Rehabilitation Services and Vocational Assistance Project (RSVP)

Recommendation

NCVA will continue to monitor the implementation of the Rehabilitation Services and Vocational Assistance Project (RSVP) to ensure that the objective of VAC to provide improved medical, psycho-social and vocational rehabilitation services to our veterans and their families is achieved.

As was reported in 2023, the "devil will be in the details" on how this program is being managed. To recap, what is RSVP?

Beginning in November 2022, VAC merged two expiring national contracts delivering medical, psycho-social and vocational services to veterans and their families into one contract. It is a joint venture provided by WCG International Consultants and Lifemark Health Group called Partners in Canadian Veterans Rehabilitation Services (PCVRS). VAC refers to this program as PCVRS or sometimes Rehab/PCVRS.

Both of the PCVRS contracted organizations have a wealth of experience in the field of rehabilitation and a national network of service providers.

After initial pushback and issues plaguing the rollout of this program, it appears things have settled down. That being said, the co-ordination between VAC and SISIP/Manulife on who does what to whom and when remains confusing to our veterans and their families. It is for this reason that NCVA remains adamant that SISIP/Manulife needs to be eliminated for service-related disabilities and be fully replaced by parallel VAC programs. These two programs do not work well together, as there are different eligibility criteria and different suites of benefits. Currently, the default setting remains SISIP/Manulife first, then VAC.

As of October 2023, all Rehab/PCVRS participants were transitioned to the new program. From VAC's perspective, the program is going relatively well. There are some challenges being experienced such as provider wait times in certain areas such as Quebec, slow processing of payments for certain providers, and clarifying roles and responsibilities of certain positions. The PCVRS team has been very receptive to feedback and VAC is continuing to identify the challenges and develop action plans to address the issues including increased training. As of March 31, 2024, there were approximately 12,600 participants in PCVRS.

As an aside, veterans can be disengaged from the Rehab/PCVRS program for a number of different reasons, such as when they have completed their rehabilitation goals, being assessed as having a Diminished Earning

Capacity (DEC), and continuing with Income Replacement Benefit (IRB) or deciding not to participate in the program.

We would express our appreciation to Major (Ret'd) Bruce Henwood for his insights on this topic. A seriously disabled veteran, he represents the NCVA as a member of the Minister of Veterans Affairs Care and Support Advisory Group (CASAG) and is also a Senior Consultant to The War Amps of Canada (a member organization of NCVA).

Major Henwood has also provided the following comments on the work of CASAG and a "wish list" of VAC improvements.

Care and Support Advisory Group Update/ Recommendations

The Care and Support Advisory Group submitted their report to the minister on June 12, 2024. This was then followed up with a verbal presentation to the minister by the authors. No formal response to the report has been received, as of yet.

The report consisted of two parts: the first being five recommendations pertaining to continuity of care and the second part providing two recommendations regarding homelessness.

Continuity of care recommendations included the following:

(i) Expansion and simplification of eligibility criteria to enhance access to continuity of care supports.

(ii) Increased financial and programmatic support for frail veterans to bridge the gap between remaining at home and transitioning to long-term care.

(iii) Leveraging and expanding specialized knowledge in the care and support of aging veterans.

(iv) Establish a Centre of Excellence for care and support of the aging veteran research, identifying unique needs and working nationally with partners.

(v) Designate regional hubs for care and support of aging veterans to offer a range of services and supports.

Homelessness recommendations focused primarily on rebuilding trust with veterans experiencing or at risk of homelessness and included the following:

(i) Establish a "relationships first" model with a dedicated VAC case-management team.

(ii) Establish a network of trusted and vetted service providers, partners and peers to facilitate VAC access.

Points to Ponder

There are many areas within VAC that can be improved to provide a better experience for the veteran and their family; many of these go unnoticed or unidentified by the department. Some are not new, however, and with turnover within the department, some of these points to ponder get lost in the shuffle.

The following can be summarized as *"Wouldn't it be nice if…?"*

(i) The National Contact Centre Network (NCCN)'s current hours of 8:30 a.m. to 4:30 p.m. local time Monday through Friday were extended to include after hours or times on weekends to allow for those working to better access the NCCN.

(ii) Access to an assigned Veterans Service Agent (VSA) was made available for those seriously disabled veterans who do not have case management services and they would not have to go through the NCCN or *My VAC Account*.

(iii) VAC's *My VAC Account* provided access to the veteran's pensioned conditions Summary of Assessment.

(iv) VAC set up pop-up kiosks at shopping centres/malls where veterans or their families passing by could casually query about VAC or at least initiate contact with the department for follow-up.

(v) VAC established/permitted self or buddy referrals to Occupational Stress Injury (OSI) clinics to negate the requirement for VAC pre-approval. Additionally, allow family physicians to make referrals to the OSI clinics for their veteran patients.

(vi) VAC removed the requirement for acupuncture treatment to require a physician's prescription.

(vii) VAC provided automatic reassessments of the "fifths" entitlement rather than the veteran having to initiate.

(viii) VAC provided outreach services for seriously disabled veterans who are not case managed either through *My VAC Account* or by phone. The current practice of two to three years between contact is too long, especially for aging veterans.

(ix) VAC provided notice of changes in treatment benefits, such as massage therapy no longer requiring a physician's prescription (as of January 2024).

(x) VAC initiated outreach to aging/frail veterans who are not in receipt of the Veterans Independence Program (VIP) to proactively set up VIP benefits that would benefit the veteran and support the spouse in the event of the veteran's passing.

(xi) The VAC treatment benefits online database indicated if a specific treatment is not covered by VAC by simply indicating "not a covered benefit" rather than sending the veteran on a wild goose chase trying different wording. Iridology is a good example of where nothing shows up on the VAC treatment benefit grid, whereas indicating "not a covered benefit" ends the search so the veteran knows one way or the other.

(xii) The VIP Grant Determination Tool was improved to consider inflation, cost of living and recognition of rural areas when doing the calculation for housekeeping services.