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BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

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Good morning Chairman Roe, Ranking Member Walz, and Members of the Committee. Thank you for the opportunity to discuss the Department of Veterans Affairs (VA) Office of the Inspector General's (OIG) report on the Veterans Crisis Line (VCL). I am accompanied today by Matthew Eitutis, Acting Veterans Health Administration (VHA) Member Services Executive Director.

Introduction

VA recognizes the importance of VCL as a life-saving resource for our Nation's Veterans who find themselves at risk of suicide. Of all the Veterans we serve, we most want those in crisis to know that dedicated, expert VA staff, many of whom are Veterans themselves, will be there when they are needed. The primary mission of VCL is to provide 24/7, world class, suicide prevention and crisis intervention services to Veterans, Servicemembers, and their family members. However, any person concerned for a Veteran's or Servicemember's safety or crisis status may call VCL.

Positive Actions Taken to Date

Since 2007, VCL has answered nearly 2.6 million calls and dispatched emergency services to callers in crisis over 67,000 times. Consistent with our mission, we have implemented a series of initiatives to provide the best customer service for every caller, making notable advances to improve access and the quality of crisis care available to our Veterans, such as:

- Launching “Veterans Chat” in 2009, an online, one-to-one chat service for Veterans who prefer reaching out for assistance using the Internet. Since its inception, we have answered nearly 314,000 requests for chat.
- Expanding modalities to our Veteran population by adding text services in November 2011, resulting in nearly 62,000 requests for text services.
- Opening a second VCL site in Atlanta in October 2016, with over 200 crisis responders and support staff.
- Implementing a comprehensive workforce management system and optimizing staffing patterns to provide callers with immediate service and achieve zero percent routine rollover to contracted back-up centers.

VCL is the strongest it has been since its inception in 2007. VCL staff has forwarded over 416,000 referrals to local Suicide Prevention Coordinators on behalf of Veterans to ensure continuity of care with their local VA providers. Initially housed in 2007 at the Canandaigua VA Medical Center in New York, it began with 14 responders and two health care technicians answering four phone lines. In the past 6 months, VCL has nearly doubled the capacity to ensure appropriate access to Veterans. Today, the combined facilities employ more than 500 professionals, and VA is hiring more to handle the growing volume of calls. Atlanta offers 200 call responders and 25 social

service assistants and support staff, while Canandaigua houses 310 and 43, respectively. Despite all this, there still is more that we can do.

VA Office of Inspector General (OIG) Report

VA OIG published a report on February 11, 2016, *Healthcare Inspection—Veterans Crisis Line Caller Response and Quality Assurance Concerns Canandaigua, New York* (Report No. 14-03540-123) and a follow-up on March 20, 2017, *Healthcare Inspection—Evaluation of the Veterans Health Administration Veterans Crisis Line* (Report No. 116-03985-181). These reports detailed issues and subsequent recommendations for VCL. The March 2017 report made 16 recommendations associated with the review that occurred June 2016 through December 2016. We take these reports very seriously. VHA concurred with all of the new recommendations and developed action plans. In fact, we were addressing many of the recommendations even before receiving the recent OIG report.

Response

Action plans have been developed to address all of the recommendations for the March 2017 Report. We expect to begin implementation in May, and to be completed by December 2017. These actions include:

- Incorporating a new Customer Relationship Management (CRM) system so caller information is automatically populated with the phone number of the caller.
- Evaluating policies and procedures related to VCL call recordings, and ensuring all staff are educated on policies, to include roles and responsibilities.

- Developing and implementing a training plan for educating staff on the use of call recordings and how to walk a caller through any concerns regarding the recording of calls.
- Establishing a governance structure to ensure cooperation and collaboration between program offices and appropriate responsibility for clinical and administrative functions.
- Developing clear guidelines for clinical and administrative decision-making. These guidelines will focus on ensuring Veterans who call receive high-quality care based on clinical judgement and operations are managed with sound business practices.
- Collaborating with other VA program offices to provide training to VCL management staff in core competencies of safe and high quality leadership.
- Adding to VCL Executive Leadership Council's (ELC) responsibilities. VCL ELC is the governance structure responsible for documenting, tracking, and directing action on clinical quality performance measures.
- Implementing root cause analysis and corrective action plans to ensure opportunities for improvement are appropriately implemented.

Progress

Prior to opening the Atlanta VCL call center in October 2016, VCL saw in excess of 3,000 calls per week roll over to back-up call centers. From January 8-14, 2017, we maintained rolled over only 58 phone calls. Since then, we continue to keep rollover calls well below one percent. This means that on average, we answer over **99 percent**

of calls received on a daily basis by the Canandaigua, New York, and Atlanta, Georgia, call centers.

VCL implemented a comprehensive workforce management system and optimized staffing patterns to provide callers with immediate service and to achieve zero percent routine rollover to contracted back-up centers.

During the time period of the second OIG investigation, VCL actively staffed the Atlanta call center. New responders were hired and trained over the course of three months, averaging 40 new responders being deployed per pay period. The standard training cycle includes three weeks of classroom instruction and two weeks of preceptorship prior to being released to independent work.

The chart below indicates VCL's progress over the course of the last several months in offering superior access for Veterans during their time of need. It is worth noting, the rollover rate has dropped even while the number of calls has increased.

Weekly VCL Access Table			
Week for 2016-2017	**Total Number of Calls**	**Total Rollovers**	**Rollover %**
10/30 - 11/5	10558	3309	31.34%
11/6 - 11/12	10485	2274	21.69%
11/13 - 11/19	11344	2484	21.90%
11/20 - 11/26	9508	1363	14.34%
11/27 - 12/3	12477	2097	16.81%
12/4 - 12/10	12,380	1,488	12.02%
12/11-12/17	12,613	1,396	11.07%
12/18 - 12/24	12,257	640	5.22%

12/25 -12/31	12,852	507	3.94%
1/1 - 1/7	14,768	294	1.99%
1/8 - 1/14	12,233	58	0.47%
1/15 - 1/21	14,117	58	0.41%
1/22 - 1/28	12,768	16	0.13%
1/29 - 2/4	13,309	11	0.08%
2/5 - 2/11	13,925	3	0.02%
2/12 - 2/18	12,690	10	0.08%
2/19 - 2/25	12,956	12	0.09%
2/26 - 3/4	13,193	28	0.21%
3/5 - 3/11	13,735	62	0.45%
3/12 – 3/18	13,711	16	0.12%
3/19 – 3/25	13,966	16	0.11%

The No Veterans Crisis Line Call Should Go Unanswered Act (Public Law 114-247) directed VA to develop a quality assurance document to use in carrying out VCL. It also required VA to develop a plan to ensure that each telephone call, text message, and other communication to VCL, including at a backup call center, is answered in a timely manner by a person. This is consistent with the guidance established by the American Association of Suicidology. In addition to adhering to the requirements of the law, VCL has enhanced the workforce with qualified responders to eliminate routine rollover of calls to the contracted backup center. We also implemented a quality management system, to monitor the effectiveness of the services provided by VCL. This also will

enable us to identify opportunities for continued improvement. As required by law, VA will submit a report containing this document and the required plan to the House and Senate Veterans Affairs Committees by May 27, 2017.

Conclusion

We appreciate OIG's review of VCL. We are committed to strengthening our governance structure so that VCL, Office of Mental Health Operation, and Office of Suicide Prevention are fully integrated, in order to ensure optimal clinical services. We are committed to seamless care from the time the Veteran reaches out to VCL, arrangements are made to ensure that the Veteran is safe, and we ensure that the Veteran receives timely care and assistance.

We also are grateful that Congress provides the resources necessary to give Veterans in crisis access to these necessary services. Thank you and we look forward to your questions.