

**STATEMENT OF
MICHAEL J. MISSAL
INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON
"AN ASSESSMENT OF ONGOING CONCERNS AT THE VETERANS CRISIS LINE"**

APRIL 4, 2017

Mr. Chairman, Ranking Member Walz, and Members of the Committee, thank you for the opportunity to discuss the Office of Inspector General's (OIG) recent work on the operations of the Department of Veterans Affairs' (VA) Veterans Crisis Line (VCL). My statement will discuss two OIG reports, one from March 2017, [Healthcare Inspection – Evaluation of the Veterans Health Administration Veterans Crisis Line](#), and one from February 2016, [Healthcare Inspection – Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York](#).

BACKGROUND

The tragedy of veteran suicide is one of the Veterans Health Administration's (VHA) most significant issues. The rate of suicide among veterans is significantly higher than the rate of suicide among U.S. civilian adults. VA's most recent estimate calculates that 20 veterans commit suicide a day. Of those veterans, approximately 14 have not been seen in VHA.

In 2007, VHA established a telephone suicide crisis hotline located at the Canandaigua, New York, VA campus. Initially called the National Veterans Suicide Prevention Hotline, its name changed to the VCL in 2011.¹ VHA established the VCL through an agreement with the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA). This agreement provided for VHA's use of the already existing National Suicide Prevention Line (NSPL) toll-free number for crisis calls.² The VCL was managed by the VHA Office of Mental Health Operations at the time of the February 2016 OIG report. Subsequently the VCL was realigned under VHA Member Services (Member Services), an organization within the Chief Business Office that runs customer call centers for VHA.³

¹ Veterans Crisis Line 1-800-273-8255 Press 1, <https://www.veteranscrisisline.net/About/AboutVeteransCrisisLine.aspx>. Accessed December 4, 2016.

² The toll-free number is (800) 273-8255.

³ VHA Member Services Member Services is an operation and support office within the Chief Business Office and has two main "front-end" elements of interaction with VA's health care enrollee population, providing oversight, review, and direct service in the following areas: Eligibility and Enrollment Determination and Contact Management.

The VCL is part of an overall strategy to reach out to veterans in a time of crisis with the goal of reduction of veteran suicide.⁴ The VCL's primary mission is "to provide 24/7, world class, suicide prevention and crisis intervention services to veterans, service members, and their family members."⁵ Since its launch in 2007, VCL staff have answered nearly 2.8 million calls and initiated the dispatch of emergency services to callers in crisis over 74,000 times.⁶ Currently, the VCL responds to over 500,000 calls per year, along with thousands of electronic chats and text messages. The VCL initiates rescue processes for callers judged at immediate risk of self-harm. The number of calls to the VCL has increased markedly since the VCL's first full year of operation in 2007, with a corresponding increase in VCL annual funding. The total number of calls answered by the VCL and backup centers was 9,379 in 2007 and grew to 510,173 in fiscal year (FY) 2016. In FY 2010, the VCL was funded at \$9.4 million, increasing to \$31.1 million in FY 2016.

A component of the VCL's long-term continuing operations plan was to expand beyond the Canandaigua Call Center to a second site, to ensure geographic redundancy and meet increasing VCL demands. The VCL and VHA Member Services leadership determined that the Canandaigua Call Center location did not have the necessary space or applicant pool to allow for the needed future growth. An expansion site was chosen in Atlanta, Georgia, because Member Services had a preexisting call center infrastructure at its Atlanta-based Health Eligibility Center (HEC).⁷ Planning began in July 2016 with a phased rollout of responding to calls starting in October 2016 and continuing over the next two months.

In our February 2016 VCL report, we identified several problems including crisis calls going to voicemail, a lack of a published VHA directive to guide organizational structure, quality assurance gaps, and contract problems. The February 2016 report resulted in seven recommendations and VHA concurred with the findings and recommendations. VHA provided an action plan and timeframe to implement those recommendations by September 30, 2016.

INSPECTION OF VETERANS HEALTH ADMINISTRATION VETERANS CRISIS LINE

In June 2016, we received an allegation related to the experience of a veteran with the VCL and its backup call centers. As a result of the complaint, and in light of the open recommendations from the OIG's February 2016 report, we expanded our scope to conduct an in-depth inspection of the VCL. During our inspection, in August of 2016, we received a request from the Office of Special Counsel (OSC) to investigate allegations regarding training and oversight deficiencies with staff that assist call responders (Social Service Assistants/SSAs). This inspection, in addition to our previous inspection, found organizational deficiencies and foundational problems in the

⁴ https://www.va.gov/opa/publications/factsheets/Suicide_Prevention_FactSheet_New_VA_Stats_070616_1400.pdf

⁵ VCL Mission Statement.

⁶ <https://www.veteranscrisisline.net/About/AboutVeteransCrisisLine.aspx>. Accessed on March 27, 2017.

⁷ The HEC provides information and customer service on key veteran issues such as benefits, eligibility, billing, and pharmacy. <https://www.va.gov/CBO/memberservices.asp>. Accessed December 1, 2016.

VCL. We also identified key changes needed by VA in order to achieve VA goals of service for veterans in crisis.

Our inspection included the following objectives:

- To respond to a complaint alleging that the VCL did not respond adequately to a veteran's urgent needs.
- To perform a detailed review of the VCL's governance structure, operations, and quality assurance functions in order to assess whether the VCL was effectively serving the needs of veterans.
- To evaluate whether VHA completed planned actions in response to OIG recommendations for the VCL, published on February 11, 2016, in our report titled *Healthcare Inspection—Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York*.
- To address complaints received from the OSC alleging inadequate training of VCL SSAs resulting in deficiencies in coordinating immediate emergency rescue services needed to prevent harm.

Veteran's Urgent Needs

Regarding the first objective, we substantiated that VCL staff did not respond adequately to a veteran's urgent needs during multiple calls to the VCL and its backup call centers. We also identified deficiencies in the internal review of the matter by the VCL staff. In the interest of privacy, information specific to this veteran is not included in the report. However, relevant information has been provided in detail to VHA.

Governance, Operations, Quality Assurance Functions

Governance is defined as the establishment of policies, and the continuous monitoring of their proper implementation, by members of the governing body of an organization.⁸ During the time of our review,⁹ the leadership, governance, and committee structure was in an immature state of development. Examples include a governance structure without clear policies and unclear mandates to review clinical performance measures and make improvements. These structural problems led to operational and quality assurance gaps.

In our February 2016 report, we cited the absence of a VCL directive as a contributor to some of the quality assurance gaps identified in the review. VHA concurred with this recommendation and provided an initial target date for completion of June 1, 2016. As of the publication of our March 2017 report, this action was not complete. We found continuing deficiencies in governance and oversight of VCL operations.

⁸ Business Dictionary's definition of governance.

⁹ Our review period was from June through December 2016.

During the August 2016 site visit to Canandaigua, the VCL's acting director told us that the VCL was using the Baldrige¹⁰ framework for governance. For the VCL, the central leadership group in this model would be the Executive Leadership Council (ELC).¹¹ The ELC integrates the business and clinical aspects of operating the VCL. We requested all ELC draft policies to ensure that the ELC had a process for achieving its intended goals. We were informed that no current policies related to the ELC existed and that creation of such policies was in progress. The VCL and the services it provides have grown considerably since 2007, but VCL leadership did not develop a plan until 2016 that defined the strategic approach for the VCL to provide consistent, timely, and high quality suicide prevention services. For its Baldrige framework goals, VCL leadership was unable to provide policies, dashboards, or quality monitors for this governance initiative.

Shortly after the publication of the 2016 OIG report, the VCL was realigned under VHA Member Services, although VA leadership stated that the VCL would remain closely tethered to VHA's clinical operations. VHA's Office of Suicide Prevention¹² leads suicide prevention efforts for VHA and coordinates and disseminates evidence-based findings related to suicide prevention. However, we found a disconnect between the VHA Office of Suicide Prevention and Member Services in communicating about suicide prevention and the VCL. While the expectation was that Member Services and subject matter experts on suicide prevention would work closely together, we found substantial disagreement about key decisions and oversight between the two groups.

The lack of effective utilization of clinical decision makers at the highest level of VCL governance resulted in the failure to include fully clinical perspectives impacting the operations of the VCL. Administrative staff made decisions that had clinical implications. Examples include disagreements about the scope of services associated with core versus non-core calls¹³ and the selection of training staff who did not have clinical backgrounds. Clinical leaders stated concerns about staff morale, decisions impacting VCL capacity of responders to assist callers in crisis promptly, and effective training of new responders.

¹⁰ The Malcolm Baldrige National Quality Award is the highest level of national recognition for performance excellence that a U.S. organization can receive. The award focuses on performance in five key areas: product and process outcomes, customer outcomes, workforce outcomes, leadership and governance outcomes, financial and market outcomes. <https://www.nist.gov/baldrige/baldrige-award>. Accessed December 23, 2016.

¹¹ ELC membership includes VCL Director, Chairperson, VCL Deputy Director, Business Operations Lead, Veteran Experience Lead, Employee Experience Lead, Partnerships Lead, Clinical Quality Lead, AFGE Leadership Member, Union Leadership Member, Clinical Psychologist, and CAC.

¹² The Office of Suicide Prevention leads suicide prevention efforts for VHA and coordinates and disseminates evidence-based findings related to suicide prevention.

¹³ Core calls are calls defined as calls resulting in referral to the Suicide Prevention Coordinator and/or calls requiring the application of crisis management skills (example: a suicidal caller). Non-core calls are defined as those that do not require specific crisis intervention skills (example: a caller inquiring about benefits).

Another example of deficient governance was a lack of permanent VCL leadership. During most of 2015, the VCL was without a permanent director. At the end of 2015, a permanent director was chosen. However, the new permanent director resigned his position in June 2016. As of December 2016, the VCL continued to operate without a permanent director.

Operations

The VCL was undergoing changes throughout our review. For example, there were three versions of the VCL organizational chart between June 2016 and September 2016. The evolving VCL staffing model was based on a service level of zero percent rollover, answering all calls within 5 seconds, and forecasting call volume based on historical interval data.

Calls to VCL and Contracted Backup Centers

To reach the VCL (Canandaigua or Atlanta) through its toll-free number, a caller is instructed to press 1 (for veterans) on the telephone keypad. If the caller does not press 1, the caller is routed to a National Suicide Prevention Line center. The caller still speaks with a responder. However, this route will take the caller to a non-VCL and non-VA contracted backup call center. If the caller presses 1, as instructed for veterans, and the call cannot be answered within 30 seconds by the VCL, it rolls over to a VA contracted backup center.

During our review, VHA leadership was in the process of implementing an automatic transfer function, which directly connected veterans who call their local VA Medical Centers to the VCL by pressing 7 during the initial automated phone greeting. Member Services leadership determined that the implementation of various communication enhancements that increased VCL access, including Press 7, voice recognition technology, vets.gov, and MyVA311,¹⁴ created increased demand for services.

When a call is answered by VCL staff, a trained crisis responder answers the call, and after engaging with the caller and building rapport, the responder asks about suicidal ideation.¹⁵ Depending upon the caller's answer, the responder may conduct a more detailed assessment of lethality, which addresses a range of both suicide risk factors as well as protective factors. Callers may choose to remain anonymous and the responder may only be able to identify the caller by phone number.

We identified a deficiency in the VCL's processes for managing incoming telephone calls. Callers may decide to remain anonymous, but in every case responders document the incoming telephone number. However, responders must manually enter the number into the electronic documentation system, increasing the risk of human error. While reviewing responders' call documentation, we found that the

¹⁴ VA is introducing 1-844-MyVA311 (1-844-698-2311) as a go-to source for veterans and their families who do not know what number to call.

¹⁵ Suicidal ideation is thinking about, considering, or planning suicide. Centers for Disease Control and Prevention, <http://www.cdc.gov/violenceprevention/suicide/definitions.html>. Accessed December 2, 2016.

documentation was often lacking in sufficient detail to facilitate retrospective assessment of the interaction between the caller and responder.

VCL call complaint data included callers' complaints about being on hold. We found that some contracted backup call centers used a queuing (waiting) process that callers may perceive as being on hold. During the queue time, or wait time, the caller waits for a responder to answer. The caller's only option is to abandon the call (hang up) and call back, or continue to wait for a responder to pick up. The backup centers had processes to record wait times and abandonment rates. We found that VCL leadership had not established expectations or targets for queued call times, or thresholds for taking action on queue times, resulting in a systems deficiency for addressing these types of complaints. At the time of our review, there were four contracted backup centers. Two of the backup centers queued calls and two did not queue calls.

VHA contracted with an external vendor¹⁶ to manage backup center performance and report back to the VCL, with administrative and clinical oversight of the contract terms by VCL managers. We found that the VHA contracting staff and Member Services and VCL leaders responsible for verifying and enforcing terms of the contract did not provide the necessary oversight and did not validate that the contracted vendor provided the required services before authorizing payment.

Atlanta Call Center

On July 21, 2016, planning for the new Atlanta-based call center started. By November 21, 2016, Member Services anticipated that staffing at the Atlanta Call Center would be sufficient to allow for zero rollover calls to backup call centers.¹⁷ Member Services leaders planned to have the Atlanta facility fully staffed and telephonically operational by December 31, 2016. Text and chat services would begin in June 2017.¹⁸

Member Services leaders made the decision to roll out the Atlanta Call Center without first establishing on-site leadership, a critical piece to ensuring proficient execution of call center function. The September 2016 VCL organizational chart called for Atlanta to have its own Deputy Director and Director for Team Operations. However as of September 20, 2016, even though the leadership positions had not even been advertised much less filled, the Atlanta office held its inaugural responder training class with plans to begin operations on October 10, 2016. As of November 8, 2016, this iteration of the organizational chart had been rescinded. VCL leadership structure reverted to that outlined in the July 2016 organizational chart, which does not include either a Deputy Director, a Director of Team Operations for Atlanta, or other leadership positions specific to the Atlanta Call Center.

¹⁶ Link2Health Solutions, Inc.

¹⁷ Backup centers will be used on a contingent basis.

¹⁸ Responders are required to have 6 months of VCL telephone experience, prior to engaging in training for text and chat services.

Bringing the Atlanta Call Center online in a three-month period entailed the rapid hiring and training of new staff. The training content is the same for responders at both the Atlanta and Canandaigua sites, but with notable differences in trainer-to-learner ratios. For instance, in order to accommodate the sizable number of trainees, class sizes were larger at the Atlanta Call Center, ranging from 44 to 62 trainees, versus 20 trainees per class at the Canandaigua Call Center. Once the responders completed classroom training and passed a proficiency test, they were assigned to work with a preceptor for one to three weeks. The preceptor-to-responder ratio at the Canandaigua Call Center is 1:1. The original plan for the Atlanta Call Center called for a 1:2 or 1:3 preceptor to responder ratio. However, due to limited preceptor availability and large class sizes, the ratios were as high as 1:16.

The supervisors hired to work at the Atlanta Call Center did not have the same skill set as those at the Canandaigua Call Center. Canandaigua Call Center supervisors first served in a responder role, while most Atlanta Call Center supervisors had not. Because of this, we were told that Atlanta Call Center supervisors would be required to complete responder training prior to supervisor training. One VCL supervisor told us that inexperience might detrimentally affect practice at the Atlanta Call Center because new responders, particularly linked with new supervisors, may be too quick to call rescues whereas more experienced responders may be able to de-escalate the situation. Despite the experiential and training differences between sites and the potential for variances in practice, with the exception of silent monitoring, we found no documentation of plans to compare metrics between sites, including rescue rates.

The rapid establishment of the Atlanta Call Center required that a substantial number of staff from the Canandaigua Call Center be detailed to the Atlanta Call Center to train staff as well as assist with workload. The diversion of Canandaigua Call Center staff to Atlanta in order to achieve VCL programmatic milestones also contributed to a delay in the development and implementation of policies, programs, and procedures for the VCL. Examples of delays cited by staff include the deferral of annual lethality assessment training for responders, the delayed rollout of chat and text monitoring at the Canandaigua Call Center, and delayed implementation and utilization of wellness programs.

Prior to the end of our review in December 2016, the VCL implemented audio call recording capability for incoming and outgoing calls for quality assurance purposes, but had yet to provide procedures, protocols, or policies that provided guidance for listening to or using recorded call information. VCL Quality Management (QM) program leaders could enhance performance improvement evaluations by using call recording to monitor the quality of interactions between responders and callers and by collecting and analyzing performance data from the new Atlanta Call Center separately from the Canandaigua Call Center. The new call center in Atlanta could have QM concerns that are no different from its Canandaigua partner, but the ability to recognize site-specific issues, especially in a new program, is facilitated by separating quality data elements by site.

Quality Assurance

Systematic collection of relevant and actionable data for analysis is crucial when making decisions that will prevent problems. To be effective, VCL's QM data collection and analysis should be accurate and inform VHA and VCL leadership and staff whether their actions effectively serve veterans and others who use VCL services. In our February 2016 report, we recommended that VHA establish a formal quality assurance process and develop a VHA directive or VHA handbook for the VCL. We reviewed the VCL QM program structure and processes, the VCL QM program manual, and the draft VCL directive and identified systems deficiencies in QM program processes. We further found that neither the VCL QM program manual nor the draft VCL directive provided a framework for a QM program structure.

Quality Management Leadership

VHA does have a directive that outlines leadership responsibilities for program integration and communication, and the designation of individuals with appropriate background and skills to provide leadership to promote quality and safety of care.¹⁹ In order to implement the foundational principles of QM, leaders within a program must be able to promote, provide, and recognize QM practices that will lead to better outcomes. After reviewing the number and types of QM roles in the VCL, as well as QM staff experience and background, we determined that the challenges likely stemmed from the QM staff's lack of training in QM principles. Member Services leadership tasked QM staff with multiple responsibilities and competing priorities that included VCL QM program and policy development, data collection and analysis, data presentation for evaluation and action planning, and identification of outcomes measures. However, the QM staff had not been provided with training in the skills needed to provide leadership to promote quality and safety of care, leading to deficiencies in the QM program.

Quality Management Data Analysis

We found that while VCL staff collect data on clinical quality performance measures, the QM program lacked defined processes for analyzing and presenting data and for developing a committee structure for reporting the analysis, making recommendations and following up.

Quality Management Committees and Planning

VHA requires a standing committee to review data, information and risk intelligence, and to ensure that key quality, safety and value functions are discussed and integrated on a regular basis. This committee should be comprised of a multidisciplinary group, should meet quarterly, and should be chaired by the Director. We did not identify a VCL standing committee that met the intent of VHA requirements outlined in Directive 1026.

Policies, Procedures, and Handbooks

VHA Directive 6330 (1), Controlled National Policy/Directive Management System, established policy and responsibilities for managing, distributing, and communicating VHA directives. VCL policies have been created in response to external reviews and

¹⁹ VHA Directive 1028, *VHA Enterprise for Framework for Quality, Safety, and Value*, August 2, 2013.

internal processes but a controlling directive has not yet been published. A draft directive was in development, dated April 4, 2016; however, it lacked defined roles and responsibilities for VCL leaders, such as the VCL Director. We found that VCL policies, procedures, or handbooks were not readily accessible for staff reference.

VCL leaders developed a QM Program Manual which was updated in July 2016 (no initial publication date was available). The program manual did not outline a framework for the QM program that is consistent with relevant existing VHA directives providing guidance for QM programs.

Outcome Measures for Quality Improvement

We found that while the VCL measured internal performance of its staff (silent monitors, End of Call Satisfaction question, and complaints), its QM data analysis did not include measures of clinical outcomes for callers. During interviews, we inquired about outcome measures to evaluate the success of a veteran's transition from the VCL to other dispositions. We identified deficiencies in the VCL QM program including data analysis and presentation of clinical quality performance measures, lack of development of a directive consistent with established VHA guidance, lack of a reporting structure for regular review of performance measures, and frequent changes in the organizational structure of the QM program. We found that deficiencies in the QM program were related to VHA leadership failing to provide a developmental plan, appointing staff into positions without formal QM training, and assigning staff multiple competing priorities.²⁰

Measurement of Program Success with Adverse Outcomes Reviews

We found that the VCL had no process in place for routinely obtaining or reviewing data on serious adverse outcomes, such as attempted or completed suicides by veterans who made contact with the VCL prior to the event. We learned that adverse outcomes were not aggregated for review by VCL leadership in order to measure performance improvement for achieving more successful outcomes. The Acting Director and Acting Quality Assurance Clinical Officer confirmed that debriefings or other reviews were not conducted after known suicide attempts or completions. By not reviewing serious adverse outcomes, VCL QM managers missed opportunities for quality improvement.

We reported systems deficiencies in the VCL Quality Management program in our 2016 and 2017 reports. VHA provides a framework for QM program structure and leadership to ensure delivery of safe and effective care; however, we found multiple program deficiencies remained during our second review.

Status of Recommendations from OIG's February 2016 Report

In our report from February 2016, we made seven recommendations. VA concurred with the recommendations and at the time provided action plans and a time frame for implementation of all recommendations by September 2016. We reviewed VHA documents submitted as evidence to support the completion of the planned actions. However, VHA has not completed the planned actions and we consider those

²⁰ VHA Directive 1026, VHA Enterprise for Framework for Quality, Safety, and Value, August 2, 2013.

recommendations as open. We would note that VHA established the time frame for implementation and not the OIG.

Inadequate Training Allegations Received from OSC

We found that VCL managers developed a process for monitoring the quality of crisis intervention services provided by responders; however, VCL lacked a process for monitoring the quality of performance by SSAs. We identified deficiencies in SSA training and substantiated complaints referred to us by the OSC in regard to SSA training and performance. Specifically, we substantiated that SSAs were allowed to coordinate emergency rescue responses independently after the end of a 2-week training period, without supervision and regardless of performance or final evaluation; that in mid-2016, a newly trained SSA contacted a caller in crisis by telephone to solicit the veteran's location, although we found that no harm resulted from the interaction; and we substantiated a lack of documentation by an SSA when closing out a veteran's case in mid-2016. We could not substantiate an allegation that documentation by an SSA resulted in conflicting information about a veteran being contacted within 24 hours. The complainant (who remained anonymous) was not interviewed by us, and we did not have identifiers for the veteran caller.

Report Recommendations

The OIG recommendations from 2016 and 2017 fall into the categories of governance/leadership, operations, and quality assurance. It is noteworthy that many of these recommendations cut across all three categories.

- **Governance** – Governance recommendations include the establishment of a VCL directive that guides structure, roles, and responsibilities. Additional recommendations include that the governance structure ensures cooperation between clinical and administrative leadership. We also recommended that lines of authority delineate that clinical leadership make clinical policy decisions.
- **Operations** – Operations recommendations include that SSAs are certified by supervisors before engaging in independent assistance with rescues. Other recommendations involve information technology infrastructure including an automated process for transcription of telephone numbers, and audio call recording with related policies and procedures. We recommended improved control of policy and document management so that updated policies and procedures and related staff training can be tracked. We issued recommendations related to backup center and contractor performance, including an enforceable quality assurance surveillance plan for contracted backup centers, and establishing targets for rollovers and call queuing. We recommended that contractors are held to the same standards as the VCL, and contract performance is monitored to assure that the terms of the contract are met. We also recommended that contractor performance is verified prior to payment.
- **Quality Assurance** - Quality assurance recommendations include establishing a formal quality assurance process that incorporates policies and procedures consistent with the VHA framework. Other recommendations include QA

leadership being fully trained in QA principles, evaluating negative clinical outcomes in order to improve, and ensuring that VCL silent monitoring frequency meets established VCL standards. We also recommended that VCL develop structured oversight processes for tracking and trending of clinical quality performance measures. We recommended that quality data be used to enhance performance, that call recording be used for quality assurance, and that Canandaigua and Atlanta are analyzed separately with performance measures. We recommended consistent quality assurance and monitoring policies are established for responder staff and SSAs.

A complete listing of the individual recommendations from both reports is attached in Appendix A and Appendix B.

CONCLUSION

Our 2016 and 2017 VCL inspections identified various challenges facing the VCL in their mission to provide “suicide prevention and crisis intervention services to veterans, service members, and their family members.” We found numerous deficiencies and made seven recommendations in the 2016 inspection and sixteen additional recommendations in the 2017 inspection. All recommendations remain open today. Until VHA implements fully these recommendations, they will continue to have challenges meeting the VCL’s critically important mission.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or members of the Committee may have.

Recommendations from *Healthcare Inspection – Veterans Crisis Line Caller Response and Quality Assurance Concerns Canandaigua, New York* (February 11, 2016)

Recommendation 1. We recommended that the OMHO (now VHA Member Services)²¹ Executive Director ensure that issues regarding response hold times when callers are routed to backup crisis centers are addressed and that data is collected, analyzed, tracked, and trended on an ongoing basis to identify system issues.

Recommendation 2. We recommended that the Member Services Executive Director ensure that orientation and ongoing training for all VCL staff is completed and documented.

Recommendation 3. We recommended that the Member Services Executive Director ensure that silent monitoring frequency meets the VCL and American Association of Suicidology requirements and that compliance is monitored.

Recommendation 4. We recommended that the Member Services Executive Director establish a formal quality assurance process, as required by VHA, to identify system issues by collecting, analyzing, tracking, and trending data from the VCL routing system and backup centers, and that subsequent actions are implemented and tracked to resolution.

Recommendation 5. We recommended that the Member Services Executive Director consider the development of a VHA directive or handbook for the VCL.

Recommendation 6. We recommended that the Member Services Executive Director ensure that contractual arrangements concerning the VCL include specific language regarding training compliance, supervision, comprehensiveness of information provided in contact and disposition emails, and quality assurance tasks.

Recommendation 7. We recommended that the Member Services Executive Director consider the development of algorithms or progressive situation-specific stepwise processes to provide guidance in the rescue process.²²

²¹ The VCL was realigned under VHA Member Services in the spring of 2016. At the time the February 2016 OIG report regarding the VCL was published, the Office of Mental Health Operations was responsible for the VCL.

²² VCL staff consider rescues, welfare checks, and dispatch of emergency services to be equivalent terms.

Recommendations from *Healthcare Inspection – Evaluation of the Veterans Health Administration Veterans Crisis Line (March 20, 2017)*

Recommendation 1. We recommended that the Under Secretary for Health implement an automated transcription function for callers' phone numbers in the Veterans Crisis Line call documentation recording system.

Recommendation 2. We recommended that the Under Secretary for Health ensure that Veterans Crisis Line policies and procedures, staff education, Information Technology support, and monitoring are in place for audio call recording.

Recommendation 3. We recommended that the Under Secretary for Health implement a Veterans Crisis Line governance structure that ensures cooperation and collaboration between VHA Member Services and the Office of Suicide Prevention.

Recommendation 4. We recommended that the Under Secretary for Health develop clear guidelines that delineate clinical and administrative decision-making, assuring that clinical staff make decisions directly affecting clinical care of veterans in accordance with sound clinical practice.

Recommendation 5. We recommended that the Under Secretary for Health ensure processes are in place for routine reviewing of backup call center data, establish wait-time targets for call queuing and rollover, and ensure plans are in place for corrective action when wait-time targets are exceeded.

Recommendation 6. We recommended that the Under Secretary for Health ensure processes are in place to require contracted backup centers to have the same standards as the Veterans Crisis Line related to call queuing and wait-time targets.

Recommendation 7. We recommended that the Under Secretary for Health ensure that VHA Member Services leadership, Veterans Crisis Line leadership, VHA Contracting Officers, and Contracting Officer Representatives implement the quality control plan and conduct ongoing oversight to ensure contractor accountability in accordance with their roles as specified in the contract with backup call centers.

Recommendation 8. We recommended that the Under Secretary for Health ensure that training is provided to Veterans Crisis Line quality management staff in the skills needed to provide leadership to promote quality and safety of care.

Recommendation 9. We recommended that the Under Secretary for Health ensure the development of structured oversight processes for tracking, trending, and reporting of clinical quality performance measures.

Recommendation 10. We recommended that the Under Secretary for Health ensure processes for Veterans Crisis Line quality management staff to collect and review adverse outcomes so that established cohorts of severe adverse outcomes are analyzed.

Recommendation 11. We recommended that the Under Secretary for Health direct the Veterans Health Administration Assistant Deputy Under Secretary for Health for Quality, Safety, and Value to review existing Veterans Crisis Line policies and determine whether the policies incorporate the appropriate Veterans Health Administration policies for veteran safety and risk management, and if not, establish appropriate action plans.

Recommendation 12. We recommended that the Under Secretary for Health ensure that Veterans Crisis Line quality management staff incorporate call audio recording into quality management data analysis.

Recommendation 13. We recommended that the Under Secretary for Health ensure that processes are in place to analyze performance and quality data from the Atlanta Call Center separately from the Canandaigua Call Center data.

Recommendation 14. We recommended that the Under Secretary for Health ensure that quality assurance monitoring policies and procedures are in place and consistent for both Social Service Assistants and responders.

Recommendation 15. We recommended that the Under Secretary for Health ensure that supervisors certify Social Service Assistant training prior to engaging in independent assistance with rescues.

Recommendation 16. We recommended that the Under Secretary for Health ensure a process is in place to establish, maintain, distribute, and educate staff on all Veterans Crisis Line policies and directives that includes verifying the use of current versions when policies and directives are modified.