DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Follow-Up Review of the Veterans Crisis Line

Canandaigua, New York; Atlanta, Georgia; and Topeka, Kansas

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Executive Summary

The VA Office of Inspector General (OIG) conducted a follow-up healthcare inspection to assess sustained performance of actions taken to close previous OIG recommendations at the Veterans Crisis Line (VCL), located in Canandaigua, New York; Atlanta, Georgia; and Topeka, Kansas.

VCL is a telephone crisis hotline, also providing text and chat services, to veterans, service members, and their family members. VCL plays a significant role in Veterans Health Administration (VHA)'s suicide prevention efforts. OIG staff evaluated areas of concern related to VCL identified in two previous OIG reports, *VA OIG Healthcare Inspection–Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York,* Report No. 14-03540-123, February 11, 2016; and *VA OIG Healthcare Inspection–Evaluation of the Veterans Health Administration Veterans Crisis Line,* Report No. 16-03985-181, March 20, 2017 (referred to here as the March 2017 review).

All recommendations made in the two previous VCL reports, February 2016 and March 2017, were closed as of March 28, 2018. In this follow-up review, OIG staff addressed three VCL areas of concern:

1. Governance structure and oversight
2. Operations
3. Quality management

VCL sustained actions related to governance and oversight, as well as monitoring of its backup center. VCL sustained improved operations processes and reduced rollover calls to the backup center with a new call routing process. VCL sustained actions related to quality management leadership training, policies, and processes. During the current review, OIG staff found that VCL quality managers need to address issues affecting rescue efforts, in which emergency services are dispatched to the location of a person who has contacted VCL and who has been determined to be in imminent danger. The OIG made one recommendation related to improving location determination of veteran callers who need rescue.

VCL Governance Structure and Oversight

During the March 2017 review, VCL was aligned under VHA Member Services and lacked adequate clinical oversight. At that time, VCL had a clinical advisory board, whose members served as the source of clinical expertise, but it was found to have low attendance and minimal impact on VCL clinical operations. The executive leadership committee, a leadership group responsible for integrating the business and clinical aspects of operations, lacked policies to guide its function and duties and did not demonstrate sufficient analysis of VCL performance

data. The OIG also found during the March 2017 review that VCL lacked both a permanent director and a directive to formalize operations guidance.

During the current follow-up review, OIG staff found that VCL was realigned under the Office of Mental Health and Suicide Prevention, which resulted in improved clinical guidance and oversight. With increased clinical input, VCL transitioned its clinical advisory board to a partnership council, that "has the strategic goal of marrying the VCL's clinical services with a state-of-the-art call center business operational infrastructure." OIG staff found that VCL maintained an Executive Leadership Council charter, held regular meetings, and analyzed VCL performance data. VCL hired a permanent director and as of May 31, 2017, began operating under a directive that delineated clinical and administrative decision-making responsibilities, which remained in effect during the current review. VCL sustained actions related to governance and oversight, and no additional recommendations were made in this area.

During the March 2017 review, OIG staff found deficiencies in VCL's oversight of performance by its contracted backup centers related to routine reviewing of backup call center data, establishing performance targets with accountability, and enforcing a quality assurance surveillance plan. OIG staff recommended that backup centers and VCL have the same standards for call queuing and wait time, so that callers receive the same level of service regardless of where the call is routed. During the current review, OIG staff found that VCL decreased backup center operations from four centers to a single backup center, and its revised contract contained a quality assurance plan with performance metrics matching VCL's targets. OIG staff found that the VCL contracting officer's representative (COR) sustained improved oversight of communication with the backup center regarding the quality assurance surveillance plan and backup center performance. Because of these sustained improvements regarding VCL's oversight of the backup center, no additional recommendations were made in this area during the follow-up review.

VCL Operations

During the March 2017 review, OIG staff found that VCL had delays in the launch of the second call center in Atlanta and an increased number of rollover calls to the backup center that were attributed to

- Overly ambitious timelines,

- Lack of on-site leadership,

- Inadequate staffing and training resources, and

- Lack of a formal business plan for accomplishing goals.

During the current follow-up review, OIG staff found that of the three VCL sites, the Atlanta Call Center had the highest percentage of responder positions occupied, and its new responders

participated in a standardized VCL training program. VCL tracked and compared training efficacy by site and had implemented responder silent monitoring as a quality control at all three sites.[1] OIG staff found that the improved responder training processes at the Atlanta Call Center were also implemented during the launch of the Topeka Call Center. VCL's use of a new call routing process better utilized staff at all three sites and reduced rollover calls to the backup center. No additional recommendations were made related to operations specific to the Atlanta or Topeka Call Centers.

VCL Quality Management

During the March 2017 review, the OIG made recommendations regarding the leadership of quality management staff, which had a negative impact on data analysis of performance indicators, and identification of system issues present in monitoring of quality provided by responders. The OIG also made recommendations related to social service assistants' training overall, the supervisory approval process for social service assistants to work independently, and development and distribution of new or updated policies. During the current follow-up review, OIG staff found that quality management program leaders received training in quality management principles and followed through on other planned actions. Enhanced quality management staffing, as reflected in VCL's organizational structure, had a positive impact on functioning of quality management processes. VCL had action plans in place for expansion of social service assistants' roles. OIG staff found that VCL quality management has an opportunity to address issues affecting rescue efforts, in which emergency services are dispatched to the location of a veteran who has contacted VCL and who has been determined to be in imminent danger.

The OIG made one recommendation that the VCL director ensures analysis of rescue efforts ending because the caller's location cannot be found, identifies and analyzes metrics that may have contributed to the inability to locate these rescues, and takes remedial action.[2]

Comments

The Under Secretary for Health did not concur with the recommendation based on the absence of a current industry standard; however, VHA's planned actions are consistent with the intent of the recommendation. (See appendix C, pages 25–26 for the executive in charge's comments.)[3] The

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[1] Silent monitoring is a quality assurance tool used by the VCL. During silent monitoring, quality management staff listen to and/or observe a responder's activities when engaging with a caller or a Social Service Assistant's activity when conducting a rescue. The quality management staff then provide feedback to the responder or Social Service Assistant on areas of strength and areas for improvement.

[2] The OIG directed the recommendation to the VCL director; the executive in charge, Office of the Under Secretary for Health, responded.

[3] Recommendations directed to the Under Secretary for Health (USH) were submitted to the executive in charge who has the authority to perform the functions and duties of the USH.

OIG supports the proposed actions, particularly the sharing of information with the National Suicide Prevention Lifeline to promote changes on the national level that will improve life-saving efforts. The OIG considers the recommendation open and will follow up on the planned actions until they are completed.

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Abbreviations

COR	contracting officer's representative
OIG	Office of Inspector General
OMHSP	Office of Mental Health and Suicide Prevention
SSA	social service assistant
VCL	Veterans Crisis Line
VHA	Veterans Health Administration

Introduction

The VA Office of Inspector General (OIG) conducted a follow-up healthcare inspection at the Veterans Crisis Line (VCL) with call centers located in Canandaigua, New York; Atlanta, Georgia; and Topeka, Kansas; to evaluate if the VCL had sustained performance of actions taken to close the earlier OIG recommendations related to VCL governance and oversight, operations, and quality management.

Background

As of 2017, suicide was the tenth leading cause of death in the United States. According to the Centers for Disease Control and Prevention, nearly 45,000 people died by suicide in 2016, an average of one suicide death every twelve minutes. Veterans Health Administration (VHA) reported, "In 2016, the suicide rate was 1.5 times greater for Veterans than for non-Veteran adults, after adjusting for age and gender."[4] The suicide rate for veterans aged 18–34 showed an increase from 2015 to 2016, rising from 40.4 to 45 suicide deaths per 100,000 population. Additionally, the suicide rate for women veterans was found to be 1.8 times greater than for non-veteran women. The overall rate of suicide increased for veterans from 2005 to 2016; however, those engaged in VHA care had a lower rate of increase, 13.7 percent, than those who were not in VHA care, 26 percent.[5]

Significant suicide prevention efforts have been underway for over a decade in VHA. In 2007, VHA established a telephone suicide crisis hotline. Initially called the National Veterans Suicide Prevention Hotline, its name changed to the VCL in 2011. The primary mission of the VCL is "to provide 24/7, world class, suicide prevention and crisis intervention services to veterans, service members, and their family members."[6] Since its launch in 2007 through February 2019, the VCL had answered more than 3.5 million calls and initiated the dispatch of emergency services to callers in crisis nearly 100,000 times. The VCL anonymous online chat service, added

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[4] Department of Veterans Affairs, Veterans Health Administration, Office of Mental Health and Suicide Prevention. *Veteran Suicide Data Report*, 2005–2016. September 2018. https://www.mentalhealth.va.gov/docs/data-sheets/OMHSP_National_Suicide_Data_Report_ 2005-2016_508-compliant.pdf. (The website was accessed on November 1, 2018.)

[5] This is the most current suicide data available from VHA, published in the *VA National Suicide Data Report* in September 2018. The report examined suicide data from 2005–2016. When compared side-by-side for 2016, veterans who were recently using VHA services had higher rates of suicide than those who had not recently used VHA services, veterans overall, and non-veterans. VA attributes this to veterans seeking care having physical and mental health conditions that put them at greater risk for suicide. The rate of increase in suicide from 2005 to 2016; however, was lower for veterans engaged in VHA care than those who were not. https://www.mentalhealth.va.gov/docs/data-sheets/OMHSP_National_Suicide_Data_Report_2005-2016_508.pdf. *(*The website was accessed on November 1, 2018*.)*

[6] VCL Mission, Vision, and Values.

in 2009, had engaged in more than 413,000 chats.[7] In November 2011, the VCL introduced a text-messaging service to provide another way for veterans to connect with support, and since then has responded to nearly 98,000 texts.[8]

Suicide and suicide prevention have been subjects of multiple OIG reports, and continue to be a high priority for VA and Congress. VHA supports a national goal to reduce suicide within the United States by 20 percent by the year 2025 through implementation of a public health model.[9] VHA states

> Suicide prevention is VA's highest priority, and VA has made great strides in Veteran suicide prevention, especially in crisis intervention. We will not relent in our efforts to connect Veterans who are experiencing an emotional or mental health crisis with lifesaving support. Mental health and crisis support services are critical for people showing signs of suicide risk in their thoughts or behavior, but we must go beyond engaging mental health providers, to involve the broader community and reach Veterans where they live and thrive—before they reach a crisis point.

Prior OIG Reports

The VCL has been the subject of two OIG reports over the last three years. The first OIG report, *Veterans Crisis Line Caller Response and Quality Assurance Concerns,* Report No. 14-03540-123, February 11, 2016, resulted in seven recommendations (referred to in the current report as the February 2016 report or review). The VCL provided evidence sufficient to close these recommendations between April 26, 2017, and August 16, 2017.

A second OIG report, *Healthcare Inspection–Evaluation of the Veterans Health Administration Veterans Crisis Line*, Report No. 16-03985-181, March 20, 2017, was published the following year and had a larger scope than the previous review (referred to in the current report as the March 2017 report or review). During the March 2017 review, OIG staff conducted a more in-depth look at the February 2016 report recommendations which remained in an open status at the time. Additionally, the March 2017 review addressed a complaint alleging that the VCL did not respond adequately to a veteran's urgent needs; a detailed review of the VCL's governance structure, operations, and quality assurance functions in order to assess whether the VCL was

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[7] A chat is a discussion held over the Internet by sending messages back and forth, often done in a chat room. https://www.merriam-webster.com/dictionary/chat. (The website was accessed on February 20, 2019).

[8] A text is a message sent electronically usually to or from a mobile cellular device. https://www.merriam-webster.com/dictionary/text%20message. (The website was accessed on February 20, 2019).

[9] Based on the 2012 National Strategy for Suicide Prevention, released by the Office of the Surgeon General and the National Action Alliance for Suicide Prevention. https://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/overview.pdf. (The website was accessed on November 1, 2018).

effectively serving the needs of veterans; and complaints received from the U.S. Office of Special Counsel alleging inadequate training of VCL social service assistants (SSAs), resulting in deficiencies in coordinating immediate emergency rescue services needed to prevent harm. The March 2017 report resulted in 16 recommendations. By March 28, 2018, the VCL had provided evidence sufficient to close those recommendations.

VCL Locations

Previously, the VCL had two locations, Canandaigua, New York, and Atlanta, Georgia. Since the March 2017 report, the VCL opened a third call center in Topeka, Kansas, where services officially began in May 2018.[10]

Backup Center(s)

Backup centers are contracted sites that assist in responding to calls made to the VCL. The responders at the backup centers are not VA employees. Previously, the VCL contracted with four backup centers. At present, the VCL utilizes one backup center located in Portland, Oregon.

Anatomy of a Call

When a caller dials the National Suicide Prevention Hotline, the call is answered with a recorded greeting which instructs veterans to Press 1 to reach the VCL.[11] The Press 7 Initiative is another avenue through which veterans can reach the VCL by dialing 7 as directed by the outgoing message when calling any VA medical center, community based outpatient clinic, or outpatient clinic. After reaching the VCL, the caller hears pre-recorded quality assurance announcements while waiting for an available responder.[12] If no VCL responders are available, the call is then routed to a backup center.

Responder

A responder assesses the caller's risk for suicide by asking a series of questions and then categorizes the call as either a "non-core" or "core" call, for tracking purposes. Non-core calls are deemed as non-crisis and can be referred to other VA and non-VA resources. Core calls require crisis intervention. If the responder determines that the caller is in imminent danger, a

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[10] VAntage Point, Official Blog of the U.S. Department of Veterans Affairs. "Veterans Crisis Line opens new Topeka call center. Addition of third center expands support to Veterans in crisis." https://www.blogs.va.gov/VAntage/48928/veterans-crisis-line-opens-new-topeka-call-center/. (The website was accessed May 29, 2018).

[11] The VCL toll-free phone number is 1-800-273-8255. https://www.veteranscrisisline.net/. (The website was accessed on February 21, 2019).

[12] A responder is the person at the VCL who answers the incoming call and interacts with the caller. Responders are also referred to by the VCL as health systems specialists.

safety plan, or a rescue in which emergency services are dispatched, is initiated. To initiate the rescue, the responder completes an emergency dispatch form, contacts an SSA to assist with the dispatch of emergency services, and prepares the caller by informing them that emergency services have been dispatched.[13] Responders attempt to gather pertinent location and demographic information and stay connected with the caller until emergency services arrive.

SSAs

The SSA is responsible for initiating a welfare check or a rescue, also known as a facility transport plan, when a responder suspects a medical or emotional crisis.[14] The SSA uses approved resources to locate the caller, which may include online search resources or contacting law enforcement in the area thought to be where the caller is located. SSAs remain the VCL point of contact for emergency dispatchers after rescue efforts have been initiated. Callers may not divulge their location and when that occurs the use of "pinging" may be required. Pinging is a complex process that involves the local police department attempting to locate a caller using a cellular signal. Some states require a warrant (due to privacy laws) to be issued before a police department can ping a mobile device. If an SSA cannot locate a caller, a supervisor can utilize an approved non-VA database to obtain additional information.[15] The database allows the supervisor to obtain information about the caller, such as, address history, phone numbers, relatives, and other identifiable information.

Once a rescue has been handed off to the police department, the SSA waits at least an hour before following up with emergency services to obtain a disposition of the event. Information concerning the event is provided to the suicide prevention coordinator at the caller's VA home of record for further follow-up. If the caller is unable to be located after at least several hours, the rescue efforts can be terminated. A VCL supervisor (not an SSA or responder) is the only person authorized to terminate a rescue.

VCL Follow-Up Concerns

The February 2016 and March 2017 reports were published within a 13-month period with a total of 23 recommendations related to issues which impacted the VCL's ability to meet its

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[13] SSAs work behind the scenes to assist callers in imminent risk to themselves or others. SSA responsibilities include attempting to locate the caller based on information obtained by the responder, communicating with the responder and VCL supervisors, and obtaining assistance from emergency rescue services. The SSA has access to and utilizes a database of local emergency resources with information pertinent to the caller's location.

[14] A welfare check is a process by which a member of a police department checks on the well-being of a person, usually at their residence; A facility transport plan is an agreed plan between the caller and the responder for the caller to present to a VA or civilian facility for immediate care as outlined in the VA Crisis Line Health Science Specialist Training Participant Guide.

[15] The non-VA database, TransUnion TLOxp, is used to obtain personal identifiable information of a caller in emergent situations to provide to local police for dispatching emergency services. It is the only subscription-based online search resource approved by the VCL.

mission. Although the previous recommendations were closed, OIG staff found it valuable to conduct a follow-up review to ensure sustained performance of actions were taken to close the March 2017 report recommendations. During this follow-up review, OIG staff grouped the March 2017 report recommendations into three primary areas of concern, as demonstrated in table 1. The full description of each of the March 2017 report recommendations is included in appendix A.

Table 1. Follow-Up from the March 2017 Evaluation of VCL Report

Areas of Concern	Associated Recommendation Numbers
Governance, leadership, and VCL oversight	3,4
Operations and backup center oversight	5,6,7
Quality assurance, training, and monitoring of staff	1, 2, 8–16

Source: OIG staff grouping of March 2017 recommendations

Scope and Methodology

The OIG initiated the inspection in April 2018 and conducted two site visits at each of the three VCL locations in Canandaigua, New York; Atlanta, Georgia; and Topeka, Kansas. The first site visit occurred in April 2018, and the second occurred in December 2018. OIG staff toured each facility and interviewed VCL leaders and staff including the VCL director, business operations leaders, clinical operations leaders, quality management staff, and frontline staff.

OIG staff reviewed the following documents, spanning the time frame of October 2017–November 2018: the VCL organizational chart and lists of current staff, backup center contract, quality management documents, committee meeting minutes, performance data, policies and procedures related to call routing and emergency dispatch, and documents related to the Topeka Call Center launch.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Areas of Concern

OIG staff followed up on three VCL areas of concern identified in the March 2017 report: governance and oversight, operations, and quality management. The OIG found that the VCL sustained the actions related to governance and oversight as well as monitoring of its backup center. The VCL also sustained operations improvements and reduced rollover calls to the backup center with a new call routing process. VCL sustained actions related to quality management leadership training, policies, and processes. During the current review, OIG staff found that VCL quality managers need to address issues affecting rescue efforts, in which emergency services are dispatched to the location of a person who has contacted the VCL and who has been determined to be in imminent danger. The OIG made one recommendation related to improving location determination of veteran callers who need rescue.

1. VCL Governance and Oversight

Clinical-Administrative Collaboration

During the March 2017 review, OIG staff identified deficiencies in the governance and oversight of VCL operations. Due to the VCL's alignment under VHA Member Services in February 2016, OIG staff determined that the leadership provided was administrative in nature but lacked clinical expertise needed for a crisis line. To remedy the issue, the VCL had reported a plan to maintain a link to VA Office of Mental Health Operations and VHA Clinical Operations for a source of input from suicide prevention subject matter experts. Despite this plan, OIG staff found that there was significant disagreement among VHA Member Services, VA Office of Mental Health Operations, and VHA Clinical Operations about key VCL decisions and oversight.

At the time of the March 2017 review, the VHA Office of Suicide Prevention was tasked with leading suicide prevention efforts and coordinating and disseminating evidence-based findings related to suicide prevention. However, the Office of Suicide Prevention director reported having no authority over the VCL, a key player in VHA's suicide prevention efforts, as reportedly conveyed to her by the VCL acting director. OIG staff also found that there was minimal communication between the Office of Suicide Prevention and VHA Member Services regarding the VCL and its suicide prevention efforts.

In March 2016, the previous VHA member services acting director requested the formation of a clinical advisory board for the VCL comprising key stakeholders, with a purpose of fostering collaboration between clinical experts to improve VCL efficiencies and access, as well as the veteran experience. During the March 2017 review, OIG staff found low attendance at the clinical advisory board meetings, lack of discussion of performance issues during meetings, and

agenda items not being tracked to resolution. OIG staff also found that the role of the clinical advisory board had been changed to a consultative body. Further concerns were reported by clinical staff, who indicated that the clinical advisory board was ineffective in providing clinical input toward policy decisions.

OIG staff found during the March 2017 review that the executive leadership committee, the central leadership group responsible for integrating the business and clinical aspects of VCL operations, lacked policies to guide its function and duties. The executive leadership committee meeting minutes did not evidence discussion of significant VCL activities, particularly related to performance data analysis. OIG staff found during the March 2017 review that the VCL lacked permanent leadership, identifying two extended periods of time during which the VCL was without a permanent director. When a permanent director held the position in 2015–2016, his tenure was brief. Additionally, OIG staff found that VHA lacked a directive to formalize VCL requirements regarding VCL operations, such as purpose, role, and responsibilities of the staff and committees providing oversight. At the completion of the March 2017 review, VHA agreed to implement a new directive with a deadline of March 2017.

VHA Organizational Alignment

During the current review, OIG staff found that the VCL had been realigned under the now combined Office of Mental Health and Suicide Prevention (OMHSP), previously Office of Mental Health Operations and Office of Suicide Prevention. Although now merged, VHA separately defines the roles of the Office of Mental Health Services and the Suicide Prevention Program. VHA describes the Office of Mental Health Services as the "national program office that sets program and policy guidance for mental health services provided throughout VHA" with a mission of ensuring that veterans have access to mental health care. VHA states that the Suicide Prevention Program emphasizes the importance of veterans having access to high quality mental health services, as well as programs to directly address suicide. They report doing so by providing information to veterans about VA Mental Health Services and VCL hotline and chat resources. Additionally, the Suicide Prevention Program oversees Suicide Prevention Teams at VA facilities. The VCL routinely refers veterans seeking mental health care to these teams. Table 2 details the specific responsibilities of OMHSP and OMHSP leaders as related to VCL oversight.

Table 2. Oversight Responsibilities for the VCL

OMHSP	OMHSP Executive Director	National Director for Suicide Prevention
• Maintains oversight of VCL support services such as human resources and facilities operations • Ensures the VCL has adequate resources for operations • Pursues the standard that VCL responders answering calls are properly trained to promptly answer calls and that a backup plan exists for those that the VCL cannot accommodate • Responds to stakeholders • Ensures that the VCL meets American Association of Suicidology accreditation standards.	• Serves as co-chair of the VCL Clinical Advisory Board • Reviews and consults on all VCL staff training protocols and practice guidelines • Promotes partnerships both internally within VA, and externally with outside stakeholders, and collaborates with VISN [Veterans Integrated Service Network] and facility leadership to ensure the facility-related aspects of VCL services are met.	• Serves on the Clinical Advisory Board to provide subject matter expertise in suicide prevention and best practices in service delivery • Collaborates with VA medical facilities to ensure Suicide Prevention Coordinator requirements are met • Ensures VA medical facilities are aware of their role in receiving VCL referrals • Maintains an accurate database of Suicide Prevention Coordinator contact information.

Source: VCL Directive

The VCL states that while OMHSP is the primary body helping to ensure its mission, it also maintains a contract with VHA Member Services for infrastructural support such as facilities, space, privacy, travel and human resources. In fiscal year 2018, VHA Member Services had 44.6 full-time employee equivalents designated for supporting VCL.

During interviews, VCL leaders reported increased support of clinical operations since realigned under OMHSP, describing an increased emphasis on best clinical practices and more realistic expectations regarding call productivity. OIG staff found that the VCL's new organization under OMHSP provides a more direct source of clinical oversight, in place of the predominantly administrative oversight that existed when the VCL was aligned under VHA Member Services.

VCL Directive

On May 31, 2017, VHA issued a directive detailing VCL operations in response to OIG recommendations. This directive remained in effect during the current review. The directive's content includes the roles and responsibilities of OMHSP, VCL, and facility leadership.[16] Within the directive, quality assurance activities for overseeing VCL's phone, text, and chat services and backup center performance are listed. These include monitoring: clinical indicators of population

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[16] At the time the VCL Directive was published, OMHSP had not yet merged and therefore was referred to as Office of Mental Health Operations and Office of Suicide Prevention.

acuity (rescues initiated, facility transport plans, referrals to suicide prevention coordinators), customer satisfaction, call quality, complaints, and access to VCL services. The directive also identifies members of the VCL leadership team, clinical advisory board, and quality assurance team. Although VHA missed the initial publication deadline of March 2017, the document contained recommended elements and delineated clinical and administrative decision-making responsibilities.

Clinical Advisory Board

In May 2017, the VCL issued a revised clinical advisory board charter, describing it as "a multidisciplinary team of stakeholders sharing proven evidence-informed practices from within their discipline toward a strategic goal of interfacing the VCL/MCL [Military Crisis Line] clinical services with a state-of-the-art call center business operational infrastructure. The clinical advisory board shall provide overall clinical guidance, direction, specifications and recommendations to the Veteran/Military Crisis Line (VCL/MCL)."[17]

During the current review, the VCL notified OIG staff that clinical advisory board meetings were not held for the months of March–May 2018 due to the VCL "determining the value of a clinical advisory board while aligned under the clinical structure of the Office of Mental Health and Suicide Prevention (OMHSP)." The VCL stated it had continued to meet with "OMHSP Field Ops leadership to ensure solid collaboration between suicide prevention coordinators and VCL" during the months that the clinical advisory board did not convene.

In June 2018, the VCL issued a proposal to change the clinical advisory board to the partnership council with expanded membership and a redefined purpose, to "serve as a roundtable discussion forum for stakeholders to interact with their peers in an effort to continually improve the service that Veterans are able to receive through VCL by actively seeking out improvement opportunities and sharing proven practices in providing clinical services with state-of-the-art call center business operations." In July 2018, the clinical advisory board concurred with this plan. The clinical advisory board continued to meet from August through October 2018. The VCL reported that the November and December meetings had been canceled while awaiting the start of the partnership board. The VCL held the first partnership board meeting in January 2019.

OIG staff evaluated the attendance of the clinical advisory board during the months that meetings were held for the period of October 2017 to October 2018 and found that some required members were not present at the majority of clinical advisory board meetings; specifically, the executive director of OMHSP attended only two meetings. For the new partnership council, the VCL included the majority of the representatives initially in the clinical advisory board, with the

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[17] The Veterans Crisis Line is also referred to as The Veterans and Military Crisis Line. The VCL acronym remains applicable for both of these nomenclatures. Department of VA, Public Law 114-247, H.R. 5392, "No Veterans Crisis Line Call Should Go Unanswered Act" QA Assurance Plan 2017; Veterans/Military Crisis Line Clinical Advisory Board Charter, revised May 2017.

addition of VA representatives from the Vet Center Call Center, VHA Member Services, Serious Mental Health Treatment Research and Evaluation Center, Northeast Program Evaluation Center, and Veterans Benefits Administration. The new partnership council charter clarified expectations for members' meeting attendance.

The VCL attributed the decision to transition from the clinical advisory board to the partnership council to an evolution of the scope and purpose of the board now that the VCL is aligned under OMHSP. The VCL director indicated that OMHSP now delivers the clinical oversight that was lacking under VHA Member Services, when the clinical expertise of the clinical advisory board was required. While it is reasonable that an organization with evolving needs, particularly following a realignment, will make modifications to its structure, the VCL will need to ensure that other policies, such as the VCL Directive, reflect such changes.

Executive Leadership Committee Charter

During the current review, OIG staff found that the VCL had developed an initial executive leadership committee charter containing the previously lacking executive leadership committee policy guidance on March 1, 2017, with an expiration date of February 28, 2018. A subsequent executive leadership committee charter was signed by the current VCL director with similar content on November 2018.

In the most recent executive leadership committee charter, the executive leadership committee is defined as "an integrated council comprised of representatives from various VCL boards and departments representing all VCL locations, which serves as the executive leadership group that oversees organizational governance; reviews quality data to ensure information and key quality components are discussed; and promotes continuous improvement in the development of a healthy workplace environment that is consistent with the mission, vision, and core values of the VCL." The executive leadership committee is described as having oversight of the following VCL boards: Business Operations Board; Quality, Safety, and Value Board; Veteran Experience Board; Employee Experience Board; and Partnerships Board. Per the policy, the executive leadership committee requires monthly reporting from the Quality, Safety, and Value Board on VCL clinical quality data, concerns, and corrective actions, and requires that this information is communicated to the Office of Suicide Prevention. When meeting minutes were reviewed, OIG staff found that executive leadership committee meetings occurred routinely. Evaluation of VCL performance data during executive leadership committee meetings appeared thorough and included employee experience, customer satisfaction, and complaint data.

VCL Director

During the current review, OIG staff found that the VCL hired a permanent director who has served in the position since July 2017. The VCL director now reports directly to the executive director of OMHSP and attends semi-weekly meetings with OMHSP leaders as a member of the

OMHSP executive leadership group. He discussed receiving input regarding VCL clinical operations during these interactions and also contributed his own expertise to VCL clinical operations as a trained psychologist. The VCL director described regular engagement with both supervisory and frontline staff through in-person travel to each of the three VCL locations. He reported leading the VCL under the Servant Leadership Model and soliciting employee feedback regarding their experiences through various avenues, including an anonymous internal feedback site, town hall meetings, employee experience boards, book clubs, and a director's blog.[18]

As a result of the actions taken and maintained by the VCL, OIG staff found that previous concerns related to governance and oversight remained resolved.

2. VCL Operations

Oversight of the Contract Backup Center

In the March 2017 report, OIG staff found deficiencies in VCL oversight of performance by its contracted backup centers regarding routine reviewing of backup call center data, establishing performance targets with accountability, and enforcing a quality assurance surveillance plan. Deficiencies included a lack of understanding by the contracting officer's representative (COR) of the backup center contract terms, the COR not being involved in routine meetings with the contractor, and the COR not verifying quality control aspects of the contractor's performance. OIG staff recommended that backup centers and the VCL have the same standards for call queuing and wait time to ensure that callers receive the same level of service regardless of where the call was routed. OIG staff also recommended that the VCL implement the quality assurance surveillance plan and conduct ongoing oversight to ensure contractor accountability. VCL leaders implemented action plans for improvement, and the OIG recommendations were closed between November 2017 and March 2018.

During the current review, OIG staff found that VCL leaders replaced the COR following the March 2017 report. The new COR demonstrated understanding and ongoing oversight of the backup center's performance as defined by the quality assurance surveillance plan. The COR's ongoing communication with the contractor and VCL leaders, awareness of issues impacting performance, and authorization of plans to improve backup center performance when indicated were evidenced in monthly meeting minutes. The COR described routinely reviewing the contractor's required documentation, performing on-site contractor visits, and planning future modifications to the contract as necessary.

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[18] A servant-leader focuses primarily on the growth and well-being of people and the communities to which they belong. While traditional leadership generally involves the accumulation and exercise of power by one at the "top of the pyramid," servant leadership is different. The servant-leader shares power, puts the needs of others first, and helps people develop and perform as highly as possible. https://www.greenleaf.org/what-is-servant-leadership/. (The website was accessed on January 24, 2019.)

The VCL demonstrated implementation of quality controls and the same standards for the backup center resulting in improved oversight of performance. The VCL awarded a revised contract for backup center services on July 1, 2017, decreased backup center operations from four centers to a single backup center, and detailed a quality assurance plan with performance metrics matching VCL's targets.

In October 2017, the VCL implemented a new system for call handling that decreased rollover and reliance on the backup center. This system routed each call to the VCL responder available for the longest duration, regardless of VCL location, thus utilizing staff across the three VCL call centers in a more efficient way. The VCL intentionally routes a portion of incoming calls to the backup center, called "purposeful rollovers," to maintain training and performance opportunities required by the quality assurance surveillance plan.[19] The purposeful rollovers are not included in the VCL's performance data nor rollover rate. The VCL also hired additional staff and developed a process to forecast staffing needs which tracked staff availability by the hour, further contributing to the decrease in VCL rollover calls.

VCL performance data for fiscal year 2018 indicated that the VCL answered nearly 630,000 calls with an average time to answer of 8 seconds, a rollover rate of under 0.2 percent of calls, and with less than 3 percent of calls abandoned. (See appendix B.)

OIG staff determined that the VCL COR sustained actions leading to improved oversight and communication regarding the quality assurance surveillance plan and backup center performance, and the OIG made no additional recommendations in this area.

Atlanta Call Center

During the March 2017 review, OIG staff found that the VCL had expanded to a second site in Atlanta as a component of a long-term plan to ensure geographic redundancy and expanded capacity. The VCL's ultimate goal was to achieve zero rollover calls to the contracted backup centers. OIG staff found that a number of VCL staff considered the timeline for launching the Atlanta Call Center, a period of just over five months, to be overly ambitious. The VCL had not met its initial or revised deadlines to reach full telephonic operations at the Atlanta Call Center by the conclusion of the March 2017 review.

OIG staff found during the March 2017 review that on-site leadership had not been established at the Atlanta Call Center by VHA Member Services, nor had VHA Member Services developed or implemented a formal business plan for accomplishing project goals. At the time of the March 2017 review, VCL staff indicated that they had warned VHA Member Services about anticipated challenges that could hinder operational targets, including inadequate staffing and training resources, but their advice was not used to guide VHA Member Services'

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[19] The VCL contracted with the backup center to ensure they received 1,200 calls per month from 11:00 a.m.–7:00 p.m. EST, seven days a week, for proficiency with VCL training and quality assurance standards.

decision-making related to the Atlanta stand-up. OIG staff found that the inadequate planning led to a significant number of existing employees being reassigned from the Canandaigua location to the Atlanta Call Center to fill in training and operations gaps. As a result, during this period of reorganization and staff diversion, OIG staff found that the number of rollover calls to the backup centers significantly increased and that these changes effected delays in the development and roll-out of VCL processes, policies, and procedures.

During the current review, OIG staff found that as of November 2018, of the three VCL locations, the Atlanta Call Center had the highest percentage of responder positions occupied, with 267.5 out of 280 (96 percent) full-time employee equivalent positions filled. The VCL's Canandaigua location had 201 out of 257 (78 percent) full-time employee equivalent positions filled, and Topeka had 60 out of 85 (71 percent), with both engaged in hiring efforts. OIG staff found that newly hired staff at the Atlanta Call Center participated in the standardized VCL new employee orientation program, with classroom training for four weeks and a preceptorship component lasting one to three weeks. The VCL tracked and compared training efficacy by site, measured by pre- and post-training outcomes. Silent monitoring for responders had been implemented at all three sites, and inter-site data analysis was performed by the Quality, Safety, and Value Board and presented to the executive leadership committee on a monthly basis.[20] OIG staff found that the VCL was capable of comparing other metrics between sites as well, such as responder productivity. During the current review, OIG staff found that the VCL had adjusted its call routing procedures to direct callers to the responder with the longest availability, regardless of responder's site location, thus decreasing its answer time and abandonment rate. As a result, abandonment and rollover data were not separated by site, but instead analyzed as a combined VCL statistic.

Since the March 2017 review, the VCL established an on-site leadership role at the Atlanta Call Center through its assistant deputy director for team operations, who received support from Team Operations Coordinators. The assistant deputy director for team operations position was filled in February 2017. However, during the current review, the position became vacant. VCL leaders indicated that a selection to fill the position had not been made as of February 2019. VCL leaders reported supporting the Atlanta Call Center staff in the interim by having the Canandaigua assistant deputy director for team operations provide both remote and in-person coverage at Atlanta. Other VCL leaders, including the director and chief of staff, provided supplemental leadership support by participating in on-site visits to Atlanta. OIG staff observed VCL leaders from Canandaigua on-site during their Atlanta site visit in December 2018.

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[20] Silent monitoring is a quality assurance tool used by the VCL. During silent monitoring, quality management staff listen to and/or observe a responder's activities when engaging with a caller or an SSA's activities when conducting a rescue. The quality management staff then provide feedback to the responder or SSA on areas of strength and areas for improvement.

The VCL previously set a goal of having all call, text, and chat services operational at the Atlanta Call Center by July 2017. As of December 2018, text and chat services remained operational only at the Canandaigua Call Center. VCL staff indicated that while Canandaigua had adequately managed these modes of contact, the VCL maintained its plan to implement text services at the Atlanta Call Center. Despite the sustained operations at the Atlanta Call Center and the addition of the Topeka Call Center, the VCL had not reached its continued target of zero rollover calls to its backup center by the current review. It had, however, significantly reduced its rollover rate to 1–2 percent. During interviews, VCL staff characterized the zero rollover target as an aspirational goal, with a plan to maintain a contract with a backup center for emergencies and technological issues that may require additional support.

OIG staff found during the current review that both Canandaigua and Atlanta Call Centers had received accreditation from the American Association of Suicidology.[21] The American Association of Suicidology requires that a crisis center is operational for at least six months before seeking accreditation. VCL staff reported a plan to pursue accreditation for the Topeka Call Center in the future. OIG staff also found that the VCL developed a wellness program for all three sites, which included an employee recognition program, peer support groups, and wellness coaches.

Topeka Call Center

To support the implementation of the Press 7 Initiative and to meet anticipated increases in incoming calls, the VCL opened a third VCL call center in Topeka, Kansas, with an official ribbon-cutting ceremony held on May 25, 2018. As of November 2018, the Topeka Call Center filled 77 of the 115 authorized positions. The filled positions included 60 responders, seven SSAs, and 10 supervisory and ancillary staff. A remodel of the existing call center space intended to accommodate additional staff was in progress with a planned completion date of 2020.

During interviews, staff at the Topeka location expressed that they felt adequately trained prior to performing their duties. In addition, they stated that support was readily available when needed and generally reported a cohesive team environment.

OIG staff found that previous concerns related to operations remained resolved at the time of the current review and made no additional recommendations in this area.

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[21] The American Association of Suicidology accreditation process strives to recognize exemplary crisis programs, and to help other programs refine their services according to these standards. The American Association of Suicidology Accreditation Surveyor's role is both to evaluate and to assist the applying organization in reaching their highest potential according to these standards. This is one aspect of an ongoing collegial relationship with American Association of Suicidology.
http://www.suicidology.org/Portals/14/docs/Training/CrisisCenters%26Workers/Accreditation%20Manual%20and%20Application%2013th%20Edition%20January%202019.pdf. (The website was accessed on February 4, 2019.)

3. VCL Quality Management

In the March 2017 report, OIG staff made recommendations regarding the training of quality management staff, oversight of clinical quality performance measures, and analysis of caller's adverse outcomes. Additionally, recommendations encompassed identification of systems issues present in quality monitoring of responders, SSA training, the supervisory approval process for SSAs to work independently, and development and distribution of new or updated policies.

Quality Management Program Leadership and Performance Monitoring

VCL quality management staff had received training from leaders in VHA Office of Quality, Safety, and Value by November 2017. VCL quality management reports submitted to the executive leadership committee showed sustained improvements in structured oversight of quality management processes. Quality management reports submitted to the executive leadership committee included tracking and trending of VCL quality indicators and analysis of adverse caller outcomes through issue briefs and root cause analyses. Quality data from the Atlanta and Canandaigua Call Centers were analyzed separately.

By the time of the March 2017 report, VCL quality management leaders had established a process called silent monitoring for evaluating a responder's interactions with veterans on incoming VCL calls and coaching responders on areas of strength and areas for improvement. In response to OIG recommendations, VCL quality management leaders made refinements in its monitoring processes to include call recording and monitoring of SSAs. Listening to recorded calls removed limits on real-time monitoring of calls and provided for (1) targeted review of core calls and (2) complaint resolution independent of subjective reports by VCL staff or callers. Implementation of the automated call handling system provided for incoming phone numbers to be automatically transcribed into the VCL's call documentation, reducing the potential for error in documenting a caller's phone number—important if contact with a caller would need to be re-established.

Silent monitoring of SSAs was piloted in early 2018, and VCL quality management leaders identified systems issues with the piloted process. It was necessary for SSAs to notify quality management silent monitor staff when they initiated rescue efforts and thus the monitoring was not "silent" to SSAs. Further, VCL leaders needed time to negotiate the new monitoring process with the American Federation of Government Employees.[22] The pilot was suspended, and after a period of American Federation of Government Employees review, VCL quality management initiated silent monitoring of SSAs in February 2019.

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[22] The American Federation of Government Employees is the largest federal employee union representing 700,000 federal and Washington D.C. government workers nationwide and overseas. https://www.afge.org/about-us/. (The website was accessed on March 4, 2019.)

In conclusion, OIG staff determined that quality management program leaders sustained improvements resulting from actions taken to close recommendations from the March 2017 report and made no additional recommendations in this area.

SSA Training

In regard to previous recommendations for SSA training, OIG staff focused on an algorithm for rescue attempts; SSA training processes with concurrent and subsequent supervision (whether SSAs were trained by experienced SSAs, whether SSAs received supervisory approval before independent work, whether supervisors were available to SSAs during rescue efforts); and on VCL provided rescue resources for SSAs.

Algorithm

OIG staff reviewed the training and education materials developed for SSAs. SSA-specific items included the training handbook, workbook, listed responsibilities, and specific algorithms to support rescues. The materials provided to SSAs also included an integrated SSA and responder rescue algorithm.

Training and Supervision

OIG staff interviewed 16 SSAs to obtain their views on SSA education, shift supervision by non-SSAs, and the adequacy of resources for rescues. The SSAs commented that the initial part of their training was responder-focused, although following classroom instruction, the SSAs separated from the responders and trained with experienced SSA preceptors. OIG staff determined that SSA preceptors, who were experienced SSAs with additional qualifications and testing, trained supervisors who approved new SSAs, and that supervisors approved SSAs to work independently before new SSAs initiated rescue efforts without oversight by a preceptor. SSAs indicated that supervisors were previous responders and did not have SSA experience. VCL business operations leaders had a plan in place for adding organizational SSA leadership roles to enhance supervisory knowledge of the SSA role.

Rescue Resources

SSAs use online search resources that the VCL provides on a SharePoint site during attempts to find a caller's location.[23] SSAs described the resources the VCL provides as being no-cost and publicly available (not a subscription service).

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[23] Resources are search engines that SSAs use in identification of a caller's location for emergency dispatch of rescue efforts.

VCL staff reported conducting an average of 2,563 rescues each month from October 2017 through March 2018 (totals by month are shown in table 3).

Table 3. VCL Monthly Emergency Dispatches

Date	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018
Emergency Dispatches	2,564	2,627	2,561	2,693	2,284	2,651

Source: VCL number of rescues initiated from October 1, 2017, through March 30, 2018

SSAs demonstrated the resource page where they searched for patient information when conducting rescues. They noted that search resources and flow charts (algorithms) were provided to perform rescues. Occasionally, some links to online search resources either did not work or required payment to access. SSAs described instances when individual public-access search engines limited the number of free searches allowed before requiring a subscription prior to additional use. With the large volume of searches conducted by VCL SSAs, the number of free searches was frequently exceeded, and SSAs were restricted from using the resource. SSAs also did not know if there was a standard way to suggest a new resource to VCL leaders. When an SSA suggested a possible resource, feedback was not given on why it was rejected for use. SSAs interviewed noted that limited or no retraining/continuous education was available. VCL staff indicated that rescue efforts that were ended because the caller's location could not be found were not tracked, which could have identified deficiencies related to the rescue process. The OIG made one recommendation related to this area.

In conclusion, OIG staff determined that the VCL provided SSA-specific training, algorithms, and resources to help support rescues. However, OIG staff cannot comment on the qualitative aspects of SSA education. There are differences between the training needs of SSAs, who offer support with rescues when there is imminent danger, and those of responders, who actively engage with the person who has contacted the VCL. The proficiencies required of SSAs, particularly being able to obtain data about a person's location, may be difficult to replicate in a classroom or in new employee training. To that end, SSA resources need to be up to date and efficient with minimal barriers. OIG staff found that SSA resources could be outdated, there was not a well-defined process for suggesting or adding a new resource, and often there was no feedback on why a proposed resource was rejected.

OIG staff found that generally SSAs felt that responder training was a higher priority and that SSAs were not provided continuing education specific to SSA duties. Because SSAs' workflow and efficiency depended on experience, knowledge of up-to-date resources, and technical expertise; the ongoing education of SSAs may provide enhanced benefits to the VCL's rescue efforts that is equivalent in value to the VCL's established responder education and retraining.

OIG staff identified that shift supervisors are responsible for ending rescue efforts when the caller's location cannot be found, and that supervisors generally have experience as responders. OIG staff could not assess the extent to which supervisors having SSA training or backgrounds resulted in more successful rescue efforts (when the caller's location is found). OIG staff do note the importance of every team member participating in a potential rescue for a caller and providing the highest level of training and education to each team member increases the potential for a successful rescue effort.

Policy Development and Distribution

The VCL expanded its business operations arm to include staff in a knowledge management section and a policy workgroup and established new processes for VCL policy development. Leaders in these groups described continuing efforts to refine VCL processes for policy development and dissemination of new or updated policies to VCL staff and provided a decision-making tool they used for prioritizing new or updated policies. [24]

Specifically, VCL policy leaders described plans to formalize and implement a new process for SSAs to suggest search engine resources that would then be reviewed and approved, with the approval process communicated to staff on a VCL SharePoint site for transparency. The process was written into VCL policy, approved by the VCL director in early February 2019, and implemented March 17, 2019.

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[24] The VCL knowledge management section is responsible for formatting policies and collaborating with experts on internal VCL procedures and policies.

Conclusion

The OIG made no recommendations related to VCL governance and oversight. Previous concerns related to governance and oversight remained resolved. The VCL was realigned under OMHSP, which provided increased clinical guidance. The VCL maintained an executive leadership committee charter and held regular executive leadership committee meetings, in which VCL performance data was analyzed. The VCL hired a permanent director and operated under a directive that delineated clinical and administrative decision-making responsibilities.

OIG staff made no recommendations related to VCL operations. The VCL had sustained actions to resolve previous OIG concerns related to operations, regarding both oversight of the contract backup center and expansion of the VCL through its Atlanta and Topeka Call Center locations. OIG staff determined that the VCL COR maintained improved oversight of and communication with the backup center regarding the quality assurance surveillance plan and backup center performance. The VCL improved responder training processes at its Atlanta Call Center that were also implemented during the launch of the Topeka Call Center. The use of a new call routing process better utilized staff at all three sites and reduced rollover calls to the backup center.

OIG staff made one recommendation related to quality management, as the VCL needs to address issues affecting caller location rescue efforts. Quality management had followed through on other planned actions from the March 2017 review. Program leaders received training in quality management principles, and enhanced quality management staffing had a positive impact on quality management processes. Additionally, the VCL had action plans in place for expansion of SSA roles.

Recommendation

1. The Veterans Crisis Line director ensures analysis of rescue efforts ending because the caller's location cannot be found, identifies and analyzes metrics that may have contributed to the inability to locate these rescues, and takes remedial action.

Appendix A: March 2017 Report Recommendations

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

Appendix B: Fiscal Year 2018 VCL Call Handling Data

Table B.1. Fiscal Year 2018 VCL Call Handling Data

Metric	Year to Date Totals
Offered	648,721 calls
Answered	629,864 calls
Average speed of answer	8 seconds
Average handle time	33 minutes, 18 seconds
Rollover	0.172% of calls offered
Abandoned	2.72% of calls offered
Press 7	95,579 calls

Source: VCL Fiscal Year 2018 Health Operations Center Report

Definitions

Offered

All individual inbound attempts in to the VCL Avaya Telephony system. Total calls excluding calls that abandon in less than or equal to 5 seconds. Calls that are presented to one call center then to the next due to being unanswered or busy tone are counted as a single call.

Answered

All individual inbound attempts that are answered by a VCL responder.

Average Speed of Answer

Average time that a call is answered by the VCL. (Sum of all ringing time / Calls Answered).

Average Handle Time

Average time spent talking with caller and documentation after call is complete.

Rollover Percent

Total Rollover (Calls that are presented to both facilities before being unanswered for thirty (30) seconds or receive a busy tone at the second facility) / Calls Offered.

Abandoned Percent

Calls Abandoned (Greater than 5 Seconds) / Calls Offered.

Press 7

Volume of calls that are routed to the VCL through the Press 7 feature at VA facilities.

Appendix C: Executive in Charge, Office of the Under Secretary for Health Comments

Department of Veterans Affairs Memorandum

Date: July 10, 2019

From: Executive in Charge, Office of the Under Secretary for Health (10)25

Subj: Office of Inspector General (OIG) Draft Report, Follow-Up Review of the Veterans Crisis Line: Canandaigua, New York; Atlanta, Georgia; and Topeka, Kansas (2018-03390-HI-0465) (VIEWS 01115505)

To: Assistant Inspector General for Healthcare Inspections (54)

Thank you for the opportunity to review the OIG draft report, Follow-Up Review of the Veterans Crisis Line: Canandaigua, New York; Atlanta, Georgia; and Topeka, Kansas.

The Veterans' Crisis Line (VCL) has made incredible strides since February 11, 2016. From 2016–2017, the OIG provided VCL with 23 recommendations which were closed as implemented in March 2018. During this time, VCL made the improvements in oversight, operations and quality management which are described in the attached General Comments.

The Veterans Health Administration (VHA) concurs with the summary language provided by OIG, however, non-concurs with the recommendation. VHA also provides the attached General and Technical comments for OIGs consideration.

Thank you for the opportunity to review the draft report. If you have any questions, please email Karen Rasmussen, M.D., Director, GAO OIG Accountability Liaison (GOAL) Office at VHA10EGGOALAction@va.gov.

(Original signed by:)

Richard A. Stone, M.D.

Executive in Charge, Office of the Under Secretary for Health

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[25] Recommendations directed to the Under Secretary for Health (USH) were submitted to the executive in charge who has the authority to perform the functions and duties of the USH.

Comments to OIG's Report

Recommendation

The Veterans Crisis Line Director ensures analysis of rescue efforts ending because the caller's location cannot be found, identifies and analyzes metrics that may have contributed to the inability to locate these rescues, and takes remedial action.

Non-concur.

Executive in Charge Comments

There is no industry standard for the data analysis being requested. The Veterans Crisis Line (VCL) already tracks the outcomes of rescue efforts. The VCL Director will implement a formal process-improvement project to demonstrate all VA-available resources have been utilized (to include national medical record and VCL documentation system) and conveyed to local emergency dispatch centers in support of locating persons at risk of imminent harm to self or others but who do not provide location information sufficient for immediate dispatch of services to their location. Given there is no national standard in this regard, VCL will share this information with the National Suicide Prevention Lifeline network as an opportunity for further discussion within the industry.

OIG Comment

The executive in charge did not concur with the recommendation based on the absence of a current industry standard; however, VHA's planned actions are consistent with the intent of the recommendation.[26] The OIG supports the proposed actions, particularly the sharing of information with the National Suicide Prevention Lifeline to promote changes on the national level that will improve life-saving efforts. The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

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[26] The OIG directed the recommendation to the VCL director; the executive in charge responded.

OIG Contact and Staff Acknowledgments

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