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Syndicat des employé-e-s des Anciens combattants de l'Alliance de la Fonction publique du Canada

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Brief to the House of Commons Committee on Veteran Affairs

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Improving Services and Support to Veterans and their Families

The Union of Veterans' Affairs Employees (UVAE), a Component of the Public Service Alliance of Canada represents the majority of frontline workers at Veterans Affairs Canada. In preparation for our appearance before the Committee, UVAE carried out a survey of our members from coast to coast in April and May regarding their work with veterans and their families. We specifically asked them to not only identify issues and problems, but to make suggestions for improvements.

In total, 526 UVAE members from across the country participated in this survey from all regions of the country. All positions and all levels of members took part in this survey, of which 55 self-identified as Veterans. The information was collected anonymously, and we have promised the members that their input would be treated in confidence to our work with the Committee.

The areas we covered which may be of interest to the Committee included everything from initial assessment and processing of applications from Veterans through to the processes of helping Veterans navigate the system at Veterans Affairs Canada. We also surveyed them on the computerized systems they use as well as their dealings with service provider Medavie Blue Cross. In addition, we had a special focus on mental

health services for both Veterans and their families as well as support for the UVAE members who are working in this area. Finally, we asked them to highlight gaps in services to Veterans and the families and to identify other issues that they would like us to bring forward to the Committee.

Some general observations we would provide to the Committee include a high level of frustration among UVAE members who are trying their best to serve Veterans and their families. This includes frustration with having to use multiple incompatible systems, an excessive workload, and lack of communication between sections. French employees noted the translation of new systems has been poor. With some notable exceptions, many felt training to be a strong point and mentioned that they benefited from having strong and supportive mentors at work. That being said, there were mainly urgent pleas for additional mental health training and support.

In each section you will see an overall snapshot of the survey results along with their highlighted concerns and suggestions for improvement from the front-line staff. We have also included a sampling of comments which they provided in their survey responses.

At the end of this brief we will be making several recommendations to the Committee as you continue your work to improve services and support to Veterans and their families. We hope that you will consider these suggestions from the people who work every day to support our Veterans and we also hope that you will convey the need for change to the government and senior departmental officials.

Our Veterans deserve better and the members of the Union of Veterans' Affairs Employees are ready and willing to do our part.

Section 1: Intake and Initial Assessment

About 35% of those taking the survey work in Intake and Initial Assessment. Most responded that they feel the system does not work well, or at least has some significant problems. Although, about 10% reported that things have improved thanks to changes made in recent months.

Problems ranged from not having enough help, lack of training tools and documentation, long wait times, technical computer problems, and that the new screening tool is not helpful. The amount of duplicated work, convoluted business processes that are open to interpretation, and illogical or unnecessary division of work were also mentioned repeatedly. Many employees noted that although intake process identifies a lot of needs, the Veterans often don't have the eligibility to have those needs met. It was also noted that current systems are intrusive and, at times, inappropriate, giving them the potential to trigger mental health symptoms in clients.

Other problems with Intake and Initial Assessment include:

The intake system sets up a false sense of security as the Department's documents lead Veterans to assume that when they go through intake they will get the help they need - not be put in a queue to wait for years until they get one set of benefits to unlock other benefits.

There are issues getting reports from community providers to support claims and getting medical documentation from the CAF. Case Managers are not allowed to look at Service Health Records to find evidence to support a claim.

They spend a lot of effort assessing clients, but do not have a matched intervention to the assessment. They simply decide who to case manage and that is all. Each level of assessment should have a corresponding level of intervention.

The Assessment form (AC Assessment) is very dated, collects more information than is required to deliver benefits (privacy issue) and does not even speak to benefits programs clearly enough.

Volume of work is increasing (more applicants) and quality is decreasing (Veterans applying for everything/all programs). This is causing a perfect storm from a workload perspective as you try to find ways to “make it work” for everyone, while those who should be applying for programs are forced to wait significant wait times.

They place too much pressure on staff to do administrative tasks instead of focusing on clients. The systems are not veteran centric, or trauma informed and as such our processes place extra undue pressure and stress on our clients. They felt the systems were so intrusive and inappropriate that they trigger mental health symptoms in clients. The new GC Case system was rolled out extremely poorly and it has increased the workload of case managers 2-3x. This means spending more time putting things into the system instead of having the time to focus on connecting with Veterans.

FCR, training, lack of management knowledge of policy and procedures are also issues. No follow up by management team when issues arise. No QA process for new employees therefore mistakes are never corrected. Issues are not dealt with in a timely manner.

PSC claims take far too long. The process seems to have more layers than necessary. Veterans should not be waiting 18 months for a decision.

Suggestions for improvement:

Improve communication between areas (DBU, NCCN, AO) so that clients are receiving the same messaging throughout. Also, maybe sharing what each area does (as a presentation or a PDF/PowerPoint) so everyone has a better idea of what we all offer/do for our Veterans.

Bring in additional staff to help share the high workload- there is a lot of work, and a lot of it is emotional support work with clients, which can be draining on staff. Additional intake staff would be ideal.

Create a comprehensive document all veterans need to sign before engaging with rehab program, so expectations are clear. Access to service health records if Veterans give us consent. Getting proper diagnosis of PTSD. So many people diagnosed when in fact they have other mental health concerns that were prior to enrollment.

Streamline application approval. It's better a few Veterans get more money than they deserve than thousands of Veterans having to wait years to get anything.

Provincial supports in office that we can access instead of having to submit assytnet and other email requests just to get a consult. It makes the process overly wieldy and takes too much time to get an answer. Allow case managers to talk directly to staff in DEC and financial benefits and disability units so we can get answers for our clients quickly. Our system right now re-traumatizes Veterans and that is morally and ethically wrong.

The Department must stop reliance on paper and change adjudication of claims completely electronically. Must scan the previous paper client files and make them accessible electronically. Much more efficient!

The Deputy Minister should spend more time travelling across Canada to Area Offices to see our reality, not just hear about them from a small group of Area Directors.

We have to change the performance chart: many tasks have been added to our workload and take longer time as an example, BPOs now work tasks that were meant for adjudicators, and no changes to the performance have been made. Also, tasks for BPOs from the RCMP team are heavier than the ones for CAF BPOs, without additional income or acknowledgement.

Enable empowerment of staff for ideas and decisions and things will change. Needs collaborative leadership styles over the very dusty current processes. Lots of talk about ‘agile’ at leadership levels but honestly, very little real understanding of what it means and almost no commitment to culture change.

Additional Comments

“There is a tremendous amount of duplicated work, convoluted business processes that are open to interpretation, and illogical or unnecessary division of work (institutionalized lack of teamwork/"passing the buck").”

“They place too much pressure on staff to do administrative tasks instead of focusing on clients. The systems are not Veteran-centric, or trauma informed and as such our processes place extra undue pressure and stress on our Clients. Our systems are so intrusive and inappropriate that they actually trigger mental health systems in clients.

The new GC case system was rolled out extremely poorly and it has increased the workload of case managers 2-3x. This means we spend more time putting things into the system instead of having the time to focus on connecting with Veterans. “

“The constantly changing rules and outdated business processes pose additional challenges to decision-making that is already complex. VAC is constantly changing things that affect decision making and often does not finish fully implementing one change before it moves on to another. Some change expectations are communicated verbally and never written down.”

“The process is convoluted and sometimes the Veteran says they feel like their "whole" isn't being considered, just their "parts". They feel exhausted having to do each claim separately and they feel the linkages get broken about how they're doing overall when they are limited to speaking to a knee or a shoulder in each claim. There are too many forms and too many times the Veteran has to approve and release data. “

“Still serving members can’t differentiate which program to apply. Now that applications can be done ‘online’, still serving members and Veterans may be applying for a program which they are not eligible for. By doing so, it amplifies the work to be done by front line workers in having to explain why they can’t apply for this or that program/benefit/services. Disability applications are taking much too long to get adjudicated.”

“The intake process identifies a lot of needs, but often for Veterans who have no eligibility to get those needs met. We know there are problems that we cannot address for years. The intake system also sets up a false sense of security, as the Department's documents lead Veterans to assume that when they go through intake they will get the help they need - not put in a queue to wait for years until they get one set of benefits to unlock other benefits.”

“We spend a lot of effort assessing clients, but we do not have a matched intervention to the assessment. We simply decide who to case manage and that is all. Each level of assessment should have a corresponding level of intervention. Also, the one Veteran one standard does not work. A releasing member with 20 years’ service and complex issues is not the same as a reservist who worked P/T for a summer 20 years ago and has been somewhat independent for the last 20 years. We need to understand that there are different Veterans’ experiences and different levels of intervention required.”

“Volume of work is increasing (more applicants) and quality is decreasing (veterans applying for everything/all programs). This is causing a perfect storm from a workload perspective as you try to find ways to “make it work” for everyone, while those who should be applying for programs are forced to wait significant wait times.”

“Vets wait too long for decisions on disability claims once all required documentation is in. Hopefully the new procedures with creating "teams" in DBU should help speed the process up.”

“Lack of interview spaces at offices that have high walk in intake problems. Currently there is one intake room and a veteran friendly room with a laptop. This room is not designed for intake. Nowhere to write ~~if~~ for clients to review papers.”

“A large amount of applications resulting in high caseloads, overworked. Clients are often applying for as many as a dozen or more health conditions which is admin heavy for case managers to deal with. Incorrect information is being given to them and they are just applying for as many things as they possibly can, but each condition requires a decision even if they qualify or not. Working in two systems (GCCASE and CSDN) is quite frustrating as well.”

“Many Veterans are ill-equipped to provide details or support of their applications simply because they can be far too complex for them coupled with their health issues, can lead to very unsatisfied clients. Our policies are too strict and require way too much evidence, especially in the case of disability benefits. Compound this with the ridiculous wait times for disability benefits and it equals a recipe for disaster for the Veterans, who don't get the support they need, the financial benefits to help keep them afloat and also the closure they are looking for.”

“No training manuals or officers, no advancement or org charts, managers are not held responsible for QA, there are no HR supports or information sources for staff, they are at the whim of managers who may or may not be informed. Managers are not held responsible for errors or omissions, they have no go to resources to use themselves, it is often like the blind leading the blind and if one of the folks involved is burnt out or doesn't care, the whole web falls apart. There is rampant discrimination and harassment that cannot be addressed because often management is the offender and there is no support for staff making the complaint. They are at the mercy of the managers and often its the managers who are perpetrating the offence. So, if you want to end your career, complain or ask for help.”

Section 2: First Contact Resolution Around 25% answered that their work involves first contract resolution, and more than half felt that there are problems with the process.

In general, there was a sentiment that FCR often results in those with no knowledge of the Veteran or their community making decisions based on "tools", which are more about money than specific need. These tools assume a certain prevalence of provincial support that is not always available in rural areas. It was also reported that software is substandard, that there are too many programs and different benefits, and seriously backdated decision making. Workers also felt that Management is out of touch with needs of front-line workers, thus leading to low morale overall.

Workers also complained that looking at an address on CSDN does not tell them if the Veteran lives in an urban or rural area, what kind of community support is available, etc. Therefore, there is a lot of time required to review the file and ensure nothing is being overlooked. This translates into a situation where there are long wait times for Veterans and the information provided is not always accurate.

Other issues with FCR include:

VSAs are receiving calls for an area they potentially have no knowledge of. In central Ontario, a VSA in Kingston can receive an FCR call for a client in Toronto or Thunder Bay. What purpose is served by having them take down the information only to have to send it to the VSA in the AO to follow up. It's duplicating work.

Older Veterans or those in distress or who have severe symptoms of PTSD find using the toll-free number challenging.

It is challenging to have Veterans get information from many different people. Guided Support has helped with Veterans in complex situations so that they only deal with 1 person.

The focus needs to be on the resolution. FCR and postal codes distribution do not complement each other. It needs to be one or the other. FCR and the first point of contact with a transfer to a Postal code VSA is not efficient and often results in multiple VSAs involved in the file. This is a drain on the VSA resources.

Specifically, on processing a request for change in services:

For those who feel it does not work well, reasons included the fact that there is too much paperwork and reasons for decisions are not clearly explained to Veterans. Decisions are untimely, postponed, and it can take too long to respond to immediate needs. There are also many policies and business processes to follow that can turn it into a very lengthy process. Additionally, there is confusion between providers / treatment benefits vs. rehab causes extra work for CMs and frustration for clients.

Clients are frustrated with the backlog of decision making. There are constant changes in the services offered to clients, therefore difficult to keep up with at times in conjunction with the heavy workload and caseload. There are issues due to the multiple units that work on one clients file and the lack of communication between them (for example, we cannot just simply call someone from the financial unit to explain something to us that the client is demanding to know).

Adding a health condition to rehab and adjudication of section 9 to section 8 involves a Veteran reapplying to the program once a condition is deemed service related. Needless.

There are inconsistencies with NCCN and Medavie Blue Cross (MBC) when dealing with address changes and VIP reassessments. Date change is sometimes put in effect

on date of call as opposed to actual move. Also, PO Boxes are put in residence address; people don't normally live at the post office. And if the person moved to a PCH, AL or LTC, the name of the facility is not put in the address line.

Clients will request a new VSA or CM but due to tight staffing numbers this is not possible. It is difficult to address performance issues leading to requests for working with new CMs and VSAs.

There is too much overlap between VAC and Blue cross that is confusing for Veterans, providers, and VAC employees.

Dealing with service providers who do not understand or comply with vac requirements and need to be negotiated with every provider. Unresponsive service providers.

Suggestions for improvement:

There should be more staff, particularly in offices with a high number of walk-in clients. Retention needs to be addressed - this could be improved by providing better training, better support to staff, more acknowledgement for the work done, and fair pay for the work. This work should be paid at a WP-3 level. Work-design could be improved so VSAs are not constantly being pulled in so many competing directions (i.e., having to be available for FCR calls, walk ins, direct calls, Guided Support clients, and their regular workload). Perhaps the employer needs to hire an additional NCCN level of agent who has more training/some authority to handle calls such as VIP reassessments.

Need for more training for Front Line staff to handle complex clients and better respond from Security Department to support our safety. We often feel dismissed when complaints are launched. Poor equalization of career opportunities. Nepotism is high. Too much investment in a small group of people continually promoted, supported, huge department investment in a small few and it may not be warranted.

We need to be able to have NCCN transfer the call to a licensed psychologist if needed. Case managers do not need to be yelled and swore at.

Need for improved training, acknowledgement from managers of all the work VSAs do. Re-classification to WP-3. More time to focus on the job at hand, without being pulled in other directions.

Some Veterans who are 'repeat clients' always calling with the same issue or complaints should be managed differently in order to eliminate these calls as they take away from serving Veterans in genuine need.

More benefits for spouses or caretakers of Veterans with mental health issues.

Streamline, areas of expertise, stop making people jump from one workload to another, all workloads should have people responsible for their completion, not jumping from workload to workload putting out the fire of the day.

It all comes down to culture. But the problem with that is no one in the EX level thinks they are the problem! Need to really focus on staff - and maybe training or counselling for EX staff on modernized leadership styles? Stop the DG task forces where they talk about details that knowledgeable staff have worked through a year ago! Wish I could say something more concrete, but really think the problem to many of the issues at VAC is the culture.

Needs based assessment/approvals. Nothing is approved without an identified/assessed need. An investigative branch to find fraudulent claims/behaviour would go a long way as well.

Let's create a workstation where Veterans can complete their applications at Veteran's Affairs with helpers available to them. Make it mandatory for the CF and Veteran's affairs to access all CF member's medical/dental/MPRR/CF records from a single database that is unlocked to Veterans Affairs as soon as the member gives permission to access. Seamless. Why make the CF member/Veteran the go-between! They are the weakest link yet most responsible for whether the large systems give them what they need. Creates hardship and heartache and isn't necessary!!

It is not effective time management or use of time to continually get interrupted with FCR calls when you are trying to process apps (VIP, LTC, and POC 13). Should have separate staff on phones and separate staff processing apps/POC 13.

Have designated trainer (experienced) staff from each work group in each office who advise, train and write procedures - have them work as a group across the country, have them be assigned to this task specifically so they have the time needed to train and update.

Get rid of VAC formulary...each province uses its own formulary and the drugs are approved by Health Canada - VAC overview is NOT required and simply causes too many problems for clients who need to have their medications...Process with SAU is not needed at this time.

Allowing clients to enter their own Direct Deposit details in My VAC Account is convenient but leads to excessive errors. Submission via the DD form is slow and frustrating. The Annual Declaration form is frustrating for many clients - the MVA version doesn't work half the time, and other clients "forget" or don't bother to return it - leading to suspension of pension. I wish it could be done away with, or left to a mere phone call - like with VIP follow-ups. Adding rich text to MVA secure messaging would allow VAC employees to provide clients with hyperlinks to forms/websites/etc without requiring clients (many with low computer skills) to highlight/right click or copy/paste links. It would also allow for bullet points and sectioning - rather than a "wall of text".

VAC should clarify its mission & vision - are we providing services to Veterans? or serving members? what is our obligation to provide supports to families. These all seem to conflict with what is outlined in public messaging and what is actually permitted in legislative authorities and the intent of the programs and benefit when originally designed and developed.

Ensuring that there are always sufficient people on and how calls are distributed from the call center. No time for wrap up. Can get one call after another. The new program the VSTM uses to schedule can have a VSA on three times in a week. Sometimes in a row. Extremely difficult to get calls done in a timely manner.

Either use FCR to assign calls and have the VSA take it to complete resolution or distribute the calls by postal code. The goal is to have one VSA deal with the call after it is transferred from the NCCN. Having multiple VSAs is frustrating for clients and the VSAs. "taking it as far as you can needs to be replaced with this is your call complete it.

Additional Comments

"The new FCR model is not good. It is a very inefficient use of time as it is predicated on the idea VSAs are not allowed to make outgoing calls on the days they are scheduled to be on FCR. There have been many days when I have finished all my other work except for calls I need to make to clients but, because I'm on FCR, I can't make my calls and I have very little useful work I can do while I simply wait for the phone to ring. And there can be anywhere from 30-90 minutes in between calls. It's simply not an effective use of my time."

"VSA's constantly have a massive workload and not enough time to deal with it. On top of this they have to deal with a lot of walk-ins in many offices (as in my situation). On top of this, in my office, VSA's have to provide lunch coverage and other coverage for when the one Administrative Assistant is on lunch, on training and away. On top of this, we have to take FCR calls. I expect to be asked to vacuum the office when I leave as I seem to do every task in the office."

"There is not enough staff, when an FCR staff calls in sick, other staff who should have a workload day to get their work done, are put on FCR to cover. There is sometimes a lack of consistency and lack of control over one's work schedule. It is a very frustrating model. There is also no wrap up time and the calls sometime come in one after the other. The VSA is unable to complete one task before another call comes in. Sometimes by the time the VSA is able to input the information, you forget or notice that something is missed, VSA cannot make an outbound call to the Client for clarification until they have a workload day. Sometimes the VSA has many follow- up calls to make on a workload day, only to be told on the workload day that they are now on FCR because staff called in sick and they are short staffed. It is highly stressful to be on FCR, with no wrap up time or the inability to take a break after a difficult call. VSAs are also concerned when they need to click off for multiple washroom breaks and the other

VSAs are on calls, so there are not enough VSAs available. It is a very restrictive Model. VSAs are also asked for their availability schedule ahead of time, however life sometimes happen, unexpected events such as a sick child can occur, and it causes a lot of stress and anxiety if the VSA is scheduled to be on FCR. Sometimes the school may call for a child to be picked up from school on an FCR day which can cause anxiety if the VSA is on FCR."

"The problem is built-in inefficiency. This new model was meant to address the issue where the correct use of the old system for doing FCR (every VSA logged into the queue to take calls) was not properly followed in some areas. This was leaving responsible VSAs with too high a workload because they took a high volume of FCR calls while others took none and calls were also being dropped. It appears maybe managers in some areas took a hands-off approach to this and the correct thing to do would have been to simply stop this by enforcing the old policy. Meanwhile the new model focuses on having people on FCR only on certain days, but far from hands-off it is a highly scheduled and highly enforced system. It's a scheduling nightmare most months and any unforeseen absences only add to the problems. and it was adopted across the country even in areas that did not have the old problem, i.e. where all VSAs were conscientious about taking calls (as was the case in my area)."

"FCR does not work. It relies on everyone doing a consistent job. We are to take the call as far as we can and then hand it off to the GEO VSA for fu. However, there is really no consistency of how far that is and no fu from VSTMs when it isn't done. For instance I might get a call and spend 1 hour and do everything screening, GDT, assessment, VIP interface and letter and another VSA will get the same call and say yes we have the application and let it go at that. When we bring these discrepancies up our managers just shrug their shoulders that they have no power over a VSA who is managed by another VSTM especially if they are in another location. I think going back to GEO VSA getting the call and doing the work is the best. Clients like the consistency of dealing and asking for 1 person."

"This is the worst system ever invented - system is very broken and promotes quantity over quantity service. I hear every day veterans saying why can't they talk to a specific agent or GEOVSA as they have a history with particular agents. Staff and our veterans do not like the FCR model I believe everyone preferred the old way where only assigned Staff would address the issue unless urgent then an intake person would get involved. Management has made a bad client service model even worse with this new scheduling FCR days - the scheduled agent seem to call in sick and no one really picks up the slack so the pressure is on to provide fast poor quality service with minimal follow through - VAC is moving to a call centre model with high turnover disgruntled staff and equally disgruntlement clients!"

"Clients hate it. Different person every time, having to explain over and over. I, as an employee hate it. Too many fingers in the pot, other VSAs in different offices providing

misinformation to my clients, not doing all the work, clients complaining about no consistent contact. Not being able to get to my caseload. It's horrible."

Section 3: VACS's computerized systems

95% of respondents use VAC's computerized systems in their day to day work. About 50% reported encountering some kind of problem with the system.

Many complaints had to do with poor connectivity, lag time, crashing systems, and lack of training on the new system. It was repeatedly noted that the addition of new systems without making a full transition from the old way of doing things makes the whole process more complicated. There were also many complaints addressing the fact that there are too many passwords for programs and a large administrative burden, due to the fact that they are required to document in multiple locations, two different systems.

Other issues with VACS's computerized systems include:

Poor implementation of GC Case. Outdated technology - Differing access between CSDN and GC Case leads to missed info/double documentation - DBU processing. I had a client's application stuck at the 'calculation/pay' stage for 3 months and NOBODY could give me an answer. Not the DBU, not adjudication, not the manager.

Letters are time consuming and should pre-populate with information already on the file, Duplicate button should be on Resources to avoid duplication of work with only new information to be inputted for each renewal.

MBC does not have access to view updates in new system, cannot move Rehab applications forward until DND info has been received and verified in system, cannot close Rehab at all without DEC decision which takes a great deal of time to process.

Suggestions for Improvement

Don't roll out a computer program until you've got a working program from start to finish. Get back to one system ASAP.

Training on new programs that roll out should be mandatory AND provided. VSAs finally got a cursory training on GC Case at the end of February. All new disability apps are in there along with case managed clients which are now on VSA case load as guided support and we didn't have access to it until recently and most of us didn't get the training yet because of COVID.

More forms and documents must be made available online or via My VAC Account. When an MVA letter says an MQ is attached, it should be attached. Additional Pension

Extension forms should be available via MVA, clients shouldn't have to ask us for a Summary of Assessment. The promised POA My VAC Account profiles need to happen in a hurry, also. This is just off the top of my head... So many improvements could be made to this system which would allow for less waiting and frustration on both sides - the clients/their representatives, and staff. The current COVID-19 restrictions (especially with mailing) just exposes these deficiencies further. If this can't be done, find a way for employees to email BLANK (no client info) forms to external third-party email addresses. There's got to be a way.

If a duplicate copy is sent to a client via NCCN Admin, it should have its own entry in sent documents and/or a clear note stating what date it was sent and what was included. The work item routing should make a hell of a lot more sense than it does (props to whoever gave us the Ontario divisions and Prairies under Field Ops - its helpful!). MVA message content should be searchable (like client notes). NCCN SHOULD BE ABLE TO SEE ALL RECEIVED DOCUMENTS, AND BE ABLE TO OPEN THEM. Clients ask us all day long to confirm whether something has been received. If they have 5 reassessments open and I can't open the three QOL documents received, how can I tell them what's missing?? Same situation for MQs. And medical documents that aren't MQs? I often can't see them at all. We also can't see reassessment packages when they're mailed. Whenever we can't open a document, we have to go to a VSA, CM, or someone else to ask them to open and confirm. How is that efficient? Sometimes we can't see the document at all (medical info submissions other than MQs) and we tell the client it's not there when it is... "Check events", we're told. More clicks. More things to remember. Just unhide the document types - done. There's so, so much more. So many inefficiencies and so many ways that we could be more efficient with our systems.

Processes: They can be made so much simpler in the decision making, research, accessing DND records, liaison with DND prior to release for the purpose of expediting future claims, trades are subject to certain risks for every person who works in the trade. If a claim is made for one of those risks, and exposure has been identified, how can it take 18 months to get a decision? Early screening and classification (triaging) of claims needs to drastically improve!!

Made lots of changes already, but more things need to change, and VETS need to be part of those changes, not stats on a ledger that says this or that so let's do this or that and see what happens. Find out from VETS what they want to see. Won't please all of us, but that is human nature. 20% angry all the time is better than 50%!!!

A new docket approval system.

Additional Comments

“They are cumbersome, and the VS toolbox needs improvement GC docs is horrible or maybe it works but we never received any training on it.”

“When some Veterans set up an MVA they don't understand that, after they input their email account - they have to answer an email sent to them in order to finalize the process.”

“Lack of updates in CSDN due to the new software and it's my understanding they don't plan to fix anything that they have messed up with their updates and if they do it will take a while. It took them close to a year to fix a problem affecting widow's’ claims some have passed away waiting! This new program to enter decision I'm told as its issues as well but then again I will not find out until later as they only let a few people have access to it!!”

“Not enough horizontal work being done at VAC. Too many conflicting messages from different sections that do not collaborate at the head office level. Too many messages and decisions that do not support the mission vision of the department. Action does not align with strategy. employees don't know what or who to believe.”

“CSA and GC Case are making our jobs less efficient. CSDN: My VAC Account 'letters and forms' and 'secure messages' should be their own windows (flipping back and forth is a pain). If a letter HASN'T been issued to the client, it shouldn't show up in sent documents at all. No one (despite several reminders) seems to pay attention to 'queued' or a blank distribution status - especially case managers. If it hasn't actually been sent via letter mail, it shouldn't say "mailed electronically" or "printed locally". We should be able to search historical letters by something other than the letter code or a date - same for work items.”

“During the Covid19 pandemic, Admins and PMAs were not provided equipment to have the capabilities to WFH. There is so much Admins can still do, to assist and continue with our duties. The amount of emails alone that we will be coming back to will be very over whelming, and the PMA back log. This will not make balancing work and home life easy and will have an impact on people’s mental health.”

Section 4: GC Case System

About 60% of those surveyed work with the GC Case System. Approximately 60% felt that there are ongoing problems with how the system is used. Many French speaking employees notes that there is significant issue with how the system was translated.

Other problems included poor functionality and a lack of training. Many feel the system was poorly designed, poorly tested, and rushed into production.

Other issues with GC Case include:

Having to go from CSDN to GC Case constantly, trying to piece together info with access not having adequate information that was readily available in CSDN. Information is difficult to get and understand. Training is far too little far too late.

Some area office staff, managers, and NCCN operators are not trained at all on GC Case. This means that they must pass requests to DBU for inquiry into a client's file rather than being able to address it themselves and get a much speedier answer to the client.

The system is getting better as they make adjustments, but it's frustrating when there's a mistake and have to request someone to fix it.

It does less than half of what it is supposed to do, and what it does do, it does it poorly. Having to enter the SAME decision data for every Rehab condition is ridiculous. It is very hard for already overworked Case Managers to make use of this system when half of the information is on CSDN.

CM's STILL cannot close/complete a Rehabilitation plan in GC Case. This means that we have Veterans sitting on our caseloads that should be removed from the system.

Slow progression: Still using CSDN just as often as GC Case, it's easy to access client's info all in one place. i.e. contact info, service, SOA, disability and financial benefits and MVA. Whereas in GC case you have to search for the info/not all is available in the system.

Suggestions for Improvement:

Simplify, simplify, simplify. And stop using multiple systems.

More people should use GC Case, consultations to make their notes in it, instead of CSDN.

Allow users to personalize their main page to accommodate individually user display and work preferences.

Either transition to GC Case or stay with CSDN. Now must check two databases that don't talk to each other. Reduces efficiency by half, plus now there's a gap where errors, omissions, and more can happen.

NEED Colour PRINTERS in each office so we may have hard copies of the different flow charts/job aids supporting documentation that is produced for the GC Case system. HO prepares all these documents, in colour, yet the district offices can't print them. In the format they were intended - some of us still use paper, for reference materials.

Making CDSN a legacy program running in the background and making all staff work in GC Case asap will be the best way forward.

Need to have only one system. Hopefully, all the information in CSDN will be in GC Case so we won't need both. Need to have a bridge between CAF information and VAC information. There is much duplication of information as well as lack of Information when it's needed - i.e.: having to wait for service and release date verification is too slow and clumsy.

Additional Comments

"Our project team staff had to wait over a month to receive computer equipment in order to work from home also due to lack of VPN access sufficient to allow volume of staff onto the network. Through hard work by IT staff situation has been rectified and kudos to them. However, it shows employer was fully unprepared for this type of working remotely. Some staff are permitted to telework but lots of others are not allowed. The current situation proves that teleworking does allow for this model of work to be employed for project."

"This system should not have been installed until it was fully operational. You learn something then they change it or a year later and the system still cannot complete some basic tasks: the letters are awful (we were told they are a priority and a year later no5 fixed), you cannot remove a closed file from your assigned cases and when completing rehab application there is a great deal of receptiveness —if declining a number of conditions you should be able to group together and complete task once instead of each one independently. Also, instead of having to open a box each time for each ADL impacted for each condition it should be condition 1, open ADL box and check all that apply and those checked must indicate the severity of impact."

"GC case was rolled out in segments which required us to transfer data from one system to another. All while doing our current work. There was no additional time made available or overtime offered until late in the year December. By then we had already been using the system for over 6 months. Training material was not provided, and online sessions were often cancelled last minute or cancelled all together. Most of learning was done individually with no additional time allotted. Directives were unclear until last minute when there was a sense of urgency created to complete data transfers by certain dates. Much like last March pre PFL roll out."

"They are getting better. The rollout of this system in the "agile work environment" was disastrous and many people were on the brink of burnout because of it. The system is working ok now for the most part."

"There are GC Case glitches and work is lost. I have to do my work in word and save it in fear of losing things. It's harder to fix mistakes as you have to put in a ticket for it and

all the functions don't work so we have to use interim processes. Then, when they do implement a process a deadline is set and we all have to learn and redo things to get tasks done. It's administrative heavy."

"There are many system glitches with the new system, GC Case. We are often working in two systems (new and old, GC Case and CSDN). Many things from the old system have been transferred over into the new system."

"The system was put into production without having the full functionality built. There are many work arounds until the functionality is built. There have been many upgrades with another coming in October. The upgrades require the whole system to essentially be rebuilt."

Section 5: Medavie Blue Cross

About 45% work with MBC and 38% reported having some type of problem dealing with an MBC representative. 55% reported delays in processing requests or receiving information from MBC.

It was reported that these delays are significant because they can prevent clients from getting their medication, services, or payments. This, naturally, can have a negative impact on the relationship between Veterans and VAC staff. There was also a general sentiment that some MBC employees believe that they are in change and VAC answers to them. Many complain about being passed around to several analysts in order to get an answer to their question and that MBC is unable to see information inputted into GC Case which requires duplication of work.

Other issues with Medavie Blue Cross include:

There is often an overlap of duties between NCCN and CSC. Also getting information and assistance from the drug unit is difficult.

It feels we work for MBC they do whatever is convenient for them. They make changes on files don't document on file, they refuse things don't give a clear explanation on letters, letters are the worst letters not clear and full of codes difficult to follow.

Unclear guidelines, they tell Veterans it's up to their case manager when it is not setting unrealistic expectations.

MBC staff categorically refuses to process the items VAC staff I have approved, forcing them to escalate to Head Office to get resolution. Other times MBC staff questions VAC staff judgement, or place limits upon decisions not included in VAC decision. MBC letter to Veterans are the absolute worst! They deny benefits without any explanation of what information is required for a review, and very often don't even use the correct letter information in their decision. Simply put, MBC is a for-profit insurance company who

makes money the more they can say "NO". This is NOT how VAC is supposed to operate.

MBC won't contact clients. It's not VAC staff's job to know their job so they're basically calling them to relay a message to clients. It's a waste of time that could be used more effectively elsewhere. Also, when they do the 3-year VIP reviews they are done horribly. They NEVER fill out the form they use, they just save a blank one to show they've done the work and VAC staff have no idea what was discussed with the client.

Suggestions for Improvement:

There are privacy issues with MBC. The NCCN must ask for address, DOB, phone #, name and file / service #. Or name file # and password. MBC only asks for name, file # and DOB. They give out and discuss private health matters. This is not secure enough. It should be consistent with department security measures.

We need more training on MBC, their processes, who does what and where. They have several different locations and the trick is to talk to the right person the right dept which is impossible sometimes. It is not uncommon to speak to 3 different people, tell your story 4 times and spend 1 hour on the phone and still not have an answer. Of course, if you are scheduled for FCR that day it is done on a day you are not scheduled because on an FCR day we can't make outbound calls.

Quicker turnaround time for prescriptions that a veteran is using on a regular basis & keeps being renewed.

MBC has shown time and again that they barely know legislation, policy, and business processes related to treatment benefits. They could really benefit from additional training. Their training should also include learning to do everything possible to aid Veterans. When they deny claims incorrectly, that work comes back to vac and ends up wasting taxpayer money.

When it comes to processing reviews for treatment benefits, it would be great if we had the time to contact each Veterans, tell them what medical documentation we need, and wait for it to be sent in before processing our review. But given that we have a 12-week service standard, and are processing cases only a few days before they are due, we do not have the time or the resources to chase down information that good Veteran service on the original decline would have addressed.

Ghost shopping - set out parameters for numerous validation tests to ensure that there is fair, competent, and consistent application of the rules for granting benefits, etc. This should be done regularly as means to ensure the highest (not minimum) standards are being met.

Audit Blue Cross about the work performed. They are a private company with a mission of making profits by cutting corners affecting the Veterans and cutting in the verification and process and red tape causing misdealing of taxpayer money."

Provide all Veterans who serve 10 years in with full B-line Medavie Blue Cross coverage to access full suite of health service, in line with existing process, and provide Veterans with automatic $360,000.00 entitled amount upon release. These two decisions would allow for those who truly require rehab case management to receive it, lower caseload numbers significantly, end the adversarial and toxic mistrust between Veterans and Department. By removing the adjudication component of the department and the need to claim for individual injuries and conditions, Veterans would feel supported in having their full needs met and the government would save a significant amount of money that is currently spent on litigation and paying adjudicators at present time.

Additional Comments

“MBC can be challenging to deal with. They don’t have access to the info we need, for example I have a client who has run out of funding for pc and they shouldn’t. I can’t find out the invoices the client has submitted and what MBC has paid, I just know there is no more funds left in this benefit year to pay their provider island health. This makes it impossible to correct. Not only that but the client has received funding for something he wasn’t approved for so he is in an overpayment situation.”

“The biggest issue is their denials of benefits that Veterans are entitled to. They are also now completing VIP reassessments for PCGs and Veterans (regular reassessments, not just the 3 year follow up). That is VSA/public servant work, and this is a slippery slope towards giving more public service work to private corporations.”

“They often send out denial letters that when we follow up their staff actually say they're NOT denial letters. But the letter actually says DENIED! They're ridiculous. The redress process is convoluted and no one is ever accountable. Veterans have been very frustrated and confused and angry at us since we contracted the services to Medavie. The optics are that Medavie is profiting by telling Veterans their claims are denied when they really mean "we need more information" or "if you challenge this we'll reconsider" or "please ask one level higher." For every dollar they don't spend on granting Veteran's claims, they should have to pay back $2 to VAC.”

“They will give info to clients or providers about programs without understanding the program or Veteran setting the Veteran and department up for conflict if the Veteran doesn’t actually qualify. Things like saying the Veteran can’t have x but a case manager can approve it.”

“MBC has shown time and again that they barely know legislation, policy, and business processes related to treatment benefits. They could really benefit from additional training. Their training should also include learning to do everything possible to aid Veterans. When they deny claims incorrectly, that work comes back to VAC and ends up wasting tax payer money.”

"Miscommunication between VAC and Medavie can mislead Veterans. Sometimes they refer back service approvals to case managers when it's simply through A-line coverage they need to approve. The fact that Medavie doesn't have access to our GC Case system is also limiting."

"System of communicating directly with MBC is convoluted and delayed. MBC systems are confusing. MBC is not always timely in their responses to frontline staff though they do try. Was contracting out this work really a positive move re: financial savings? Ultimately MBC seems to answer to MBC not to VAC."

Section 6: Staff Training

About 60% of those surveyed felt that they had been given adequate training, with slightly more (65%/ 67%) reporting that they had been given adequate time for this training and that it has been delivered in a format that allowed them to participate.

For those who raised concerns, some included that training in their unit is rushed, and only a portion of what the field receives, even though they are the ones who review all of their decisions. Many also felt that training begins too late, once they've already started to receive requests for review of new programs. This adds to the sense of urgency to get it done quickly so they can preserve service standard.

Although some approved of the WebEx training, some also feel limited by the format, as they feel uncomfortable asking questions while online with many other people. They don't want to interrupt.

Other issues with Staff Training include:

For the N1LA Unit, even though we are supposed to be able to review every Departmental decision, the training we received is only a fraction of that given to the field. We receive it months after programs come into effect, usually leaving us with cases left to wait until we get trained to look at them.

NOTP shows you about 5% of your job... and that's about all the training you get. The rest you are thrown into it and made to learn on the fly.

WebEx training loses its effect, trainers tend to forget that we can't always follow as well when they flip from page to page, they need to slow down a little so we can follow what they are showing us.

Mentorship from other staff, it is a huge reason why overall training is successful. The NOTP and WebEx's were useful and informative but without the in-person mentorship from coworkers the training would not have been as successful. Mentors gave up a lot of their own time without recognition from management.

Sometimes new employees start and if they do not stand their ground, they often get pushed too soon to take on a case load. Some management is more understanding than others but when you are new in a job, it can be challenging to say that you are not ready. It can feel like "sink or swim".

Suggestions for Improvement:

"The training they give is on Webex this type of platform is good to provide information. Training should be stimulating, favor exchange of information, interactive (physically or virtually). The department should tape on external resources like The Public Service School with an interesting learning platform. Webex people navigate through as quick as possible as it is very boring."

"Different people learn differently, in different ways, different speeds, retain at different levels, require refresher training more or less often, etc. 1 way for everyone expecting everyone to fit into a box and perform at a certain level is archaic and unrealistic. It needs to change urgently."

VAC needs to have a position that is dedicated to in-person training while on the job. The VSA is required to know way too much information, coupled with that number of programs that they adjudicate on, coupled with the fact that they have to respond to clients via FCR, telephone, MYVAC account messages, walk-ins, scheduled appointments and transition interviews.

Additional Comments

"Training is always scheduled last minute with no warning - means we have to cancel our own clients/our own meetings which may have been scheduled in advance. Management does not respect this impact because management has no idea what our jobs are."

"I was given training, however I realized once I started the job that there were some gaps and some things that I was not told about and did not learn how to do. I realized when I encountered these things that I was not trained in these areas. It was impossible to ask questions when I first started because I was not aware about these things."

"Lately our training has been more online and via Webex. this is not supporting individuals who do better during face to face training. the original PFL training was a matter of a few days which was not enough. we came back extremely overwhelmed, demanding further training which did not arrive until many months later. all training we are offered is expected to be completed during our work time, which at times is challenging due to the high workload we already have to deal with."

"Training has improved, but there needs to be people tasked with training in each of the offices. Peer training is far too heavily relied upon in this department."

"Training is not done very well at VAC. Training should start with the end of the training in mind...what do we want to accomplish with this training. The end is the starting point of designing effective training. Only by identifying the goal can we properly identify the units of learning that are required. I have yet to see any training at VAC (unless the training was prepared outside of the department) that is effective and I-have been with the department for 14 years."

"NOTP was great, but I attended the First round of training 4 months into my position and the second round 6 months in so basically I half learned everything before NOTP then went to the face to face training and realized all the things I was doing incorrectly. The NOTP Web exes are great but I didn't have access to them until I already had a full case load. That's the other issue, no time for training because every office is so understaffed. They have to just pile on the files as soon as possible."

Section 7: Family Counselling programs

About 30% of those surveyed work with assisting family members of Veterans to access counselling programs. Similarly, 30% reported that they've been told to stop referring clients to programs.

For those who had experienced problems getting clients the help they need, concerns raised were primarily focused on the impact on Veterans and their families. Many noted that interrupted treatment caused additional emotional and financial stress. It has also made the relationship between the Veteran and VAC staff very strained, as it is the front-line staff who are wearing the blame for the change.

Other issues with Counselling programs include:

The department has no less than seven definitions for "Veteran" across the variety of legislations that apply to the department. A CAF member does not serve alone if he/she has a family, ask any spouse, sister, brother mother, father, or child of a serving member. VAC needs to recognize the role of 'family' as an integral part of being a Veteran. That way, family members would be eligible to services, when those services are required to support the veteran.

Veterans do not exist in a vacuum, they are a part of a wider community and family and without adequate support given to the family, the Veteran struggles. The news of the changes to POC12 were very triggering to people. Employees did not feel they were given enough information or guidance. For some families, individual counselling for the spouse or children is what is keeping the family together and it is what is keeping the Veteran alive.

Psychological treatment for family members is mainly educational in purpose (i.e. to learn about Veteran's psychological condition). Not able to treat family members' own psychological condition beyond very short-term counselling and only as it affects

Veterans' own case plan. VAC Assistance Line is offered, however feedback from Veterans and families is that this is insufficient for anything beyond short term and light psychological condition (very insufficient for chronic or severe psychological conditions of family or Veterans without A-line benefits).

Suggestions for Improvement:

Counselling for family members of Veterans should be a covered benefit to the same degree that Veterans themselves receive treatment. The more disabled the Veteran the more support the family requires. The recent change in vocational supports for spouse's where a Veteran has been deemed as DEC is punitive. The point of providing training to the spouse should be to provide the spouse with the ability to make up for the losses experienced by the family and the Veteran (income, independence, future prospects for growth etc.) To not allow the spouse to improve their and the family's situation is appalling.

Additional Comments

"One Veteran was discussing harming himself because of his spouse not being able to get the help she needs. Spouses and families go through a lot while the member serves and afterwards."

"Very significant impact on Veterans and their families. Counseling for spouses was often what kept the family healthy. Children often need services in order to avoid becoming unwell themselves. Withdrawing services really precipitated collapse of some of these family systems. Veterans do not exist in a void and their illness has major impacts on their family and support systems."

"Frustration stress helplessness depression. Solutions are available but it usually means a new therapist which people are resistant to use. its causing issues between CM and Clients."

"This is no different than other issues at VAC. Head office sections need to collaborate and give consistent messages, "case by case" decisions are good for use of judgement in adhering to policy but the policy must be followed. Make a decision in line with your strategy and stick to it. This is another issue of months ticking on while the department dithers on what to do. Veterans need the policy, transparent decisions against objective criteria in the policy and quick decisions--even if it is a no. If we are not going to fund therapy for the family member's issue; then write a coherent policy and stick to it. This constant waffling on issues undermines Veteran's confidence in VAC to be able to make a fair and equitable decision and treat all Veteran's consistently."

"Awful.....miserable.....the Veterans who have been affected by this change that I have spoken too all feel betrayed and very angry over this. one A Veteran told me that he fully expects to have to fight with VAC for his benefits but never expected to have to fight for his wife's session."

“It has had a devastating impact. It has left spouses afraid, parents afraid that their children might harm themselves, Veterans afraid for how they are hurting their families.”

“It was a huge blow to families to be told these services would no longer be available. Again, a decision made without consulting case managers who have the most indentions about client needs.

“The Veterans are frustrated, depressed and angry. Their families are not supported, it’s all about the Veteran so the family does not become a part of the solution or garner the services they need as well.”

Section 8: Mental Health Services

About 42% of those surveyed work in areas that involve mental health services for Veterans~~,~~ and about half that percentage felt that they have adequate resources to do their work.

In general, the problems with access had to do with the fact that referrals can take time and that resources in rural areas are very limited, and not all providers are registered with VAC/MBC. Some providers simply refuse to deal with MBC due to serious payment issues, and demand cash payment from the Veteran who must then seek reimbursement. 65% said there are delays in getting Veterans access to mental health services.

Other issues with Mental Health Services include:

Without having a subject matter expert with MH services in my area referrals are slower and problems solving is limited.

Resources for psychology, psychiatry, inpatient treatment, or more specialized care for some of our most unwell clients, is just not available here so they have to leave their support network and their families to get the treatment they need.

Resources for family and Veterans that do not have approved VAC psychological conditions (A-line) are simply triaged and offered short term light counselling. This is insufficient.

Resources for psychology, psychiatry, inpatient treatment, or more specialized care for some of our most unwell clients, is just not available here so they have to leave their support network and their families to get the treatment they need.

Should be someone in VAC that could research and provide a list/web sites et of available resources by region. Most times the doctors/psychologist/psychiatrist are asking us for the resources.

Several respondents did note that when Veterans do get access to services, the quality is high.

Suggestions for Improvement:

Providers need a better understanding of what VAC requires. It is time consuming explaining these to each provider. Better resources to educate providers would be helpful.

VAC should be providing training and support to mental health providers, so they know how to fill out the reports in a timely way to meet the expectations of GC case. Instead each case manager must try and provide this info to new CB provider for each Veteran. We don't have time for this! VAC should develop a template for reports that meets GC case requirements and come up with a way to monitor providers if they don't follow through.

Therapists programs should be more responsible and provide better results. Unproven therapies should be looked at for feasibility/usefulness. Some Veterans are being taken advantage of and/or placated by some therapists who just want a pay cheque, vice seeing results (or expecting Veterans to work at the programs) for the services rendered.

VAC needs to have staff psychologists. As more Veterans have mental health issues, we need to have that expertise to assist us in ensuring that those 3rd party providers and providing the best service possible. We have FNSO and SAMOs reviewing the medical information coming into the AOs, we have OTs reviewing OT reports, yet we have no one reviewing the Mental health reports.

Create a system to triage requests for psychologists. When one is required in a specific area, a request is sent and the next available psychiatrist (or any other provider) can answer the request. This would save a lot of admin tasks of having to continually contact multiple providers to determine availability all the time.

Additional Comments

"As a VSA I get the questions for the clients who are not case managed. However, because I have no authority, I don't get training on mental health programs. If I'm lucky I can talk a CM into calling a client back to answer their questions. If not, I wing it. I go back and forth between the client, ask a question of a CM then back to the client."

"Veterans are left vulnerable, and possibly triggered. VSAs do not have adequate training to help Veterans with mental health issues, and this is a huge source of attrition

- VSAs get hired thinking they are working in an administrative role, but it is more of a social work position , leaving the client but also the VSA vulnerable to additional harm."

"Due to shortages in the community Veterans are unable to find doctors, counsellors, mental health experts and other community supports. VSAs are not included in "training" and as far as I know CMs don't have resources provided along with training by location on what is locally available and worthy. So, each person develops their own skills and resources and the vets are at the mercy of the VAC staff they get when they contact us. Sometimes its good help, sometimes its not."

"When a client isn't able to obtain mental health treatment for pushing two years due to an in-progress PTSD/mental health disability, it feels ridiculous and incredibly harmful. Having the VAC Assistance Line and LifeSpeak are better than nothing, but clients need direct and consistent support WHILE they are waiting for their claims. If it truly takes this long to give them a decision, something needs to be done to bridge the gap. Serving or not serving. Client families also need MORE support."

"The delays are due to lack of therapists in the area or they all have full case loads. This cause frustrations. Also, some Veterans have been seeing the same therapist for 8-10 years with no progress - this should be investigated as that demonstrates either (a) the therapist is not very effective or (b) the Veteran may not be putting forth sufficient efforts/doing homework, etc. With more accountability/responsibility, Veterans' improvements might be much higher, resulting in more available therapists."

"Difficulty getting prescriptions renewed, inability to get medical questionnaires completed for pain and suffering applications and they simply go without the assistance they need no referrals to specialists, etc)"

"Lack of local treatment providers who are registered with MBC is a huge barrier to improved mental health well-being. The move with Pension For Life to a system where Providers set the goals rather than Case Managers and Clients working together to set the goals is a complex and challenging change, as clinical therapists likely have vastly different goals than government program administers of the rehab program."

"Having to wait months to access services with the OSI clinic. This leads to refraining from referring them there due to the wait and going to the community. This can prevent access to certain services that only OSI provides."

"Sometimes, with RCMP Veterans in particular, even with a VAC Disability Pension award for a psychological condition, there may be delays. Specifically, after release, it may take months after RCMP release for Medavie Bluecross to switch from RCMP to VAC which means that VAC has approved psychological treatment but has no authority to approve it as it remains under RCMP Health Officer until it is switched from RCMP to VAC in Medavie Bluecross."

“Accessing Psychiatric services is very difficult, especially for Veterans who are recently released with no family doctor. Veterans are unable to access new prescriptions for mental health conditions or determine if their medications need to be adjusted or changed. Limited mental health providers can sometimes cause delays as many are not taking on new patients.”

“We need to bridge the gap between "diagnosed" and "decision" for those with mental health issues. Red Zoning isn't enough. Letting CAF/RCMP deal with it when the client is still serving isn't enough. The VAC Assistance Line isn't enough. 30 days for MBC approval of an NFP, Medical Cannabis, or exceptional approval is too long for medications/Cannabis/essential items for functioning/Daily Living Aids.”

Section 9: Employee Mental Health

About 55% of those surveyed felt that their mental health has been negatively affected by their work with the department. Many reported concerns regarding high workload, the stress of processing so many claims, and the fact that administrative burden kept them from doing their jobs in a way they felt was satisfactory.

Other issues with Employee Mental Health include:

The work is draining, tiring and incessant. The importance of our self-care and mental health is not cultivated at work.

Working with injured Veterans who can be volatile can shatter my calm. You can’t help but be personally affected and anxious yourself.

Sometimes the pressures of delivering programs and services under short timelines is what has affected me in the past. Even though I work in Internal Services now and not in direct client service, we are all still affected by unrealistic deadlines.

Suggestions for Improvement:

Reclassify VSTM position to reflect management responsibilities taken on by ADs - not comparable to STEO or CMPC role. More responsibility for staff than can reasonably managed while still completing all the day’s work and special committees and projects all the time.

The minister needs to address this, yet they just bow down to the bullies to avoid media attention and it’s not right. It’s all a political game.

Additional Comments

“The job is hard, being yelled at by clients, or by hearing suicidal calls. It isn't helped by the job either, as everything we do is scrutinized and time. We are under a microscope 24/7 and it's brutal on our mental health as it tells us: our bosses don't trust us for 1 second to do our jobs like adults, so we need to be monitored non-stop like animals.”

“The constantly changing systems, massive amount of knowledge requirements, abuse from clients and their family members, and the micro-managing of staff right down to time for bathroom breaks.”

“Processing mental health claims exposes me to horrific and terrifying stories from Veterans that stay with me and influence my mood, sometimes for days. This is especially difficult to deal with when I hear the stories on the phone with clients. Having clients angry at me on the phone is also something that makes me feel very down and anxious, sometimes for days afterward.”

“Veterans are frustrated with wait times and are often angry and abusive. As first point of contact they’re rude, angry, filled with despair and sometimes suicidal. This affects me.”

“The work we do is challenging, and rewarding. The challenging clients are often unwell and can treat VSAs very rudely. And then there are the suicidal clients, who are heartbreaking. This all takes a toll - and is not at all reflected in the current pay classification.”

“I feel overwhelmed by not knowing what I can offer Vets as VSAs do not really receive mental health training but are expected to do Guided Support. Unsure why there is such a pay differential between case managers and VSAs when we do Guided support for previously case managed clients that still have high needs so I feel like my role is not appreciated

“Most work days leave me feeling drained & certain cases make me feel helpless & sad because I wish we could help everyone but policies and rules don’t always allow for that. It’s also not enjoyable to have Veterans vent all their anger & frustrations on us. Workload just increases because of being short staffed.”

“Huge impact on my own mental health dealing with needs of Veterans and their mental health. Stress of job, I have to pay for my own counselling as social work not covered by PSHCP. Rap is limited in how many visits per issue.”

“Stress has affected physical health. Employer expects more and more, but doesn’t step up to give back to employees. No opportunity to work OT and then have Comp Time to take off when we want. No extra time allowed for employees who are stressed out. The need of medical documentation for an adapted work arrangement agreement doesn’t promote employees having flexibility in the workplace.”

“I am emotionally exhausted. I have compassion fatigue. I feel anger towards vets who are taking advantage of system. I feel anger towards vets who are hired within VAC and take advantage of system. I feel frustrated vets who have been hired talk about getting awards and extra benefits in front if us ‘civilians’ who are still working to lay off our student loans. There is a conflict of interest having vets work in a system and get benefits from that same system. I am short with my family. I have nothing left to give at the end of the day. I feel resentful and depressed. This is not how I am usually. I am usually a very positive, easy going person - but I can see I am burning out because of these emotions I am having.”

“Client violence has really impacted my mental health, I am more anxious and fearful than in any other position I’ve held. Clients routinely threaten, yell, become aggressive and the dept. does very little to curb these behaviours. My case load is far too high. I was forced to go to a part time position when I requested a decrease to my case load because I was having a difficult time coping.”

“My personal life has been impacted due to the volume of work and nature of work we deal with at VAC. My home, personal life has been impacted. There are days I do not even have the energy to get out of bed or muster up energy for my personal life. Often it is due to high workload, feeling inadequate without the appropriate supports needed, or due to irate/abusive clients.”

“For YEARS VAC has expected me to manage workloads that are too big to handle well. Publicly, the Department talks about the quality of the individual work we do with Veterans. Internally there is no support for quality work because it is all about volume and statistics. This creates a crisis for me ethically that I struggle with every day. I might do an exceptional job supporting a Veteran in need but it is what I do not get done that my manager cares about.”

“Burn out. Watching people leave on short term, watching fellow CMs cry in frustration at the direction in policy dealing with issues. There are so many policies that they overlap like an onion. The requirement to time manage is constant because with the case loads you are always dealing with the most immediate issues.”

“PEI has no supports for mental health; no pension, few psychologists/ psychiatrists, no social supports either. VAC can't get its own employees access to mental health providers. EAP has no accredited psychiatric affiliation in PEI. I couldn't be referred to mental health practitioners even when I reach out. We're told to go to the walk in clinic, ask, and they might call me in a few months with a referral. So, I'm not surprised that VAC staff have no idea what is possible in mental health. They couldn't access it if they did. So, as far as improving mental health for Veterans, VAC can't help them, our management teams have no understanding of the issues.”

Section 10: Mental Health Training

When asked about whether or not employees feel there is any specific mental health training they require to work with Veterans, many noted they would appreciate help dealing with aggressive clients and more training on personality disorders. Updated suicide intervention training and non-violent crisis intervention training were also mentioned.

Other issues with Mental Health Training include:

Need more in depth training on PTSD, depression, bi-polar - and the common presentation of these conditions, and strategies for improved communication with persons with symptoms of this. Additional training on supports available for Veterans - not all VSAs are aware of supports out there. A 30-minute web-ex on dealing with difficult clients is not acceptable training for the work we do. As an example, even Service Canada sends all staff for 2 day in person 'dealing with difficult client' training. How is this not mandatory at VAC?

All VAC staff need to understand some basics about working with MH clients, however, they should also be advised of what behaviours cannot be accepted (and supported by management, all the way up the chain. If some of our Veterans/families acted/behaved the way they do at our offices, out in the community - they would be turned away and expected to only return if they could be civilized and undemanding. Being a veteran, myself, I'm appalled at what some Veterans believe is acceptable behaviour - they only got this way because VAC has been afraid to turn away poor behaving clients. Their mental health conditions are no excuse for improper behaviour - therapists will tell you this themselves. But VAC allows "bullies" to run the show, at times, because some staff are afraid of the political fallout.

There have been incidents that have occurred in office and it makes you question if as an employee you are adequately trained to handle the situation. During this pandemic, providing mental health support for Veterans and their families has been very challenging. Some conversations you can't just refer a Veteran to call the VAC assistance line, they are talking with you right now and you must start helping them put a safety plan in place and provide that crisis-intervention support.

Vicarious trauma, constant dealings with excessive anger from Veterans and limited debriefing can add to burn out of Case Managers. As part of the yearly performance appraisal there should be an assessment by a trained VAC mental health psychologist to ensure the mental health and well being of staff. If you ask, we will say we are good.... cause that is who we are. Employer should be required to check in to assess for burn out and vicarious trauma.

Additional Comments

"I wish I had more mental health training as more and more of my clients are presenting with these issues. These types of issues used to be clients who were case managed however in a need to close case plans and to ensure VAC maintains the correct ratio for clients to case managers these clients come onto my case load. As well, clients who don't comply with the rehab plan get put into the VSA caseload. They still have the same issues mostly mental health but are not case managed. I feels like I have no support from my VSTM when it comes to these files as I have recently experienced 2 situations where I told my VSTM that I was not equipped to handle such complex mental health issues and to this day these 2 clients remain on my case load."

"The lack of support and training leaves both the Veteran and VSA vulnerable. These clients can have very complex mental health challenges, and it is unfair and not right to have people without mental health training providing support for them. I have seen staff have panic attacks, go on leave for depression, staff crying, and feeling overwhelmed. more training is needed."

"It feels discouraging not to be able to find answers to my questions or having it take an inordinate amount of time to find an answer. Additionally, the lack of training has meant that I have given incorrect information to Veterans, only to realize it weeks or months later. I have also come across files from newer staff with similar errors due to insufficient training."

Section 11: Gaps in service and other service issues at Veterans Affairs Canada

There were many gaps in service and other service issues that UVAE members who were surveyed identified. They include general delays and overall wait times for services as well as housing, lack of communication, and lack of information regarding available services to Veterans and their families. In addition, there were several concerns raised about how VAC is managed and the management of services to Veterans and their families.

If a CAF Veteran has no Pain & Suffering Compensation (PSC) for a condition, they may apply for the VAC Rehab Program to obtain specific treatment while awaiting PSC approval. RCMP, however, have no access to the VAC Rehab Program and so if they do not have a Disability Pension with VAC, there is little that can be done for them outside VAC Assistance Line and/or provincial healthcare (both which may be insufficient to meet their needs). Families with healthcare issues may go unmet which can severely affect Veterans' own treatment (even if Veteran has access to said treatment).

Additional Comments

“Biggest gap is the long wait times and the expectation that the Case Manager and VSA staff are the experts in all areas of the department. As a result, clients are directed to speak with us when we have zero impact on most of the decisions that are taking too long to process or are otherwise to the dissatisfaction of the clients. This creates adversarial rather than collaborative relationships and increased staff burnout and client distrust.”

“There should be no gap in financial or medical benefits. Clients should not be taken off strength with their home department until benefits and programs are in place with VAC.”

“Most Veterans don’t even know what options are available to them. Some go list their lives with nothing and no help. There needs to be better outreach to Veterans, especially older Veterans, to let them know what they are entitled to. It needs to be easy to understand and use as older people can become confused and overwhelmed making them just think ‘never mind it’s too hard “Advocacy programs for abused and neglected clients and abused and neglected children and families. We have programs for mental and physical but not Psychosocial and Vets struggling with Disabled Family Members.”

“Focus for Veterans should not be on financial benefits alone but accessing appropriate mental health treatment. Veterans feel a lot of their health problems are related to their service even though there are no documented service relationships. They need health care coverage to accommodate this.”

“Have regular, on a 2-year basis, visits from a BPO to nationwide posts. Showing occasionally in isolated posts would work wonders at showing our RCMP members that VAC cares. Members would benefit from the technical experience of BPOs and feel better at speaking directly with decision-makers/claim preparers.”

“Our biggest obstacle to helping Veterans is how bureaucratically we respond to their applications for Disability Benefits. I don't believe that we have fully tapped the expertise of adjudication services to innovate and improve their processes to speed up applications for benefits. I believe that efforts to improve those processes have been viewed as "anti-union" and get stopped for those reasons instead of both labour and management focusing on the clients' needs. We can make improvements that won't cost a single FTE. And I firmly believe that improving the processes and making Veterans happier with the application process (by speeding up to at least 1/10th the time it takes) will improve morale in adjudication services exponentially. So, instead of focusing on individual complaints, it's time to look at the overall well-being of the union members and asking "if we improve, how we do our jobs, will 80% or more of our members be happier at work?" I think the answer to that is "yes".”

“Financial counselling is needed as part of the release process.”

“Update intakes and assessments to answer questions directly related to VAC programs & benefits without asking for unrelated information that may impact privacy (i.e. update AC Assessment). Do not implement systems or tools until they are fully operational and staff are competent to use them (i.e. GC Case had a terrible roll-out and is still being worked on over a year later). Recent change that case managed Veterans’ need assessments, recommendations and goals from approved healthcare providers. Although case managers are assessed for and hired to develop case plans, case managers are not considered health professionals and so case manager (AC Assessments) are not sufficient to develop case management goals (even though a significant number of case managers are certified professionals such as social workers, nurses, OT, etc). Please allow case managers to assess Veterans and develop goals with Veterans in the case plan (i.e. not ONLY have to ask third party healthcare professionals (psychologist, OT, physiotherapist, massage therapist, etc.) for assessments & case plan goals. These are valuable, but also please value case manager assessments.”

“Better care for our SDA vets and vets with longer service. So much of my time is with vets who have MH related to childhood with very little service time. They are awarded for PTSD when in reality it is other MH conditions that are way beyond vacs scope. Then vets that actually have PTSD are being left out as I don’t have time to get to them because the ‘media threat’ veterans get all the attention.”

“For the families of veterans... especially our senior vets... they are tasked to manoeuvre through our terribly complex system and are frequently exhausted with it. Making processes simpler would alleviate stress on them as they are already stressed with caring for their ill veterans. The call centre has been told not to share anything with them which greatly insults most of them...if they don’t have the proper release or POA. Most are trying to help and we treat them as though they have subversive motives.”

“If we want to continue to deliver the level of care and support with the ever-increasing volume of work/applications coming from veterans we need more staff! There is no magical solution to dealing with this. Artificial Intelligence, streamlining, risk mitigation are all great tools, but they cannot replace the human contact/interactions and level of support our clients expect from us.”

“For those who do not have entitlement to benefits or services from VAC, access to staff who know well the community and provincial services offered in a particular location is helpful. “Centralizing services may be cost-effective but the personal touch and lack of familiarity with community resources is having a negative impact.”

“Create seamless transition for all CAF members to access all available health services, create a system of family doctors as these are in very short supply. Veterans require family physicians to complete medical questionnaires. Perhaps VAC could hire medical doctors as family doctors for Veterans and their families to help ease their transition to civilian life and help complete medical questionnaires.”

“The key to helping Veterans is to start when they are still members. While an interview with VAC is suggested to members that are releasing, it should be a requirement. If it is made a requirement it should be resourced accordingly. Processing of applications needs to be speeded up. In today's age there is really no excuse for taking so long to process an application. If the two departments (DND and VAC) could be more closely aligned applications could be processed faster. There is a problem with shortage of staff at DND/CAF that is trickling down to VAC not being able to support Veterans properly because DND/CAF cannot support releasing members properly because DND/CAF don't want them to leave. (Retention is the goal)”

“1) MBC's client portal needs to allow uploads. 2) MVA needs big time improvements and in a hurry (start with fixing MQ attachments (if the MVA Inbox letter says it's attached, it should actually be attached!), POA accounts ASAP, and make ALL forms available via MVA forms or at least by sending via Inbox upon request). 3) We need to bridge the gap between "diagnosed" and "decision" for those with mental health issues. Red Zoning isn't enough. Letting CAF/RCMP deal with it when the client is still serving isn't enough. The VAC Assistance Line isn't enough. 4) MBC should be able to answer questions via MVA secure message. 5) NFP/Cannabis/etc exceptional approvals shouldn't take 30 days. 6) NCCN needs step-by-step training on the decision-making process (beyond the steps that clients see on MVA). 7) Case Managers and VSAs need to better understand what is/isn't available via MVA, and shouldn't tell client's decisions until the letter is ACTUALLY sent! 8) More outreach visits in communities (CMs, VSAs), which includes education for clients/reps/families on how to apply for benefits and what is taking so dang long for decisions (detailed assessment process creating a backlog). VAC employees need to be better informed, clients need to be empowered, and our technology needs to be streamlined/more efficient.”

“There’s not enough focus on the family as a unit and treating the unit as a whole. And while I agree that the main focus has to be on the veteran, the family is a big part of that and sometimes is the only thing that keeps the veteran alive so more needs to be done to help keep that family unit intact.”

“Support for spouses - they need more than short term psychotherapy usually. They sometimes have anxiety themselves from living with a person with PTSD. More recognition for the support spouses provides for mental health conditions - booking appts, medication reminders, being the rock of the family, etc (is not considered in Caregiver Recognition Benefit).”

“We need to be flexible with our clients and properly assess them as case managers before just sending them out to professionals. The case manager assessment is crucial for me to determine where veteran is at, what’s going on and what they can handle doing right away vs what can wait as there’s other pressing issues. The 30-day timeline for assessment is also not realistic. We often can’t find a provider in that timeline let along get a full assessment.”

“We have had the opportunity to reach out and speak with Veterans. One thing is always apparent is how much they appreciate the service; however, they are hesitant about contacting VAC when they have an issue or don't fully understand a program. Letters that they receive are not always clear. In order to avoid overpayment situations Veterans should be required to submit updated income offsets at minimum on a yearly basis. This also keeps them in contact with VAC and they don't feel forgotten.”

VAC Management and management of services

“Management needs to listen to our suggestions from the ground up. We've stopped bringing them forward because management gives us excuses as to why it won't work. We've put forth as a group several - and all have died at AMT with no reasoning other than "we're busy". Stop telling us we're doing a great job - start supporting us. Management who is clueless is the problem. Management parachuted in from DND/CAF with a 35 year career behind them and are just collecting their pension and doing their time at VAC is not helpful. They refuse to learn what we do and our systems which impacts those who know. Redeploy these assets internally - get rid of the 4th VSTM in Victoria and give us a STEO. At least we'd get better guidance than anything from what we're getting now. The AD promises us 'communication' and 'they're really committed to helping' but really, they're not. Fire the PFL project manager for lack of proper implementation. Right now people at HO are squabbling over what to call disengagement. But my case load isn't getting smaller.”

“VAC is more concerned about giving 1$ too much to the wrong person, than it is to making sure everyone is taken care of. If you have an overpayment, they will follow up with you the very next day. If you have been waiting 2 years for help with your PTSD, they'll tell you "too bad, keep waiting".”

‘People in charge of making decisions should do so in a timely fashion. We are now into the 8th month of waiting for the decision re Vet's family members receiving psychological treatment or not. 500 families are suffering as well as 500 VETS.”

“I think it would be very beneficial for client service if VAC hires more Case Managers. They cannot do as effective a job when they are trying to help so many clients. I think doing more to improve morale in the field offices is important because we are the ones who actually talk to Veterans and their families. Low morale can negatively affect service. I think people who have successfully performed in acting positions (and meet education and experience qualifications) should automatically be chosen to fill open positions rather than external candidates since these are people who already have shown their capacity and desire to serve this population.”

“HIRE MORE FRONT-LINE STAFF. Stop the insanity of one body part one claim. Stop the parsing of the person and give Veterans full-service for their full-person. If we're not an insurance company, why does every part of what we do feel like it is being doled-out like an insurance claim? See Veterans and their families as whole systems, please.”

“Stop taking decisions away from front line case managers. We’re the staff that know the Veterans and their families. We also have extensive education and experience in this work. Giving decisions like diminished earning capacity to random WP 2s with no experience is cruel.”

“Rather than foster the expectation of VAC funding what they want, offer more direct education. Some is already available and not widely utilized. Market what IS out there (there is lots+++) rather than focus on what is not. And perhaps some of it shouldn't be provided by VAC at all.”

“VAC needs to move away from the government bureaucracy with the excessive amount of administrative tasks both on the part of the Veteran and on the staff supporting them. Our time should be spent more supporting the Veteran and talking them through the processes. Instead we often have to reduce the amount of time spent with them since management is only taking into consideration the work they can see we have done in the system. If we don’t produce enough output and spend too much of our working hours with the Veterans, this reflects poorly on our performance because they can’t “see” the work we are doing even if the Veterans are benefitting from it.”

“Perhaps Laddering veterans through a hierarchy of VSA to CM would be more useful than the current model. For example, a pod of 5 people including 3 VSA and 2 CM. This group would include a specific number of veterans (by postal code or another method). All calls initially routed through VSAs (except CM clients). This pod method would reduce the number of people seeing each file and would increase continuity of service. For the most part the veterans would be talking to the same five people. Easier to manage illnesses and vacation time.”