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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Veterans Crisis Line Challenges, Contingency Plans, and Successes During the COVID-19 Pandemic

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Executive Summary

The Office of Inspector General (OIG) is conducting a series of reviews focusing on the Veterans Health Administration's (VHA) management of key clinical areas during the COVID-19 pandemic that are crucial to the well-being of veterans.[1] This review focused on select Veterans Crisis Line (VCL) operations ranging from contingency planning to quality metrics and lessons learned.

The VCL is organizationally aligned under the VHA Office of Mental Health and Suicide Prevention and operates 24 hours per day and 7 days per week, with call centers in Canandaigua, New York; Atlanta, Georgia; and Topeka, Kansas. Callers can access VCL by telephone, chat, or text through either the Suicide Prevention Lifeline (Lifeline: 1-800-273-TALK) and pressing 1 or when calling any VA medical facility, VA outpatient clinic, or community-based outpatient clinic by pressing 7. For veterans at risk of self-directed violence, VCL staff submit a consult to the suicide prevention coordinator (SPC) at a VA medical facility, and the SPC is responsible for ensuring the veteran receives evaluation and treatment from appropriate VA or other services.

As COVID-19 evolved, many Americans, including veterans, experienced a range of negative effects from fear and social isolation to unemployment and financial insolvency. Because of these and other stressors associated with the pandemic, an increase in the volume of incoming VCL calls, chats, and texts was expected. From January 1, 2020, to May 31, 2020, VCL handled an average of nearly 52,500 calls per month. In March, VCL reached its peak for the five-month period, handling 56,386 calls.[2] Also, during the same period, an average of 6,652 chats were handled, with a high of 6,923 chats in March; and an average of 2,924 texts were handled. During the first five months of 2020, the increased demand was transitory, with a slowing of demand to pre-COVID-19 volume as of late May 2020.

Given the possibility that COVID-19 could overwhelm existing VCL resources, the pandemic presented a real-time test of VHA's capacity to ensure that VCL's mission—"to provide veterans, service members, and their family members, who are in crisis or at risk for suicide,

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[1] World Health Organization. https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020. (The website was accessed on May 13, 2020.) Merriam Webster, *Definition of pandemic*. A pandemic is a disease outbreak over a wide geographic area that affects most of the population. https:/www.merriam-webster.com/dictionary/pandemic. (The website was accessed on May 13, 2020.) COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), a newly discovered coronavirus. The World Health Organization, *Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It.* https://www.who.int/emergencies/diseases/novelcoronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(COVID-19-2019)-and-the-virus-that-causesit. (The website was accessed on May 13, 2020.)

[2] For several days in April 2020, VCL calls were intentionally routed to the backup call center to allow for a transition to a telework-based VCL workforce. The backup call center handled 4,672 calls in April 2020—almost 2,000 more than in March 2020.

with immediate access to suicide prevention and crisis intervention services"—was met.[3] In addition to remote interviews and document reviews, the OIG surveyed 820 VCL employees as well as SPCs and case managers regarding their experiences and perceptions about support and resources needed to perform their duties, among other issues, during the pandemic.

The VCL call centers were not conducive to staff health and safety during the pandemic because staff generally worked in close proximity to one another and shared cubicles, computers, and telephones. Telework-based operations, however, had previously been considered "too much of a risk," primarily due to concerns about the quality and dependability of employees' residential internet connections and the potential for poor call quality and lost calls. Nevertheless, VCL leaders started planning for a phased telework deployment, and as the pandemic spread quickly in the United States, the VHA Office of Mental Health and Suicide Prevention leaders directed the rapid deployment of telework for VCL staff on March 21, 2020. At this point, VCL leaders' primary challenge was to transition nearly 800 VCL workers to telework-based operations as quickly as possible, while also ensuring that functional equipment, staff training, and supervision and oversight were in place.

The VA Office of Information and Technology (OIT) coordinated the acquisition of 300 computers (including a keyboard and mouse for each computer), 600 monitors, and 300 iPhones with licenses. Regional OIT staff formatted and installed the related software and ensured that VCL employees had the necessary tools to perform their duties prior to being sent home to telework. By the last week of April 2020, all 738 of VCL call center employees who wanted to telework were teleworking. VCL survey respondents who teleworked overwhelmingly reported having the necessary equipment and technical support to enable them to perform their duties at their telework location. The OIG found that to ensure continued operations, OIT prioritized VCL's equipment and other needs to rapidly deploy staff to telework.

To support the VCL mission, and in the context of telework uncertainties, VCL leaders developed a comprehensive "extreme scenarios" strategic and contingency plan that broadly included telework planning, standard operating procedure changes, call center management, and technical and clinical partner engagement. The OIG found that the VCL provided employees with training, guidance, and resources related to telework, new VCL processes, and COVID-19-specific concerns. Because the transition to telework took time to organize and was conducted in phases, some VCL staff remained in the call centers until telework was fully accomplished for those who desired it. To promote staff safety, VCL leaders and call center managers implemented a screening process and plans for telework, supplies, personal protective equipment (PPE), and cleaning. However, VCL survey respondents had mixed opinions about VCL leaders' responsiveness to the emerging pandemic, with slightly less than half stating that VCL leadership was prepared for and responded timely to the evolving COVID-19 pandemic. Multiple

[3] VHA Directive 1503, Operations of the Veterans Crisis Line Center, May 31, 2017.

respondents documented concerns such as lack of social distancing, training, and protection for high-risk employees.

According to VCL leaders, the VCL program did not need to hire additional staff to meet increased call, chat, and text demand due to COVID-19, although contingency plans were developed should call demand exceed capacity. Leaders reported that the shift to telework-based operations increased capacity to respond to incoming contacts because of a decrease in employees requesting unplanned leave, and demand did not exceed VCL resources.

As noted above, because the transition to telework took time to organize and was conducted in phases, some VCL staff remained in the call centers until telework was fully accomplished for those who desired it. To promote staff safety, VCL leaders devised seating charts, inventoried supplies and PPE on hand and placed orders as needed, and provided housekeeping schedules and workstation sanitization schedules for each call center site. Eighty-two percent (46 of 56) of respondents who said they worked in a call center reported they were able to maintain social distancing while performing their duties, and 88 percent (49 of 56) reported that other COVID-19 precautions were in place at the call centers to maintain employee safety. VCL respondents who expressed dissatisfaction with call center safety, however, reported shortages in PPE and cleaning supplies while working from their respective call center, as well as delays in implementing social distancing.

From January 1 to May 31, 2020, as the pandemic was evolving and the VCL was transitioning to telework-based operations, the VCL continued to meet performance targets for key indicators including the speed of answer for calls, chats, and texts; the rate of abandonment; and the levels of silent monitoring and caller satisfaction. In addition, the rate of VCL referrals to SPCs remained consistent, and a majority of SPCs reported that being able to monitor high-risk cases was better or about the same as before the pandemic. The OIG did not identify, nor was the OIG told about, veteran care being negatively affected during VCL's move to telework.

While not part of this review, some VCL survey respondents and interviewees reported that increased stress dealing with COVID-19 in their personal lives, coupled with the intensity of the crisis work, was overwhelming. Emotional support services that were available at the call centers, such as relaxation and wellness areas, and in-person team support, were less available due to telework, which affected employee wellness.

When asked about lessons learned, the overarching theme of VCL leaders' responses was that the VCL needs to keep current with best practices in emergency preparedness and technology to achieve its mission and meet public expectations for crisis line care. VCL leaders also identified several infrastructure-related challenges including VCL data and communication systems that were not fully automated or integrated, some technology and equipment that was outdated, and network limitations and system errors that presented operational risks. Because the VCL did not have dedicated information technology personnel, the VCL used contracts for some technology-related work, which was described as cumbersome. Lack of VCL-dedicated information

technology staff also meant that the VCL had to coordinate equipment and services through regional OIT departments and, when having a system problem, VCL staff had to contact a VA service desk specialist who likely did not have knowledge of VCL systems and technology. These challenges made their experience responding to COVID-19 more difficult, and moving forward, the VCL could benefit from a broader and more agile technology and equipment plan, its own cadre of information technology staff, and managing its own contracts.

Lessons learned also included the need for additional support staff, better succession planning with overlap for key positions, and maintaining an inventory of items such as headsets, keyboards, and cell phones. VCL survey respondents had suggestions for improving future emergency response processes, a majority of which involved better planning and being more proactive, better communication and transparency, and more and better equipment or supplies.

Overall, VCL leaders repeatedly expressed that although initially reluctant, the transition to telework had improved staff morale and decreased unplanned leave usage, as well as positioned the VCL to recruit additional staff and enhance future services operations. The OIG was impressed with VCL leaders' and employees' efforts to promote employee health safety and ensure that the VCL met its mission to provide immediate access to crisis intervention services during the COVID-19 pandemic.

The OIG did not make any recommendations.

Comments

VHA acknowledged receipt of the report and provided technical comments.

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Contents

Abbreviations

CDC	Centers for Disease Control and Prevention
COVID-19	coronavirus disease 2019
EHR	electronic health record
OIG	Office of Inspector General
OIT	VA Office of Information and Technology
OMHSP	VHA Office of Mental Health and Suicide Prevention
PPE	personal protective equipment
RONA	redirect on no answer
SOP	standard operating procedure
SPC	Suicide Prevention Coordinator
SSA	social service assistant
VCL	Veterans Crisis Line
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

Due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic on March 11, 2020, and called for countries to activate emergency response processes.[1] The Veterans Health Administration (VHA), the nation's largest integrated healthcare network, had already begun issuing guidance to Veterans Integrated Service Network (VISN) directors and other relevant leaders about actions needed to mitigate exposure to and transmission of COVID-19. On March 23, 2020, VHA published its *COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan* (Response Plan) outlining VHA's critical infrastructure and clinical operations during the pandemic.[2]

The Office of Inspector General (OIG) is conducting a series of reviews focusing on VHA's management of key clinical areas that are crucial to the well-being of veterans, particularly during the COVID-19 pandemic. This review focused on select Veterans Crisis Line (VCL) operations ranging from contingency planning to quality metrics and lessons learned.

Background

Due to the COVID-19 outbreak in the United States, the Centers for Disease Control and Prevention (CDC) recommended "social distancing" and issued guidelines to reduce the virus's spread in the business setting.[3] While this dramatic intervention was necessary from a public health standpoint, the "secondary consequences of social distancing," including financial stressors, social isolation, and medical concerns, may increase the risk for suicide.[4] On March 15, 2020, VHA's Deputy Under Secretary for Health for Operations and Management issued a memorandum to VISN directors and mental health liaisons that noted "social isolation is

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[1] The World Health Organization, *Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It.* https://www.who.int/emergencies/diseases/novelcoronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(COVID-19-2019)-and-the-virus-that-causesit. (The website was accessed on May 13, 2020.)World Health Organization. https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020. (The website was accessed on May 13, 2020.) Merriam Webster, *Definition of pandemic*. A pandemic is a disease outbreak over a wide geographic area that affects most of the population. https:/www.merriam-webster.com/dictionary/pandemic. (The website was accessed on May 13, 2020.)

[2] Veterans Health Administration-Office of Emergency Management, COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan, Version 1.6, March 23, 2020.

[3] Centers for Disease Control and Prevention, *Social Distancing.* https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html. (The website was accessed May 7, 2020.) Social distancing is physical distancing from other people outside one's home.

[4] Reger, Mark A. PhD, Ian H. Stanley, MS, and Thomas E. Joiner, PhD. Viewpoint. "Suicide Mortality and Coronavirus Disease 2019—A Perfect Storm?" *Journal of the American Medical Association, Psychiatry*, published online April 10, 2020.

an appropriate infection control procedure, but it can have unintended negative effects on mental well-being." The memorandum further encouraged facilities to continue to provide "robust support for those who may be at risk of suicide or otherwise are vulnerable in their mental health."[5]

VCL

In 2017, veterans accounted for 6,139 suicide deaths nationwide, resulting in a rate of 27.7 suicides per 100,000 veterans.[6] Combating veteran suicide has been a longstanding priority of VHA, and the VCL plays a significant role in VHA's suicide prevention efforts.

VHA implemented the VCL program in July 2007 as a telephone suicide crisis hotline for veterans, families of veterans, and military personnel. Chat and text options were subsequently introduced. The VCL is organizationally aligned under the VHA Office of Mental Health and Suicide Prevention (OMHSP) and operates 24 hours per day, 7 days per week at call centers in Canandaigua, New York; Atlanta, Georgia; and Topeka, Kansas.

Veterans can contact the VCL through two methods. First, when a caller dials the National Suicide Prevention Lifeline (Lifeline: 1-800-273-TALK), the call is answered with a recorded greeting that instructs veterans to press 1 to reach the VCL. The Lifeline network is a hotline for those in emotional distress or suicidal crisis. In calling the Lifeline, individuals "in need of immediate assistance are connected to the nearest available crisis center within a national network of more than 160 crisis centers."[7] The VCL is a member of the Lifeline network.

The Press 7 Initiative is the second avenue through which veterans can reach the VCL. When calling any VA medical facility, VA outpatient clinic, or community-based outpatient clinic; veterans can press 7 and be connected to the VCL. The caller hears a pre-recorded quality assurance announcement while waiting for an available VCL responder who is usually a health

[5] VHA Deputy Under Secretary for Health for Operations and Management Memorandum, *Ensuring Continuity in Suicide Prevention While Managing COVID-19*, March 15, 2020.

[6] Department of Veterans Affairs, Office of Mental Health and Suicide Prevention, *2019 National Veteran Suicide Prevention Annual Report*, https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf. (The website was accessed on May 4, 2020.)

[7] The Lifeline is funded through the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). National Suicide Prevention Lifeline SAMHSA Call Center Metrics Part 1: Service and Efficiency.

science specialist. If no VCL responders are available, the call is routed to a contracted backup call center.[8]

VCL responders interact with individuals contacting the VCL through calls, chats, and texts (crisis contacts).[9] Responders are trained to identify the caller's level of risk for harm, and when imminent, initiate dispatch of emergency services.[10] Social service assistant (SSA) responsibilities include conveying information to emergency rescue services to allow police dispatch to locate the caller, communicating with the responder and VCL supervisors, and obtaining assistance from emergency rescue services.

VCL staff are responsible for coordinating and tracking a caller's transport to the closest VA or civilian emergency department and for tracking the outcome and disposition of all contacts for whom emergency dispatch is requested.[11] For veterans at risk of self-directed violence, VCL staff submit a consult to the suicide prevention coordinator (SPC) at a VA medical facility nearest to the veteran's location of preference. The SPC is responsible for ensuring the veteran receives evaluation and treatment from appropriate VA or other services.

Prior OIG Reports

In a 2017 report, *Healthcare Inspection–Evaluation of the Veterans Health Administration Veterans Crisis Line*, the OIG identified concerns related to governance structure and oversight, procedural and clinical issues, and quality management. The OIG made 16 recommendations, all of which were closed as of March 28, 2018.[12]

In a 2019 report, *Follow-Up Review of the Veterans Crisis Line,* the OIG reviewed the three VCL sites for governance structure and oversight, operations, and quality management. The OIG made one recommendation related to analysis of rescue efforts that remained open as of July 21, 2020.[13]

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[8] VHA Directive 1503, *Operations of the Veterans Crisis Line*, May 31, 2017. The backup call center, located in Portland, Oregon, does not provide chat services. This directive was in effect at the time of the events discussed in this report and was rescinded and replaced by VHA Directive 1503, *Operations of the Veterans Crisis Line Center*, May 26, 2020. The two policies contain the same or similar language related to managing referrals (consults) from VCL responders to SPCs; however, the directive issued in 2020 expanded VCL staff responsibilities.

[9] VCL responders interact with individuals contacting the VCL through calls, chats, and texts. In this report, calls, chats, and text will be used interchangeably with the term crisis contacts. The Canandaigua call center provides call, chat, and text services. The Atlanta call center provides call and text services. The Topeka call center provides call services.

[10] VHA Directive 1503.

[11] VHA Directive 1503. Dispatch of emergency services "indicates that the caller or someone else was in imminent danger and unable to stay safe on their own, necessitating immediate intervention."

[12] VA OIG, Evaluation of the Veterans Health Administration Veterans Crisis Line, Report No. 16-03985-181, March 20, 2017.

[13] VA OIG, *Follow-Up Review of the Veterans Crisis Line,* Report No. 18-03390-178, July 31, 2019.

Why the OIG Did This Review

As COVID-19 evolved, many Americans, including veterans, experienced a range of negative effects from fear and social isolation to unemployment and financial insolvency. Because of these and other stressors associated with the pandemic, an increase in the volume of incoming VCL calls, chats, and texts was expected.

From January 1, 2020, to May 31, 2020, VCL handled an average of nearly 52,500 calls per month. In March, VCL reached its peak for the five-month period, handling 56,386 calls.[14] Also, during the same period, an average of 6,652 chats were handled, with a high of 6,923 chats in March; and an average of 2,924 texts were handled. During the first five months of 2020, the increased demand was transitory, with a slowing of demand to pre-COVID-19 volume as of late May 2020.

Given the possibility that COVID-19 could overwhelm existing VCL resources, the pandemic presented a real-time test of the VCL's adaptability and professional capacity to respond to challenges resulting from the rapidly evolving pandemic. This report focuses on the planning efforts and actions taken to ensure that the VCL's mission—"to provide veterans, service members, and their family members, who are in crisis or at risk for suicide, with immediate access to suicide prevention and crisis intervention services"—was met.[15] This report also summarizes observations and lessons learned from the perspectives of VCL leaders and staff.

Scope and Methodology

Due to COVID-19-related stay-at-home orders, the OIG conducted a remote review beginning on May 4, 2020. OIG staff reviewed relevant VHA and VCL standard operating procedures (SOPs), handbooks, and policies; VHA guidance on managing care amid COVID-19; VCL staffing and training data; the backup call center contract; and processes for and assignment of computer equipment to support VCL telework. The OIG team also reviewed VCL data from January 1 to May 31, 2019, and from January 1 to May 31, 2020, to understand changes in volume, timeliness, and quality-related performance.

The OIG team interviewed the OMHSP Executive Director, VHA's Director for Suicide Prevention, VCL Acting Director, VCL Suicide Prevention Clinical Officer, VCL Clinical Communications Outreach Specialist, VCL Director of Quality and Training, VCL Deputy Director, Quality and Training of Clinical Care, and other VCL staff knowledgeable about the areas under review. The OIG also interviewed backup call center leaders, the VA contracting

[14] For several days in April 2020, VCL calls were intentionally routed to the backup call center to allow for a transition to a telework-based VCL workforce. The backup call center handled 4,672 calls in April 2020—almost 2,000 more than in March 2020.

[15] VHA Directive 1503.

officer representative, and VA Office of Information and Technology (OIT) Operations and Services staff with relevant knowledge.

The OIG surveyed 820 VCL employees to determine their perceptions about leadership's response to the pandemic, the provision of computer equipment and training for telework-based operations, and the quality of VCL services during the transition, among other areas. The OIG received 222 responses (27 percent).[16] When calculating the percentage of agreement or disagreement with a question, the OIG removed from the denominator responses marked as "not applicable" or that were left blank.

The OIG also surveyed 335 facility SPCs and case managers, of whom 258 responded (77 percent), to determine their perceptions as to whether they had the time and resources to assure that high-risk patients received appropriate monitoring and services during the pandemic, among other issues.

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).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, § 7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leadership, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

[16] The breakdown of responses by location included 105 from Canandaigua, 86 from Atlanta, 26 from Topeka, and five from Other, such as virtual employees.

Review Results

VCL leaders and staff told the OIG that, during the pandemic, VCL staff were uniformly committed to the overarching goal of ensuring that VCL operations continued and that quality and timeliness were maintained. To do this, the VCL workforce needed to stay healthy and work from a safe environment that minimized the risk of COVID-19 exposure and transmission. However, one of the VCL's long-established operational tenets—that staff working from communal call centers delivered the most effective and reliable crisis hotline services—presented a challenge relative to staff safety.

Historically, VCL employees reported in-person to call centers located in Canandaigua, New York; Atlanta, Georgia; or Topeka, Kansas. The physical layout of the call centers was generally an "open concept" in a large shared space, and was similar to other call centers, including the backup center. The call centers, however, were not safe environments during the pandemic because staff generally worked in close proximity to one another and shared cubicles, computers, and telephones. Further, VCL leaders told the OIG that in the past, telework-based operations were considered "too much of a risk," primarily due to the potential for poor connectivity and lost calls, and that telework for clinical operations staff (VCL responders and other non-administrative staff) had not been a priority consideration before COVID-19.[17]

Therefore, VCL leaders' primary challenge was to transition nearly 800 VCL workers to telework-based operations as quickly as possible, while also assuring that computer equipment and cell phones were functional, staff were trained on telework requirements and protocols, and processes for ongoing supervision and oversight were in place. To further shape this challenge, VCL leaders needed to coordinate across VA programs and offices, such as OIT, in a large bureaucracy not typically known for its agility.[18]

1. Telework Timeline and Contingency Development

When the COVID-19 risk became apparent, VCL leaders took prompt and appropriate actions to promote staff safety and ensure continued quality operations.

As the COVID-19 outbreak continued to unfold, public health officials were simultaneously learning about the virus and its transmission and revising community health recommendations, such as social distancing and limited group gatherings, based on the most current information available. When VCL began preparations for telework in late February and early March, CDC

[17] Leaders reported that they had previously discussed testing telework to be able to expand operations for the 988 initiative, a national three-digit crisis line number. According to one VCL leader, implementation of the 988 initiative was expected within two years.

[18] In addition to providing information technology support to VHA, OI&T also supports the Veterans Benefits Administration and the National Cemetery Administration.

guidance on managing community spread was not definitive, varying by location and circumstance. On March 3, 2020, the Office of Personnel Management provided preliminary guidance to federal agencies to "prepare the Federal workforce for the potential impacts of [COVID-19]." The guidance stated that agencies should review their continuity of operations plans to ensure that as many employees as possible had been identified as telework employees and were "telework ready." On March 23, 2020, VHA published its COVID-19 Response Plan which outlined several provisions "to protect healthcare personnel during an infectious disease outbreak/epidemic/pandemic." One such provision was to provide telework options for employees when the work could be accomplished via telework.

Given these circumstances, the OIG found that VCL leaders' efforts to implement telework for VCL clinical operations staff corresponded to the Office of Personnel Management's guidance and VHA's COVID-19 Response Plan. Table 1 includes the timing of key VCL telework-related decisions and actions as reported by VCL leaders.

Table 1. Summary of the VCL Telework Deployment Timeline

Week(s) of 2020	Event or Activity
March 1	VCL leaders began initial discussion of equipment needs for VCL telework.
March 8	Over 100 VCL support staff members began teleworking.
March 15	VCL leaders began meeting daily to track COVID-19-related issues such as levels of disinfecting supplies, screening for symptoms, and physical distancing at the three call centers. On March 21, a director within OMHSP sent an email to VCL leaders directing the rapid deployment of telework for VCL staff. A goal to have 50 percent of VCL staff teleworking by April 15 and 100 percent teleworking by May 1 was established. VCL leaders also developed a risk-benefit analysis regarding conversion to telework operations.
March 22	VCL staff began drafting telework SOPs and developing extensive contingency plans. On March 23, OMHSP leaders consulted with and received information from the National Center for Ethics in Healthcare regarding ethical considerations during pandemics.
March 29	One of the call center's employees informed VCL leaders of testing positive for COVID-19, prompting the need for immediate deployment of VCL staff to telework at that call center. An equipment and readiness tracker was developed.
April 5	The first VCL clinical operations employees were deployed to telework, and a formal deployment plan across the three call centers was developed.
April 12 and April 19	The rapid deployment telework plan was fully implemented, in a phased approach, across the three call centers.
April 26	100 percent of VCL staff who elected to telework were teleworking (738 of 797).[19]

Source: OIG compilation and analysis of VCL documents.

The VCL's large-scale transition to telework-based operations over a six-week period, starting on March 21, 2020, presented many opportunities for process breakdowns to negatively affect

[19] Of the 797 VCL employees, 738 elected to telework.

veteran care. To mitigate this possibility, VCL developed a comprehensive "extreme scenarios" strategic and contingency plan incorporating five general objectives:

1. Telework planning that encompassed equipment, training, testing, telework-specific SOPs and quick reference guides, and telework-specific technology requirements
2. SOP changes that largely focused on enhancing call management efficiencies through appropriate triage and re-routing of non-emergent calls to other intervention options such as chat or text
3. Call center management that included ways for leaders and supervisors to support VCL staff, maintain morale, and promote staff safety at the call centers
4. Partner engagement–technical that generally covered COVID-19-related call management and transfer processes
5. Partner engagement–clinical that generally included alternate support options to manage incoming workload such as tele-mental health providers, local SPCs, and the VA Health Eligibility Center[20]

Each objective included from two to eight strategies and metrics with assigned responsibility, progress and completion dates, and status. A summary of the VCL's strategic and contingency plan is in appendix A.

VCL survey respondents had mixed opinions about VCL leaders' responsiveness to the emerging pandemic. Forty-eight percent (99 of 206) of VCL employees believed that VCL leadership was prepared for and responded timely to the evolving COVID-19 pandemic. One respondent documented, "As far as I know as soon as leadership was advised to have workers transition to work from home the process was started. I also noticed how [a call center] leadership team remained in the building while we were sent home." Fifty-two percent (107 of 206) of VCL employees believed that VCL leadership was not prepared for and did not respond timely to the evolving COVID-19 pandemic. Multiple respondents documented concerns such as lack of social distancing, training, and protection for high-risk employees.

Sixty-three percent (131 of 207) of VCL employees believed that VCL and VHA leadership provided adequate resources and instructions to address COVID-19-related concerns, while 37 percent (76 of 207) of respondents disagreed. Concerns about resource availability largely focused on cleaning supplies and personal protective equipment (PPE) in the call centers and equipment after telework deployment.[21]

[20] The Atlanta VCL occupies the fourth and fifth floor of the VA Health Eligibility Center in Atlanta, Georgia.

[21] PPE is equipment worn to reduce exposure to illnesses and injuries and includes items such as gloves, masks, and body suits. https://www.osha.gov/personal-protective-equipment. (The website was accessed on July 23, 2020.)

2. Response Plan Implementation

The VCL coordinated and simultaneously implemented complex action plans that resulted in the successful transition to telework-based operations.

VCL leaders' attention to several key strategic components supported the transition to telework operations. This section of the report discusses VCL staffing, training, and information technology supporting telework, as well as staff's health safety in the call centers.

Staffing

Considering the expected increase in VCL crisis contact volume, sufficient staffing to meet demand was critical to ensure continuous operations. VHA requirements state that the VCL Director is responsible for "maintaining appropriate staffing levels to achieve target service levels."[22]

Data provided by VCL leaders showed 789 employees across the Atlanta (386), Canandaigua (324), and Topeka (79) call center locations. Thirty-five responders and SSAs were new hires to the VCL from January 1, 2020, to April 30, 2020; however, VCL leaders reported that these were routine hires and not hired in response to the pandemic.

According to VCL leaders, the VCL program did not need to hire additional staff to meet increased call, chat, and text demand due to COVID-19, although contingency plans were developed should call demand exceed capacity. Examples of strategies included

1. Working with the Lifeline, American Association of Suicidology, and Crisis Text Line to publicize the need for private virtual volunteers to further augment crisis center staffing;[23]
2. Exploring the possibility that SPCs could manage incoming chats and texts; and
3. Providing refresher training to leaders, supervisors, and support staff, most of whom had been frontline responders early in their VCL careers, to manage incoming crisis contacts, if needed.

Leaders reported that the shift to telework-based operations increased VCL's capacity to respond to incoming contacts because of a decrease in unplanned staff leave. Specifically, in March and April 2019, prior to the pandemic, VCL data showed that staff utilized over 10,000 hours of unplanned leave each month. In March 2020, VCL staff utilized 10,800 unplanned leave hours, with about 2,800 of those hours occurring March 29–31, after a call center employee tested positive for COVID-19.[24] After the transition to telework began, unplanned leave usage for April

[22] VHA Directive 1503.

[23] The Crisis Text Line is a private company that provides free 24/7 text line services and answers texts from people in the United States who are in crisis.

[24] Calls that exceeded VCL resources during that timeframe were rolled over to the back-up call center.

was about 6,800 hours and in May was about 5,300 hours. The decrease in unplanned leave increased the availability of staff, and in turn, VCL's capacity to respond to incoming contacts.

According to VCL leaders, supervisors managed a small number of crisis contacts during the transition to telework, but demand did not exceed VCL resources, and the VCL did not need to employ strategies 1 and 2 above.

VCL Staff Training

VCL frontline staff are in the unique position of intervening with individuals at different points during a suicidal crisis, including the moments or hours before an individual plans to attempt suicide. Because of the sensitive nature of these interactions, staff must be knowledgeable about suicide interventions and rescues. The VCL provides new employee orientation in the three locations in multiple forms for responders and SSAs including three to four weeks of classroom instruction and evaluation of readiness to begin work, and one to three weeks of preceptor training and assessment of readiness for independent work.[25] In the context of an evolving pandemic and concerns about safety, additional training and guidance relative to telework and the resulting changes in some VCL processes were required.

The OIG reviewed training records for 35 responders and SSAs newly hired from January 1 to April 30, 2020, with most employees entering on duty after March 1 as VCL telework options were being explored. VCL leaders recognized that the traditional training and preceptor approaches required modification to promote employee safety and developed technical guidelines for in-person and virtual precepting. The methods outlined included use of Y cables between two headsets (to allow sharing of headsets), computer screen sharing, and Skype conversations. VCL leaders provided documentation that 23 of the 35 new hires were precepted and cleared to take calls independently as of July 21, 2020, while the remainder continued their training.

Depending on their call center sites, VCL employees the OIG interviewed had different experiences related to each call center-based precepting and social distancing. For example, one VCL responder trainee did not express concerns about the safety of the precepting arrangement and advised that social distancing and masks were enforced. A VCL employee at a different call center told the OIG that, initially, social distancing and masks for precepting were not being enforced, but remote precepting was allowed when responders began teleworking.

The OIG also found that VCL provided employees with training, guidance, and resources related to telework, new VCL processes, and COVID-19-specific concerns. Some examples included

[25] Veterans and Military Crisis Line Orientation and Employee Handbooks, Atlanta October 2018, Canandaigua April 2018, Topeka April 2018. Veterans Crisis Line Health Systems Specialist Training Participant Guide, June 2019. Veterans Crisis Line Social Service Assistant Training Participant Guide, July 2019. Responders must complete 11 training modules and SSAs must complete 9 training modules specific to their job responsibilities.

- Telework requirements and expectations, including a comprehensive array of HOW TO documents (such as using an Apple iPhone hotspot), contingency plans for technology-related breakdowns or outages, a telework training video, and a virtual supervision job aid;
- Contingency plans for virtual communications and documentation for facility transport plans and emergency dispatches;
- Resource sheets for responders including ways for veterans to communicate with their clinical team remotely, what to do if they had flu-like symptoms, how to get prescription refills, and how to access VA services during the shutdown;
- A COVID-19 Coach application for responders to download, focusing on coping and self-care; and
- Daily COVID-19 updates to all VCL staff via email.

The OIG surveyed all VCL employees regarding their perceptions about training and found

- Eighty-eight percent (180 of 204) of VCL respondents who teleworked reported receiving the necessary telework training to enable them to perform their duties from a telework location; and
- Seventy-eight percent (123 of 158) of VCL respondents who answered the question reported receiving training or special instructions on how to respond to VCL callers expressing COVID-19-related concerns.

In addition, VCL staff reported receiving information and training in multiple ways, including from their supervisors, through emails and protocols available on the VCL SharePoint site, and through other informal communications. During interviews, some responders asserted that certain aspects of training were not sufficient, and several reported that while they were given written information and instructions, they were left to "figure [it] out" from there.

Information Technology Equipment and the Transition to Telework

The OIG was told that, from an information technology standpoint, the move to telework for VCL clinical operations employees was considered a high-risk endeavor. To minimize the potential for service disruptions, the call centers used copper-wire T1 lines that carry large amounts of data quickly and reliably. During telework, however, VCL clinical operations employees would be largely reliant on the Wi-Fi networks in their homes.[26] Because commercial internet service and data capabilities vary by provider, location, and plan, VCL and information technology leaders were uncertain as to whether high quality and dependable crisis call

[26] VCL teleworkers were provided with instructions on setting up a hotspot on their government-issued iPhone if they were unable to connect to the VA internet.

management could be maintained. One VCL manager described "looking for the point in this pandemic where the risks of not acting outweighed the risks of what might happen" with telework-related information technology problems.

On March 21, 2020, an OMHSP leader directed that VCL staff should be rapidly deployed to telework. VCL and OIT then promptly assigned points of contact to coordinate activities and addressed several concerns that complicated the deployment.

Competition for Limited Information Technology Resources at a Time of High Demand

At each VCL call center, workspace and equipment was generally shared by call center employees in a 24-hour period. Each workspace included a desktop computer, monitor(s), computer mouse and keyboard, microphone headset, desktop telephone, and all the connecting cables. For transition to telework, each employee needed to be issued similar equipment to set up a home workspace, as well as an iPhone.

According to OIT staff, during the initial phases of the pandemic, VA was trying to shift as many employees to telework as possible. In this context, both information technology equipment and OIT staff to make it operational were in high demand. Each of the three VCL call centers was supported by a different OIT regional office, and as a result, VCL's transition to telework had to be coordinated with three OIT points of contact with various resources and other demands. According to a pre-existing arrangement, Canandaigua was selected as the distribution site for the information technology-related equipment for all VCL call centers. Once the computers were sent from Canandaigua to the receiving sites, regional OIT staff were responsible for labeling and entering each computer into the property management program, and formatting and installing the correct software. Further, regional OIT staff were responsible for ensuring that VCL employees were able to connect to the VA intranet site and access the programs needed to perform their duties. One VCL staff member told the OIG that it took four hours for OIT to troubleshoot a problem and connect the computer to the VA intranet.

Despite the multiple and time-consuming activities, by all accounts, OIT prioritized VCL's equipment and other needs to assure continued operations. One leader told the OIG, "Just the amount of equipment that was rushed to us, the IT [information technology] support that was necessary for that. It is unheard of, in my VA career that something so huge happened so quickly. It really took a village."

New Microsoft Windows 10 and an Application Software Incompatibility Issue

In the call center, prior to the pandemic, VCL staff were using computers with Microsoft Windows 7 installed. According to OIT staff, an application that automatically entered the

caller's telephone number into the documentation system used by VCL responders to document call center contacts was not compatible with Microsoft Windows 10, and the VCL had an exception that allowed the continued use of Microsoft Windows 7.[27] When the decision was made to transition to telework, some staff were assigned existing computers from the call center to use for teleworking and some were issued new computers. The new computers had Microsoft Windows 10 installed. VCL staff, who were assigned computers with Windows 10, were instructed to manually enter callers' telephone numbers into the VCL documentation system. Therefore, some VCL staff had the dual challenges of transitioning to telework and learning how to access the VA secure intranet, while also learning how to use Microsoft Windows 10 and manually documenting callers' numbers. Table 2 reflects a timeline of information technology-related activities from March 24 to April 28, 2020, that was central to VCL achieving a telework-based operation.

[27] Microsoft Windows 7 was no longer supported as of January 2020. VA's goal was to upgrade all appropriate systems to Windows 10 on or before January 2020.

Table 2. Summary of the VCL Equipment Acquisition and Deployment Timeline

2020 Date	Event or Activity
March 24	OIT was contacted to provide assistance with acquiring and deploying equipment for VCL employees to begin teleworking.
March 25	OIT and VCL leaders discussed plans to transition 50 percent of VCL staff to telework and the equipment that would be needed to accomplish the task by April 15, 2020. The initial timeframe for moving the other 50 percent of VCL staff to telework was set for October 2020. Equipment requested by VCL • 300 computers (including a keyboard and mouse), • 600 monitors, • 300 soft iPhone licenses, and • 300 iPhones.
March 30	OIT and VCL leaders met and OIT agreed to • Establish an urgent request through Telecom Business Office for 300 iPhones, • Provide the requested 600 monitors from current inventory, and • Divert 300 lifecycle refreshed computers to the Canandaigua VCL. The timeframe for the second shipment of VCL telework equipment shifted from October 1, 2020, to May 31, 2020. OIT initiated an equipment request for • 300 computers (including a keyboard and mouse) and • 600 monitors. A request was submitted to issue 100 computers to the Atlanta VCL for immediate telework deployment. An urgent request was submitted through the Telecom Business Office for an additional 300 iPhones.
April 1	300 computers arrived at the Canandaigua VCL.
April 2	OIT diverted 133 lifecycle refresh computers to the Atlanta VCL.
April 3	The Topeka VCL requested 40 computers, 80 monitors, and 90 iPhones.
April 8	OIT entered the Topeka VCL equipment request into the OIT intake portal and requested 700 iPhones.
April 15	VCL was asked to fully deploy to telework no later than April 20, 2020.
April 16	VCL leaders informed OIT that computers did not have microphone jacks and Atlanta VCL staff were not able to use their headsets. VCL requested laptop replacements be sent to Atlanta.
April 17	VCL leaders informed OIT of receiving 150 laptops and 160 monitors.
April 28	OIT created a report of equipment acquisition and deployment for the VCL telework initiative.
April 29	100 percent of VCL staff who elected to telework were teleworking.

Source: OIG compilation of interviews and VCL documents

Ninety-five percent (194 of 204) of VCL respondents who teleworked reported having the necessary equipment and technical support to enable them to perform their duties at their telework location.[28] Of the 10 respondents who reported not having the necessary equipment,

[28] Of the survey respondents, 75 percent (166 of 222) reported working at home or a telework location, 17 percent (38 of 222) reported working at both the call center and a telework location, and 8 percent (18 of 222) reported working at the VCL call center only.

seven cited poor audio quality or headset issues and three cited inadequate technical support during their shifts.

Staff Safety in the Call Centers

Because the transition to telework took time to organize and was conducted in phases, some VCL staff remained in the call centers until telework was fully accomplished for those who desired it. To promote staff safety, and in accordance with VHA's COVID-19 Response Plan, VCL leaders and call center managers were expected to implement precautionary measures to reduce staff's risk of exposure and transmission. In addition to VHA-wide screening for signs of respiratory illness and exposure to COVID-19 for all patients, visitors, and staff entering VHA buildings, the VCL

- Devised a telework deployment plan for each call center based on a survey sent to call center staff regarding telework, the presence of high-risk medical issues, and whether they would volunteer to be in the office, if needed;
- Inventoried supplies and PPE on hand at each of the call centers and, in coordination with the Assistant Deputy Director for Resource Management, placed supply orders. In some cases, excess supplies at one site were shipped to another VCL site; and
- Provided an Environmental Management Service housekeeping schedule and workstation sanitization schedule for each call center site.

While efforts were made to social distance at each call center site, VCL staff from the three sites reported that overlapping shifts and precepting of new employees sometimes made this difficult.

Canandaigua

The Canandaigua VCL is located on the Canandaigua VA Medical Center campus and has 256 clinical staff assigned to the call center. According to emails and a timeline provided by a Canandaigua VCL manager, COVID-19 screening for all employees entering the call center began on March 18, 2020. Cleaning tips were also provided to supervisors. On March 19, discussions were held between VCL team operation coordinators and a labor union representative regarding mapping out workstations based on reasonable accommodation seating, spreading out staff each shift, and assigning staff to specific workspaces. Further, staff were instructed to hold meetings virtually by telephone or Skype and arrangements were made to borrow space from another program housed on the Canandaigua VA Medical Center campus to promote social distancing. On April 4, VCL employees were assigned workspace seating as they started their shifts.

VCL managers inventoried supplies and PPE on hand, which included approximately 900 masks, as well as hand sanitizer and disinfecting wipes. Over several days in late March and early April, additional wipes and sanitizers were ordered with estimated arrival dates in late April and

early August. Canandaigua VCL leaders advised supervisors and SSA leads about the availability of masks and hand sanitizer in the office area.

Upon interview, several Canandaigua VCL staff reported concerns about safety measures in the call center, including

- A shortage in wipes, which resulted in rationing to one wipe per shift and staff being given hand sanitizer to wipe down equipment,
- A delay in implementing social distancing,
- An assigned seating chart, but staff were not placed six feet apart, and
- Concerns that "some leadership" were not wearing masks when on-site, despite the guidance that masks were to be worn by staff when outside their cubicles.

Atlanta

The Atlanta VCL occupies the fourth and fifth floor of the VA Health Eligibility Center in Atlanta and has 356 clinical staff assigned to the call center. Arrangements had been made to expand VCL space to the fourth floor, but the new space had not been activated prior to COVID-19. In general, staff cleaned their workstations with disinfectant wipes before starting their shifts, and housekeeping staff performed general cleaning both before and during the pandemic.

In late March, a contracted housekeeping crew cleaned and disinfected the fifth floor. To reassure staff that it was safe for them to return to workspaces, messages were sent via the emergency alert system that deep cleaning had been completed and staff could return to work. Atlanta VCL leaders also told the OIG that they tried to be lenient when concerned staff elected not to immediately return to the call center.

According to Atlanta VCL leaders, staff were able to practice social distancing because the VCL was quickly able to expand to the fourth floor, and that while on-site, staff were required to wear masks. However, leaders said they could not attest that there was exactly six feet between every person, every time, at every shift.

Upon interview, several Atlanta VCL employees reported concerns about safety measures in the call center, including

- Not being able to social distance. Reportedly, even though there was another floor, it was not used;
- Not having enough masks at the call center, so staff were encouraged to have their own. In some of the rooms, wearing masks was not enforced; and

- Not consistently having access to cleaning supplies and not receiving consistent instructions for disinfecting equipment; for example, staff were asked to use hand sanitizer to clean desks after running out of cleaning supplies.

Topeka

The Topeka VCL is located on the Colmery-O'Neil VA Medical Center campus and has 69 clinical staff assigned to the call center. The VCL staff screened everyone entering the VCL building for a week until the medical center assumed the screening responsibility for the entire campus.

VCL leaders provided the OIG with an assigned seating chart initiated in March 2020 to promote social distancing at the Topeka VCL. The OIG learned in an interview with a Topeka VCL staff member that the call center had about 10 cubicles, and that to social distance, four employees would be assigned and "spread out" to each corner of the room. The Topeka VCL also had separate rooms with two workstations, and to social distance, assigned one employee to each of those rooms.

The Topeka VCL had assigned housekeepers six days a week on all three shifts whose primary responsibilities were to pay special attention to and provide increased frequency of cleaning high-touch surfaces during the COVID outbreak. Topeka VCL staff who spoke to the OIG confirmed that staff were provided disinfecting wipes and were responsible for cleaning their workstations while housekeeping staff cleaned the public spaces on all shifts.

According to staff members the OIG interviewed, the Topeka VCL call center provided sufficient handwashing stations, hand sanitizers, wipes, masks, and gloves. The VCL survey results reflected that most of the Topeka VCL survey respondents believed the call center took appropriate actions to maintain employee safety.

Call Center Safety Survey Responses

In the OIG survey, VCL employees were asked to identify their work locations. VCL employees who responded that they worked some or all the time in a call center during the pandemic were also asked about safety measures in their respective call centers. Eighty-two percent (46 of 56) of respondents who said they worked in a call center reported they were able to maintain social distancing while performing their duties, and 18 percent (10 of 56) reported not being able to do so. Table 3 reflects the breakdown of employees' responses by call center locations.

Table 3. Perceptions of Ability to Maintain Social Distancing by Location

Location	Total Responses	Yes Responses	Yes (Percent)	No Responses	No (Percent)
Canandaigua	28	21	75	7	25
Atlanta	15	13	87	2	13
Topeka	12	11	92	1	8
Other	1	1	100	0	0

Source: OIG analysis of survey results to the question "Have you been able to maintain "social distancing" while performing your job duties? (Y/N)"

Eighty-eight percent (49 of 56) of respondents reported that other COVID-19 precautions were in place at the call centers to maintain employee safety.[29] Table 4 reflects the breakdown of responses by call center location.

Table 4. Perceptions of Other COVID-19 Precautions in Place by Location

Locations	Total Responses	Yes Responses	Yes (Percent)	No Responses	No (Percent)
Canandaigua	28	23	82	5	18
Atlanta	15	14	93	1	7
Topeka	12	11	92	1	8
Other	1	1	100	0	0

Source: OIG analysis of survey results to the question "Are other COVID-19 precautions in place at the Call Center to maintain employee safety? (Y/N)"

VCL respondents who expressed dissatisfaction with call center safety generally cited concerns about inadequate social distancing, insufficient access to protective materials such as wipes and masks, and infrequent deep cleaning.

Several survey respondents and interviewees reported they felt their personal safety concerns about working out of the call centers were not a priority of VCL leadership. The OIG noted that, while in the minority, these sentiments were largely expressed by staff in the Canandaigua call center, about a five-hour drive from the COVID-19 epicenter in New York City.

3. Continuous Quality Management

The VCL met its mission to provide immediate access to suicide prevention and crisis intervention services while also maintaining quality performance during the COVID-19 pandemic.

[29] Thirteen percent (7 of 56) of staff reported precautions were not in place at the call center.

During interviews, several VCL leaders acknowledged a frenetic environment during the transition to telework but, overall, felt the transition went smoother than expected. A VCL employee wrote that leaders moved to implement telework "in record time," but prior to telework, there were no directions or resources for staff in crowded workspaces. In response to the survey, an SPC documented "the referrals from the VCL have been timely and as well done as ever…Whatever transitions the VCL team made was seamless from the facility end." Some VCL employees had differing opinions, citing a lack of information, equipment, and training. Because opinions were subjective and could not be validated, the OIG elected to assess the effectiveness of the VCL's response to the pandemic based on the end result; specifically, whether key performance targets were achieved and maintained and negative veteran outcomes attributable to the telework transition were avoided.

VCL Quality Metrics

The VCL collects and reviews metrics for all telephone calls including access and timeliness, referrals to SPCs, the quality of the responder's communications with the caller, and customer satisfaction. Collectively, quality metrics are used to identify areas needing improvement and forecast scheduling and staffing requirements.[30]

Access and Timeliness

The VCL's key performance indicators in this area include the number of inbound calls, chats, and texts answered; the speed at which they were answered; and the abandonment rate (when the caller hung up prior to receiving service).

Incoming Crisis Contact Volume

Table 5 reflects the number of calls, chats, and texts handled by the VCL from January 1, 2020, to May 31, 2020. Contact volume generally provides the denominator from which achievement of performance measures is derived.

[30] VHA Directive 1503.

Table 5. Volume of Calls, Chats, and Texts (January 31–May 31, 2020)

Metric	January	February	March	April	May
Calls Answered	52,975	50,888	56,386	48,345	53,753
Chats Handled	6,561	6,229	6,923	6,867	6,680
Texts Handled	3,090	2,829	3,024	2,745	2,933

Source: 2020 VCL metrics data from January 31 through May 31, 2020.

Average Speed of Answer

The average speed of answer refers to the "average time calls are in queue before connecting with a crisis counselor during a certain time period." There is no industry standard for speed of answer for crisis line calls. To provide perspective, a survey of Lifeline call center participants (distributed in January 2017) reflected that 29 call centers used targets from 5–130 seconds or within 3–5 rings.[31]

For the VCL, the average speed of answer was consistently about nine seconds from January 1, 2019, to May 31, 2019. By comparison, from January 1, 2020, to April 30, 2020, the speed of answer was between 10–12 seconds. In May, after the implementation of telework, the speed of answer improved to about eight and a half seconds. VCL leaders anecdotally reported that staff may have wanted to show increased efficiency to keep the new telework privilege, as well as staff having fewer distractions in their homes during telework.

VCL leaders told the OIG that VCL's goal was to answer calls in three rings or less. Leaders explained that calls not answered in three to four rings (about 20 seconds) would be redirected to another responder (redirect on no answer (RONA)). According to a data analytics manager, VCL's RONA goal is zero because the additional 20 seconds callers are kept waiting could pose a risk to veterans in crisis.

During interviews, several leaders identified a system breakdown during the transition to telework, reporting that RONAs increased from two–four per day prior to telework to 20 per day after implementation of telework. One leader attributed this performance decline to teleworkers' inexperience with a new software package and the change from landline telephones (used in the

[31] Lifeline Crisis Call Center Metrics. "The average speed of answer can easily be skewed by outliers—particularly when a sample size is low. With a large sample, over an extended period, outliers may have little impact and the average speed of answer will appear within target range. Despite this, several callers could have waited unacceptably long periods of time for their call to be answered. Measuring over short periods of time allows these outliers to be seen more clearly. The key is to measure the interval (hourly/half hourly) success rate and use that to determine how to adjust schedules to increase the percentage of intervals in which average speed of answer or service levels goals are met (North American Quitline Consortium, 2010)." To establish benchmarks and baseline data, the Lifeline Call Center Metrics Workgroup composed of Lifeline crisis center directors and experts in the field of behavioral health delivery systems, developed a Lifeline Call Center Metrics Survey that was distributed to Lifeline centers in January 2017. "This survey included 49 questions that addressed detailed call center operations and metrics specific to service and efficiency measures. A total of 128 of 159 (81 percent) centers responded."

call centers) to mobile phones. Another leader attributed the increase in RONAs to a lag in data communication when a VCL call was routed to a teleworker's home, but because of home network connectivity, the ring was not immediately recognized on the teleworker's computer, and the mobile phone rang three times and was then redirected. The problem was addressed by increasing the number of rings from three to five before the call was redirected to another VCL responder.

Abandonment Rate

"The call abandonment rate is defined as the percentage of callers who hang up or disconnect prior to their call being answered."[32] "There is no industry standard for call abandonment rate."[33] However, VCL leaders told the OIG that the VCL target for abandoned calls was less than 5 percent.

From January 1, 2019, to May 31, 2019, the VCL's call abandonment rate was less than 3 percent. During the same period in 2020, the call abandonment rate ranged between 3 and 3.6 percent, still falling well under the target.

Clinical Indicators of Population Acuity

In this category, VCL monitors the percentage of crisis contacts that result in the dispatch of emergency services such as local police or emergency responders. Emergency dispatch is used when a person "is in imminent danger and unable to stay safe on their own, necessitating immediate intervention."[34] While there are no performance targets associated with this measure, the data are useful in understanding the level of callers' distress and the intensity of services required to safely and effectively manage callers' needs.

As the incoming call, chat, and text volume increased, so did the emergency dispatches; however, the proportion of emergency dispatches remained constant around four percent of total incoming calls, chats, and texts across both 2019 and 2020. Although COVID-19 was an added stressor in 2020 (based on VCL's coding for COVID-19 concerns), the consistency in referrals suggests that, overall, COVID-19 did not materially affect callers' acuity or levels of risk of self-harm.

While emergency responders were a stretched resource in some geographic areas during the COVID-19 pandemic, VCL leaders and clinical operations staff the OIG interviewed stated they were unaware of emergency dispatch delays.

[32] Lifeline Crisis Call Center Metrics, p. 19.

[33] Lifeline Crisis Call Center Metrics, p. 20.

[34] VHA Directive 1503. A facility transport plan is conducted when the risk to the person is acute but can self-transport or be transported by a trusted other.

Referrals to SPCs

Managing veterans in crisis involves comprehensive systems-level strategies involving an array of professionals across several phases of care.[35] Once VCL responders have assessed a patient's risk and taken appropriate actions to mitigate harm, information concerning the event is provided to SPCs or suicide prevention case managers at the caller's preferred facility for further follow-up.[36] SPCs and case managers respond to VCL referrals and coordinate treatment and services, among other duties.[37] As the incoming call, chat, and text volume increased, so did VCL referrals to SPCs. The proportion of referrals remained fairly consistent, between 17 and 19 percent, from January 1 to May 31 across both 2019 and 2020.

The OIG surveyed SPCs to understand the impact of COVID-19 on SPCs' ability to respond to and follow-up with veterans at high risk for suicide. Most of the 240 survey respondents (93 percent) reported their ability to monitor high-risk cases was better or about the same as prior to the pandemic.

The OIG noted, however, that 27 percent (64 of 240) of SPC and case manager survey respondents reported that they encountered difficulties performing their jobs during the pandemic. The difficulties cited were generally related to increased workload; information technology challenges during telework; difficulty with resources; and personal stress and anxiety.

In addition, more than 20 percent of SPC survey respondents noted that, during the pandemic, they were having more difficulty accessing outpatient medical appointments, housing, and financial assistance for callers in a timely manner. Nevertheless, 41 percent (99 of 240) of the respondents reported that they were able to arrange outpatient mental health appointments in a more timely manner since the COVID-19 pandemic started.

Despite the challenges, 97 percent (234 of 242) of survey respondents were not aware of poor veteran outcomes related to system breakdowns. For privacy purposes, the survey instructed respondents not to provide veteran-specific personally identifiable information in any of the survey's text fields. Therefore, the OIG was reliant on interviews to identify veterans who may have experienced poor outcomes. Three of the eight respondents who reported being aware of negative veteran outcomes indicated that they wished to be contacted by the OIG to discuss COVID-19 and related concerns. However, none of the three provided veteran-specific negative outcomes due to VCL delays or process change. One interviewee told the OIG that the concern

[35] U.S. Department of Veterans Affairs, *National Strategy for Preventing Veteran Suicide 2018-2028*.

[36] VHA Directive 1503.

[37] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, November 11, 2008, amended November 16, 2015.

was related to a delay securing an appointment and delayed admission to a community treatment program. The OIG noted that these types of delays could happen at any time, pandemic or not.

Silent Monitoring

Silent monitoring of telephone calls is the process whereby staff evaluate the responder's use of listening skills, completion and thoroughness of the lethality assessment, degree of collaborative problem-solving, and resources or referrals provided. If a supervisor determines that the responder did not adequately assist in mitigating a caller's identified risk, the call is rated "Unsuccessful." The measure includes the percentage of staff monitored in each pay period, with a target of 80 percent, as well as the percent of monitored calls meeting silent monitoring expectations, with a target of 99 percent.

With the exception of one data point, it did not appear that the COVID-19 pandemic affected the percentage of the staff-monitored measure. While the Canandaigua and Atlanta call centers did not meet the 80 percent threshold in January 2020, the underperformance could not be attributed to the COVID-19 pandemic. In April 2020, the Canandaigua site recorded a 66 percent compliance rate, which was attributed to staff's transition to telework, with supervisors and silent monitors working as responders to provide coverage. All other data points for January 1, 2020, to May 31, 2020, across the three sites, met or exceeded the 80 percent target. For the same period, all three call centers met or exceeded the 99 percent target for the Successful Silent Monitoring measure.[38]

Customer Satisfaction

To assess customer satisfaction, VCL telephone responders ask near the end of the call: "If you were in crisis, would you call VCL again?"[39] The measure includes veterans and other callers whose reported experience met the satisfaction goal, with a target of 95 percent.

Satisfaction for both veterans and third-party callers met or exceeded the 95 percent target for the period January 1, 2020, to May 31, 2020.

VCL Survey Results

Twenty-eight percent (61 of 216) of VCL staff reported encountering difficulties performing their job duties during or due to COVID-19, and generally cited technical difficulties with network connections, software, or headsets; having added tasks and responsibilities; helping callers cope; and concerns about personal safety. Additionally, 39 percent (24 of 61) of survey

[38] In February 2020, the Canandaigua VCL call center achieved 98.85 percent compliance with the successful silent monitoring measure. The OIG rounded this number to 99 percent.

[39] VCL, Health Science Specialist Participation Guide, June 2019.

respondents who had difficulty performing their job duties during the pandemic, felt the difficulties affected caller care.

Seven percent (15 of 206) of survey respondents reported being aware of poor outcomes related to system breakdowns during the COVID-19 pandemic. However, respondents interviewed by the OIG did not report adverse veteran outcomes. Rather, interviewees told the OIG about concerns such as difficulty with social distancing prior to commencing telework, as well as problems with telephone audio and headsets, which had the potential to result in dropped calls or the inability to recontact vulnerable callers.

While not a specific survey question, some VCL respondents reported that increased stress dealing with COVID-19 in their personal lives, coupled with the intensity of the crisis work, was overwhelming. At the call centers, stressed workers could use designated relaxation and wellness areas, debrief in-person with supervisors after difficult calls, and attend monthly peer support groups with team members. With telework, however, in-person emotional support services were less available.

VCL Oversight

The VCL Executive Leadership Council 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. According to policy, the Executive Leadership Council 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.[40] The OIG reviewed Executive Leadership Council meeting minutes from March 27, 2019, to May 27, 2020, and found documentation to support performance of required oversight.

4. Lessons Learned

VCL leaders and employees acknowledged a chaotic telework transition but ultimately believed that the VCL was better positioned for future expansion and initiatives.

OIG Observations

Throughout the course of this review, the OIG was impressed with VCL leaders' and employees' vigorous and resolute efforts to promote employee safety and ensure that VCL services continued unabated, and that these efforts were successful in a short period of time. As noted

[40] VHA Directive 1503.

previously, some VCL employees had differing opinions about leaders' efforts. For example, the perception of several VCL employees was that VCL leaders tried to do the best that they could to get people quickly transitioned to telework, while other employees reported through interviews that the transition to telework was delayed or chaotic or both. While not specifically stated, the OIG interpreted some of the comments to indicate that VCL leaders should have anticipated a scenario requiring a shift to telework-based operations and been better prepared to execute a deployment plan. The OIG found minimal evidence to support this position. However, the OIG noted that prior to the pandemic, VCL leaders had considered the possibility of telework to support the future 988 initiative.[41] Nevertheless, the OIG also acknowledges that, in the context of a global health emergency with an unknown trajectory, retrospectively evaluating VCL leaders' decisions and plans does not help with past actions but could affect future decisions and planning.

With the benefit of hindsight, the OIG noted that the general nature of working within a large bureaucracy may have influenced VCL leaders' pre-pandemic decisions and strategic planning. Historical and sometimes outmoded mindsets and practices, such as VCL leaders' positions that quality crisis services were best delivered from a communal call center, can become ingrained. Further, budgetary constraints and policy requirements shape many decisions and actions but can also limit innovation. In this case, VCL leaders were aware before COVID-19 that some VCL equipment and technology was outdated and opportunities existed to upgrade systems and operations. An OIT employee told the OIG, however, that about 10 percent of VCL equipment was refreshed annually.

Ultimately, COVID-19 forced the issue of telework for VCL clinical operations staff. VCL leaders repeatedly expressed that this move improved staff morale and decreased unplanned leave usage, as well as positioned the VCL to recruit staff and enhance services for the eventual implementation of the 988 initiative.

VCL Observations and Lessons Learned

In exploring the VCL experience during the COVID-19 pandemic, the OIG asked VCL leaders about lessons learned. The overarching theme of responses was that the VCL needs to keep current with best practices in emergency preparedness and technology to achieve its mission and meet public expectations for crisis line care. VCL leaders summarized several infrastructure-related challenges that made their experience responding to COVID-19 more difficult:

[41] The OIG was also told that the backup center transitioned to telework-based operations one month before the VCL did so. Because the OIG had no information on the contractor's infrastructure and strategic planning efforts, the OIG could not comment on whether the backup center's earlier transition to telework was related to better foresight or planning.

- The VCL needed a broader and more agile technology and equipment plan. VCL data and communication systems were not fully automated or integrated, some technology and equipment was outdated, and network limitations and system errors presented operational risks.
- The VCL needed its own information technology staff and to manage its own contracts. Because the VCL did not have dedicated information technology personnel, the VCL used contracts for some technology-related work, which was described as cumbersome. Lack of VCL-dedicated information technology staff also meant that the VCL had to coordinate equipment and services through regional OIT departments and, when having a system problem, VCL staff had to contact a VA service desk specialist who likely did not have knowledge of VCL systems and technology.

VCL leaders identified lessons learned and opportunities to improve preparedness and operations for potential future emergencies. One VCL leader reported the need for additional support staff and better succession planning with overlap for key positions. The leader told the OIG that, in planning and responding to COVID-19, the VCL could not afford to lose a critical player. Several other VCL leaders commented on the need to have an inventory of items like headsets, keyboards, Personal Identity Verification card readers, and cell phones available, as the pandemic caused shortages of these types of equipment.

Also, 42 percent (92 of 220) of the respondents had suggestions for improving future emergency response processes. The majority of suggestions involved better planning/more proactive (33), better communication/more transparency (32), and more/better equipment or supplies (16). Examples of suggestions included "listen to people who work for you," "invest in updated computer hardware and software," and do not "wait too long to enact… processes."

Conclusion

In the OIG's opinion, VCL leaders' and employees' vigorous and resolute efforts to promote employee safety and ensure the integrity of the VCL mission during the COVID-19 pandemic were remarkably successful.

The VCL call centers were not conducive to staff's health and safety during the pandemic, because staff generally worked in close proximity to one another and shared cubicles, computers, and telephones. VCL leaders' primary challenge was to transition nearly 800 VCL workers to telework-based operations as quickly as possible, while also ensuring functional equipment, staff training, and supervision and oversight were in place.

OIT coordinated the acquisition of 300 computers (including a keyboard and mouse for each computer), 600 monitors, and 300 iPhones with licenses. Regional OIT staff formatted and installed the related software and ensured that VCL employees had the necessary tools to perform their duties prior to being sent home to telework. By the last week of April 2020, all 738 of VCL call center employees who wanted to telework were teleworking. VCL survey respondents who teleworked overwhelmingly reported having the necessary equipment and technical support to enable them to perform their duties at their telework location. However, reported concerns included poor audio quality, headset issues, and inadequate technical support. By all accounts, OIT prioritized VCL's equipment and other needs to ensure continued operations and rapidly deployed staff to telework.

To support the VCL mission, and in the context of telework uncertainties, VCL leaders developed a comprehensive "extreme scenarios" strategic and contingency plan and provided employees with training, guidance, and resources related to telework, new VCL processes, and COVID-19-specific concerns. VCL survey respondents had mixed opinions about VCL leaders' responsiveness to the emerging pandemic.

To promote staff's health safety within the call centers, VCL leaders devised seating charts; inventoried cleaning supplies and PPE on hand and placed orders as needed; and provided housekeeping schedules and workstation sanitization schedules for each call center site. Some VCL survey respondents reported delays in implementing social distancing and shortages of cleaning supplies and PPE.

From January 1 to May 31, 2020, VCL met performance targets for key indicators including the speed of answer for calls, chats, and texts; the rate of call abandonment; and the levels of silent monitoring and caller satisfaction. In addition, the rate of VCL referrals to SPCs remained consistent with an increase in caller volume, and a majority of SPCs reported their ability to monitor high-risk cases was about the same or better than before the pandemic. The OIG did not identify, nor did VCL employees or SPCs tell the OIG about, veteran care being negatively affected during VCL staff's transition to telework.

While not part of this review, some VCL survey respondents and interviewees reported that increased stress dealing with COVID-19 in their personal lives, coupled with the intensity of the crisis work, was overwhelming. Emotional support services that were available at the call centers were less available due to telework, which affected employee wellness.

When asked about lessons learned, the overarching theme of VCL leaders' responses was that the VCL needs to keep current with best practices in emergency preparedness and technology to achieve its mission and meet public expectations for crisis line care. VCL leaders also identified several infrastructure-related challenges that made their experience responding to COVID-19 more difficult, and that moving forward, the VCL could benefit from a broader and more agile technology and equipment plan and its own cadre of information technology staff and to manage its own contracts. Lessons learned included the need for more support staff, better succession planning with overlap for key positions, and maintaining an inventory of items such as headsets, keyboards, and cell phones.

VCL survey respondents had suggestions for improving future emergency response processes, a majority of which involved better planning and being more proactive, better communication and transparency, and more and better equipment or supplies.

The OIG was impressed with VCL leaders' and employees' efforts to promote employee health safety and ensure that the VCL met its mission to provide immediate access to crisis intervention services during the COVID-19 pandemic.

The OIG did not make any recommendations.

Addendum

VHA acknowledged receipt of the report and provided technical comments. The OIG clarified the following items:

- SSA responsibilities, page 3
- SPC location, page 3
- Deputy Director, Quality and Training of Clinical Care title change, page 4
- "VCL OMHSP leaders" replaced with "OMHSP leaders," page 7
- Title of an official on an email, page 7
- "Commit suicide" replaced with "attempt suicide," page 10
- Availability of emotional support services, page 24

Appendix A: VCL's Strategic and Contingency Plan

Table A.1. VCL Strategic and Contingency Plan

PLANK 1: Telework Planning	
Strategy 1	Create telework option for frontline staff.
Strategy 2	Create equipment and information technology deployment timeline to coincide with telework implementation.
PLANK 2: SOP Changes	
Strategy 1	Mitigate impact of high frequency callers to alternative methods of support.
Strategy 2	Explore a restructure to develop a triage line – determine if not a crisis, set up system for call back or routing to chat/text.
Strategy 3	Explore use of a screener for chat/text.
Strategy 4	Develop feasibility/plan for briefer interventions to shorten calls in a clinically appropriate way.
Strategy 5	Explore ways to reduce aftercall work time.
Strategy 6	Explore shutting down self-check quiz and directing to chat/text.
Strategy 7	Determine feasibility of increasing number of chats taken.
PLANK 3: Current Call Center Management	
Strategy 1	Communicate to VCL staff- what we're doing to maximize public health/well-being, messaging for morale, physical and emotional care, and rallying the team, and SOP for pandemic issues.
Strategy 2	Obtain detail for administrative officer support.
Strategy 3	Wellness team to detail a plan for helping Clinical Operations staff cope for calls of desperation that we may feel very helpless about.
Strategy 4	Develop solution for precepting to ensure social distancing.
Strategy 5	Develop solution for social distancing / handwashing upon arrival across sites.
Strategy 6	Develop video messaging from leadership.
Strategy 7	Implement strong structure of supervision, communication, and support within clinical operations (Daily huddles from [VCL Chief of Staff, other VCL leaders and managers]).

Strategy 8	Develop process for Quality Assurance and Training to relieve burden from call center staff for things such as correspondence, consult calling, etc.
PLANK 4: Partner Engagement - Technology	
Strategy 1	Develop myVA311 as national COVID information line by 1 May 2020 and develop call transfer process to and from VCL.42
Strategy 2	Determine if Lifeline can have additional "press X" option to link to the national COVID information line. Explore changing VCL interactive voice response to notify people there may be wait times and ways to get other assistance.
Strategy 3	Consider sharing/shifting staff between Lifeline, VCL and CTL.
Strategy 4	Develop Quick fix memorandum of understanding/Contract options, possibly 3-6 months out.
Strategy 5	Determine feasibility/place messaging on VCL.net or other public facing website to drive folks to appropriate resources.
Strategy 6	Track and mitigate use of VCL as VHA emergency line on Google/national announcements.
PLANK 5: Partner Engagement - Clinical	
Strategy 1	Identify tele-mental health clinical resources available to VCL.
Strategy 2	Explore SPCs possibly taking chats/texts.
Strategy 3	Member Services leadership to consider whether they can decrease any of their operations to help with VCL triage if trained.
Strategy 4	Identifying and implementing a plan to direct callers who call about potential massive hospital bed shortage.

Source: VCL Strategic and Contingency Plan from the Extreme Scenarios spreadsheet provided by VCL Senior Leaders

[42] 1-844-MyVA311 (1-844-698-2311) is "VA's go-to source for Veterans and their families who don't know what number to call."

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