exposed a greater need for changes to the program’s eligibility criteria, and for more preventative type programs. There is a need for a continuum of care approach as opposed to the health care maintenance approach of the current VIP. Overall, the eligibility criteria are too complex and therefore VIP is

not effectively meeting the needs of some Veterans and surviving spouses/primary caregivers.

- VIP activities are within the VAC mandate of services. There is no overlap with any other federal government programs or services or with provincial home care offerings, the VIP is rather a top-up to the services offered from a recipient's home province.
- There is room for the Department to expand on its communication and information sharing with both DND and the provinces in order to more efficiently and effectively serve dual recipients.
- The evaluation team has determined that there is a degree of VAC programming duplication between the VIP and the Treatment Benefits Program as well as between the VIP and the Long-term Care Program.
- VAC roles and responsibilities are currently under review to help improve efficiency of services to recipients, this change is not limited to VIP and will therefore have a strong impact on total service delivery for the Department. As the transformation agenda moves forward, the Department should see increased relevance to recipients and efficiency in service delivery.

## 5.0 PROGRAM SUCCESS

Program success is an important consideration in an evaluation as it measures the stated outcomes of the program and determines how and whether the outputs help achieve the program objective. The objective of the VIP is “to provide financial assistance to eligible Veterans and other recipients so that they receive the home care and support services they need to remain independent in their own homes and communities”<sup>69</sup>.

### 5.1 Background of performance measurement at VAC and in Federal Government

In April 2009, the federal government implemented a new evaluation policy and directive requiring departments to place more rigour around reporting on program performance and the measurement of outcomes, including providing an annual report on the state of performance in the Department.<sup>70</sup> The Department has been actively involved in performance measurement however, a perennial problem has been the difficulty in obtaining the necessary performance information for reporting on outcomes and to assist program management decision making. As noted in the first annual report on VAC’s program performance, “*The overall departmental capacity in performance measurement is simply not adequate at present*”<sup>71</sup>.

In response to the new policy and new requirements, VAC is engaged in implementing evaluation frameworks, performance measurement plans and logic models for all program areas. A key challenge for the evaluation team is that little historical performance information is available as past reporting has been focussed on activities/outputs rather than outcomes.

The program’s current Performance Measurement Plan and logic model<sup>72</sup> (updated August 2010 to reflect outcome alterations) is used as the key component of the measurement of success. The Program Activity Architecture for the Department and accompanying performance measures are currently in the process of being updated again. The expected outcomes of the VIP and their associated performance indicators are as stated in Table 5.

#### Current program performance indicators

The VIP is a long standing program that has only recently developed performance indicators. Under the VIP Performance Measurement Plan, the reporting cycle on most

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<sup>69</sup> VIP Program Logic Model. VAC Program Performance Unit. August 2010.

<sup>70</sup> The April 2009 Treasury Board *Evaluation Policy* and the *Directive on Evaluation Function* promote the collaboration between evaluation and program managers to improve the design, delivery and measurement of performance for organizational policies and programs. The Head of Evaluation is also required to provide an annual report on the state of performance in the Department through reviewing and providing advice to the Department.

<sup>71</sup> Drebit, O. *Performance Measurement within Veterans Affairs Canada: The First Annual Report to the Departmental Evaluation Committee on the State of Performance Measurement of Programs in Support of Evaluation within Veterans Affairs Canada (VAC)*. Head of Evaluation, Veterans Affairs Canada. October 2010.

<sup>72</sup> Please see Annex B.

indicators is quarterly, and bi-annually or tri-annually on others. These reporting figures were used, to the extent possible, to assess achievement of outcomes. These performance indicators and measurements are derived from National Client Survey results and from document reviews, file reviews, and corporate statistics. The performance indicators identified in the Performance Measurement Plan which assist in measuring the progress towards the established outcomes include:

**Table 5: VIP outcomes and associated performance indicators**

Outcome	Performance Indicators
<b>Immediate Outcome</b> – Eligible Veterans and other recipients have access to home care and support services	<ul style="list-style-type: none"> <li>• Program reach</li> <li>• Ability to access VIP providers</li> <li>• Timeliness of access to benefits and services</li> </ul>
<b>Intermediate Outcome</b> – Eligible Veterans' needs for home care and support are met	<ul style="list-style-type: none"> <li>• Recipient self-report of needs being met</li> </ul>
<b>Ultimate Outcome</b> – Eligible Veterans and other recipients are able to remain in their own homes and communities	<ul style="list-style-type: none"> <li>• Average age of institutionalization</li> <li>• Rate of nursing home admission</li> <li>• Recipient self-reported reliance on services</li> </ul>

**NOTE:** At the time of the evaluation fieldwork, the evaluation team did not have the updated outcomes. At the time the ultimate outcome was 'eligible Veterans' physical, mental and social needs are met'. This outcome was altered and actually moved to become the intermediate outcome, while the intermediate outcome became the ultimate outcome as stated above.

The evaluation team assessed VAC's VIP Performance Measurement Plan and found that the indicators have been clearly defined and are appropriate to support decision-making. However, there are major deficiencies in reporting on performance-related information necessary to properly manage and evaluate the VIP. For example, there is no tracking of recipients who became eligible for VIP through a determination of frailty; the only information available is estimated based on file reviews and sampling. Also, the VIP Intermediate care performance data is inadequate to support the measurement of outcomes. In fact, VIP intermediate care is measured mainly under the LTC program due to the fact that it is care in a facility.

Other performance indicators/targets to capture on an ongoing basis to aid in the measurement of outcomes and performance targets suggested by the evaluation team include:

- Average recipient duration on VIP/LTC.
- Number of VIP recipients who would require care in a facility if not for VIP.
- Trend of VIP recipients requesting VIP and then applying for other VAC programming gateways (e.g. Disability Pensions).
- Functional assessment score trends of VIP recipients from home care through the different levels of facility care (continuum of care profile).
- Program use and attrition trends for short-term periods/acute use of the VIP (e.g., reduced or terminated elements within a contribution arrangement).
- Track the impact (e.g. health change/maintenance) of providing VIP for those OSV who qualify for home care while on a waitlist for a long-term care bed.
- Average age of entry to LTC of non-VIP home care users compared to VIP home care users.

## **5.2 Progress towards expected outcomes**

This section will assess the program's progress towards meeting the expected outcomes of the VIP. For the purposes of this section, the measurement of progress towards the three levels of expected outcomes of the VIP only applies to those eligible for the VIP; additional comments regarding non-VIP and non-VAC potential recipients will be addressed in the unintended impacts section.

The primary method of assessing the achievement of desired outcomes was through the 2010 National Client Survey and the Long-term Care Survey results analysis (VIP specific). The surveys provided the evaluation team with valuable recipient feedback on timing, location, information presented, recipient expectations, and satisfaction with the VIP's service/program delivery. In addition, the analysis of information gathered was supplemented by examining a sample of recipient files in CSDN, a document review, statistical data analysis, process maps, and interviews with VAC staff in Head Office, regional offices and district offices as well as other key stakeholders.

### **5.2.1 Immediate Outcome – Eligible Veterans and other recipients have access to home care and support services**

#### Program Reach

Based on the assessment of the relevance and rationale for the VIP the evaluation team also assessed how successful the Department is in reaching the VIP target population. The assessment was conducted through document reviews, analysis of VIP uptake data compared to potentially eligible recipients and program attrition, as well as through interviews with key VAC staff.

Overall, the VIP has just under half of the total VAC population accessing program services and supports, with the majority of recipients being WSV and their surviving spouses. By 2015 surviving spouses/primary caregivers will be the largest group of VIP recipients and by 2016 the CFV population is projected to overtake the WSV population.

As can be seen in Table 6, over three quarters of WSV VAC recipients are in receipt of VIP compared to only 28 percent of CF VAC recipients.



**Table 6: VIP recipient population as a percentage of total populations**

	All	WSV	CFV	Spouses/ Primary Caregivers
<b>Total Veteran Population</b>	749,000	155,700	593,700	N/A*
<b>Total VAC population</b>	218,612	68,769	62,895	78,657
<b>Total VIP population</b>	107,798	55,591	17,742	34,465
<b>percent of VAC population (VIP- VAC population reach)</b>	49	81	28	44
<b>percent of Veteran population (VIP -total Veteran population reach)</b>	14	36	3	N/A

Source: VAC Quarterly Statistics as of March 31, 2010. Statistical estimate of surviving spouse/primary caregiver population is not available.

In terms of program reach, the STCL survey conducted with releasing CF members in support of the LASS found there may be a group of CF that the VIP (and VAC) is failing to reach. Of the survey respondents, approximately 10 percent of the population appeared to have a need for VIP but were not in receipt of benefits<sup>73</sup>. Of the non-recipient survey population indicating chronic conditions, over half indicated this condition was attributable to their military service, indicating potential unmet needs and program reach issues<sup>74</sup>.

#### Ability to Access VIP Providers

According to the 2010 NCS results, 85 percent of VIP recipients strongly agreed or agreed that they were able to find people to help them with the VIP services they need. A supporting file review conducted by the Program Performance Unit, also found that 91 percent of recipients reported no difficulty accessing VIP services.

Statistics on the number of eligible recipients for VIP versus the number of recipients with a transaction (i.e. submitting claims) is a potential indicator of accessibility of the program. According to the data received from the Statistics Directorate, 5 percent<sup>75</sup> of VIP registered recipients in 2009-2010 did not have a VIP claim transaction. Although this figure may not be entirely attributable to access, it is a valid yardstick to measure the percentage of the VIP population who may have accessibility to service issues. The figure may also indicate the possibility of individuals gaining eligibility to VIP to attain access to other needed programs and benefits (i.e. Treatment Benefits), as discussed in section 4.5, Relevance of Program Eligibility Criteria.

The 2010 LTC Client Satisfaction Questionnaire results show that 95 percent of respondents feel they always or usually have access to specialized services such as

<sup>73</sup> MacLean MB, Poirier A & Sweet J. *Veterans Independence Program Need - Indicators from the Survey on Transition to Civilian Life*. Life After Service Studies (LASS) Secondary Analysis (2011 Series – Release 1). Research Directorate, Veterans Affairs Canada. February 14, 2011.

<sup>74</sup> Thompson JM, MacLean MB, Van Til L, Sudom K, Sweet J, Poirier A, Adams J, Horton V, Campbell C, Pedlar D. *Survey on Transition to Civilian Life: Report on Regular Force Veterans*. Research Directorate, Veterans Affairs Canada, Charlottetown, and Director General Military Personnel Research and Analysis, Department of National Defence, Ottawa. 04 January 2011:103 p.

<sup>75</sup> VAC Statistical Directorate.

physiotherapy, dental care, and so on, when they need them. Also, 97 percent are completely or mostly satisfied with the quality of the professional staff (e.g. nurses, doctors) as well as their access to spiritual guidance.

Interviews with field staff conducted for the evaluation found that there are some access to care issues present; mainly, in some rural and remote areas where there are fewer care options and provider availability. Issues related to remote access to services identified by the field staff interviewed include the following:

- few registered service provider options (e.g., Meals on Wheels, Merry Maids, etc.) and fewer options, if at all in remote areas for specific specialist services and supports (e.g., adult day programs);
- distance hinders access to home care and support services (mileage and minimum hour visit requirements impacts cost of care);
- more dependence is placed on family and informal caregivers instead of on registered service providers.; and
- barrier to service for some is that unregistered providers are fearful of signing claim form due to potential tax implications.

According to interviews with field staff, VAC's mitigation strategy for this challenge is to enable neighbours and family outside the home to provide services (unregistered providers) and to collaborate with provincial authorities. Hollander's home care report as part of the Alberta Continuing Care Strategy from May 2010 highlights that self-managed care is a key component of VIP. Given the unequal distribution of service providers across Canada, especially in rural and remote areas, this flexibility is an important feature of the VIP and allows providers to range from family members, friends and neighbors to agencies and companies.<sup>76</sup>

The 2008 CHCA *Portraits of Home Care* report also discussed rural access to home care. The report identifies that, access to home care is generally consistent between rural and urban settings, but access, service delivery and response time in some remote communities may be affected by an absence of service providers and by human resource challenges<sup>77</sup>. The CHCA confirms the evaluation's interview results, as it found that VAC recipient access to home care may also be inconsistent between rural and urban settings due to the availability of providers<sup>78</sup>.

Some interviewees indicated that there were instances where evidence of discriminatory treatment of Veterans by provincial home care occurred. Examples given to the evaluation team included instances where the provincial home care program would not provide some home care services such as bathing, or refused to provide some services if there was awareness that the Veteran was a recipient of VAC benefits or services, as it was then assumed that VAC would pay for the services. As discussed in the relevance section of the report, this further indicates a fundamental

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<sup>76</sup> Hollander M & MacAdam M. *Strategic Review of Home Care Services as Part of the Alberta Continuing Care Strategy*. Strategic Literature Scan of National and International Home Care Services. Alberta Health and Wellness. May 2010.

<sup>77</sup> Canadian Home Care Association. *Portraits of Home Care in Canada*. March 2008.

<sup>78</sup> Ibid.

communication issue with provincial home care authorities. It appears that there is a lack of awareness of VAC's role as a top-up provider. This may be due to confusion of VAC's responsibility for coverage of benefits related to disability pensioners.

### **Timeliness of access to benefits and services**

There is limited performance data on this indicator as VAC provides contributions to the recipient only and acts as an arms' length provider. Due to the self-directed nature of the program, VAC is not involved in the interaction between the service provider and the recipient (i.e., turn-around of request to delivery of the service). The only performance measure associated with timeliness for the VIP is "average time between application for VIP service and establishment of the contribution arrangement". This measure is captured tri-annually; the 2008 figure shows a turnaround time of 22 days. The average turnaround time for re-assessments is 16 days. In general, feedback from the majority of field interviewees is that there are no wait times for VIP once eligibility and need are established.

### **Linkage and Contribution of Outputs to Outcomes**

An analysis and overview of results for 2009-2010 Performance Snapshot and the Service Delivery Area reports of activities show that the program is not meeting the 100 percent target of annual follow-ups by 10 percent. The remainder of the performance targets are met or exceeded.

The outputs of VIP include:

- new contribution arrangements;
- amended contribution arrangements;
- re-assessment contribution arrangements;
- annual VIP follow-ups ; and
- VIP payment transactions.

Assessments of eligibility for program access and determination of recipient needs lead to establishing contribution arrangements for the delivery of VIP services and supports to meet the identified needs of recipients. Throughout the year recipients may be reassessed to have the contribution arrangements altered to meet changing needs. Contribution arrangements may also be amended due to a change in service provider and/or service provider rates. Also, in order to reimburse recipients/providers for the service provided, VAC issues payment transactions through Medavie Blue Cross (contracted third-party payment processor). These program outputs lead to the first outcome of the program; eligible recipients have access to home and community care and support services.

Other outputs generated from the Department that assist staff in delivering services and supports to recipients with the aim of meeting outcomes include: strategic plans, policies, program directives, business processes, assessments and decisions.

### **5.2.2 Intermediate outcome– Eligible Veterans’ needs for home care and support are met**

The intermediate outcome of the VIP ties in strongly to the relevance of the program as both relate to meeting the needs of Veterans and surviving spouses/primary caregivers. This outcome is closely linked to health and well-being. The World Health Organization and *Veterans Health Care Regulations* both similarly define health as ‘a state of physical, social and mental well being’.

The 2010 National Client Survey was the main indicator used to assess the degree of success in achieving this outcome, as it is direct feedback from VIP recipients themselves.

The satisfaction performance target for the VIP is: 80 percent of VIP recipients living at home who “strongly agree” or “agree” that VIP meets their needs. The performance result of 86 percent exceeds the target. This is also an improvement from the previous survey results in 2007, where 74 percent of recipients indicated that VIP met their needs. As mentioned in the relevance section, the WSV agree the most strongly (87 percent) that the VIP meets their needs, while the CFV feel the least strongly (81 percent) that VIP meets their needs. In general, CFV are less likely to report that VAC is meeting their basic needs. Field interviews for the evaluation discussed in the relevance section also confirm this analysis. The supporting 2010 Program Performance Unit file review found that 88 percent of VIP recipients self-report that their needs are being met through the VIP, regardless of service.

Though there is little health outcome information related to recipients of intermediate care services in LTC facilities, results from the 2010 LTC Client Satisfaction Questionnaire show 99 percent of VIP respondents in facilities were completely or mostly satisfied with the personal care received in relation to their needs (dressing, bathing, toileting, and other such assistance). In addition, 99 percent were completely or mostly satisfied with the help received getting around the facility (mobility assistance). Finally, 97 percent were completely or mostly satisfied with the recreation and social activities available in the facility.

Although this does not speak directly to ‘home care’ it indicates that Veterans care and support needs are being met in facilities as well. There is a current gap in performance data for those individuals in a facility bed. By the fall of 2011, it is anticipated there will be outcome data available regarding Veterans in facilities (including VIP intermediate care recipients). Several quality of care indicators, such as physical and social, have been added to the nursing assessment tool and will provide the Department with relevant outcome performance related data. The outcome as it is stated now, does not link well to individuals in facilities (another indicator of intermediate care not fitting into the VIP).

A significant factor affecting the program’s ability to meet needs of individuals depends first upon service eligibility criteria rather than needs identified.

## Linkage of Outputs to Intermediate Outcome

Although other factors (e.g., health status, family support, community and provincial support programs) may also influence this outcome, VIP recipient's access to home and community care and support services is the main drive in achieving the intermediate outcome.

### 5.2.3 Ultimate outcome— Eligible Veterans and other recipients are able to remain in their own homes and communities

This relates to the overall objective of the VIP and is the most important outcome of the program. Several other factors also influence this outcome (e.g., provincial support, informal caregiver support from family or friends) which creates challenges in linking the VIP directly to this outcome. However, there is overwhelming evidence of the direct linkage between provision of home support services and delay or avoidance of institutionalization, as shown by the following:

- Approximately 91 percent of VIP recipients self-reported reliance on services in order to remain in their own home, according to the 2010 NCS.
- Only four percent of VIP recipients were admitted to nursing homes in 2009-2010<sup>79</sup>.
- Average VIP recipient duration in intermediate care since 2000 is just under two years (1.7 years for WSV and 1.5 years CFV)<sup>80</sup>.
- Based on corporate statistics for those receiving their first VIP intermediate care payment between 2007-2008 and 2009-2010, the majority began VIP with home care elements<sup>81</sup>. The data indicates these individuals were able to remain at home for an average two years longer before moving to a facility, compared to those entering VIP through the intermediate care element.
- The evaluation team was unable to find Canadian statistics on the average age of admission to a nursing home except for in a Canadian Union of Public Employees document, which quoted the average age of admission for all Canadians as 86 years old in 2002<sup>82</sup>.
- A recent study conducted by Dr. Hollander and MacAdam<sup>83</sup> referenced actual savings achieved by British Columbia over a 10-year period as a result of introducing a pro-active policy to substitute home care services for facility care. In fact, results showed that “utilization of some 21 person-years per 1,000 population 65 years or older was shifted from residential care to home care, for individuals with ongoing care needs” (Hollander and MacAdam, p.3).

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<sup>79</sup> 2009-2010 VIP Performance Snapshot. VAC Program Performance Unit.

<sup>80</sup> FHPCS transaction data.

<sup>81</sup> Based on an analysis of FHPCS first transaction data for the sample recipient population.

<sup>82</sup> *Residential Long-Term Care in Canada: Our Vision for Better Seniors' Care Summary*. Summary of a 100-page research report. Canadian Union of Public Employees (CUPE). October 2009.

<sup>83</sup> Hollander M & MacAdam M. *Strategic Review of Home Care Services as Part of the Alberta Continuing Care Strategy*. Strategic Literature Scan of National and International Home Care Services. Alberta Health and Wellness. May 2010.

- Dr. Hollander also found very positive impacts resulting from the provision of VIP to Overseas Veterans on a provincial bed waitlist for Type II care in the Continuing Care Research Project.

A 2008 internal departmental file review of VIP recipients found that in many cases the VIP does assist greatly in the provision of a higher income which, in itself is known to improve health. The file review also found anecdotal evidence on many files that confirmed that VIP was helping to keep Veterans at home and that Veterans wanted to stay at home as long as possible. Of the files reviewed, 32 (16 percent) of the War Service Veteran group were receiving personal care and/or nursing care, which would indicate that they would be a candidate for LTC if this care was not available in the home.

An important factor when considering the progress towards the ultimate outcome is the difference in life situations for the WSV compared to many CFVs; in general, the goal for the WSV is to stabilize their health and prevent/delay institutionalization, while for the younger CFV, the goal is to regain health and independence and reintegrate into civilian life. This outcome is therefore not necessarily applicable to the whole CF group.

### **Linkage of Outputs to Ultimate Outcome**

The VIP theory surmises that if eligible Veterans and other recipients have access to the VIP services they need and, if as result of these supports their home care and support needs are met, then VIP will contribute to the ultimate outcome. Although other factors (e.g., health status, family support, community and provincial support programs) may also influence this outcome, based on the evidence and analysis, it is the opinion of the evaluation team that, as a result of the VIP recipients' access to home and community care and support services, the ultimate outcome is achieved.

By supporting the achievement of program outcomes, the VIP provides support to achieving VAC's first strategic outcome: *"Eligible Veterans and other recipients achieve their optimum level of wellbeing through programs and services that support their care, treatment, independence and re-establishment"*. Although other factors (e.g. health status, family support, community, provincial support programs and other VAC programs and supports) may also influence this outcome, VIP recipients have access to home and community care and support services. By having these needs met, VIP recipients are enabled to remain in their own homes and communities. Therefore, VIP directly supports the achievement of this outcome.

### 5.3 Unintended impacts

It appears that unintended impacts related to the VIP may be occurring. Examples of unintended impacts include:

- Some recipients in rural and remote areas may not have access to some services and supports.
  - As discussed earlier in the success section under the progress towards the first program outcome.
- Certain VAC recipients and non-VAC recipients may have needs that are not being met by the VIP.
  - As noted in the findings of the *Survey on Transition to Civilian Life*, there appear to be unmet needs and program reach issues for approximately 10 percent of a recent survey population (Table 3).
- Various recipients receiving services which they may not require.
  - As elaborated on in the relevance and success sections approximately 30 percent of the surveyed CFV VIP population may not need the VIP support they are receiving (Table 3).
- Eligibility criteria and assessment methodology excluding some individuals who have VIP-like needs.
  - For example, a War Service Veteran without a pensioned condition and is not low-income, who may be at risk because of declining health, social isolation or for other reasons, is not eligible for VIP and would not receive any assessment of need.
- Long-term dependencies created for some recipients who appear to have short-term needs.
  - As explored under the relevance section, in terms of long-term access to the program for some of the younger CFV.
- Outcomes are not necessarily appropriate for some CFV and the intermediate care element.
  - Not aiming to maintain health of most CFV and prevent institutionalization.
  - Difficult to link 'home care needs and supports are met' when in a facility setting.

These potential unintended impacts were identified and analyzed based on information collected from the recipient survey, recipient file review, document review, as well as staff and key informant interviews.

## 5.4 Overall Conclusions of Program Success

- The risk/impact of not capturing sufficient performance information is high. There is a risk to program management by not accurately measuring recipient uptake and progression through the continuum of care. This also impacts on the ability to evaluate program success and results in gaps in information needed to manage the VIP.
- There are many unmet needs for home care and support services among the CFV population (including VAC recipients and non-VAC recipients) therefore the program is not achieving the optimum level of performance for this recipient group.
- There are different performance results for each recipient group and even though they have the same desired program outcomes, the actual results achieved are different for the surviving spouse/primary caregiver recipient group as they do not have access to the whole spectrum of VIP benefits and services.
- There appears to be recipients receiving services which they may not need on a long-term basis, but the evaluation team is not able to confirm this due to a lack of ongoing monitoring and file documentation<sup>84</sup>.
- Based on possible inappropriate long-term use of the program it appears that the VIP may be creating dependencies for a particular service or benefit.
- Although VIP provides physical ADLs and IADLs, there is a lack of mental and social support focus, which is an important component of overall health and well-being, and is a relevant aspect for the younger CFVs who are trying to reintegrate into society.
- VIP should focus on in-home outcomes as this more in-line with the original program objective and the provision of 'home care'.
- Although there has been progress and effort in improving VAC's state of performance measurement and reporting, the evaluation team agrees that the lack of performance information related to outcomes still represents a significant challenge for evaluation reporting purposes.

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<sup>84</sup> Thompson JM, MacLean MB, Van Til L, Sudom K, Sweet J, Poirier A, Adams J, Horton V, Campbell C, Pedlar D. *Survey on Transition to Civilian Life: Report on Regular Force Veterans*. Research Directorate, Veterans Affairs Canada, Charlottetown, and Director General Military Personnel Research and Analysis, Department of National Defence, Ottawa. 04 January 2011:103 p.



## **6.0 PROGRAM EFFICIENCY AND EFFECTIVENESS**

In order to evaluate the effectiveness of the program, the evaluation team considered whether the outputs of the program were being effectively achieved in relation to the resources utilized and whether the results demonstrated that the program was achieving its objective effectively from a cost and outcome achievement perspective.

### **Changing VIP Roles and Responsibilities**

The VIP is managed by a relatively new organizational structure led by the VIP Program Management Unit, with the assistance from the Performance Measurement Unit, Policy Division, and Finance Division. The Residential Care Directorate is also involved in the management of the intermediate component of the VIP, through management of the Long-Term Care program. The VIP is delivered through the Service Delivery Management area, via the regional and district offices with operational support and guidance from Head Office. The payment processing for the VIP is conducted through a third-party contract that is managed via the Department's Contract Administration Unit.

### **Recent Program and Administrative Changes**

Since the program was first implemented in 1981, it has seen many changes in terms of the eligibility to Veterans and other recipients, the scope, services offered, the delivery of the program and the processing of payments. For a program chronology of the VIP, please see Annex K.

Specific examples of changes the VIP has undergone include:

- award of the third-party contract for payment processing to Medavie Blue Cross (2002);
- expansion of eligibility criteria to included primary caregivers (2005), surviving spouses (2008) and allied veterans (2010);
- increased delegated authority to CSAs to approval renewals and reassessments of contribution arrangements of low risk recipients (2006);
- Frail Policy (2003) and policy revision (2011) that clarifies providing VIP when a pensioned condition contributes and impacts the recipients' ability to remain self-sufficient in their principal residence;
- advance pay is introduced as an alternative method of payment (1992);
- registered service providers are introduced and VAC staff are encouraged to discontinue offering the advance payment method (2003);
- introduction of case manager title and change in recipient case load to high-needs only (2010);
- reduction of home visits by VAC staff for assessments, and maximizing use of already completed assessments (2010);
- amended contribution arrangement form and one signature requirement (2010);
- increased CSA delegated authorities to the same level as case managers; and
- direct deposit payment option (2011).

Significant organizational changes in Head Office have also occurred in the past few years, including the addition of a VIP Program Management Directorate and the re-organization of the National Operation Division to create Service Delivery Management. These organizational shifts have resulted in new positions, roles, responsibilities and reporting relationships for VAC staff. Some of these relationships have not yet been clearly defined and divided, causing some confusion among Head Office staff in terms of division of responsibilities and for field staff in who to contact on specific topics. The unintended impact in some situations is the creation of information and project ‘silos’ among divisions and some field staff feeling confused and not in receipt of complete information and policy direction. Progress is being made in Head Office to streamline and rationalize management of the VIP; however, this seems to have resulted in a mix of program, functional and geographical management, which is not always consistent, so there are “many fingers in the pie”. With several directorates involved, communication protocols are often unclear and lead to inefficiencies in program management and delivery. Some areas, such as policy and processes, are trying to come together as an integrated whole through the program areas. These will be discussed below in Current Roles and Responsibilities for the VIP.

Aside from these VIP-specific changes, VAC has realized many other changes, including the implementation of the New Veterans Charter and its suite of programs. The addition of this significant program has meant that district offices have had to learn and work within a new set of legislations, policies and processes, on top of existing programming.

Recent research studies<sup>85</sup> assessed the potential of incorporating one common assessment tool, and associated levels of care, for assessment of eligibility and need for VAC programs. The Hollander and Prince Framework for Organizing Integrated Systems of Care for People with Ongoing Care Needs<sup>86</sup> outlines ten administrative and clinical best practices for organizing a system of continuing/community care, including a single/coordinated entry system, standardized system level assessment and care authorization and a single system level recipient classification system. Although an integrated model is an attractive solution, it was found to be outside the scope of this evaluation.

## **Current Roles and Responsibilities for the VIP**

During the interview process for the evaluation, the team determined that there continues to be some perceived confusion of roles and responsibilities, specifically at the Head Office level between program management, operations, and performance measurement and from the regional and district office staff for who to contact with questions. Field staff interviewed made frequent comments in regards to unclear/grey policies, the lack of business processes or procedures provided following updated policies (or no training provided) and confusing mixed messages from Head Office regarding policy interpretations. Communication is problematic, both among Head

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<sup>85</sup> Keeping the Promise, Continuing Care Research Project, and Health Care Services Review.

<sup>86</sup> Hollander M & MacAdam M. *Strategic Review of Home Care Services as Part of the Alberta Continuing Care Strategy*. Strategic Literature Scan of National and International Home Care Services. Alberta Health and Wellness. May 2010.

Office units and to the field. Timely delivery of consistent information is an issue of which the Department is aware, and is in the process of addressing.

At the time of the fieldwork (fall 2010), the Service Delivery Advisory Team (SDAT) was responsible for addressing questions of clarification with one voice to staff. The SDAT has since been rolled into the responsibility of Program Management. Program Management is also responsible for the release of directives, business processes and other operational information. All policy updates must now be accompanied by business processes and directives. An interview with policy representatives indicated that all VIP policies, program directives and processes should be updated and distributed to the field along with communication and training plans by spring/summer 2011. As part of this process, an operational impact assessment is also conducted to determine timing and release impacts on field staff and recipients.

During the evaluation fieldwork, the Deputy Minister also announced additional departmental re-organizations. First, the Program Management Division has integrated its operations with the Service Delivery Management Division in the Service Delivery (SD) Branch. The purpose of this amalgamation was to ensure VAC program outcomes are more clearly and strongly linked to service delivery processes. Secondly, the policy, communications and commemoration activities were amalgamated into one branch to ensure VAC policy options are well communicated and that recipients are appropriately consulted during a time of rapidly changing recipient demographic profiles and needs<sup>87</sup>.

There are also several changes underway in regards to roles and responsibilities for field staff. With the conversion from area counsellor to case manager, recipient caseload has changed from approximately 300 recipients for each area counsellor to 30-40 high needs, case managed recipients for each case manager. This change means that lower risk recipient caseloads will be transferred to CSAs. In order for the CSA to properly counsel and administer services their delegated authority is being assessed as well as the required training. The risk to recipients is that potential needs are not being identified appropriately and in sufficient time, due to high caseloads and assessments being conducted over the telephone only.

## **The Future**

In today's aging workforce the Department is beginning to see the first group of baby boomer staff retiring, of whom many had substantial departmental knowledge and program management/delivery experience. With the future departure of additional staff, and the shift in organizational responsibilities, it will be an ongoing challenge to retain corporate knowledge and skilled staff.

As the demographics of VAC recipients have begun to change dramatically, the Department is in the process of moving forward and evolving to meet the needs of the growing group of new Veterans, transitioning to civilian life, and their families, who have different needs than the traditional recipients. The 2009-2014 Five Year Strategic Plan

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<sup>87</sup> Suzanne Tining, Deputy Minister. Email to All Department & Agency Mail Users. Subject: On the road to transformation. 2010/11/17.

identifies that while VAC's mandate will not change, the recipient profile is already changing as is the nature and mix of benefits and services needed; therefore a strategic priority will be to ensure VAC's workforce will evolve as well as its service model to meet the needs of the changing group of recipients.

The following excerpt from a feature story in Maclean's magazine (MacQueen, February 23, 2011) illustrates one provincial approach of an integrated care model:

*"Ontario's \$1.1-billion Aging at Home Strategy has seen an overdue investment in badly needed nursing home and rehab beds, and home-care services. It's allowed Nowaczynski, at a cost of less than \$500,000 a year, to lead a roving team including a social worker, occupational therapist, a nurse and nurse practitioner. Keep just 10 people a year out of nursing homes and the program pays for itself, he says. Then there's Dr. Samir Sinha, the dynamic new director of geriatrics at Mount Sinai in Toronto, who approaches eldercare with evangelical zeal. The hospital board gave him a mandate to do what's best for its older patients, to make geriatrics a core priority, to have an integrated team deal with every aspect of their hospital stay—and, where possible, to meet their needs as outpatients or at home. "Our goal," says Sinha, "is that people in the community never have to come visit our hospital.""*

## **Regional Variances**

Although the VIP is a nationally delivered home care program, it is a top-up to provincial home care services and supports, therefore the degree of involvement of VAC resources is directly related to the supports that provinces are able to put in place. The type and degree of support offered across Canada varies from province to province, leading to some areas of the country having a stronger role and responsibility for VIP recipients than other areas. During the interview process, it was also mentioned that as provincial budgets tighten, the degree of support offered through the home care services has decreased.

Regional variances are a reality that affects the consistent application of the VIP across the country. Another factor affecting regional variance is the interpretation and application of VAC policies and procedures. The 2010 VIP Audit reported policy interpretation and policy application inconsistencies. At the time of the audit, and still underway, were policy initiatives aiming to create a national policy framework with ongoing monitoring. Other factors which may influence regional variances in VIP are:

- cost of services varies across the country – snow removal in the Atlantic provinces compared to lawn maintenance in British Columbia (contribution arrangement limits same everywhere);
- WSVs and WSV surviving spouses/primary caregivers are more dependant; proximity to support service is very important; this group uses traditional access methods; and
- CFVs and CFV surviving spouses/primary caregivers are generally more comfortable using technology and other non-traditional approaches to access support services.

## Program Inputs

Inputs of the VIP program include the direct and indirect costs associated with delivering and supporting the VIP (program costs and administrative costs). The input costs being reported and analysed in this evaluation are those that are incurred annually. Estimated 2010-2011 costs for the VIP program developed by the Department in response to the *2010 Independent Assessors Report* fiscal year were provided to the evaluation team. Estimated figures are illustrated in Table 10.

## Program Costs

In 2009-2010 VAC paid out just under \$338 million in VIP program benefits, as shown in Annex L, VIP Expenditures by Element. The 2011-2012 VAC Forecast Cycle document highlighted that in 2009-2010, war service expenditures made up 85 percent and Canadian Forces expenditures made up 15 percent of the overall VIP expenditures and that by 2019-2020, war service expenditures are forecasted to make up 47 percent and Canadian Forces expenditures 53 percent of the overall VIP expenditures.<sup>88</sup>

Average program costs vary by recipient type, region and element. The average program cost for the VIP per recipient for 2009-2010 was \$3,135. War Service Veterans have higher average costs than Canadian Forces Veterans, due to increased utilization. In 2009-2010, WSVs had an overall average cost of \$3,827 while CFVs had an average cost of \$2,607. Surviving spouses/primary caregivers had an average cost of \$2,174<sup>89</sup>.

## Administrative Costs

The 2006 Treasury Board Submission to renew the VIP indicated that the Department does not capture administration costs, including full-time staff utilization (FTEs), on a program by program basis. A high level estimate of for VIP from the Treasury Board Submission indicated annual program delivery costs of approximately \$27 million. Subsequent estimates have confirmed the accuracy of this estimate with program administrative costs estimated at approximately \$30 million (less than 10 percent of total expenditures) for 2009-2010. This increase is in line with expectations due to program expansions since 2006 and increased age-related needs of the war service population cohort.

The following table summarizes all input costs for 2007-2008 to 2009-2010 to provide the total average costs per recipient (including program and administration costs):

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<sup>88</sup> Veterans Affairs Canada Client and Expenditure Forecast. 2011-2012 VAC Forecast Cycle. VAC Statistics Directorate. August 2010.

<sup>89</sup> Ibid.

**Table 7: Program Input Costs**

Fiscal Year	Program Input Expenditures					Number of Unique Recipients	Average Cost per Recipient
	Salary	O&M	FHCPS	Program	Total Expenditures		
2007-2008	(§)	(§)	(§)	(§)	\$332,562,498	103,119	\$3,225
2008-2009	(§)	(§)	(§)	(§)	\$351,117,534	106,076	\$3,310
2009-2010	(§)	(§)	(§)	(§)	\$370,079,603	107,798	\$3,433

Source: Veterans Affairs Canada Client and Expenditure Forecast, 2011-2012 VAC Forecast Cycle.

Note: (§) means "Protected from disclosure in accordance with the provisions of the *Access to Information Act*".

The number of FTEs, as well as Salary and Operations and Management (O&M) expenditures for the VIP were derived from estimates for the 2010-2011 fiscal year. These estimates were provided to the evaluation team by Service Delivery and Commemoration Branch and Policy Programs and Partnerships Branch, showing a projected 350 FTEs required for the VIP. Salaries and O&M for the VIP were then discounted back by 4 percent per year for each of the years evaluated. Salary and benefits and O&M expenditures are not coded by program area, and the Department does not have a framework for capturing these costs. Salary (§) and O&M expenditures (§) include both Head Office and field estimate costs, but not FHCPS contract estimate costs relating to VIP transactions (§).

Combining the input costs with the program costs shows a total estimated weighted average cost of the VIP at \$3,433 per recipient for 2009-2010. This means that the total average administrative cost is reasonable at slightly less than (§) per recipient.

### Resource Efficiency and Effectiveness Initiatives

Due to the Transformation initiative's effort to streamline administrative processes and improve recipient service, recent and anticipated changes will have a significant impact on the resources required for VIP:

- amended VIP contribution arrangements process and form requiring only one signature will streamline the application process and save the program an estimated 12 FTEs (Nov 2010);
- direct deposit payment option for VIP (April 2011);
- amended delegated authority levels will enable CSAs to approve elements at a higher limit, therefore avoiding the need to wait for case manager approval and freeing up time for case managers to focus on case managed recipients (April 2011);
- implement batch mailing of annual follow-up forms and monitoring is being reviewed for implementation and it is estimated that it will save an estimated 15 FTEs (Anticipated initiation August 2011); and
- pend process streamlining is being reviewed for implementation (anticipated initiation is July 2011).

Understandably these decisions were made/are under review in order to improve service for VIP recipients in the future and anticipated savings are only a forecast at this time and thus the evaluation team was unable to assess impacts on efficiency and effectiveness of the program.

## Program Outputs

The VIP has a number of outputs, including some outputs that cannot be directly linked to the program itself. VAC does not track the number, or percentage, of several outputs that are conducted in regards to a specific program, including case manager assessments, nursing assessments and occupational therapy assessments. A list of VIP outputs produced over the past five years was listed in the Program Success section (section 7.0), regarding linkage of outputs with progress towards meeting outcomes.

There is a lack of up-to-date information on turnaround times (TATs) for processing VIP claims. In terms of processing new applications and reassessments, the standard target is four weeks between application and establishment of contribution arrangement. The 2008 figures show that the average TAT is 22 days for first applications and 16 days for reassessments. VIP recipients are to have had at least an annual follow-up conducted by a VAC staff member; as of March 2010 Performance Snapshot report, 10 percent of recipients had not received a follow-up for that fiscal year.

Once a Veteran is deemed eligible for VIP, they typically retain such benefits for the remainder of their life, as discussed in the relevance and outcome sections. Since 2009-2010, only 1,220 recipients have had their VIP benefits end for reasons other than death, as illustrated in Table 8 below:

**Table 8: Program Attrition**

	<b>2007-08</b>	<b>2008-09</b>	<b>2009-10</b>
Death	9,913	10,302	10,154
Moved to Chronic Care <sup>90</sup>	n/a	n/a	n/a
Other Termination Reasons <sup>91</sup>	692	944	1,220

Due to a lack of continuum of care profile data, the evaluation team had difficulty tracking the transition from the home to a facility. Although the number of LTC recipients with a VIP status of 'terminated' or 'expired' is an indication of transition, a lack of specificity by program area rather than bed type or care level, does not enable further analysis of the attrition from VIP to the LTC program. Also, Table 8 does not reflect reduced contribution arrangements but VIP recipients may have specific elements terminated or reduced. These individual recipient changes are not currently captured as program performance measurements.

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<sup>90</sup> See Annex G: Evaluation Successes and Limitations.

<sup>91</sup> Data integrity is suspect due to the caveat that some come off and go back on VIP for varying reasons and/or some recipients only have one year contribution arrangements that need to be manually followed up, or the system counts as terminated.

## 6.1 Efficiencies

Program costs and the number of recipients continue to rise annually. For the 2007-2008 to 2009-2010 period, total program expenditures increased from \$303 million to \$370 million, and the number of recipients increased from approximately 103,000 to 108,000. While total program costs increased by 22 percent, the total cost per recipient increased by only 17 percent, indicating that the program was more efficient in delivering more services to recipients while not increasing the administrative costs. According to estimates provided by the divisional areas, since 2007-2008 program spending increased by 11.5 percent while the salary and O&M costs increased by only 9.3 percent.

It is difficult to compare and measure the efficiency of the program over a number of years, as there have been so many significant changes in and around the VIP. Efficiency is however, largely measured by the satisfaction of recipients who receive services and support under VIP. The Continuing Care Research Project also reviewed the comparative costs for OSVs before and after the introduction of the OSV pilot program and estimates that 7-8 times as many people could be cared for in the home as compared to a facility, for the same money.

Due to large recipient numbers, inefficiencies in case management, length of approval processes and expediency of assessments, there appear to be inefficiencies in the delivery of the VIP<sup>92</sup>. This section will highlight on some of the issues identified by the evaluation team.

### Short-term and Long-term Care Access to the Program

VIP was originally designed to support elderly Veterans to avoid/delay LTC, not for meeting acute/short-term needs nor institutional needs. WSVs and CFVs are in differing life health situations as mentioned earlier in the report, so more monitoring and supporting processes would improve the efficiency of VIP delivery. CFVs were added as an eligibility type to the VIP, however few supporting processes and procedures were provided to staff to guide in dealing with their differing life and health situations.

There is evidence that many staff have a fear of repercussions of removing VIP entitlement for CFVs as there is a strong possibility of political and media attention. As Public Servants are limited by *Privacy Legislation* and are unable to discuss specific cases, in cases of media interest, the public often does not understand why VIP was removed, especially when popular sentiment is very supportive of Veterans. The program's complex eligibility system is also a factor in the way the public views the program on the surface, and who does or does not have access.

FHCPS does allow the system user to create a contribution arrangement for less than one year; however, as the system defaults to twelve months, it is the responsibility of the user to manually enter a termination/review date, and remember to follow-up to determine if there is a continued need for VIP. Two limitations appear to be present

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<sup>92</sup> 2006 VIP RMAF/RBAF.



when assessing short-term contribution arrangements: (1) The system capability is there, however there is a lack of supporting process documentation and (2) the conventional practice in the field is not to implement contributions for less than one year terms.

There is difficulty in tracking those in receipt of VIP benefits for less than one year, as there is no specific termination code for short time use. Also, there is difficulty in tracking decreased use of the program, for example if the individual is reassessed and continues to receive VIP, but at a lower frequency level. A majority of field staff indicated that some VIP recipients may not need VIP and suggest there should be more re-assessing of continued needs. Feedback from the field also showed no knowledge of the ability of the system to retain contribution arrangements for less than one year, nor was there any documentation found online. On an ongoing basis, about 10 percent of follow-ups are overdue, which means that the individual could continue receiving support even beyond one year. In the majority of interviews, it was mentioned that the longer recipients are on VIP, the harder it may be to stop support as recipients become reliant on the services. This is not an efficient use of resources and was addressed in the first recommendation.

An analysis of duration times on VIP since 2001 (cumulative recipient count) shows that the average duration on VIP is almost four years, with only 12 percent of CFV recipients accessing VIP for less than one year<sup>93</sup>.

**Table 9: CF Duration on VIP (non-facility elements) since 2001**

Duration	Count	Percent
0 - 1 year	2,369	12
1 - 5 years	11,094	57
6 - 10 years	6,069	31
<i>Average Duration</i>	<i>3.68</i>	
<i>Total Recipient cumulative count</i>	<i>19,532</i>	

NOTE: This is a cumulative count, so the team was not able to distinguish how many of this group began the VIP within the last year and should not be included. Removing current-year recipients would provide a more robust view of the duration on VIP.

## Pends

Another area where efficiency should be improved is with regard to those recipient claims that are placed in “pending” status. A pend can occur for a number of reasons such as surpassing contribution arrangement expenditure limits, submitting a claim for an element that is not approved, or submitting a claim for an expired period. A point-in-time pend status report is generated and provided to the district for follow-up and disposition. However, the system is unable to track the number, type or reason over time for resolved pends and managers are unable to obtain aggregated or sorted historical data to see why recipients’ claims are pended and if there are trends or patterns which may signal a need for action. Thus there is no way of knowing if

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<sup>93</sup> FHPCS data.

program adjustments are needed to address repetitive aspects of this workload-intensive process. It is the opinion of many district interviewees as well as Contract Administration, that most pends are resulting from insufficient funds in the recipients account. In other words, recipients are claiming funds beyond their established contribution agreement. A recent point-in-time VIP pend report confirms the frequency of pends due to insufficient funds with almost three quarters of the pends generated for this reason. Without additional tracking data, the evaluation team feels there is a possibility of an inefficient administration of resources in the districts. This may also indicate VIP assessment inefficiencies.

## **Assisted Living Facilities**

Efficiencies could be gained by allowing Veterans to enter assisted living facilities if the level of care is appropriate for the care provided by the facility. Some Veterans may not be able to care for themselves at home, but because of a lack of VAC support for assisted living facilities, are moving into LTC facilities. The team does not have statistical data to support this finding, however past studies and reports, staff interviews and recipient file reviews support the fact that assisted living facilities are being requested and VIP needs to align its support with this housing choice. The Continuing Care Research Project as well as a recent internal study found that there is potential for VAC to obtain systems level efficiencies by substituting lower cost home care or supportive housing for LTC, when possible. VAC recently amended its definition of principal residence to reflect changing societal trends in housing options, such as assisted living.

## **Efficiency Conclusions**

In order to gain additional efficiencies for the program, the Department should consider the following:

- VIP is not appropriately supporting short-term access to the program due to lack of program processes for staff to support the delivery of services and a lack of system configurations to appropriately track contribution periods for fewer than twelve months.
- There appear to be inefficiencies with regard to processing pended VIP claims and there is also a lack of tracking data for these pended claims.
- The Transformation work is also conducting several streamlining initiatives which may impact positively on efficiency, continued efforts by this team should aid in streamlining administrative duties within the program.

Other factors highlighted in the report that relate to efficiencies:

- streamlining eligibilities and access to programs would provide additional efficiencies and avoid unnecessary applications to gateway programs; and
- re-aligning VIP design as a home care approach versus a mix of home care and facility care would enable the program to focus its attention and demonstrate progress towards outcomes more efficiently and effectively.

## 6.2 Effectiveness

During 2009-2010 there were just under 108,000 VIP recipients including 56,000 WSVs, 18,000 CFVs, and 34,000 spouses/primary caregivers. VIP individual needs vary from straightforward to complex; as such, the level of VIP benefits each recipient receives varies depending on needs.

As demonstrated throughout the report, the VIP is considered a successful program by assisting recipients in maintaining more of their independence and preventing or delaying their institutionalization, resulting in substantial health care expenditure savings and other societal benefits<sup>94</sup>.

### Value for Money/Cost-Effectiveness of the VIP

There is compelling evidence, as documented throughout the report, that VIP contributes to allowing recipients to stay in their home for as long as possible and thereby preventing the cost of substantially more expensive care delivered in a facility setting.

VIP services are aimed at eliminating or delaying the need for institutionalization resulting in reduced health care cost. The table below demonstrates the considerable cost-effectiveness realized from home care of Veterans compared to the cost of care in a facility.

**Table 10: Cost of VIP versus long-term care in institutions**

	Average Cost of Care in Contract Bed	Average Cost of care in Community Bed (includes LTC & VIP beds) <sup>95</sup>	Average Cost of VIP Intermediate Care Bed	Average Cost of VIP (at home)
<b>2009-2010</b>	\$ 61,961	\$13,486	\$ 9,483	\$ 2,761
<b>2008-2009</b>	\$ 61,926	\$12,937	\$ 8,918	\$ 2,646
<b>2007-2008</b>	\$ 57,103	\$12,806	\$ 8,488	\$ 2,573

NOTE: The Department often reports on LTC beds by type rather than by program. A Contract bed is solely under the LTC program, whereas a community bed can be accessed by both programs. Due to this fact, the evaluation team also included the average cost of a VIP bed through the intermediate care element.

Since there was an absence of sufficient performance information to fully evaluate the ability of the VIP to achieve its expected outcomes the evaluation team had some limitations associated with measuring the cost-effectiveness of delivering the VIP. In order to provide more strength in the value for money assessment portion of the evaluation, the team reviewed recent extensive cost-effectiveness reports conducted, especially the 2008 *Continuing Care Research Study*. The CCRP examined costs from two potential views: (1) caregiver time at minimum wage and (2) caregiver time at

<sup>94</sup> Strengthening people with their communities and closer to their family, by freeing up some money the Veteran may have needed to spend on health care bills they are able to refocus finances on other items that help to improve their life. Also, support through VIP allows provinces more resources to focus on other individuals in need.

<sup>95</sup> A VAC community bed can be under both the LTC program (Type II & III) as well as the VIP (Type II); dollar figure data is presented by bed type rather than by program due to statistical reporting format available.

replacement wage<sup>96</sup>. In each situation, results indicated that care for individuals in the community was less expensive than caring for individuals in a facility. The overall average total societal cost range for caring for someone in the community was estimated at \$31,000-\$37,000 compared to \$87,000-\$111,000 in a facility<sup>97</sup>. In summary, the CCRP found that community care compared to facility care was substantially more economical, with cost-effectiveness estimated between \$50,000 and \$80,000 for care in the home. Please refer to Annex M for additional review of cost-effectiveness of home care in external and internal studies.

In lieu of an actual count on the number of individuals who would not be at home if not for VIP, the team used personal care use by recipients for 2009-2010 as one indicator to determine an estimate of the number of individuals who would otherwise be in an institution if not for VIP<sup>98</sup>. The evaluation team also considered the percentage of VIP recipients participating in the 2010 NCS self-reporting that they would not be at home if not for VIP, as well as a comparison of those receiving their first VIP intermediate care transaction between 2007-2008 and 2009-2010. These estimates are solely based on VAC costs and are considered to be minimal and conservative estimations. The team realizes that the VIP is a top-up provider, so the actual total cost per recipient (i.e., including provincial and private expenditures) are unknown.

To calculate a range of savings generated by the VIP, the team used two different 2009-2010 expenditure figures: the average VIP intermediate care cost per recipient and the average LTC community bed, other than contract bed, cost per recipient (identified in Table 10).

**Table 11: 2009-10 cost comparison of VIP personal care users and LTC costs**

		Total estimate cost comparison (based on 6,482 recipients X cost per recipient)
Number of personal care VIP users at home	6,482	
Average personal care dollar/recipient	\$3,301	\$21,397,082
Average total VIP dollar for those in receipt of VIP personal care at home	\$7,027	\$45,549,014
Average intermediate care dollar/recipient (Type II)	\$9,483	\$61,468,806
Average LTC community dollar/recipient (Type II and III)	\$13,486	\$87,416,252

In 2009-2010 there were 6,482 users of VIP personal care at home. The average total VIP contribution for the recipients in receipt of personal care was \$7,027 (almost \$2,500 below the average intermediate care expenditure). The average cost difference of keeping this group at home rather than in a facility is approximately \$16 to \$42 million

<sup>96</sup> Study conducted based on primarily 2006 costing data. Informal caregiver time was costed using \$8 per hour minimum wage rate and \$60 per hour for replacement wage for professional services and \$27 per hour for all other services.

<sup>97</sup> Hollander M, Miller J, and MacAdam M. *The Continuing Care Research Project*. Synthesis Report conducted for Veterans Affairs Canada and the Government of Ontario. April 2008.

<sup>98</sup> Supportive method used by internal file review conducted to extract information indicating that the VIP services were meeting the intent of the program and if the expected outcomes could be gleaned from information on recipient files.

annually. Annex N, Number of VIP Recipients (non-intermediate care) by Dollar Band Expenditure highlights that less than three percent of VIP recipients at home actually spend over \$9,000, indicating that VAC is spending well below the point of cost-effectiveness for care in the home compared to the average facility bed rates paid per recipient for both the VIP intermediate care and the LTC community beds<sup>99</sup>.

Another strong indication of the value of providing VIP to Veterans is the percentage of recipients surveyed in the 2010 NCS that indicated they relied on VIP to remain at home and in their community (92 percent of WSV). Applying the same costing methods above to this group shows the significant cost savings of providing VIP versus LTC.

**Table 12: Cost savings of WSV self-reporting reliance on VIP**

		<b>Total estimate cost</b> (based on 51,144 recipients X cost per recipient)
92 percent of 55,591 <sup>100</sup> =	51,144	
<b>Estimate average VIP dollar/WSV recipient at home<sup>101</sup></b>	\$3,200	\$163,659,904
<b>Average intermediate care dollar/recipient (Type II)</b>	\$9,483	\$484,995,897
<b>Average LTC community dollar/recipient (Type II and III)</b>	\$13,486	\$689,724,208

NOTE: As surviving spouses/primary caregivers are not eligible for nursing home care through the VIP the evaluation team removed this group from the following calculation population. Also, due to conflicting data from the CF Survey on Transition to Civilian Life regarding needs, as well as the average age of CF Veterans being 58 years old, this group was also removed from the calculation to provide a more accurate and credible calculation of those who would otherwise be in an institution. The evaluation team does note that there are some CFVs who would otherwise be in a facility if not for VIP or are currently in a nursing home (341). The same average dollar expenditures by recipient are used as in Table 11.

Based on the above estimate calculations, the potential cost savings of VIP at home versus VIP intermediate care in a facility for WSV recipients could be as much as \$320 million annually.

A comparison of VIP recipients who entered the program through the VIP intermediate care element at an average age of 84, compared to those who received home care benefits from the VIP that entered intermediate care at an average age of 86 further adds to the evidence of cost savings<sup>102</sup>. Based on the estimate calculations in Table 12, this two year delay represents substantial savings realized by providing VIP home care and is estimated to be approximately \$32 million annually (\$6,283 per recipient)<sup>103</sup>.

<sup>99</sup> It should be noted that the calculations in this section do not include the cost of services/supports offered to Veterans through the VAC Treatment Benefits program, other government departments, or through informal caregivers. However, recipients could be in receipt of such supports whether at home or in a facility.

<sup>100</sup> 2009-2010 WSV VIP population. VAC Quarterly Fact Sheet. VAC Statistics Directorate. March 2010.

<sup>101</sup> The average VIP program expenditure for recipients at home for 2009-2010 was \$2,761 while the average expenditure for WSV recipients at home was approximately \$3,200.

<sup>102</sup> FHCPS data.

<sup>103</sup> The calculation was based on 84 percent of the 2009-2010 VIP intermediate care population (5,990) multiplied by the average WSV recipient cost at home (\$3,200) and compared to the average VIP intermediate care recipient cost (\$9,483). Total savings over the two years is estimated to be \$63 million.

The evaluation team concludes that the VIP is very cost-effective when compared to long-term care costs.

## **Effectiveness Conclusions**

- VIP has long been considered a successful program by assisting recipients in maintaining more of their independence and preventing or delaying their institutionalization, as well as providing financial and care support to informal caregivers and families.
- By providing VIP the Department is aiding in achieving substantial health care expenditure savings and other societal benefits for Canada, as if there was not VIP, these individuals would be relying more strongly on provincial support as well as support from informal caregivers and not-for-profit organizations.
- The majority of VIP recipients feel they would not be at home if not for VIP; if there were no VIP, the cost implications on the health care system are not known, but deemed to be very significant.
- When comparing the average cost of VIP per recipient to that of care in the facility, there is clear cost-effectiveness evident.
- There are areas that VIP could improve cost-effectiveness as it pertains to efficiencies: monitor and support the use of short-term contribution periods (when appropriate); maximize use of already completed assessments; streamline and fix administrative issues associated with pends; provide more policy and program design support to other housing options (e.g. assisted living) to prolong and delay higher cost institutionalizations.

### **R5 It is recommended that the ADM, Service Delivery (Critical):**

- 5.1 Make adjustments in processes, systems and capacity (HR and data capture) so that the necessary information is available to manage and evaluate the VIP on an ongoing basis;**
- 5.2 Implement a tracking process in the FHCPS system to report on pends generated and their results;**
- 5.3 Institute ongoing measurement of utilization of resources for the VIP; and**
- 5.4 Put in place a system edit and/or an internal quality control check to improve the data integrity of the Canadian Forces Still-Serving eligibility field.**

## **Management Response:**

- 5.1 Management agrees with this recommendation. Currently the majority of VIP processing is done through the Medavie Blue Cross System, FHCPS, providing limited statistics. A business case for 'Electronic Tracking Functionality for the Veterans Independence Program' was prepared by SDC in March, 2011. This

initiative has been developed to allow for VIP adjudication transactions to be tracked within the CSDN. The project is expected to start in June 2011. This system enhancement will strengthen the Department's ability to track and capture output information that will allow for efficiency monitoring.

The second part of program performance is in the measurement of recipient outcomes and determine if the program is actually having a positive impact on the ability for recipients to remain in their homes and communities. In the last Client Satisfaction Survey, VIP Program Management added questions that provided more recipient outcome questions than in the past. The intent is to continue with that direction going forward. Secondly, VAC's Research Directorate is working with data from the "Life After Service Study", secondary analysis is ongoing and VIP Program Management will continue to work with that team to maximize recipient outcome data to better inform future direction.

Lastly, under Transformation, a Business Process Re-engineering initiative will be undertaken to map then streamline VIP processes in the field. This will consider the "recipients experience" and should inform where we can improve that experience going forward.

- 5.2 Management agrees with this recommendation. As part of the Pends Reduction project, Program Management is working with Contract Management and the payment contractor to reduce the number of Pends returned to District Offices for action. Part of this initiative will be to develop monthly reports which show the number of VIP claims rejected and pending in each District. These reports are expected to be available in July 2011.

The comprehensive VIP tracking system (described in 8.1) will be developed within the CSDN to capture and report on all data involving VIP claims processing, including additional Pends data. The target date for this enhancement is 2012/13.

- 5.3 Management agrees with this recommendation. Service Delivery and Program Management is currently working on a workload measurement/allocation model for case managers. Following the implementation of the tools to support this model in summer of 2011, Service Delivery and Program Management will then be focussing on workload measurement of VIP. Also, the development of the VIP electronic tracking enhancements in the CSDN, due to start in June 2011 will provide Service Delivery and Program Management with a central view and accurate information on work associated with administration and delivery of the Veterans Independence Program.
- 5.4 The issue of still-serving Canadian Forces members is not unique to VIP but to all programs. With respect to the VIP, this issue is relevant to the follow-up process and the corrective actions for Recommendation 1 should address this issue. Management will also consider using a random file sample for the review to address the issue.

## **Management Action Plan:**

<b>Corrective Action to be taken</b>	<b>OPI (Office of Primary Interest)</b>	<b>Target Date</b>
5.1 Establish Electronic Tracking Functionality for the Veterans Independence Program within the CSDN.	DG SDPM & IT	Start project Summer 2011  Completion March 2013
5.2 Develop monthly Pend/Reject reports from FHCPs.	DG SDPM	July 2011
5.3 Develop and implement a workload measurement/allocation model.	DG SDPM	Start project late summer 2011  Completion March 2013
5.4 The corrective action in Recommendation 1 will address 5.4.		

### **6.3 Alternatives/Suggestions for Improvements**

Over the years, different alternatives have been applied to the delivery of the VIP in order to improve efficiency and effectiveness; the most significant change was changing the primary method of payment for the program to advance pay. This initiative did not prove to provide the intended results of less impact on resource use as program costs were negatively impacted, thus the approach was reverted back to reimbursement.

Internal studies were also conducted to assess the viability of changing the program, or part of the program, to a grant based program. Although an initial study indicated this would be feasible, more efficient and cost-effective for the program, a subsequent study determined that this would only be partially true as costs associated with changing the legislation and policies would outweigh the benefits. The largest group, the WSV, would have to be grand-fathered in as a change process for these elderly Veterans would be problematic. The risk associated with changing the delivery of this program is also high due to the high profile of this program politically and publically. It is inevitable that if any changes are made to the VIP, the public at large will be concerned if perceived as negative in any way.

Several research studies also reviewed the idea of a totally needs-based system. The studies assessed the applicability of industry standard assessment tools and levels of care models that would enable the VIP to be totally needs-based and eliminate the cumbersome eligibility and entitlement processes, ensure services are provided in line with the level of care of the individual required, and allow for departmental tracking of recipient care levels, trends and changing needs. However due to very high cost implications for a recipient group that is drastically declining, such an approach was deemed not fiscally viable as the Department does have an assessment tool which appears to meet minimum need requirements.



## 6.4 Overall Program Efficiency and Effectiveness Conclusions:

- Though the VIP has improved efficiency over the years, there is room for increased efficiency delivering VIP and in better meeting program outcomes.
  - Designed by recognized experts in the home care field and has been positively reviewed since implementation in 1981.
  - Continuous efficiency adjustments (e.g. advance pay was tested, but was deemed not efficient so it was eliminated).
- Though the cost per recipient has reduced over the years, there have been additional eligibilities that are limited to two elements and/or low dollar contributions, while the aging Veterans have increasing needs thus the cost per recipient for this group is growing, though the WSV population is dropping off at a steady pace.
  - New recipients that are younger and potentially not in need for VIP for their entire life appear to continue to receive VIP, cost savings could be realized by promoting more independence and monitoring health improvements more diligently.
- Although there has been an increase of \$1 million in salary and O&M costs since 2007-2008 there has been a 5,000 increase in recipients as well as a recognized increase in age related needs and program consumption. Thus efficiency of the program has increased over time.
  - Though additional eligibilities and recipients with differing needs have come on to the VIP, there have been no major staffing additions, but there have been adjustments of required skill sets, increase in delegated authorities and responsibilities and a re-allocation of tasks and resources.
- Data and system limitations restricted the evaluation team's ability to comment on overall cost-effectiveness of the VIP and to quantify the extent to which the program is exceeding the outcomes.
- The program has a centralized policy, procedures and monitoring mechanism in place, however to date there have been issues with consistency in communication and application.
  - Policy area making great strides to streamline policies in the spring of 2011 (i.e. program policy overhaul eliminating unnecessary information in policy and pushed down to processes, procedures, and directive level).
  - Service Delivery area is also involved to assist in the processes/directives and the communication of the policy packages with one voice to all staff.
- There do not appear to be alternative design and delivery approaches that would be more efficient and still provide value for money, however within the existing program design and delivery approach, efficiency gains could be realized.
  - Some models, such as the United-States totally self-directed approach, could be more applicable for the younger CFV; however, there are accountability issues which would have to be resolved.
  - Grants rather than contributions for some elements of the contribution arrangement may be more efficient for the younger CFV, but as shown by recent media issues, feedback surrounding disability awards and the rapid mortality of the WSV group, the program delivery mechanism should be

- re-examined with a view to tailoring to the needs of the growing CFV and surviving spouse/primary caregiver population.
  - Advance pay, which is considered a quasi-grant approach, was determined to be less cost-effective and less efficient in delivering VIP than the reimbursement method.
- Forecasting for new program expansions has been a challenge given the limited history from which to base the forecast; in some program areas, this has resulted in an over-estimation of the planned expenditures (e.g. Survivor Expansion estimates) as actual recipient numbers and associated program spending have been much lower than estimated<sup>104 105</sup>.
  - The Department does not track administration costs by program area and less statistically valid approaches such as file reviews, samples and observations are employed.
  - System and data limitations may be a factor in limiting the ability of the Department to monitor and report on resource use by program area.
- Risk, accountability, cost-benefit, organization capacity and system limitations are some of the factors that the Department considers when assessing whether the most economical approach is used to achieve the desired results (e.g. outsourcing of payment processing for the VIP, use of contracted health professionals for assessments).
- In order to minimize the use of resources in achieving results, the Department has made several changes:
  - transferring delegation of authorities downward;
  - adjusting program delivery (e.g. minimizing home visits and more use of technology/telephone reviews);
  - outsourcing contracted assessments and payment processing;
  - eliminating two components of the program (heavy housekeeping in 1994 and ARC in 1993) due to program reviews; and
  - limiting access to the program to very restricted Veteran categories.
- More capacity to minimize resource use could be possible with more investment in technological approaches.
- Overwhelming evidence shows that the resources expended on the VIP are minimal when compared to the value of outcomes achieved.
  - Cost savings between \$175 million and \$380 million annually compared to LTC.
  - High satisfaction level self-reported by recipients that VIP meets their needs (86 percent) and enables them to remain in their homes (91 percent).

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<sup>104</sup> It should be noted that these forecasts do not speak to the capabilities and expertise of internal VAC forecasting as the estimates were provided by the Department of Finance.

<sup>105</sup> MacLean MB. *VAC Health Services Review Client and Expenditure Impact of Proposals*. Appendix E: Independent Review of the Cost Estimates. Veterans' Health Services Review. May 21, 2008.

## **7.0 DISTRIBUTION**

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Deputy Coordinator, Access to Information & Privacy

Program Analyst, Treasury Board of Canada, Secretariat (TBS)

Comptrollership Branch (TBS)

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## Australia:

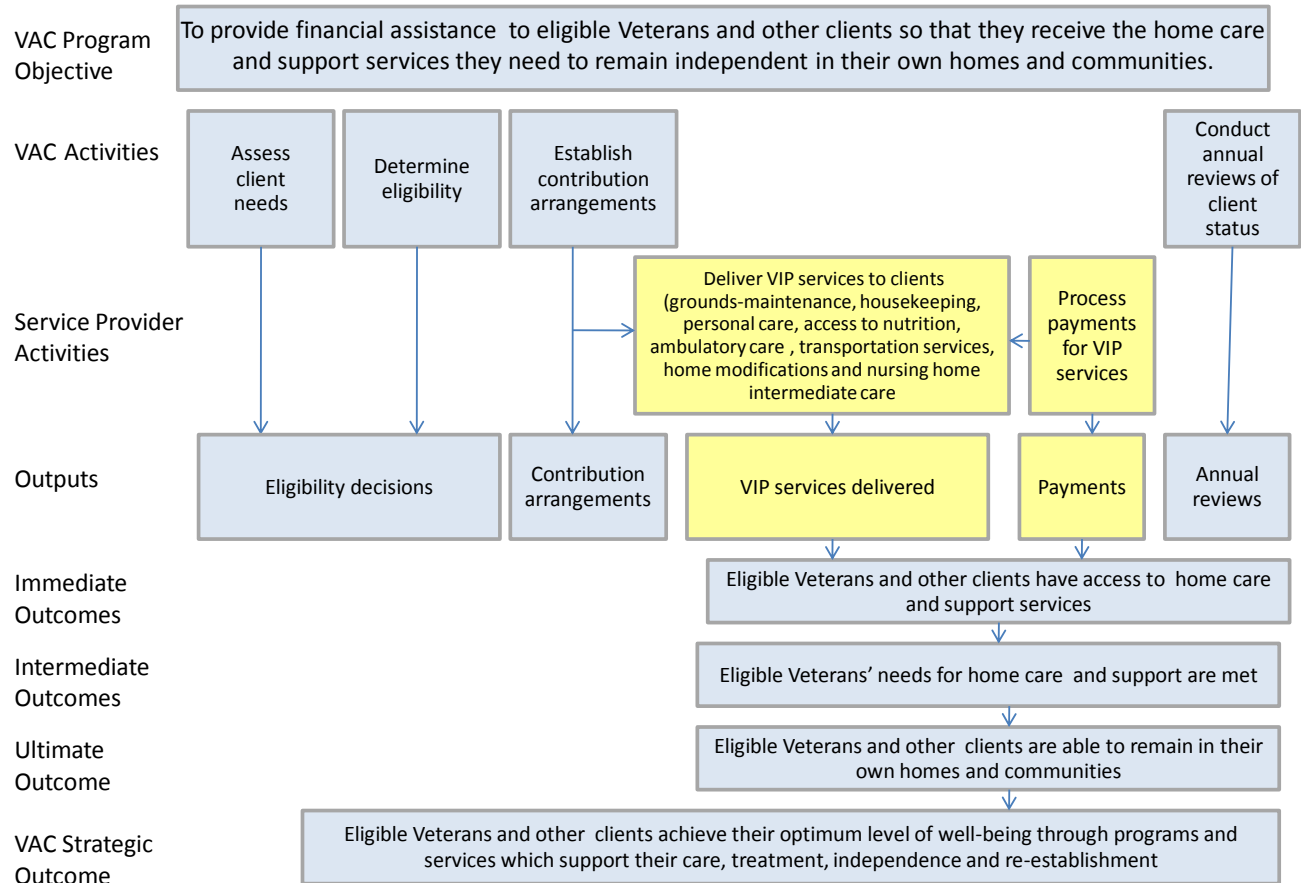
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## Annex A: VIP Evaluation Terms of Reference

<b>Project Title and Number</b>	<b><i>Evaluation of the Veterans Independence Program</i></b>					<b>2010-11.01</b>
<b>Project Type</b>	Summative Evaluation					
<b>Project Authority</b>	DG DIR/MGR(s)	Orlanda Drebit, DG, AED Kevin Edgecombe, A/Director, AED				
<b>Background</b>	<ul style="list-style-type: none"><li>• The Veterans Independence Program (VIP) is a national home care program provided by Veterans Affairs Canada to help VIP recipients remain healthy and independent in their own homes or communities.</li><li>• It was established in 1981 and has been expanded in terms of benefits and VIP recipient eligibility periodically over the years.</li></ul>					
<b>Project Objectives</b>	<ul style="list-style-type: none"><li>• To assess the extent to which the Veterans Independence Program continues to address a demonstrable need and is responsive to the needs of Veterans.</li><li>• To assess the linkages between the objectives of the Veterans Independence Program and (i) federal government priorities and (ii) departmental strategic outcomes.</li><li>• To assess VAC roles and responsibilities in delivering the Veterans Independence Program.</li><li>• To assess progress toward expected outcomes of the Veterans Independence Program (incl. immediate, intermediate and ultimate outcomes) with reference to performance targets and program reach, program design, including the linkage and contribution of outputs to outcomes.</li><li>• To assess Veterans Independence Program resource utilization in relation to the production of outputs and progress toward expected outcomes.</li></ul>					
<b>Scope</b>	Covers several SSAs including 1.2.1.2 Non-Departmental Institutions - Veterans Independence Program; 1.2.3.1 Veterans Independence Program - Home Care Services; and 1.2.3.2 Veterans Independence Program - Other Services.					
<b>Resources</b>	<b>Hours</b>	<b>DG</b>	<b>DIR</b>	<b>MGR</b>	<b>OFF</b>	<b>TOTAL</b>
	Planning	40.5	40.5	364.5	364.5	810
	Field Work	40.5	40.5	364.5	364.5	810
	Reporting	20.25	20.25	182.25	182.25	405
	<b>Totals</b>	101.25	101.25	911.25	911.25	<b>2,025</b>
<b>Notes</b>	<ul style="list-style-type: none"><li>• The Transfer Payment Policy requires an evaluation prior to the renewal of the VIP Terms and Conditions November 30, 2011.</li><li>• In addition to the risk rankings, this area was specifically mentioned by VAC senior management during our interviews as a candidate for evaluation.</li><li>• An evaluation of VIP is part of the coverage required by the <i>Evaluation Policy</i> during the 5-year cycle of all transfer payments.</li><li>• The evaluation will be informed by the findings of the VIP Audit conducted in 2009.</li></ul>					
<b>Time Frame</b>	Planning: JUL/10 – SEP/10 Field Work: OCT/10 – JAN/11 Reporting: FEB/11 – MAR/11					

## Annex B: Veterans Independence Program Logic Model

Updated 2010-08-23



## Annex C: Description of VIP services and supports

- **grounds maintenance**, including grass cutting and snow removal;
- **housekeeping**, including help with routine tasks such as doing the laundry, cleaning the home, or preparing meals;
- **personal care services** to assist with personal needs, such as bathing, dressing, and eating;
- **access to nutrition services**, like Meals-on-Wheels and Wheels-to-Meals;
- **health and support services** provided by health professionals;
- **ambulatory (out-patient) health care** for certain health and social services provided outside the home, such as adult day care, and travel costs to get to these services;
- **social transportation** costs to foster independence, for activities such as shopping, banking, and visiting friends when transportation is not otherwise available;
- **home adaptations** to modify things like bathrooms, kitchens and doorways so that it is easier to do basic everyday activities such as prepare a meal, maintain personal hygiene, and sleep. Home adaptations do not include general renovations or repairs; and
- **nursing home care** when living at home is no longer practical and a greater level of nursing and personal help is needed.



**Annex D: Total Number of Recipients by Service Type from 2007-2008 through 2009-2010.**

<b>Service Type</b>	<b>Number of VIP Recipients</b>		
	<b>2007-2008</b>	<b>2008-2009</b>	<b>2009-2010</b>
War Service Veteran	60,083	57,378	55,591
Canadian Forces Veteran	14,073	15,433	17,742
War Service Survivors/Primary Caregivers	27,356	31,667	32,711
Canadian Forces Survivors/Primary Caregivers	1,607	1,598	1,754

## Annex E: Health and Home Care – Nationally and Internationally

In all societies, there is a recognized obligation to care for the elderly. Society in general is aging; there is major population cohort that is rapidly approaching senior years when there is increased risk to health and resulting possible loss of independence. As society ages, there will be more pressure to provide assistance from the government to support them in their homes. If this assistance is not delivered in the home, research indicates that there is increased risk of injury, chronic conditions and an inability to manage independently at home. The result may be increased admissions to hospitals and long-term care institutions at greatly increased cost as illustrated by the following excerpt from a feature story in *Maclean's* magazine (MacQueen, February 23, 2011):

*“The problem is so much more than a numbers game, but the statistics make a compelling case for reform. Already, those 65 and older consume 44 percent of provincial and territorial health spending. Thirty years ago, health spending accounted for an average of 29 percent of provincial program costs. Now it tops 39 percent on average, and in Ontario, eats almost 46 percent of program spending. Today, about 14 percent of the population is 65 years or older. Their numbers will double in the next two decades, while those 85 and older will quadruple. What impact that will have on health care financing—while the workforce shrinks proportionately—is anyone’s guess.”*

Many researchers advocate home care for the elderly as a more economical alternative to care in a facility. A 2006 Statistics Canada health report<sup>106</sup> compared government-subsidized home care usage from 1994-1995 to 2003. Statistics from the report indicate a significant gap exists in home care between what is needed and what is being provided to Canadians. Indications are that the availability of home care for those in need is shrinking. Decreased numbers suggest a declining level of support from the government, a shortage of home care staff and health professionals, and increased support delivered from other caregivers (e.g., informal caregivers). The Continuing Care Research Project also underlines that there is further potential to invest in home care as a substitute for care in a facility<sup>107</sup>. The *Maclean's* magazine article also states the following:

*“Certainly the system would already be in collapse if not for the work of more than two million informal caregivers, usually spouses or adult children, whose work allows seniors to remain at home. The Canadian Institute for Health Information (CIHI) estimates the economic contribution of informal eldercare at \$25 billion a year”<sup>108</sup>.*

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<sup>106</sup> Wilkins, Kathryn. Statistics Canada Health Report. Government-subsidized home care. Vol. 17, No. 4 (2006)

<sup>107</sup> Hollander M, Miller J, and MacAdam M. *The Continuing Care Research Project*. Synthesis Report conducted for Veterans Affairs Canada and the Government of Ontario. April 2008.

<sup>108</sup> MacQueen K. Don't seniors deserve better? *Macleans magazine*. February 23, 2011.

## Annex F: List of Interviewees

The evaluation team interviewed a total of 82 individuals including VAC Head Office, regional, and district staff as well as provincial home care representatives and DND evaluation colleagues.

<b>Head Office Interviews – 20 Interviewees</b>	
	<ul style="list-style-type: none"> <li>• 2 VIP Program Management</li> <li>• 2 Service Delivery management</li> <li>• Program Performance Unit</li> <li>• 3 Policy</li> <li>• 2 Finance</li> <li>• Legal</li> <li>• Central Operations</li> <li>• 4 Service Modernization Initiatives</li> <li>• 2 Research</li> <li>• 2 Contract Administration</li> </ul>
<b>Field Interviews – 62 Interviewees</b>	
Winnipeg (23)	<ul style="list-style-type: none"> <li>• 5 National Contact Centre Network Staff</li> <li>• 2 Client Service Team Managers</li> <li>• 3 Case Managers</li> <li>• 4 Client Service Agents</li> <li>• District Nursing Officer</li> <li>• Senior District Medical Officer</li> <li>• 2 Standards Training and Education Officers</li> <li>• Regional Medical Officer</li> <li>• Regional Director Client Services</li> <li>• Regional Director General</li> <li>• 2 Provincial Home Care Representatives (Winnipeg Regional Health Authority)</li> </ul>
Ottawa (18)	<ul style="list-style-type: none"> <li>• 2 Client Service Team Managers</li> <li>• 3 Case Managers</li> <li>• 5 Client Service Agents</li> <li>• 2 District Office Nurses</li> <li>• Senior District Medical Officer</li> <li>• District Director</li> <li>• Provincial Home Care Representative (Champlain District Community Care Access Centre)</li> <li>• 3 Department of National Defence evaluation colleagues</li> </ul>
Montreal (21)	<ul style="list-style-type: none"> <li>• 2 Client Service Team Managers</li> <li>• 5 Case Managers</li> <li>• 6 Client Service Agents</li> <li>• Occupational Therapist</li> <li>• District Nursing Officer</li> <li>• Senior District Medical Officer</li> <li>• Regional Program Officer</li> <li>• Standards Training and Education Officer</li> <li>• Regional Director Client Services</li> <li>• 2 Provincial Home Care Representatives (Centre local de services communautaires Laval/Valleyfield)</li> </ul>

## **Annex G: Evaluation Successes and Limitations**

Although the evaluation team was faced with limitations and barriers in collecting and analysing information, there were also several successes for the evaluation:

### **Successes**

- Recent departmental surveys with recipients, including the 2010 National Client Survey, 2010 Long-term Care Satisfaction Survey, and the 2010 Canadian Forces Transition to Civilian Life Survey for the Life After Service Studies program and research.
- Consolidation and inventory of a substantial body of recent external national home care reports and academic articles.
- Current research initiatives and recent internal studies:
  - VIP Re-engineering Project Initiation Document
  - Transformation Agenda
  - Internal VIP recipient file reviews (program area and performance area)
  - 2010 VIP Audit.
- Major initiative (Transformation Agenda) underway at the same time as the evaluation created opportunities to share research and information to assist both projects.
- Current actions underway to address VIP (and other programs) findings of the Independent Assessment of VAC promotes interest and conversation on the relevance and success of the VIP.
- Full participation from program area management and field staff despite a period of intense workload, media and political scrutiny and organizational change.
- Gerontological Advisory Council provided a great deal of invaluable research and reference material which was very useful for the evaluation.

### **Limitations**

By evaluation design, methodologies and consultations:

- Finite opportunity to conduct site visits due to availability of key informants and competing departmental initiatives.
- Competing departmental priorities (e.g., transformation initiatives, access to information/privacy issues).
- Comparative review of other Veterans' home care programs was limited to internet research and already known analysis/reports.
- Document review of home care programs in Canada relied heavily on already completed analysis/comparisons.

Data limitations:

- Data not always captured by program area but often from a functional, geographic and/or individual recipient perspective.
- The data is often not aggregated into useable or easily accessible information for decision making. For example, LTC reporting is often a mixture of VIP NHIC and

LTC program users, as reporting is based on the bed type and often not associated with the program eligibilities.

- Inability to connect some data to program area, and between programs, creates a challenge in linking certain program outcomes.
- Uneven reliability and availability of data (performance and cost-effectiveness), for example resource utilization and the rate of substitution of home care for facility care.
- Inaccurate count on the number of still-serving CF members accessing VIP as the current count is not updated in the system on a frequent and continuing basis. There are some data integrity issues pertaining to this group.
- Specific element usage data gaps limited the ability of the evaluation team to provide analysis on linking program use to relevance, for example, when comparing potential VIP services overlap with the Treatment Benefits Program.
- Gap in performance outcome data for those individuals in a nursing home bed (i.e. VIP intermediate care).
- Lack of continuum of care profile data prevented analysis of the transition from the home to a facility. The current data is collected by bed type or care level but not by program (i.e. VIP and LTC).

#### Performance Measurement:

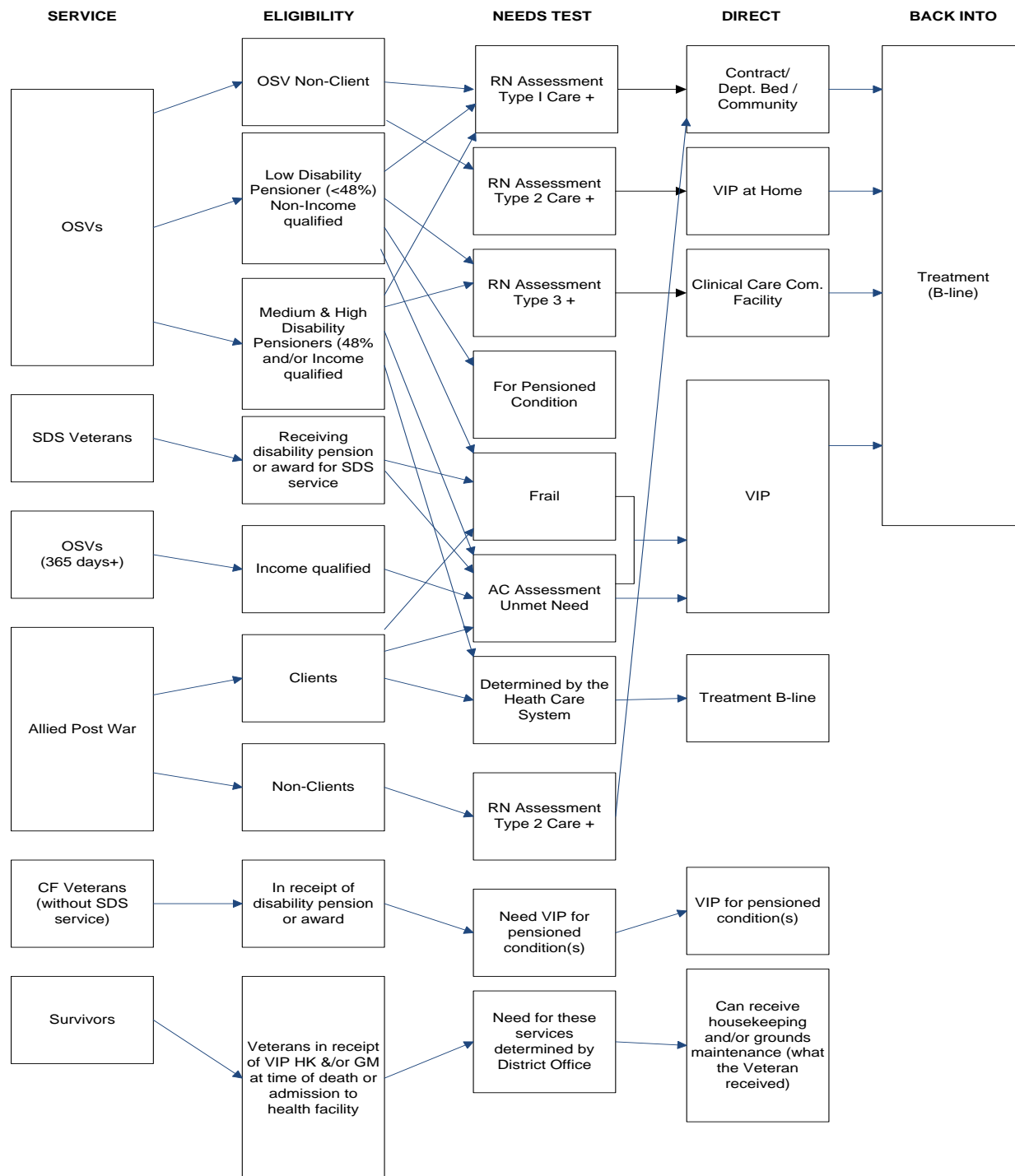
- Need for additional performance data due to the evolving nature of the Program and the addition of new recipient groups, the Department is still in the process of determining what information/data to capture.
- Each additional new layer of complex eligibility criteria creates new challenges in creating and extracting performance information.
- Performance data is neither easily collected nor compiled.
- Both CSDN and FHCPS capture data but appear to have limited capacity/capability to share information with each other.
- The data provided by each system do not meet the full potential or requirements for performance measurement of the VIP.
  - The CSDN was designed as a program delivery tool for case managers and collects and consolidates information about individual recipients using a unique identifier.
  - The FHCPS is a third-party system owned and managed by a private health care company (Medavie – Blue Cross) under terms of a contract with VAC. It is a payment system which pays invoices from VIP Providers and reimburses recipients and collects information gathered for payment purposes. Regular MIS reports (based on Veteran File Number [VFN]) are provided to VAC as well as a daily, weekly and monthly data file upon which VAC is able to query. However, the recipient identifier used (VFN), does not include some recipients (surviving spouse/primary caregivers) and some key information is either not collected or is not easily accessible. For example, there is no tracking of Pended Contribution Arrangements in terms of aged analysis, history, duration and disposition. The lack of historical information makes it difficult to spot and flag trends or issues.

Perhaps the most important deficiency is the inability to track, on an ongoing basis, the number of VIP recipients who would require care in a nursing home or long-term care facility, if not for VIP. This information could provide an ongoing success measurement for the Program and allow current and historical cost/benefit analysis. It would also aid in decision-making and case management with regard to individual recipients by balancing the cost of care in the home against the cost of care in a facility. The lack of this crucial data creates a major challenge in measuring one of the key outcomes of the VIP. A direct measure of this would be very costly; another proxy indicator through an indirect measure could provide useful and cost-effective information.

Concurrent Change:

- Recent and ongoing program policy and process changes during the evaluation period (e.g. new eligibilities, new forms and processes).
- Evaluation entity was non-static due to planned and recently implemented streamlining initiatives (some changes not in place long enough to be evaluated or in the process of implementation).
- Significant program changes (23) since program inception.
- Complexity of inter-relationships and linkage with other VAC programs.
- Organizational changes at the time of evaluation (Program Management merged with Service Delivery and separated from policy, changing role of case manager and recipient service agent).
- Recent change to overall program objective and program outcomes after the evaluation fieldwork phase.

## Annex H: VIP Eligibility Structure



Source: MacLean, MB. VAC Health Services Review: Client and Expenditure Impact of Proposals. Figure 6: Entitlement Based Eligibility for Health Services . May 21, 2008.

**NOTE:** This eligibility structure is missing the 2010 addition of the Allied Veterans eligibility under the VIP.

## **Annex I: Potential Duplication/Overlap with other VAC programming**

### VIP Home Adaptations and Treatment Benefits POC 13 (Special Equipment) Home Adaptations

The VIP provides for a home adaptation to enable a recipient to carry out the activities of daily living while Treatment Benefits (POC 13) provides for a home adaptation to facilitate the use of a surgical/prosthetic device or aid in the home. Home Adaptations under POC 13 is just one of the approved supports for the element. Fundamentally, the POC 13 home adaptation benefits and the VIP home adaptations element overlap in that the output provided to recipients and goal of the output is the same, to improve mobility around the home. Though the output and the overall outcome are similar, the eligibility criteria and description of the benefit differ.

Eligibility under the Treatment Benefits (POCs) includes entry to the suite of programs by virtue of being in receipt of the VIP Home Care Service, Ambulatory Health Care Service, or Intermediate Care Service. The incentive for staff to use POC 13, if there is a choice based on dual-eligibility, is the higher delegated authority and financial limits. Interview results with field staff regarding the two programs include comments questioning why there is a need for two similar programs, and that home adaptations under VIP is rarely used due to its low delegated authority level for Case Managers (\$500 compared to \$5,000). There are few home modifications that would fit in the \$500 range. The general consensus was that the criteria and rules for each program are slightly different, but could probably be handled under one program.

Though a FHCPs transaction query for recipients accessing both elements did not report any potential 'double-dippers', the evidence does show that there may be inconsistent use, or inappropriate use, of home adaptation elements due mainly to restrictions in delegated authorities<sup>109</sup>. The evaluation team was not able to identify how many recipients/field staff may by-pass the VIP element totally and go through POC 13 for this reason. This in itself may be a strong reason as to why there would be no dual-program usage visible; to save time, the Case Manager may not even apply for VIP home adaptations for \$500 when they can go straight to \$5,000 under POC 13. The evaluation does not have sufficient evidence to prove that 'by-passing' is occurring, but interview results suggest this is a reality.

During the analysis phase of the evaluation, the Transformation team announced an amended delegated authorities table for the VIP which included amending the authority level for Case Managers for home adaptations to the maximum VIP rate payable (\$5,560 in 2010). This change should sufficiently address the potential for misusing POC 13 adaptations for VIP needs.

In 2009-2010, the home adaptations element was used by 501 VIP recipients, which is less than 1 percent of the total VIP population. Due to data request limitations, the

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<sup>109</sup> A limitation of the evaluation is that the specifics of the home adaptations supports provided under VIP are unknown as, unlike the POCs, the VIP elements do not have benefit codes for items. A file review of the recipients accessing the VIP home adaptations element would be required to determine how the element was applied.



evaluation team does not have a count on the total number of users of the specific home adaptation benefit codes under POC 13, but overall 26,984<sup>110</sup> recipients accessed POC 13 in 2009-2010.

#### VIP Home Adaptations and Treatment Benefits POC 1 (Aids to Daily Living)

There were no mentions of potential duplication of POC 1 (Aids to Daily Living) and VIP home adaptations by field staff; however, when the evaluation team began analysing the program descriptions of both they found that VIP home adaptations has little information as to 'what' is included under the element. The purpose of the element would lend itself to the inclusion of 'adjustments' (home adaptations) to a household that would aid individuals in mobility around the house – i.e. aids to daily living such as grab bars. However, since there is no specific data available on the use of VIP home adaptations, the team is not able to conclude if smaller aids are used. If such adjustments (modifications) to a household are eligible under the VIP home adaptation element, the Program Area may want to clarify and communicate this to staff as it does not seem to be known or communicated.

The data provided through FHCPs transaction queries show that over a three year period, WSVs accounted for between 75 to 88 percent of all dual program (POC 1 and VIP home adaptation) users. The most frequently used POC 1 element for this group was bathroom aids, and accounted for just under 95 percent of all transactions. Based on this FHCPs transaction data, it shows that over half of all VIP home adaptation recipients are also recipients under the POC 1 program. It is the evaluation team's belief that the supports provided under the POC 1 benefit could in fact be provided under the VIP home adaptation element.

#### Health and Support Services and Treatment Benefits POC 8 (Nursing Services) and POC 12 (Related Health Support Services)

As with the POC 13, after a review of policies, benefit descriptions and some feedback from field staff, the evaluation team thought there was potential of some 'double-dipping' of similar POCs (POC 12 ,related health services and POC 8, nursing services) and VIP health and support services. However, as with the comparison of POC 13 home adaptations and VIP home adaptations highlighted in the above section, the FHCPs data transaction analysis does not prove that there is overlap occurring.

The evaluation team was again faced with a limitation regarding the unknown specifics of the health and support services provided (e.g. occupational therapy assessment, foot care, etc.) under the VIP as there are no specific benefit codes within the VIP elements. Though the number of foot care transactions for the 30 percent<sup>111</sup> of recipients receiving both VIP health and support services and POC 8 indicate that approximately 75 percent of that population could be receiving foot care support from VAC under two programs, the risk is minimal and speculative. To put these numbers into perspective, the impact is only 15 percent of overall health and support services recipients for 2009-2010

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<sup>110</sup> VAC Corporate Information System. Treatment - Unique Clients by POC. 2010.

<sup>111</sup> FHCPs data.

(equates to only 28 individuals<sup>112</sup>), and this group accounts for less than 1 percent of the total respective POC users.

Another data request for all VIP recipients using POC 8 and POC 12 may have provided additional information and trend data on use by VIP recipients, however at this point the team would say that there is overlap in services evident, but if the use of health and support services continues to increase and is used for foot care, there could be risk of 'double-dipping'.

#### VIP Nursing Home Intermediate Care (NHIC) and the Long-Term Care Program

The VIP NHIC is meant to meet the needs of lower care individuals (Federal Type II) while LTC is meant to take on the higher/chronic needs of individuals (Federal Type III); however, as introduced in the report, the LTC program has evolved with recipient demand to include intermediate care in community beds and eligibilities evolved, the two programs have become somewhat intertwined in their offerings. It was indicated through the evaluation team's file review, and corroborated through interviews and corporate statistics, that there are some recipients receiving care through VIP NHIC that are beyond Type II care needs. This may occur because staff, due to workload or other factors, may wish to avoid the administrative requirements, and burden on the recipient and family, to move the recipient from the VIP to the LTC. Also, due to the fact that the Department works with provincial authorities, who have regional differences in levels of care, the VAC federal level of care might not necessarily be applied in the same manner for each recipient case. In fact, as the level of care requirements for provincial admission to facilities increases, the federal levelling becomes less relevant. During the report writing stage of the evaluation, the team was also made aware of proposed policy changes to address potential NHIC individuals who are beyond Type II care but are not eligible for the LTC program.

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<sup>112</sup>

Ibid.

## VAC Federal Levels of Care Descriptions

Federal Level of Care	Description <sup>113</sup>
<b>Adult residential care (Federal Type I Care)</b>	Is the provision in a health care facility of: a) personal and supervisory care; b) assistance with the activities of daily living, and any social, recreational and other related services to meet the psychosocial needs of the residents of the facility; and c) accommodation and meals.
<b>Intermediate care (Federal Type II Care)</b>	Is the provision in a health care facility of: a) daily nursing and personal care under the supervision of qualified medical and nursing staff; b) assistance with the activities of daily living, and any social, recreational and other related services provided to meet the psychosocial needs of residents of the facility; and c) accommodation and meals.
<b>Chronic care (Federal Type III Care)</b>	Is the provision in a health care facility of: a) daily supervision, nursing care, personal care and therapeutic services, by qualified medical and nursing staff; b) assistance with the activities of daily living, and any social, recreational and related activities provided to meet the psychosocial needs of residents of the facility; and c) accommodation and meals.

The cost of a community bed under the VIP and under the LTC program are both determined by the province and based on the provincial assessment of the recipient's need level; VAC then determines the amount the recipient is eligible to receive based on service eligibility and the Department's accommodation and meals rate. Since it is the province that determines the cost of the bed based on the recipient's care requirements, recipients in both types of community beds are assessed for VAC's contribution portion in the same manner. Contract beds are different; these beds are held specifically for VAC, and so then have a different value.

Recent work completed internally for the Department in response to '*The Report of the Independent Blue Ribbon Panel on Grants and Contributions*', recommended that the two programs should be streamlined into one program. The panel that worked on the above noted Blue Ribbon report suggested that the government needs to simplify administration of programs while strengthening accountability. Two specific recommendations related to this issue that were identified by the report are: (1) horizontal coordination in program administration should be improved and (2) the process should be simplified and made more transparent<sup>114</sup>.

The only disadvantages of a program merger mentioned by the field was from one interviewee who flagged a potential impact on resourcing; however, the Residential Care Directorate indicated that there would be little to no impact from a management perspective at Head Office, and field staff administering the programs identified no disadvantages. In fact, the majority of field staff said it would simplify the process and free up time.

<sup>113</sup> Veterans Program Policies section 1.1.1. DEFINITIONS – Interim Policy- effective Feb 15, 2005.

<sup>114</sup> Lankin F and Clark I. *From Red Tap to Clear Results, The Report of the Independent Blue Ribbon Panel on Grants and Contributions*. Independent Panel for the Treasury Board Secretariat. December 2006.

Advantages of combining the two programs, as identified by field staff delivering the program, include:

- LTC is a better fit for Intermediate Care, as the recipient is no longer at home;
- Single point of entry to a LTC bed for recipients;
- Streamlined eligibilities, policies, procedures and payment processing;
- Reduced administrative burden on both VAC and the recipient/recipient families; and
- More resources/time available to better serve recipient and provide additional support.

Head Office staff also indicated that the issue has been raised in the past, with the recommendation that two programs be merged; however, to date, there has been no appetite to make the necessary changes. It is the evaluation team's belief that an opportunity exists for VAC to streamline and align its programs and policies to better meet demographic needs as part of the Transformation agenda. In order to combine the two programs, the following would most likely be required:

- Change in parliamentary votes would be required as they are currently under separate votes, and are therefore paid out of different budgets
- Change in regulations to accommodate merger/changes in program eligibility
  - There would need to be some work around eligibility, aligning them by bed type (e.g. community versus contract bed eligibility) instead of by program
- Submit new program Treasury Board submission and new program Terms and Conditions
- Update policies, processes and procedures
- Streamline the two payment processes
  - Most likely this would mean through the FHCPS and therefore including under the contract. The impact here would be higher transaction costs for the Department and fewer departmental resources in Kirkland Lake required.
  - However, the Department should consider allowing facilities to continue to send the bill directly to Medavie, as this is easier on the recipients and families involved.

## Annex J: Other Government Home Care Programs

### Potential Overlap with Federal Government Department Programs

#### Department of National Defence

As part of the 1984 *Canada Health Act*, Canadian Force members are specifically excluded from the definition of ‘insured persons’. The Department of National Defence (DND) therefore has its own health care system, the Canadian Forces Health Services (CFHS) system. The CFHS is an all-encompassing health care system that provides health care to Regular Force personnel from the time of enrolment to the effective date of release, and to Reserve Force personnel during specified periods based on duty status<sup>115</sup>. Services included under the spectrum of home care are home making and nursing services, which are subject to a needs assessment and approval by a nursing services, which are subject to a needs assessment and approval by a physician. For the fiscal year 2009-2010, DND reports that the number of CF members accessing the DND Home Care Program for nursing services is 184 and 120 for personal support/home maker services<sup>116</sup>. Some still-serving CF members are eligible for VIP, but the program policy clearly identifies that to qualify for the home assistance; the member cannot be eligible for benefits under the VIP.

In April 2009 DND also implemented a program for sick and injured Canadian Forces members. The *Mobility Assistance for Sick and Injured Members of the Canadian Forces* program offers assistance to members who require home/vehicle adaptations or home assistance due to their sickness or injury<sup>117</sup>. The program policy clearly identifies that to qualify for the home assistance; the member cannot be eligible for benefits under the VIP. As per DND statistics for fiscal year 2009-2010, 81 CF members accessed the home adaptations portion of the Mobility Assistance Program and 65 members accessed the home assistance (snow removal and grounds maintenance) portion of the program.

A review of departmental (VAC) opinion regarding this program is that it does not duplicate or replace any VAC program, and specifically VIP. The DND program was created to address the gap between the recipient’s immediate need, and the application for and confirmation of eligibility for VAC programs. Although the DND-VAC transition process is outside the scope of the evaluation, a recent DND evaluation<sup>118</sup> identified that there are issues with transition from DND to VAC. The evaluation provided recommendations centered on simplifying the transition process and better information sharing between the departments to help improve and reduce service gaps for CF members, and ensure a more seamless transition.

To the extent that the DND mobility program may at some point in time present an overlap or duplication of services, the number of recipients involved and the applicable

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<sup>115</sup> Department of National Defence website. <http://www.forces.gc.ca/health-sante/pub/fs-fd/cfhs-ssfc-eng.asp>

<sup>116</sup> Department of National Defence. Directorate Military Personnel Strategy & Coordination. CF / VAC Continuity Program.

<sup>117</sup> Chapter 211. Mobility Assistance for Sick and Injured Members of the Canadian Forces. Compensation and Benefits Instructions. May 15 2008.

<sup>118</sup> Department of National Defence. *Evaluation of Support to Injured CF Members and their Families*. Chief Review of Services. 1258-165 (CRS). June 2009.

costs to VAC are considered by the evaluation team to be low risk and low impact as they must be related to a pensioned condition or health need and criteria ensures the member may be a recipient of only one program. Essentially, the potential risk falls within issues of transition and information sharing between DND and VAC; however, both departments are aware and are working towards solutions.

#### Indian and Northern Affairs Canada/Health Canada

The departments of Indian and Northern Affairs Canada (INAC) and Health Canada provide some home and community based health-related services to First Nations and Inuit people including: home care for those with disabilities and persistent or acute illnesses, as well as the elderly.

INAC has an Assisted Living Program which provides services to First Nations individuals living on-reserve who have functional limitations due to age, health problems, or a disability, and who require care. Components of the care include in-home care (e.g. homemaker services), foster care (supervision and care in a family setting), and institutional care (Type I and Type II)<sup>119</sup>.

Health Canada's First Nations and Inuit Home and Community Care (FNIHCC) Program is designed to complement the social home care services provided by INAC. FNIHCC provides services such as home support and personal care, in-home respite, and nursing services, that do not duplicate INAC services<sup>120</sup>.

VAC is only able to identify those First Nation recipients who have self-identified through their Indian Registry Number (IRN); therefore, the Department does not have a comprehensive count of its First Nation recipients. However, based on self-reporting, the estimated number of recipients that are First Nation's and in receipt of VIP services would be approximately 92 as of March 31, 2010<sup>121</sup>.

#### **Potential Overlap with Provincial Home Care Programs**

The evaluation team relied heavily on a study conducted in March 2008, by the Canadian Home Care Association entitled, *Portraits of Home Care in Canada*, to examine and compare home care programs available in Canada. In addition, the evaluation team referenced a report by Dr. Hollander entitled a *Strategic Review of Home Care Services as Part of the Alberta Continuing Care Strategy* which included a survey of the provincial home care services and supports available.

In Canada, each province is responsible for establishing its own home and community care support services. As a result, there are variations in eligibility, access, availability and level of support. Within each province, there are also multiple health authorities and regions that may also experience regional variations from each other. What is common to all is that provinces and territories have residency as a basic eligibility and all home care services are provided based on assessed need. Approximately half of

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<sup>119</sup> INAC Assisted Living Program. <http://www.ainc-inac.gc.ca/hb/sp/alp-eng.asp>

<sup>120</sup> Canadian Home Care Association of Canada. *Portraits of Home Care in Canada*. March 2008.

<sup>121</sup> Corporate Statistics. Number VIP recipients by IRN indicator. VAC Statistics Directorate. Retrieved January 20, 2011.

the provinces and territories have no income testing for home care. The provinces with income testing generally have fees applying to long-term supports (i.e. home support) and/or residential care which are tested according to net income, using varying approaches.

Ontario, Manitoba, Quebec, Prince Edward Island and the three territories do not charge any direct fees for home care services. There are varying levels of program usage limits across Canada; some provinces have service limits, while others do not. A variety of assessment tools are used, including some provincially specific assessment tools and international data collection tools. The majority of the jurisdictions however use the Resident Assessment Instrument for Home Care (inter RAI-HC), which was designed to identify recipient needs, using the Minimum Data Set for Home Care (MDS-HC)<sup>122</sup>.

In Dr. Hollander's work for Alberta, he concluded that all provinces offer the following services: nursing; personal support; and respite care. Few provinces also offer transportation or supportive housing while most provinces have some support for day programs, homemaking, meals and self directed care<sup>123</sup>. None of the jurisdictions offered grounds maintenance at the time. This finding is important because it re-establishes the fact that only VAC's VIP offers grounds maintenance as a component of its home care program.

An internet review of provincial health care information by the evaluation team found similar results to the CHCA and Hollander reports. It should be noted that many provinces listed 'light homemaking' as a home care support service, however when compared to VIP, the available housekeeping tasks were less and eligibility/availability of the support to citizens was more stringent, had associated fees and/or was based on low-income. The following table provides a very high level coverage of home care by province and therefore should be interpreted carefully as even within a province there may be varying levels of home care provisions. Also, in some instances, such as for transportation services, it may not be covered through home care but a municipality may have supports through not-for-profit organizations or on a volunteer/small fee basis.

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<sup>122</sup> Canadian Home Care Association. *Portraits of Home Care in Canada*. March 2008.

<sup>123</sup> Hollander M & MacAdam M. *Strategic Review of Home Care Services as Part of the Alberta Continuing Care Strategy*. Strategic Literature Scan of National and International Home Care Services. Alberta Health and Wellness. May 2010.

## Overview of Home Care Services/Supports by Province

Services	BC*	AB	SK*	MA	ON	QC	NB*	NS*	PE	NL*
Nursing	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Personal Support	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Homemaking/ Housekeeping	✓	✓*	✓	✓	✓	✓	✓	✓	✓	✓
Meals/Nutrition	✓	✓*	✓	✓	✓*	✓	✓		✓	✓
Grounds Maintenance										
Adult Day Programs	✓	✓*	✓	✓*	✓*	✓	✓	✓*	✓	✓
Respite Care	✓	✓	✓	✓	✓*	✓	✓	✓	✓	✓
Home adaptations			✓	✓	✓	✓	✓	✓		✓
Social Transportation										

Sources: Provincial Home Care website review, CHCA 2008 Portraits of Home Care, Hollander 2010 Alberta Health and Wellness Strategic Review (Table 3: Home Care Services: Service Offered and Wait List (2008)).

### Notes:

There are varying degrees of funding coverage, eligibilities, and access limitations across the country. Some provinces also require user fees for benefits and/or use income testing as eligibility criteria.



Indicates funded by the province/local health authority.

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Indicates there may be user fees associated with the service/support.



## Annex K: Program Chronology

Year	Nature of Amendment
1981	Aging Veterans Program introduced
1984	Aging Veterans Program renamed the “Veterans Independence Program” (VIP)
1984	First extension of VIP benefits to income-qualified War Service Veterans
1989	VIP benefits extended to Canada Service Veterans
1990	One-year continuation of housekeeping and/or grounds maintenance services to surviving spouses of VIP Veterans
1991	VIP benefits extended to special duty area pensioners
1992	VIP benefits extended to income-qualified Veterans under 65 years of age, overseas service Veterans and merchant navy Veterans.
1994	VIP extended to Veterans who meet the service requirement of a Canada Service Veteran (365 days) and who require VIP services, where the cost of the services reduces their income below the WVA income ceiling.
2001	<ul style="list-style-type: none"> <li>- VIP benefits extended, based on income level, to the following civilian groups who served overseas in wartime: the Newfoundland Overseas Forestry Unit; the Corps of (Civilian) Canadian Fire Fighters for Service in the United Kingdom; nursing aids and other members of the Canadian Red Cross and St. John's Ambulance; Ferry Command personnel.</li> <li>- Military service pensioners granted access to VIP for pensioned conditions.</li> <li>- VIP extended to “seriously disabled” (in receipt of a disability pension assessed at 78 percent to 100 percent) War Veterans for any condition, based on need without requiring a link to a pensioned condition.</li> </ul>
2003	<ul style="list-style-type: none"> <li>- Lifetime VIP housekeeping and/or grounds maintenance benefits extended to qualified survivors, or if no survivors, qualified primary caregivers of Veterans who were receiving these services either at the time of death or admission to a health care facility, where the Veteran died within a year of admission.</li> <li>- VIP services extended to at-home Veteran recipients on a wait list for a Priority Access Bed (formerly the “OSV at-home Pilot Project”).</li> <li>- VIP services extended to POW's who are totally disabled but who are not receiving a disability pension.</li> <li>- VIP services extended to recipients entitled to a pension for wartime service, regular force service or special duty service and at risk due to frailty.</li> <li>- VIP Services extended to medium disabled (in receipt of a disability pension assessed at 48 percent to 77 percent) War Veterans for any condition, based on need without requiring a link to a pensioned condition.</li> </ul>
2005	Lifetime VIP housekeeping and/or grounds maintenance services granted to primary caregivers of Veterans who, at any time since 1981, received these services at the time of death or admission to a health care facility.
2006	VIP extended to recipients of Detention Benefits and Disability Awards under the <i>Canadian Forces Members and Veterans Re-establishment and Compensation Act</i> .
2008	VIP housekeeping and/or grounds maintenance extended to survivors of War Veterans who were not in receipt of VIP when they died.
2010	VIP benefits extended to: Allied Veterans who served during the WWII or Korean War, have at least ten years post-war residency in Canada, reside in Canada and are eligible for WVA; and, eligible family members or dependants of these Veterans.

## Annex L: VIP Expenditures by Element

	2007-08	2008-09	2009-10
Housekeeping	\$ 107,307,280	\$ 180,942,540	\$ 196,406,022
Grounds Maintenance	\$ 46,210,584	\$ 49,576,374	\$ 48,461,353
Personal Care	\$ 19,867,618	\$ 20,513,989	\$ 22,900,277
Access to Nutrition	\$ 7,795,374	\$ 8,285,628	\$ 9,149,059
Ambulatory Care	\$ 913,936	\$ 923,162	\$ 986,175
Social Transportation	\$ 2,711,309	\$ 2,510,292	\$ 2,279,665
Home Adaptations	\$ 437,234	\$ 387,284	\$ 547,863
Intermediate Care	\$ 54,381,306	\$ 55,968,223	\$ 56,804,901
Health & Support Services	\$ 90,281	\$ 116,308	\$ 164,585
Adult Residential Care	\$ 304,756	\$ 223,202	\$ 166,719
<b>TOTAL</b>	<b>\$303,182,712</b>	<b>\$320,024,735</b>	<b>\$337,979,883</b>

## Annex M: Literature Review Summary of Cost-Effectiveness of Home Care Compared to Facility Care

- 2008 Continuing Care Research Project – Conducted an intense two part research project that analyzed the time, effort and cost of caring from someone at home compared to in a facility in part 1, and also included care in supportive housing in part 2. Data was collected from informal caregivers to build estimated costs to care for an individual at home (caregiver time, government costs, and other health related costs). This figure was then attributed by level of care (SMAF model) and compared to facility recipient costs to determine the overall difference in societal costs by level of care and location of care. The CCRP examined costs from two potential views: (1) caregiver time at minimum wage and (2) caregiver time at replacement wage<sup>124</sup>. In each situation, results indicated that care for individuals in the community was less expensive than caring for individuals in a facility. The overall average total societal cost for caring for someone in the community was \$31,000-\$37,000 compared to \$87,000-\$111,000 in a facility<sup>125</sup>.
- 2008 RMAF/RBAF – Found that data from recent Canadian and international studies verifies that home can be a cost-effective alternative to facility and acute care. “Evidence indicates that outcomes such as recipient satisfaction and/or quality of life are the same, or better, for home care recipients compared to residential care recipients.”
- Overseas Veteran pilot report found most people prefer to remain at home.
- Keeping the Promise – discusses Canadian research that has demonstrated that integrating health and social services for older adults can provide cost-effective services and reduce rates of institutionalization.
- Internal study found that “under the existing entitlement-based approach, VAC provides relatively high amounts of health benefits to individuals who are fully functioning in their communities, and lesser amounts to those who have more extensive needs.”
- A recent study conducted by Dr. Hollander and MacAdam<sup>126</sup> referenced actual savings achieved by British Columbia over a 10-year period as a result of introducing a pro-active policy to substitute home care services for facility care. In fact, results showed that “utilization of some 21 person-years per 1,000 population 65 years or older was shifted from residential care to home care, for individuals with ongoing care needs” (Hollander and MacAdam, p.3).
- No recent Statistics Canada Residential Care Facilities data of general public was found to compare to VAC average admission age.

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<sup>124</sup> Study conducted based on primarily 2006 costing data. Informal caregiver time was costed using \$8 per hour minimum wage rate and \$60 per hour for replacement wage for professional services and \$27 per hour for all other services.

<sup>125</sup> Hollander M, Miller J, & MacAdam M. *The Continuing Care Research Project*. Synthesis Report conducted for Veterans Affairs Canada and the Government of Ontario. April 2008.

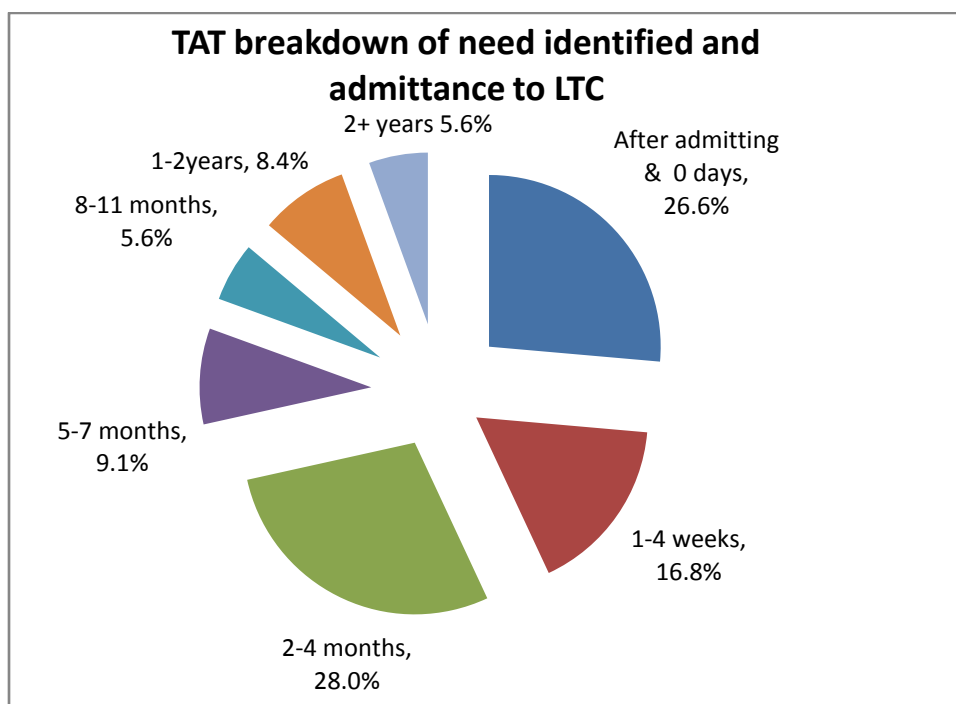
<sup>126</sup> Hollander M & MacAdam M. *Strategic Review of Home Care Services as Part of the Alberta Continuing Care Strategy*. Strategic Literature Scan of National and International Home Care Services. Alberta Health and Wellness. May 2010.

## Annex N: Number of VIP Recipients (non-intermediate care) by Dollar Band Expenditure

	>= 0 and <20	>= 20.01 and <3000	>=3000.01 and <6000	>=6000.01 and <9000	>9000.01	Total
<b>2007-2008</b>	88	74,769	21,013	4,437	1,898	102,205
<b>2008-2009</b>	91	75,829	22,175	4,853	1,983	105,471
<b>2009-2010</b>	73	74,929	24,371	5,434	2,349	107,156

## Annex O: Audit and Evaluation VIP Intermediate Care Recipient File Review Findings

- Sample files were pulled based on the criteria that they had a NHIC transaction between April 1, 2009 and December 31, 2009.
- 49 (35 percent) of the sample files pulled left NHIC sometime between April 1, 2009 and September 9, 2010.
- Those leaving NHIC compared to those starting NHIC is approximately 6:1.
- In terms of timelines e.g. TATs, this information is cumbersome to find but the reviewers were able to find the dates for the majority of the cases within the Client Notes in CSDN (non-query area).



- Almost half of the files (44 percent) showed the details of the need for LTC centered around the caregiver being unable to care for the Veteran, then with 30 percent relating to hospitalization and 23 percent to the recipient being unable to care for themselves. In three percent of the cases, the need was unable to be determined.

<b>Number of cases by type of need identified and TAT time segment</b>							
	<b>TAT breakdown of need identified and admittance to LTC</b>						
<b>Details of Need</b>	After admitting and 0 days	1-4 weeks	2-4 months	5-7 months	8-11 months	1-2 years	2+ years
Caregiver unable to care	14	8	18	9	15	6	3
Recipient unable to care	10	6	8	4	1	3	1
Hospitalization	11	9	15	0	2	3	4
Other	3	1	0	0	0	0	0

- When the caregiver is unable to care, VAC seems to know of the need further in advance (this group has higher frequency of 5-7 month and 8-11 month identification prior to LTC admittance).
- Of those whose need is based on hospitalization, the need is identified approximately two years in advance, half of the time (indicates potential multiple hospitalizations).
- All files had a caregiver indicated:
  - 34 percent of the files had housekeeping and/or grounds maintenance on their current contribution, indicating that the spouse/primary caregiver receives support via VIP.
- The average start of the first VIP contribution arrangement was April 2004.
  - Three quarters had housekeeping on their first contribution arrangement, almost 40 percent had grounds maintenance and just over 25 percent had intermediate care and/or personal care.
- The average start of the first VIP contribution for Intermediate Care was December 2006 (40 recipients):
  - Average first NHIC contribution arrangement was \$13,552.
  - Average current NHIC contribution arrangement was \$14,049
- The overall average length of stay in intermediate care is three years.
- Of the sample population, almost 35 percent had left VIP intermediate:
  - Over three quarters of the recipients that left care was due to their death;
  - 6 percent of the sample population (8 recipients) appear to have left and moved to chronic care under the LTC program.
- There are a number of cases of the recipient's federal level flipping back and forth (e.g. Type II to Type III and back again).
- 11 recipients were not deemed Federal Level Type II's. Of that group:
  - 2 were removed from NHIC during/after the sample transaction period and moved to LTC Chronic Care;
  - 3 files were assessed as Type III but passed away before VIP could be removed;

- 1 had NHIC removed as they improved and moved into an Assisted Living facility;
  - 4 files were found to continue to receive VIP NHIC despite being assessed as Type III; and
  - The federal level for one file could not be found.
- CSDN notes are majorly payment notes and/or 'called recipient, no v/m call back' or 'recipient called NCCN, transfer to DO'. Not much recipient health/status info available unless there was a DNO or other assessment on file.
- Information on recipients' physical, social and mental health needs were not always easily identifiable:
  - Almost 70 percent of the files indicated cognitive/memory issues and 31 percent depression/anxiety.
  - The most common needs identified were for wheelchairs and foot care (POC needs), with a few identifying the request for someone to sit with the recipient.
  - Though 45 percent of files had no DNO assessment available, the majority of the files (except for 9 cases) had some information in recipient notes regarding ADLs (found in AC assessments, provincial assessments, notes, etc.); however, there is often only a summary or status update available.
  - Although a strong percentage (42 percent) seemed to participate in activities at the facility, many were restricted by health limitations, or simply were not interested in socializing.
  - A small percentage of the files seemed to make visits into the community, but many received visitors.
- 22 (15 percent) of the cases had complaints; there was no dominant area of complaints identified.
- Some potential efficiencies identified where DNOs use the provincial placement assessment to determine Federal Type levelling (issue is there are only in the paper file, not on CSDN):
  - 56 percent of files had a VAC DNO assessment on file.
  - 12 percent of files had a provincial assessment on file (mainly the Ontario CCAC assessment)