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BEFORE THE
SUBCOMMITTEE ON HEALTH, COMMITTEE ON VETERANS' AFFAIRS
US HOUSE OF REPRESENTATIVES
HEARING ON
DIAL 988 +1: EXAMINING THE OPERATIONS OF THE VETERANS CRISIS LINE
SEPTEMBER 18, 2024

Chairwoman Miller-Meeks, Ranking Member Brownley, and Subcommittee Members, thank you for the opportunity to discuss the Office of Inspector General's (OIG) oversight of the Veterans Crisis Line (VCL). The OIG's Office of Healthcare Inspections routinely reports on the quality of services provided across the Veterans Health Administration (VHA) and on risks to patient safety. There is almost no service that VA provides that carries the same high level of risk and urgency than the services provided by VCL responders to a veteran in immediate mental health crisis. While not clinicians, responders are expected to engage callers through active listening, motivational interviewing, problem solving, and safety planning. Responders assess each caller's level of risk for harm and implement appropriate action to stabilize a crisis as quickly as possible. Stabilization efforts can involve significant coordination between VCL staff, emergency personnel, and VHA clinicians while maintaining open communication with the veteran in crisis. Not unlike interventions delivered in a hospital or outpatient setting, this coordination can involve a complex interchange of assessment and administrative activities that must always be precise. Veterans, their families, and caregivers rely on this crisis intervention service. Its role in reducing the risk of veteran suicide cannot be overstated.

A September 2023 OIG report, *A Patient's Suicide Following Veterans Crisis Line Mismanagement and Deficient Follow-Up Actions by the Veterans Crisis Line and Audie L. Murphy Memorial Veterans*

Hospital in San Antonio, Texas, details a devastating incident in which a veteran died by suicide less than an hour after interacting with a VCL responder.[1]

The veteran, in their mid-thirties, was a VHA patient and had prior documented reports of suicidal thoughts and behavior over the span of almost three years. In early 2021, the veteran initiated a text contact with a responder at 10:14 p.m. The veteran described a plan for suicide involving use of firearms and hanging themselves from a rafter in the shed from where they were texting. The summary of the text exchange recorded in the veteran's electronic health record noted that the veteran and VCL responder established a safety plan that included involving a family member, distancing from and securing identified lethal means, taking medications as prescribed, and calling medical providers the following day.[2] The responder documented that the text exchange ended without incident at 11:29 p.m., and the required consult (referral) was placed for the facility's suicide prevention coordinator (SPC). In the following days, the facility SPC documented several unsuccessful attempts to reach the veteran and the family member involved in the safety plan. The SPC initiated a welfare check with the local sheriff's office and was informed that the veteran hanged themselves in the shed the same evening of the VCL text exchange.

The OIG independently obtained the actual text exchange from the veteran's family member. After careful review, the oversight team determined that not only did the responder's documentation of the texts inaccurately summarize the exchange, but the responder also did not offer critical support and intervention to this veteran who was clearly in crisis. The OIG found that the responder did not assess and address risk and consider immediate rescue efforts, failed to understand the veteran's access to identified lethal means and alcohol use, and neglected to access the support of an on-site family member. These failures collectively contributed to the tragic outcome for this veteran and their family. The healthcare inspection also revealed that VCL leaders failed to conduct a thorough and comprehensive review after being made aware of the veteran's death by suicide. The missed opportunities detailed in the September 2023 report resulted from critical deficiencies of a single responder, as well as leaders not holding their staff and themselves accountable for falling short of their mission.

This statement highlights themes and identifies improvements that can be made to better ensure consistency in high-quality crisis interventions. The findings of serious deficiencies in the selected reports highlighted below do not reflect the quality of care that VHA leaders and staff provide every day

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[1] VA OIG, *A Patient's Suicide Following Veterans Crisis Line Mismanagement and Deficient Follow-Up Actions by the Veterans Crisis Line and Audie L. Murphy Memorial Veterans Hospital in San Antonio, Texas*, September 14, 2023. The OIG identified numerous issues in the care and services delivered by both the VCL and the Audie L. Murphy Memorial Veterans Hospital where the veteran was a patient. Given the focus of this hearing, and the number of issues identified in the report, this statement will focus on the VCL.

[2] Lethal means refers to objects, including weapons and substances, that may be used for self-harm.

to veterans across the system; however, dismissing these findings as one-offs or an isolated system breakdown, impedes a thoughtful analysis and the broad application of lessons learned.

COORDINATING CARE FOR VETERANS IN CRISIS DEPENDS ON ACCURATE RISK ASSESSMENTS BY VCL STAFF

The OIG recognizes the extreme pressure responders face in meeting the immediate needs of a veteran in crisis in a setting where there is no room for error. All VCL interactions do not demand the same level of resource coordination and intervention as those described in the reports highlighted in this testimony, but each must be initiated with an understanding of the immediate risk. It is essential that these risk assessments include reviewing the veteran's access to lethal means, considering other risk factors such as alcohol and other substance use, as well as identifying and including individuals who can offer immediate support to the veteran. Without such an assessment, a responder cannot make time-sensitive decisions aimed at stabilizing the crisis and initiating appropriate supportive efforts.

Lethal Means Assessments Must Be Immediate and Thorough

The time between contemplation of suicide and an attempt can be minutes, and failing to immediately and accurately assess such risk can be fatal for the veteran. After the OIG independently obtained and reviewed the text transcript discussed earlier between the veteran who received care at the Audie L. Murphy Memorial Veterans Hospital and the VCL responder, it was clear that the responder did not address the veteran's admission that they had "tested" the hanging apparatus in the shed and described "feeling everything fade." Despite that admission, the responder inaccurately documented in the record that the veteran "had not put any plans in to action" and more aggressive rescue efforts were not considered.

An OIG report published in April 2021 found similar failings. Despite the caller informing the responder that they had a firearm in hand and "will shoot anyone that comes into [the] apartment," the responder did not adequately engage in mitigating the immediate threat, assess homicidal ideation, or conduct a safety plan with the caller.[3] Shortly after the call ended, the veteran shot and killed a family member.

Alcohol and Other Drugs Must Be Considered in Every Assessment

In the September 2023 OIG report related to the veteran's suicide by hanging, the responder failed to inquire about the veteran's current alcohol use although the veteran had texted thoughts of getting "drunk enough to get it over with." Alcohol use is a recognized risk factor for suicide as it can impact judgement and reasoning and, during an acute crisis, can influence a responder's assessment of risk and a commensurate response. Based on a postmortem sample, the veteran likely had a blood alcohol level between 0.06 and .13 during the text exchange, suggesting that the veteran may have had impaired

[3] VA OIG, *Insufficient Veterans Crisis Line Management of Two Callers with Homicidal Ideation, and an Inadequate Primary Care Assessment at the Montana VA Health Care System in Fort Harrison*, April 15, 2021.

judgment and reasoning due to alcohol use. In *Deficiencies in the Veterans Crisis Line Response to a Veteran Caller Who Died* (a 2020 report), the OIG found similar concerns when a responder failed to consider the increased risk when a veteran described consuming a significant amount of alcohol prior to initiating the call, and hours later died from combined acute intoxication with alcohol and other prescription and nonprescription medications.[4]

Including Trusted Family Members and Friends during Crisis Management Can Improve Intervention Outcomes

VCL guidance promotes inclusion of individuals identified by callers who can help support safety planning, especially when lethal means are accessible. Yet, the September 2023 report detailed further evidence of failures to meet the veteran's needs during their crisis when the text exchange showed the veteran willingly allowed the responder to call or text an identified supportive family member in the house just feet away from the shed where the veteran was located. When asked during an OIG interview why that family member was not notified of the crisis, the responder stated, "we don't involve [family members]," a response that was inconsistent with the VCL's guidance. The family member told the OIG of being unaware that the veteran had contacted the VCL but acknowledged receiving a text from the veteran during the same time period requesting that the firearms in the house be secured. The family member also reported that the patient's prior suicide attempts involved firearms, and if the information had been provided that the patient was considering hanging as a means, they could have intervened differently.

CONSISTENT, HIGH-QUALITY CRISIS INTERVENTIONS REQUIRE SUPERVISORY OVERSIGHT AND A STRUCTURED QUALITY MANAGEMENT PROGRAM

No healthcare system is perfect, and VHA is no exception. Since 2019, VHA has committed to becoming a high reliability organization (HRO), an initiative with a goal of zero patient harm with leadership that reflects a commitment to building and nurturing a culture of safety that relies on evidence-based tools to continuously evaluate and improve the safety and efficacy of processes.[5] The OIG has reported on the progress of individual medical facilities in implementing HRO principles and has attributed multiple findings in OIG reports to leaders failing to uphold these principles.[6] A crucial aspect to successfully implementing HRO principles is using protocols to drive process improvements.

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[4] VA OIG, *Deficiencies in the Veterans Crisis Line Response to a Veteran Caller Who Died*, November 17. 2020. All recommendations from this report have been closed, following VHA's provision of information responsive to the recommendations.

[5] VHA National Center for Patient Safety, VHA's HRO Journey Officially Begins, accessed September 5, 2024.

[6] See, for example, VA OIG, *Care Concerns and Deficiencies in Facility Leaders' and Staff's Responses Following a Medical Emergency at the Carl T. Hayden VA Medical Center in Phoenix, Arizona*, July 2, 2024; VA OIG, *Leaders at the VA Eastern Colorado Health Care System in Aurora Created an Environment That Undermined the Culture of Safety*, June 24, 2024.

Contrary to this, the OIG has consistently found major gaps in assessing and addressing the quality of VCL responders' performance.

Silent Call-Monitoring Can Be an Effective Quality Management Tool When Used Consistently

In 2016, VCL leaders initiated silent monitoring of responders' calls. Silent monitors are specialists trained to listen to active calls, assess them for risk, and provide coaching on identified areas for responder improvement immediately following monitored calls. The goal was to have one monitoring for 80 percent of responders at least every two weeks. Despite this established quality review framework, the OIG's April 2021 report on the veteran that shot a family member found that VCL leaders failed to ensure that sufficient silent monitored calls were conducted for all staff. The lapses in oversight contributed to the tragic outcomes described in that report. As a result, the OIG recommended the VCL evaluate the percentage of completed silent monitored calls and establish benchmarks for individual staff requirements. That recommendation has since been closed as implemented.

However, the September 2023 report found additional, previously unidentified gaps in the VCL's silent monitoring program. The VCL responder at issue was, in fact, a trained silent monitor working overtime shifts in the role of a responder. The OIG found there was no silent monitoring for any of their contacts as a responder from January 2019 through the day the oversight team requested this information in early February 2022. In an interview, the VCL's director of quality and training reported that there was no process to conduct silent monitored contacts for staff performing responder duties for overtime. After the OIG provided VCL leaders with the transcript of the text messages in March 2022, the leaders assigned staff to complete a retrospective silent monitoring of the same responder's interactions with seven individuals who contacted the VCL from October 16, 2020, through October 26, 2021. The reviewers noted the responder's inadequate performance in assessing caller risk, collaborative problem solving, involving a third party to address immediate access to lethal means, and in clearly and accurately documenting interactions with callers. The OIG recommendation, now closed after VHA provided sufficient documentary evidence of implementation, asked the VCL to strengthen the quality management oversight of staff who provide crisis management services, including overtime coverage.

Delays in Establishing Processes for Retaining Text Messages Prevented Effective Quality Management of Crisis Interventions

Individuals may contact the VCL via telephone, text message, or web-based chat. The September 2023 report found that despite the VCL launching text-messaging services in November 2011, a retention process for those text exchanges did not occur until May 2022, months after the OIG initiated the healthcare inspection detailed in the report, and over a decade after introducing the text-messaging option. The OIG determined the lack of text retention processes prevented leaders from conducting comprehensive quality assurance reviews of text-messaging contacts, relying instead on the responder's summary of each text encounter.

Leaders' failure to ensure a robust text contact management quality assurance review program limited supervisory oversight that could identify performance deficiencies and enable corrective actions. Although VCL leaders described a multiyear process to resolve information technology issues for text-message retention as a barrier to implementation, during this healthcare inspection, VCL leaders adopted an immediate interim solution that allowed responders to simply copy and paste text transcripts into the record, thereby addressing an OIG recommendation to ensure text retention and quality reviews.

Timely Root Cause Analyses Must Be Completed to Improve Deficiencies

Across VHA, a fundamental tool used by quality and safety teams to evaluate an adverse event is a root cause analysis (RCA). The RCA is conducted by a multidisciplinary team of experts, including the organization's leaders, focused on understanding how an error or a close call occurred and how to prevent the situation from recurring. Specific to the VCL, its leaders established a patient safety risk manager position in 2018 and initiated an RCA program the following year. The VCL's standard operating procedure instructs that, upon notification of a VCL contact's death by suicide, the risk manager determines the need for an RCA. In the April 2021 report related to the shooting, the OIG noted that the VCL did not conduct a timely RCA because of confusion surrounding how best to review the responder's inadequate performance.

During interviews for the September 2023 report regarding the veteran's suicide by hanging, VCL's director of quality and training reported that despite an issue brief informing leaders of the completed suicide indicating an RCA would be "chartered," once VCL leaders learned the interactions with the deceased veteran occurred through text exchange and were therefore not recorded, VCL leaders determined an RCA would not be feasible. However, 11 months after the event, which was three weeks after the OIG notified VCL of the healthcare inspection, and before giving them the complete text transcript, the VCL's executive director stated that "we saw additional points related to systemic concerns" that warranted an RCA. The OIG concluded that VCL leaders' failure to conduct a timely review of the veteran's contact contributed to a delay in the identification of systemic and performance deficiencies and implementation of corrective actions.[7]

LEADERS MUST HOLD THEMSELVES AND STAFF ACCOUNTABLE FOLLOWING ERRORS

The grief of a family and other loved ones who lose a veteran to suicide is overwhelming and can have a deep effect on the care teams that work every day to prevent such occurrences. OIG teams repeatedly find dedicated VHA professionals that go above and beyond their duty to provide high-risk veterans

[7] VCL's director of quality and training reported that RCAs were discontinued and replaced with a minimum requirement of an annual analysis of reports on critical incidents and near misses submitted through the VCL Reporting Hub since August 2021. The VCL Reporting Hub is a web-based system that centralizes reporting and allows staff to input data and to generate reports and notification messages.

with the resources and interventions they need. The OIG also recognizes these professionals require significant support and sensitivity when, despite those efforts, a veteran completes suicide.

However, the OIG expects that leaders recognize boundaries between the efforts to support their staff and actions that may compromise the integrity of an independent review.

After the OIG scheduled interviews with VCL staff for the 2023 report, the OIG found that the director of quality and training instant messaged the subject responder stating that the "main points are to only answer the question asked – don't volunteer anything extra." Further, this director offered the responder suggestions about the content of the upcoming OIG interview, including "They will ask you about the interaction and likely about related policies and procedures," and "I think they are going to be interested in the fact that you're an [silent monitor] who was working as a [responder]."

Additional communication between the VCL leader and responder suggested messaging failed to prioritize the deceased veteran and the value of reviewing the events to improve the safety and efficacy of crisis interventions for future veteran callers. Other instant messages stated, "I have confidence that the Veteran couldn't have received better" and "I wish I could have protected you from this." The OIG made several recommendations addressing the concerning conduct by VCL leaders, one of which remains open at this time as not fully implemented. When leaders do not hold their staff accountable and intentionally compromise the integrity of any OIG work being conducted to improve services provided to veterans, functioning as a high reliability organization becomes an impossible goal.

SENSITIVITY AND RESPONSIVENESS TO TRAGIC OUTCOMES MUST BE ENGRAINED IN POLICY AND STRICTLY ADHERED TO BY ALL STAFF

VA has a unique and important obligation to the families and other survivors of the veterans it serves. The intent behind appointment reminders and "caring letter" correspondence specifically aimed at engaging and supporting veterans who have received treatment for a suicide attempt or suicidal ideation is noble. Yet, extreme sensitivity must be practiced to ensure such outreach does not exacerbate grief or retraumatize families of the deceased. Caring letters are an evidence-based suicide prevention intervention that involves sending periodic messages with simple expressions of care and concern to veterans who use VA health care and contact the VCL, usually for a 12- to 24-month period.[8]

During reviews for the September 2023 report, the OIG found that facility staff continued to leave messages on the veteran's phone and sent caring letters to their home. Because VCL leaders failed to develop procedures that would have ensured the Caring Letters Program received notification of the veteran's death, and facility leaders did not ensure timely placement of the alert noting the veteran had died in the patient electronic health record, the bereaved family's grief was repeatedly exacerbated for months after the veteran's suicide. The OIG recommended the VCL take actions to strengthen processes

[8] "Memorandum of Understanding Between VA Quality Enhancement Research Initiative (QUERI) And Veteran Crisis Line," July 30, 2019.

to make certain that caring letters are not sent following a veteran's death. The recommendation is now closed.

VHA IMPLEMENTED THE VCL "988 PRESS 1" THREE-DIGIT DIALING CODE

Most recently, the OIG reviewed how the VCL prepared for the 2022 implementation of the National Suicide Prevention Hotline three-digit dialing code "988 press 1."[9] The report focused on VCL responder and supervisor staffing and training, including "postvention" support awareness; information technology equipment and support; and quality metrics data and oversight.[10]

VCL leaders, in conjunction with Office of Information and Technology officials, assessed, planned for, and implemented technology changes related to the three-digit call option. The OIG found that the VCL did not encounter technology concerns. An OIG survey distributed to frontline staff reflected positive feedback regarding technology equipment and support, with 89 percent of survey respondents reporting having the necessary equipment and 83.2 percent reporting having the necessary technical support.

Because VCL leaders may have overestimated an increase in call volume, they aggressively hired responders. Such aggressive hiring ultimately decreased the ratio of supervisors to responders. To provide adequate performance assessments and training, the OIG recommended that VCL leaders provide an appropriate ratio of supervisors to frontline staff.

The OIG survey also asked frontline staff whether they were aware of postvention resources. These resources, provided by VHA, are available to frontline staff and supervisors because of their exposure to potentially traumatic experiences. Approximately 72 percent of frontline staff who responded were aware of postvention services, and 72 percent of frontline staff responded feeling supported by their supervisors to access postvention resources. Because the OIG was concerned that frontline staff's awareness and feelings of support from supervisors to use postvention resources was not closer to 100 percent, the OIG recommended that the VCL director ensure supervisors and staff are aware of the postvention resources.

The OIG was encouraged by findings related to quality data collection and analysis by VCL leaders. Quality metrics data were reported monthly to VCL leaders and included call volume, timeliness to

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[9] VA OIG, *Veterans Crisis Line Implementation of 988 Press 1 Preparation and Leaders' Response*, August 22, 2024. This phone number was established by the Federal Communications Commission designating 988 as a national suicide prevention hotline number. On July 16, 2022, callers were able to contact the VCL by using 988 press 1. National Suicide Hotline Designation Act of 2020, Pub. L. No. 116-172, 134 Stat. 832 (2020), codified at 47 U.S.C. § 251 (2023). After the act was signed into law, the name of the hotline was changed from the National Suicide Prevention Hotline to the 988 Suicide and Crisis Lifeline. There were two recommendations included in this report. The first OIG request for an update on the status of the implementation of the recommendations will be on or about November 22, 2024.

[10] A postvention is an "intervention conducted after a suicide, largely taking the form of support for the bereaved." This process allows for the emotional release necessary for "those who have endured a traumatic occurrence." VCL S-ACT-311-2009, Veterans Crisis Line Standard Operating Procedure for Postvention, August 2020. The OIG did not examine the content or utilization of the postvention resources.

answer calls, average time per call, number of dispatches of emergency services for individuals at risk of imminent harm, number of staff cleared for independent work, and the interactive quality of the call through silent monitoring. The silent monitoring goal of an assessment at least once every two weeks for 80 percent of the crisis responders improved from August 14 to December 17, 2022, to achieve that goal.

CONCLUSION

September is recognized as Suicide Prevention Month to raise awareness of the suicide crisis and heighten efforts to engage with individuals who are at risk for suicide. For VA, this is a daily commitment. The OIG has witnessed thousands of dedicated VA staff educating veterans and their families while treating those who are at risk for suicide. The dismal statistics of completed veteran suicides do not diminish those efforts and must not be used to suggest such efforts are ineffective or futile. When veterans engage with VHA, they should expect that the care delivered will be compassionate, safe, and effective. We must hold all leaders accountable for meeting these expectations. The findings and recommendations in the reports highlighted in this testimony should be used by VA leaders to continuously test whether their operations are free from OIG-identified deficiencies and provide safe and high-quality services. The OIG will continue to oversee and spotlight areas in which VHA and the VCL can take action to improve their operations to meet the needs of all veterans, especially those at risk for suicide.

Madam Chair, this concludes my statement. I would be happy to answer any questions you or members of the subcommittee may have.