DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Suicide Prevention Coordinators Need Improved Training, Guidance, and Oversight

REVIEW | REPORT #20-02186-78 | JUNE 6, 2022

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Executive Summary

Suicide is a national health crisis. According to the Department of Veterans Affairs (VA) fiscal year (FY) 2018–2024 Strategic Plan, its prevention is VA's highest clinical priority. VA established the Veterans Crisis Line to provide services to veterans 24 hours a day, seven days a week. When a veteran calls the crisis line, the crisis line responder can send a referral to the nearest VA medical facility. As part of the Veterans Health Administration's (VHA) national veteran suicide prevention strategy, suicide prevention coordinators at VA medical facilities are required to reach out to veterans referred from the crisis line.[1] Coordinators provide access to assessment, intervention, and effective care; encourage veterans to seek care, benefits, or services with the VA system or in the community; and follow up to connect veterans with appropriate care and services after the call. VHA's Office of Mental Health and Suicide Prevention is responsible for issuing policy and guidance for managing crisis line referrals. The VA Office of Inspector General (OIG) conducted this review to evaluate whether coordinators properly managed crisis line referrals to ensure at-risk veterans were reached.

What the Review Found

The review team found that coordinators mistakenly closed some veteran referrals because they lacked the proper training, guidance, and oversight necessary to maximize chances of reaching at-risk veterans referred by the crisis line. VHA lacked comprehensive performance metrics to assess coordinators' management of crisis line referrals, and coordinators lacked clear guidance on how to manage crisis line referrals. Until VHA provides appropriate training, issues adequate guidance, and improves performance metrics, coordinators could miss opportunities to reach and assist at-risk veterans. This report focused on the following issues:

- Coordinators overstated the number of veterans reached within three days.
- Coordinators did not intersperse calls as required to increase chances of reaching veterans.
- Coordinators did not always make required attempts to reach veterans who received care or assistance in the community.
- Managers did not provide effective oversight for coordinators to process referrals.

[1] For the purposes of this review, the term "coordinators" includes suicide prevention coordinators and any VA medical facility suicide prevention staff assigned the responsibility of handling referrals sent from the crisis line.

Coordinators Overstated the Number of Veterans Reached within Three Days[2]

The crisis line's data indicated that coordinators reached about 133,000 of the approximately 163,000 referred veterans (about 82 percent) within three days of the receipt of the referrals during the 15-month review period.[3] Although the crisis line data indicated about 82 percent of veterans were reached, the team's review of the call management system and the veterans' electronic healthcare records revealed about 20 percent of veterans that were listed as reached had not actually been reached at the time the referrals were closed.[4] Based on the results of this review, the team projected that coordinators only reached about 62 percent of referred veterans within three business days of the receipt of the referral, rather than the 82 percent reported.

These reporting discrepancies occurred because coordinators lacked formal training on selecting the appropriate patient outcome codes when they closed referrals in the call management system. Additionally, medical facility officials who supervised the coordinators and crisis line staff who collected the call management system data for the program office did not test or verify the accuracy of the patient outcome information reported by the coordinators since they were not required to by policy. Until the program and medical facility officials address these data integrity issues, VHA will not be able to effectively monitor coordinators' management of referrals and make informed decisions.

Coordinators Did Not Intersperse Calls as Required to Increase Chances of Reaching Veterans

In March 2020, VHA issued a policy requiring the three required call attempts to veterans be made on separate days; however, some coordinators continued an earlier practice of closing referrals on the same day as the first call attempt.[5] Before the new policy, VHA guidance directed coordinators to make three attempts to reach referred veterans, but it did not specify when the call attempts should be made nor did it prohibit all the attempts from being made on the

[2] See VHA technical comment 1 on page 31. VHA asserts in its comments that the OIG has mischaracterized the problem in the finding and states the "…coordinators did not overstate the number of veterans they directly reached as opposed to miscoding the contacts made by other licensed Mental Health staff." The OIG disagrees with VHA's assertion that this is a coding error. The OIG's review of the call management system notes, and the veterans' electronic healthcare records showed, that neither the coordinators nor other mental health staff at the facilities had contacted the veterans within the 3-day period before the coordinators closed the referrals.

[3] The review period started in March 2019 and ended in June 2020. Three days is the program office's performance metric. Appendix A provides additional details on the scope and methodology.

[4] See VHA technical comment 2 on page 31. VHA requested the OIG add language to the end of this sentence stating the veterans had been contacted by another licensed staff. The OIG did not add this language because it found no evidence in the call management system notes or the veterans' electronic healthcare records that the coordinators or other medical facility staff had reached the veterans before the coordinators closed the referrals.

[5] VHA Memorandum, *Continuity in Mental Health Services and Suicide Prevention Activities*, March 21, 2020.

same day.[6] The practice of making all the call attempts in one day and closing the referrals could reduce the chances of reaching veterans, as they may not be available on that day.

The review team evaluated referrals closed on the same day as the first call attempt when data indicated the veterans were not reached and identified about 8,500 out of approximately 29,800 referrals met these criteria during the review period.[7] A sample review of the approximately 8,500 referrals did not identify valid reasons, such as inaccurate contact information, for about 97 percent of the closures.[8]

VHA did not explicitly state that coordinators had to intersperse their call attempts on separate days until the issuance of the March 2020 COVID-19 memorandum. However, even after VHA issued the March 2020 memorandum, the team estimated that coordinators failed to intersperse calls for about 15 percent or 1,290 of the veterans who had same-day closures.

Some coordinators did not intersperse calls as required because they claimed to be unaware of the requirement. Additionally, some coordinators closed referrals quickly because they incorrectly believed closures were required for other medical facility staff to be able to see the crisis line notes in veterans' electronic health records.

Coordinators Did Not Always Make Required Attempts to Reach Veterans Who Received Care or Assistance in the Community

When veterans are transported to local hospitals or local emergency dispatch services performed a welfare check, coordinators are required to make three attempts to contact veterans after the crisis line responders refer them to coordinators. The review team found that coordinators did not make the required attempts for 49 of the 115 sampled referrals where the referrals involved veterans who received suicide intervention care or assistance in the community. As a result, the team estimated that coordinators did not make the required attempts to reach approximately 3,500 veterans who received suicide care or assistance in the community from March 2019 through June 2020. These veterans did not receive any additional follow-up after the closure of their referrals.[9]

Most of these veterans had referrals that were designated emergent by the crisis line because veterans needed emergency services or presented imminent threats to themselves or others. These veterans also often had past suicide attempts or reported suicidal ideation with the means

[6] VHA, *Suicide Prevention Coordinator Guide*, June 19, 2015.

[7] The review period for these referrals started in March 2019 and ended in June 2020.

[8] Coordinators are not required under VHA policy to document reasons for closing referrals without attempting to reach the veteran or after only one call attempt.

[9] The review team noted that other medical facility staff did not follow up on 12 (24 percent) of the 49 veterans after the coordinators closed the referrals.

to commit suicide. Suicide rates are particularly high within one month of calling the crisis line and remain substantially elevated through 12 months.[10]

Under VHA policy, coordinators are expected to reach veterans, and follow-up is to be conducted by coordinators where "clinically indicated" after the closure of the referrals. It was often not clear from reviewing the call system management notes and veterans' medical records why the coordinators did not make all the required attempts before closing referrals for these veterans. Some coordinators stated they did not try to reach veterans to conduct follow-up if they confirmed the veteran had been hospitalized, the veterans did not have high-risk flags, or they had alerted the veterans' current providers (e.g. primary care or mental health) of the need to follow up with the veterans.

The program officials the team interviewed acknowledged that the coordinators all should have made the required attempts to reach these veterans before they closed the referrals, even if the veterans had received care or assistance in the community. Coordinators are permitted under VHA policy to use their clinical judgment to conduct follow-up after the closure of the referrals. However, call management system notes and the veterans' electronic health records often lacked documentation explaining why the coordinators did not make all the attempts to reach these veterans before they closed the referrals and how they determined the veterans did not require any follow-up after the closure.

The team concluded VHA needs to consider developing clearer guidance for coordinators regarding the requirement to reach these veterans that may be at higher risk for suicide, clarify the expectations it has for follow-up when the referred veterans have received care or assistance in the community, and ensure coordinators document their rationale for not making all the required attempts to reach the veterans.

Managers Did Not Provide Effective Oversight for Coordinators to Process Referrals

VHA updated its policy in May 2020 to include a requirement for Veterans Integrated Service Network (VISN) and medical facility directors to monitor referral performance.[11] However, the updated policy still does not explicitly require VISN and medical facility directors to monitor outcomes, ensure referred veterans receive assistance, and confirm coordinators intersperse their call attempts. The team also confirmed with VISN and medical facility managers who supervise the coordinators that the managers do not routinely evaluate the coordinators' success in reaching veterans or check whether coordinators are interspersing their call attempts.

[10] Claire M Hannemann MPH et al., "Suicide mortality and related behavior following calls to the Veterans Crisis Line by Veterans Health Administration patients," *National Library of Medicine* (December 29, 2020).

[11] VHA Directive 1503, *Operations of The Veterans Crisis Line Center*, May 26, 2020.

The program office informed the review team in May 2020 that it planned to monitor the coordinators' success at reaching veterans.[12] As of March 2021, the program office was still in the process of developing a monitoring report.[13] However, the program office does not plan to monitor coordinators' call attempts to ensure compliance with VHA's policy on the interspersing of calls on separate days.

What the OIG Recommended

The OIG made five recommendations to the under secretary for health that include improving data integrity, training coordinators on using patient outcome codes, developing additional guidance, monitoring compliance with requirements to space calls over three days, and evaluating program data for additional opportunities to improve services for referred veterans.

VA Comments and OIG Response

The under secretary for health concurred or concurred in principle with all the report's findings and recommendations and submitted action plans for recommendations 1 through 5. Appendix C provides the full text of their comments.

The OIG will assess the satisfactory completion of the actions in conjunction with its routine recommendation follow-up. Overall, the proposed corrective measures in VHA's action plans appear to be responsive to the recommendations and the OIG will monitor the implementation of the recommendations until all stated actions are documented as completed.

The OIG incorporated clarifying information in the report where appropriate from the under secretary for health's comments, particularly their 13 technical comments. The OIG added text or footnotes to the report to address requests from technical comments 3, 5, 11, and 13.

The OIG did not make the revisions requested by VHA technical comments 1, 2, 8, or 12, but instead added footnotes within the report to explain why it declined to do so. In each instance, VHA incorrectly asserted the OIG's statements were inaccurate. In comments 1 and 2, VHA claimed the OIG overstated the number of veterans who were not reached and that this was only a coding error because veterans may have been reached by other medical facility staff. However, as previously explained in footnote 2, call management system notes and veterans' electronic

[12] See VHA technical comment 3 on page 31. VHA clarified that medical facility staff are only required under VHA policy to perform follow-up when clinically indicated and that regardless of the documentation, failure to make three phone attempts and to send a letter violated current VHA policy.

[13] See VHA technical comment 4 on pages 31–32. VHA reported that it established a monitoring report and implemented a crisis line dashboard and validated the dashboard for national use in August 2021. The OIG team did not include this information in the draft report because this report and dashboard were not in place during the review period (15 months, ending June 30, 2020).

healthcare records showed that neither the coordinators nor other mental health staff at the facilities had contacted the veterans within the three-day period before the coordinators closed the referrals. The OIG therefore affirms that the finding is accurately stated and supported. In comment 8, VHA requested that the OIG revise its conclusion to state that VHA *may* need to enhance its coordinator oversight processes, but the OIG stands by its conclusion that stronger oversight *is* needed. For comment 12, VHA contended that the OIG did not consider cases where veterans did not need follow-up or could not be reached when it prepared its projection of the number of calls closed on the same day as the first call attempt. However, the OIG did consider these types of cases, and they were not included in the projection as discussed on page 26 of appendix B.

The OIG also did not make requested revisions to the report but added footnotes to address technical comments 4, 6, 7, 9, and 10 because VHA requested the OIG add information that was either outside the review period and not assessed (comments 4, 6, 7, and 10) or repeated information that was already presented in the report (comment 9). See appendix C for VHA's technical comments.

LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluation

Contents

Abbreviations

OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

Suicide prevention is a national health crisis and VA has designated it as its highest clinical priority.[14] In 2007, the Joshua Omvig Veterans Suicide Prevention Act mandated VA provide mental health services 24 hours a day, seven days a week, to support veterans in crisis.[15] The act required VA to establish a "toll-free hotline, available at all times, staffed by appropriately trained mental health personnel."[16] In response, The Veterans Health Administration (VHA) launched the Veterans Crisis Line, making it available to all veterans—even those not registered for or enrolled in VA health care. VA encourages veterans and their loved ones to call the crisis line when emotional issues reach a critical point or other situations occur that may place a veteran at risk for suicide.

The crisis line responders provide veterans a broad range of assistance from giving veterans the information they seek on VA services or programs to conducting crisis intervention care services in the community. Crisis line responders can dispatch emergency services or request welfare checks which may lead to the hospitalization of the veterans. If a veteran desires and is eligible for follow-up services through VA, crisis line responders refer the veteran, regardless of whether the veteran received suicide intervention care in the community, to suicide prevention coordinators at the nearest VA medical facility for follow-up and coordination of care.[17] The coordinators are essential to veterans' continuity of care after contact with the crisis line.

Coordinators are required to reach out to veterans who have contacted the crisis line and accepted a referral as part of VHA's national veteran suicide prevention strategy.[18] Continued follow-up allows coordinators and other medical facility staff to

- ensure the veteran is safe and to connect them with appropriate care benefits or services within the VA system or in the community, and
- perform additional suicide risk assessments.

[14] VA, *Department of Veterans Affairs FY 2018–2024 Strategic Plan*, May 31, 2019.

[15] H.R.327-Joshua Omvig Veterans Suicide Prevention Act, Pub. L. No 110–110 (2007).

[16] VHA Directive 1503, *Operations of the Veterans Crisis Line Center*, May 26, 2020.

[17] Coordinators should follow-up with veterans after the closure of referrals where clinically indicated. However, VHA guidance does not include follow-up procedures for closed referrals; thus, other medical facility staff, such as social workers and doctors, may follow-up on the referred veterans as part of the veteran's clinical care. See VHA technical comment 5 on page 32.

[18] VHA Office of Mental Health and Suicide Prevention, *National Strategy for Preventing Veteran Suicide, 2018–2028.*

The VA Office of Inspector General (OIG) conducted this review to evaluate whether VHA suicide prevention coordinators managed crisis line referrals properly to ensure they reached at-risk veterans.[19]

Governance Structure and Responsibilities

VHA's Office of Mental Health and Suicide Prevention (program office) issues policy and guidance establishing the requirements for managing crisis line referrals.[20] The crisis line center policy focuses on the requirements and procedures for operating and overseeing the crisis line and only includes general guidance about managing referrals made to coordinators. The policy outlines the general oversight roles and responsibilities of the program office, Veterans Integrated Service Networks (VISNs), and medical facilities, and emphasizes decentralized oversight and management of referrals.

Program Office Responsibilities

The program office is responsible for setting program and policy guidance for mental health services provided throughout VHA and ensuring the crisis line has adequate resources to operate and meet the demand for all inbound and outbound calls, texts, and chats. The program office, in collaboration with VISN and VA medical facilities, is also responsible for making sure coordinators are continually educated and understand their roles in acting upon referrals and assuring coordinators follow up, as appropriate, with complete documentation.[21] However, VHA's policies and guidance do not assign responsibility to the program office to oversee coordinators' management of crisis line referrals.[22] According to the Office of Mental Health and Suicide Prevention's executive director, the office only advises coordinators, while medical facility managers are responsible for supervising them. The program office has established policy and national metrics to help advise the coordinators and local managers.

[19] For purposes of this review, the term "coordinators" includes suicide prevention coordinators and any medical facility suicide prevention staff assigned the responsibility of handling referrals sent from the crisis line.

[20] For purposes of this report, the program office includes the Veterans Crisis Line Center.

[21] VHA Directive 1503, May 31, 2017, and May 26, 2020.

[22] VHA Directive 1503, May 31, 2017, and May 26, 2020; VHA, *Suicide Prevention Coordinator Guide*.

The program office established a metric to guide coordinator performance:

1. **Timeliness of the first attempt to contact the veteran:** Was it performed within one business day?[23]

The program office also established one accountability metric:

2. **"Demonstrated attentiveness" and timeliness of referral management:** Was the referral to the coordinator properly closed within three business days?

Inside the program office, the director of field operations facilitates monthly meetings with coordinators to address questions and challenges and to disseminate information regarding changes in guidance or procedures. According to the director, the program office reviews and tracks the two national performance metrics. However, local facility managers are required to oversee the overall productivity and work assignments of coordinators. If a suicide prevention coordinator has not closed a referral within three business days, the director of national care coordination will follow up weekly with the coordinator until it is closed.

Veterans Integrated Service Network Requirements

Prior to May 2020, VHA policy on crisis line operations made VISNs responsible for supporting the implementation of each component of VA's suicide prevention program and coordinator activities.[24] The VISNs were also responsible for ensuring coordinators had the time and resources needed to manage crisis line referrals.[25] However, the policy did not provide any guidance as to how the VISNs were expected to fulfill these responsibilities. A policy update in May 2020 included more specific guidance and made the VISNs responsible for implementing a crisis line referral and performance management system. The policy specifically assigned VISN directors the responsibility for implementing standardized processes for crisis line referral management and reporting.[26]

[23] See VHA technical comment 6 on page 32. VHA requested a number of clarifications in this paragraph. It requested the OIG use the term "monitor" instead of "metric," but OIG did not make this change because it is the OIG's practice to use "metric" to describe a process where a benchmark has been set as a standard of measurement. The OIG also did not add that VHA monitored consults that were closed with no contact because this metric was not in place during the OIG's period of review. The OIG agreed that the metric, demonstrated attentiveness and timeliness of referral management, could be described as an "accountability" metric and added wording to this effect.

[24] VHA Directive 1503 assigns additional responsibilities for the implementation of the suicide prevention program to other entities such as medical facilities and outpatient clinics.

[25] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008 (amended November 16, 2016).

[26] VHA Directive 1503, May 31, 2017, and May 26, 2020.

Medical Facility Requirements

Before May 2020, VHA policy required medical facility directors to only have plans for managing all crisis line referrals for mental healthcare services in a coordinated manner within established time frames.[27] However, updated policy

- increased directors' oversight requirements,
- required directors to monitor and improve their facilities' referral results on an ongoing basis, and
- required chiefs of staff at the medical facilities to monitor their coordinators' crisis line referral performance relative to the performance metrics established by the program office.[28]

Suicide Prevention Coordinators' Roles and Responsibilities

VHA requires each medical facility and very large community-based outpatient clinic to have suicide prevention coordinators who conduct veteran outreach and improve mental health care coordination for at-risk veterans.[29] In June 2020, VHA employed 540 coordinators at 135 medical facilities[30] to help monitor at-risk veterans and ensure they received proper care. Most coordinators are social workers and have specialized experience providing direct care to patients who are suicidal or experiencing mental health issues. Coordinators identify at-risk veterans, consult with providers, and facilitate the resolution of the veteran's needs identified in the referral.[31] The coordinators train VA staff who have contact with veterans so the staff members know how to get immediate help for veterans expressing a suicide plan or intent. The coordinators also collaborate with and provide training to community organizations who have contact with veterans. Coordinators follow a veteran's treatment progress and track and report on at-risk veterans and veterans who attempt suicide.

[27] VHA Directive 1503, May 31, 2017.

[28] VHA Directive 1503, May 26, 2020.

[29] VHA Handbook 1160.01.

[30] See VHA technical comment 7 on page 32-33. VHA requested the OIG revise this statement to change 135 "medical facilities" to "healthcare systems." The OIG did not make this revision because "medical facilities" refers to the 135 unique VA medical centers and healthcare systems that were included in the crisis line referral queue at the time of the review. VHA also wanted to clarify that VHA has a total of 171 VA medical centers (VAMCs) and 94 Very Large Community Based Outpatient Clinics (CBOCs) for a total of 265 stations and that multiple medical centers or outpatient clinics may be reported under one facility site code in the queue. These numbers are based on an updated list of VAMC and Very Large CBOCS that was published in a VHA memorandum after the audit's review period.

[31] VHA, *Suicide Prevention Coordinator Guide* and VHA Directive 1503, May 26, 2020.

Guidance for Referral Management

According to VHA policy, coordinators should help resolve the veteran's needs identified in the referral, assess the veteran for any potential risks, and coordinate the veteran's ongoing care.[32]

VHA policy requires coordinators to make their first call attempt to a veteran within one business day of receiving the referral.[33] Coordinators are expected to make a minimum of three attempts—either three phone calls or two phone calls and a letter—within three days to reach a veteran before closing the referral in the call management system.[34]

In response to the COVID-19 pandemic, VHA issued a memorandum that specifically requires coordinators make three phone call attempts to reach a veteran on three separate days and send the veteran one letter.[35] The program office updated the requirement to be consistent with VHA's national policy.[36] Once the coordinator either reaches the veteran or makes the required four attempts, the coordinator completes an electronic form in the call management system to close the referral.[37]

[32] VHA Directive 1503, May 26, 2020.

[33] These requirements only apply to veterans who were referred by the crisis line to coordinators at facilities.

[34] VHA's guidance stated that coordinators should close consults within three to five business days until VHA updated directive 1503 in May 2020, which explicitly states coordinators need to close consults within three business days. Further, during interviews, program office and medical facility staff referenced applying the three-business day standard prior to the updated directive. Thus, the review team focused on three business days versus five.

[35] VHA, Memorandum, "Continuity in Mental Health Services and Suicide Prevention Activities," March 21, 2020.

[36] VHA Directive 1232(3), *Consult Processes and Procedures*, August 24, 2016. The directive provides policy for managing mental health appointments, no shows, and consults, and includes the same requirement of three phone calls on separate days.

[37] VHA, *Suicide Prevention Coordinator Guide*.

Results and Recommendations

Finding: Suicide Prevention Coordinators Need Improved Training, Guidance, and Oversight to Ensure At-Risk Veterans are Reached

Each crisis line referral represents a unique situation in which a veteran needs help. During the review period, crisis line data showed coordinators reached about 133,000 of 163,000 veterans (82 percent) within the required three days from receipt of the referrals.[38] However, the OIG found the data were not accurate because some coordinators mistakenly closed some referrals using system codes that indicated they had reached the veteran when they had not. Coordinators only actually reached about 101,000 veterans (62 percent) within three days.

In addition, the review team determined that some coordinators did not follow the updated VHA policy issued on March 21, 2020, which required coordinators to intersperse their attempts to contact the veterans over a three-day period.[39] The OIG found the coordinators had not interspersed calls for an estimated 1,290 veterans who were not reached between March 22, 2020, and June 30, 2020.

The OIG also found that coordinators did not always make required attempts or follow up with and reach approximately 3,500 veterans who received suicide intervention care in the community. The crisis line classified most of these cases as emergent referrals because emergency services were dispatched to the veteran, or the veteran was considered an imminent threat to themselves or others.

These conditions occurred because VHA and VISN and medical facility management officials needed to enhance the management of crisis line referrals and coordinator supervision.[40] Strengthened training, guidance, and monitoring of crisis line referrals would improve coordinator performance. Without it, coordinators could continue closing referrals improperly and miss opportunities to assist at-risk veterans. This report focused on the following issues:

- Coordinators overstated the number of veterans reached within three days.
- Coordinators did not intersperse calls as required to increase chances of reaching veterans.

[38] The review period was from March 21, 2019, through June 30, 2020.

[39] VHA, Memorandum, "Continuity in Mental Health Services and Suicide Prevention Activities."

[40] See VHA technical comment 8 on page 33. VHA requested the OIG revise the language of this sentence to indicate VHA, the VISNs, and medical facility management may need to review and enhance internal oversight process for the management of crisis line referrals. The OIG did not make these changes and affirms its position that the conditions identified by this review indicated that VHA, VISN, and medical facility officials need to enhance coordinator oversight.

- Coordinators did not always make required attempts to reach veterans who received care or assistance in the community.
- Managers did not provide effective oversight for coordinators to process referrals.

What the OIG Did

The team reviewed and analyzed information for approximately 163,000 referrals in the call management system. The team assessed whether coordinators properly closed the referrals after they were received from the crisis line, properly coded the outcomes of their follow-up efforts, and made required call attempts to reach veterans.[41] According to the call management system data, coordinators did not reach approximately 29,800 veterans (18 percent) during the 15-month review period.

The team reviewed two samples from the 163,000 veteran referrals made during the review period. The team selected 990 referrals from the 133,000 referrals where call management system data indicated coordinators had reached the veterans. For these referrals, the team reviewed the follow-up notes coordinators annotated in both the crisis line referrals and the veterans' electronic health records to confirm the coordinators had reached the veterans at the time they closed the referrals. If the team could not confirm this, the team assessed the records to determine if the coordinators had made all the required call attempts.

The second sample consisted of 157 veteran referrals selected from the approximately 29,800 where call management system data indicated coordinators had not reached veterans before closing the referrals. In these instances, the team reviewed coordinators' follow-up notes in the call management system and veterans' electronic health records to determine if the coordinators made the required number of call attempts before closing the referral. Furthermore, the team analyzed the spacing of the actual call attempts to determine if referrals were closed on the same day as the first attempt without a valid documented reason, such as a disconnected or incorrect phone number. The team used the number of unsupported same-day closures for the 15-month review period to estimate the number of referrals after March 21, 2020, where the coordinators did not intersperse call attempts over three days as required by VHA policy.

Finally, the team also surveyed 114 VISN and medical facility managers and 162 coordinators at 43 randomly selected medical facilities to identify the local oversight related to coordinators' management of crisis line referrals.

[41] The team reviewed veterans' electronic health records for the two-week period after the coordinators' receipt of the referral.

Coordinators Overstated the Number of Veterans Reached within Three Days

For the 990 referrals where the coordinators closed the referrals in the system within three days indicating they had reached the veterans, the team reviewed the call system management notes related to each of the referrals and, where applicable, the veterans' VA electronic health records to confirm whether the coordinators had reached the veterans. The team's review disclosed that 143 veterans did not have any supporting documentation in either the call management system or the electronic health records showing they had been reached. Based on the results of this review, the team projected the call management system's data overstated the number of veterans the coordinators reached within three days by about 32,000 veterans.

By adding the estimated 32,000 additional veterans who had not been reached to the initial approximately 29,800 unreached veterans in the call management system data, the team estimated the coordinators actually did not reach a total of about 62,000 veterans. As shown in figure 1, the team estimated that coordinators only reached and assisted about 101,000 veterans within three business days of the receipt of the referrals rather than the approximately 133,000 veterans reported in the call management system data.

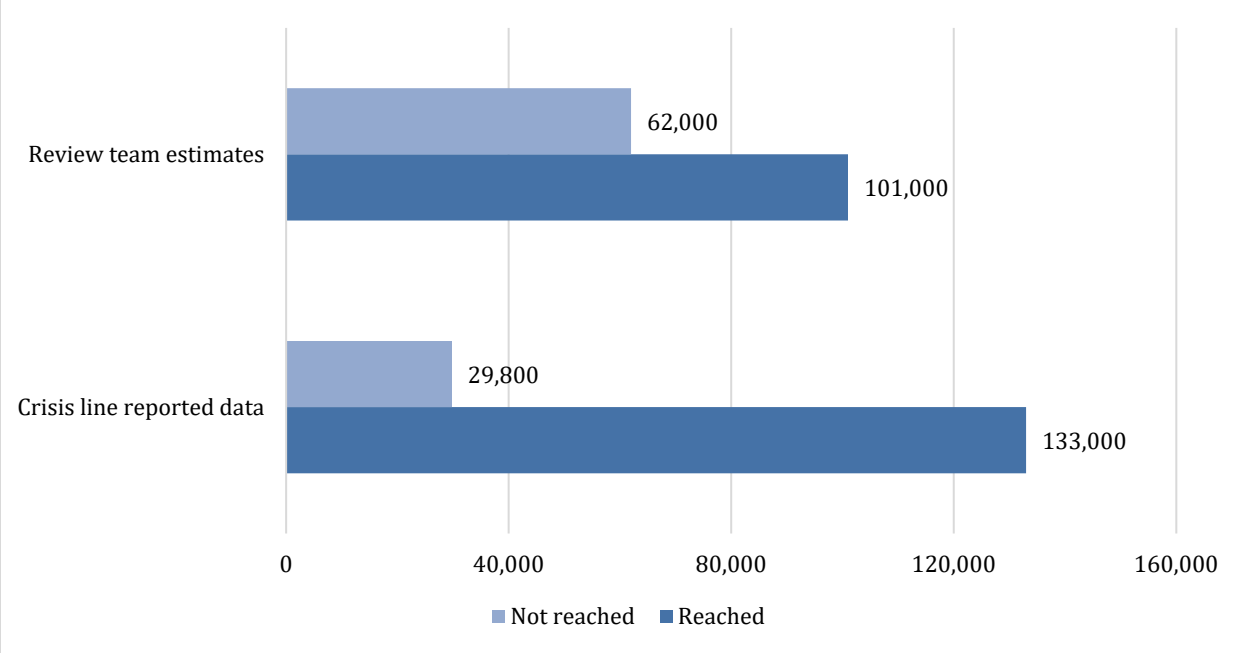

Figure 1. *The crisis line reported data and review team's estimated projections for number of veterans reached within three days during the 15-month review period.*

Source: Crisis line referral data extracted from the crisis line call management system and review team's statistical projections.

The call management system data incorrectly showed that coordinators reached almost 82 percent of veterans within three days, but on review by the team, coordinators only reached

about 62 percent of veterans in that timeframe. This approximate 20 percent discrepancy in the reported data occurred because coordinators lacked formal training on the appropriate codes to select when they completed call management system forms to close the referrals.[42]

Coordinators are required to fill out a call management system form for each veteran, using system codes to show the follow-up actions they have completed for the referred veterans before closing the referral. The call management system form is intended only to document the actions of the coordinators. Coordinators should only select codes that reflect the actions they have taken and the results.[43] However, some coordinators used codes that reflected the work that crisis line responders completed before they referred veterans to the coordinators, which can be erroneously interpreted as the coordinators reached the veterans. Consequently, coordinators sometimes marked codes in error that made it appear they had reached the veterans and provided some assistance when they, in fact, had not.

These types of cases were incorrectly counted by information technology staff who collected the data as referrals where the coordinators reached and assisted the veteran. Medical facility officials who supervised the coordinators and crisis line information technology staff did not identify the coding errors. They did not test or verify the accuracy of the information the coordinators entered on the forms because it was not required by policy.[44]

At the time of the review, the team's discussions with crisis line information technology staff disclosed that the program office was unaware that some coordinators were coding the referrals incorrectly. As such, the data in the call management system continues to overstate the number of veterans reached within three days. Without controls to ensure accurate data, VHA is unable to effectively monitor coordinators' management of referrals and make informed decisions. As of March 2021, the program office was in the process of testing its call management system data.

Coordinators Did Not Intersperse Calls as Required to Increase Chances of Reaching Veterans

Some coordinators continued closing referrals on the same day even after VHA's March 2020 policy required coordinators to make call attempts to veterans on separate days.[45] The review team evaluated approximately 29,800 referrals where veterans were not reached to find ones that

[42] See VHA technical comment 11 on page 34. VHA stated it does not agree with the OIG's statement that the reported 20 percent discrepancy occurred due to a lack of formal training because it cannot find evidence in the report as to how the OIG reached this conclusion. From the sample of 31 cases, the review team judgmentally selected 10 coordinators to interview that managed these cases. These 10 coordinators had indicated they had not received formal training on how to select the appropriate codes when they completed the call management system forms and closed the referrals.

[43] VA, *Veterans Crisis Line (VCL) Response Application User Guide*, ver. R37, June 13, 2019.

[44] VHA Directive 1503, May 31, 2017, and May 26, 2020.

[45] VHA, Memorandum, "Continuity in Mental Health Services and Suicide Prevention Activities."

were closed on the same day as the first call attempt. The review team identified about 8,500 referrals where the referral was closed on the same day as the first call attempt.[46]

Since VHA did not explicitly state that coordinators had to intersperse their call attempts on separate days until the March 2020 COVID-19 memorandum, the team examined just over 1,300 veterans' referrals from March to June 2020 that coordinators closed on the same day they received the referral. The team also reviewed a sample of 31 veterans from the approximately 8,500 total referrals closed within one day during that time on the basis that the three-day requirement to intersperse calls could not be met in that time. The review showed that about 97 percent of the sampled referrals did not have a valid reason for why the coordinators closed the referrals on the same day as their first attempt to reach the veteran.[47] Based on these results, the team projected coordinators did not provide valid reasons explaining their failure to intersperse call attempts for just over 1,290 veterans (or about 15 percent) who had same day closures after the issuance of the memorandum requiring coordinators to intersperse calls.

Coordinators' practice of closing referrals on the same day as the first call attempt could decrease the chances of successfully reaching veterans. Veterans might not be available on a single day when the coordinator attempts the call because they could be working or otherwise unavailable to answer the phone.

Prior to March 2020, VHA's guidance required coordinators to make a minimum of three follow-up attempts—either three calls, or two calls and one letter—but did not specify when the call attempts should be made nor did it prohibit all the attempts from being made on the same day.[48] Moreover, the team noted that the crisis line responders did not always include in the referral the best day or time to call the veterans. Thus, based on the team's review of the referrals, the coordinators made the required phone attempts at their discretion, generally during normal business hours from Monday through Friday during the hours of 8 a.m. to 5 p.m. According to the director of national care coordination and the former acting director of field operations, the practice of spacing the calls is important because it can improve the coordinators' chances of reaching veterans.

The program office provided the March 2020 memorandum to coordinators via email.[49] The program office updated the requirement to intersperse calls on separate days to be consistent with

[46] The review period was from March 2019 to June 2020. The review involved referrals where veterans were marked as not reached.

[47] The team reviewed call management system information and veterans' electronic health records to determine if coordinators documented valid reasons, such as inaccurate contact information, for same-day closures. See appendix B for additional information about the statistical sampling methodology and related estimates. Although, coordinators are not required under VHA policy to document reasons for closing referrals without attempting to reach the veteran or after only one call attempt.

[48] VHA, *Suicide Prevention Coordinator Guide*.

[49] VHA, Memorandum, "Continuity in Mental Health Services and Suicide Prevention Activities."

VHA's national policy.[50] In addition, the crisis line's director for national care coordination stated that the requirement to intersperse calls on separate days was discussed during weekly meetings with coordinators. After VA issued the memorandum, the percentage of referrals where coordinators did not intersperse their call attempts and closed the referrals on the same day declined, as shown in figure 2.

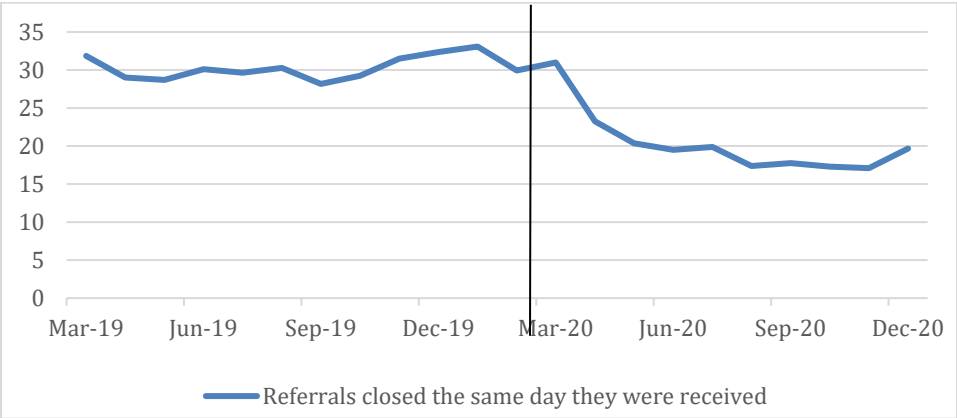

Figure 2. *Percentage of referrals where coordinators did not intersperse call attempts.*
Source: OIG analysis of crisis line referral data.
Note: The vertical line indicates when the requirement was established in March 2020.

Even so, some coordinators still claimed during interviews that they were unaware of this requirement. As a result, they followed prior policy and practices to process crisis line referrals.

Some coordinators incorrectly believed that they must close referrals in the call management system so that other VA healthcare providers can see the referral information in the veterans' electronic health records. This led some coordinators to close referrals before they made reasonable efforts to reach veterans within the three business days.

Coordinators Did Not Always Make Required Attempts to Reach Veterans Who Received Care or Assistance in the Community

In situations where a veteran calls the crisis line and the crisis line responder deems the veteran an imminent threat to self or others, the responder may initiate community-based services, including requests for local emergency dispatch services to perform a welfare check or to transport the veteran to a local hospital. The crisis line responder will also send a referral to a coordinator at a VA medical facility for these cases, where the coordinator must still make the three required attempts to reach the veteran. Of the sample of 115 referrals where coordinators did not make all the required attempts to reach veterans, 49 involved veterans who received suicide intervention care or assistance in the community. Furthermore, the review team noted

[50] VHA Directive 1232(3).

that other medical facility staff did not follow up on 12 (about 24 percent) of these veterans after the coordinators closed the referrals. As a result, the team estimated that coordinators did not make all the required attempts to reach approximately 3,500 veterans who received suicide care or assistance in the community from March 2019 through June 2020, and these veterans did not receive any additional follow-up after the closure of their referrals.

VHA's crisis line management policy requires coordinators to make at least three attempts to reach all referred veterans because it is important for coordinators to help resolve the veteran's needs identified in the referral, assess the veteran for any potential risks, and coordinate the veteran's ongoing care.[51] Referred veterans who have received suicide intervention care or assistance in the community are considered to be at-risk because emergency services were dispatched to address the veterans' medical or mental health emergency, or the veterans presented an imminent threat to themselves or others. In addition, many of these veterans have a history of past suicide attempts or reported suicidal ideation with the means to commit suicide. A paper authored by several VHA program office staff also noted that suicide rates are particularly high within one month of calling the crisis line and remain substantially elevated through 12 months.[52]

However, the team's review of veterans' call system management notes and electronic health records disclosed coordinators did not always make all the required attempts to reach and follow up with veterans. Of the 115 referrals that coordinators closed without making all the required attempts to reach the veterans, 49 belonged to veterans who had been admitted to a non-VA hospital or emergency room or received a welfare check—about 43 percent. The team's survey results disclosed that over 90 percent of the 162 surveyed coordinators followed up on veterans who had welfare checks, and only about 60 percent reported they followed up if veterans were discharged from a non-VA hospital.

Under VHA policy, coordinators are expected to attempt to reach veterans, and follow-up is to be conducted by coordinators where "clinically indicated" after closure of the referrals. Some coordinators closed referrals and did not make all of the required attempts to reach these veterans, but it was often not clear from reviewing the call system management notes and veterans' medical records why the coordinators did not make all the required attempts. Based on interviews and survey responses, some coordinators stated they did not try to reach veterans to conduct follow-up if they confirmed the veteran had been hospitalized, the veterans did not have high-risk flags, or they had alerted the veterans' current providers (e.g. primary care or mental health) of the need to follow up with the veterans. Example 1 shows how some coordinators confirmed the veteran received suicide intervention care in the community and closed the referral without making any additional attempts to reach the veteran.

[51] VHA Directive 1503, May 26, 2020.

[52] Hannemann MPH, "Suicide mortality and related behavior."

Example 1

> *A veteran called the crisis line on May 13, 2020, with suicidal ideation. The veteran had a past suicide attempt in 2014 and suffered from depression and posttraumatic stress disorder. A coordinator attempted to reach the veteran by phone on May 14, 2020, without success, but reached the veteran's partner the following day, who stated that the veteran was at a local hospital. The coordinator closed the referral using the "hospitalized" code and never made any more attempts to reach the veteran after discharge to see if the veteran's needs were fully addressed or whether further VA care or services were needed.*

The program officials the team interviewed acknowledged that the coordinators all should have at least made the required three attempts to reach the veterans before they closed the referral, even if the veterans had received suicide intervention care or assistance in the community. However, the same program officials also contended under VHA policy that medical facility staff only had to perform follow-up when clinically indicated. While the review team acknowledges coordinators are permitted under VHA policy to use their clinical judgment, the call management system notes and the veterans' electronic health records often lacked documentation explaining why the coordinators did not continue to try to reach these veterans before they closed the referrals and how they determined the veterans did not require any follow-up.

Since veterans who receive suicide intervention care and assistance in the community may be at higher risk for suicide, the team concluded VHA needs to consider developing clearer guidance for coordinators regarding the requirement to reach these veterans, clarify the expectations it has for follow-up when the referred veterans have received suicide intervention care or assistance in the community, and ensure coordinators document their rationale for not making all of the required attempts to reach the veterans.

Managers Did Not Provide Effective Oversight for Coordinators to Process Referrals

VHA's May 2020 updated policy now requires VISNs to provide oversight of policy implementation and performance management within the VISN, and medical facilities are required to provide oversight of the medical facility referral outcomes and monitor and improve the performance and results on an ongoing basis. However, the updated policy does not explicitly identify what performance outcomes the VISNs and medical facilities should monitor.[53]

The team surveyed managers and coordinators at 43 randomly selected medical facilities and their respective VISNs, after the issuance of the May 2020 policy to assess local oversight of the

[53] VHA Directive 1503, May 26, 2020.

coordinators and the management of crisis line referrals. Responses from roughly 89 percent of the managers surveyed and about 84 percent of the coordinators surveyed disclosed the following:

- VISN and medical facility managers were unaware of the oversight responsibilities. Over half (about 54 percent) of the managers stated they were not responsible for monitoring crisis line referrals.
- Coordinators were not uniformly monitored. Almost half (about 46 percent) of the coordinators reported they only met with their managers on an as-needed basis, and nearly one third (roughly 29 percent) responded their supervisors did not discuss referral outcomes and ways to improve the management of crisis line referrals with them.
- Only about 27 percent reportedly monitored whether coordinators reached veterans. The survey also disclosed none of the managers monitored whether coordinators interspersed calls over three days.

As a result, local VISN and medical facility managers have not established effective oversight mechanisms to help them identify similar referral management issues to those the team identified during its review. Moreover, the crisis line's director of national care coordination only monitors and follows up with coordinators when they do not close referrals within the three-day period. The program office managers also have not established a mechanism to ensure coordinators intersperse calls on three separate days, as required. Due to the lack of oversight at the VISNs and medical facilities, the program office needs to establish specific monitoring requirements for VISNs and medical facilities to oversee the coordinators' management of referrals.[54] Monitoring could include processes, such as having medical facility supervisors perform a periodic sample review of referrals and report identified deficiencies and corrective actions to the program office.

The crisis line's director of national care coordination informed the team in May 2020 that the crisis line has begun developing a report to assess the rates at which the coordinators fail to reach veterans. As of March 2021, this report was still under development. The program office plans to use the data to assess and compare medical facility coordinators' performance and identify facilities experiencing problems. Lower-performing facilities may need the program office's assistance to identify the root causes and remedial actions to improve the number of veterans reached. However, the program office does not plan to include the coordinators' interspersing of calls on separate days in this report.

[54] See VHA technical comment 9 on page 33. VHA requested the OIG edit this section and add numerous responsibilities and requirements at various levels per VHA directive 1503. The OIG did not make these edits because the requirements and responsibilities are discussed throughout the report, to include pages 2-4, and within in this section, first sentence on page.

Conclusion

VHA has opportunities to strengthen training and improve guidance and oversight to enhance coordinators' chances of reaching more at-risk veterans referred by the crisis line. The review team determined coordinators reached fewer veterans within three days than reported and potentially missed opportunities to maximize the number of veterans reached by not interspersing call attempts as required after the issuance of policy in March 2020. Further, the review found that higher-risk veterans who received suicide intervention care in the community did not always receive follow-up when coordinators did not make all the required attempts to reach veterans before closing the referrals. Coding errors continue to result in inaccurate data, and as a result, VHA is not positioned to effectively manage the program and take corrective actions, as needed, to ensure veterans receive assistance. Until the program office provides additional training, issues clear guidance, and provides VISN and facility managers accurate information and performance data for their facilities, VHA will not have assurance that at-risk veterans receive the help they need.[55]

Recommendations 1–5

The OIG made the following recommendations to the under secretary for health:

1. Ensure program officials in collaboration with regional and local leaders address call management system data integrity issues before they use data to assess the management of referrals.
2. Have the program office develop formal training and guidance for coordinators on how to use patient outcome codes and regional and local leaders ensure the training is completed.
3. Ensure regional and local managers regularly review crisis line referral information in the electronic health records to verify coordinators are completing and documenting appropriate follow-up on referrals and the program office performs regular audits, monitors, reports upon, and initiate actions, as needed, to ensure compliance with and completion of referral follow-up.
4. Consider guidance within coordinators' training tools to clarify the expectations for coordinators to follow up on referred veterans who have been hospitalized in a non-VA hospital, admitted to an emergency department (VA and non-VA), or provided a welfare check.

[55] See VHA technical comment 10 on page 33-34. VHA requested the OIG revise this sentence to reflect ongoing efforts to enhance coordinator training and guidance and provide data to strengthen coordinator oversight and engagement with at risk veterans. These edits were not made because these changes were not implemented at the time of the review and were not evaluated by the review team.

5. Have regional and local managers monitor coordinators' call attempts to ensure they are interspersed over a three-day period and provide them with referral closure information to assist in their monitoring.

Management Comments

The undersecretary for health concurred or concurred in principle with all the report's findings and recommendations and submitted action plans for recommendations 1 through 5. Appendix C provides the full text of the undersecretary's comments.

In response to recommendation 1, the undersecretary stated that the program office created a crisis line dashboard in June 2021 that includes real-time data on requests and process improvement opportunities, identifies performance gaps in response to VCL requests, and allows for national monitoring of VCL requests. The program office, in collaboration with the field, validated and reconciled the data contained in the dashboard. A finalized version was distributed to the field in August 2021. The program office also plans on conducting routine sample reviews of call management system data to ensure data integrity.

For recommendation 2, the program office will provide a formal recorded training to suicide prevention staff and have VISN chief medical officers attest that they reviewed the training.

For recommendation 3, the program office will assist with the development of a local assurance program and an attestation procedure to ensure a local process is in place. The program office will also provide monthly monitoring report to VISN chief medical officers regarding referral closures and identify when performance requires further scrutiny.

In response to recommendation 4, the program office will provide clarifying guidance on follow up procedures for referred veterans hospitalized in a non-VA hospital, admitted to an emergency department, or provided a welfare check. VISN chief medical officers will provide attestation that all suicide prevention staff received the updated guidance.

For recommendation 5, the program office will assist the field with creating local quality assurance practices. Local managers will also review a sample of closed referrals to ensure calls were interspersed on three separate days.

OIG Response

The OIG will assess the satisfactory completion of these claimed actions in conjunction with its routine recommendation follow-up. Overall, the proposed corrective measures in VHA's action plans appear to be responsive to the recommendations, and the OIG will monitor the implementation of the recommendations until all actions are documented as completed.

The under secretary for health provided 13 technical comments in its response to this report. The OIG incorporated clarifying information in the narrative of the report where appropriate and added explanatory footnotes as needed to address these technical comments. Specifically, the

OIG updated the narrative or added footnotes in the report to incorporate clarifications VHA requested in technical comments 3, 5, 11, and 13. The OIG did not revise the narrative and only added footnotes to the appropriate sections of the report to address the nine remaining technical comments. The OIG provides the following explanations for why it addressed these technical comments in the footnotes.

The OIG did not make the revisions requested in VHA technical comments 1, 2, 8, and 12 because VHA incorrectly asserted the OIG's statements were inaccurate or wrong. In comments 1 and 2, VHA asserted the OIG overstated the number of veterans who were not reached and that this was only a coding error because veterans may have been reached by other medical facility staff. However, the OIG affirms its position that neither the coordinators nor other medical facility staff had reached the veterans within the three-day period before the coordinators closed the referrals. In comment 8, VHA wanted the OIG to revise its conclusion to state it "may" need to enhance its coordinator oversight processes, but the OIG still stands by its findings and conclusion that stronger oversight is needed, not "may be" needed as VHA suggests. For comment 12, VHA contended that the OIG did not consider cases where veterans did not need follow-up or could not be reached when it prepared its projection of the number of calls closed on the same day as the first call attempt. The OIG did consider these types of cases, and they were not included in the projection as discussed on page 26 of appendix B.

The OIG also did not make the revisions VHA requested in technical comments 4, 6, 7, 9, and 10 because VHA requested the OIG add information that was either outside the review period and not assessed (comments 4, 6, 7, and 10) or repeated information that was already presented in the report (comment 9). See appendix C for VHA's technical comments.

Appendix A: Scope and Methodology

Scope

The review team conducted its work from May 2020 through December 2021. The team reviewed crisis line referral data and veterans' electronic health records during the approximately 15-month period ending June 30, 2020. The review evaluated the accuracy of VHA data and whether coordinators or medical facility staff reached and assisted referred veterans, as appropriate, to include follow-ups after coordinators closed referrals.

Methodology

The review team performed the following actions to understand program operations, including the oversight and controls over coordinators' management of crisis line referrals and coordinators' roles, responsibilities, and processes to respond to referrals:

- Reviewed national and local policies, procedures, and guidance related to the management of crisis line referrals
- Interviewed staff from Office of Mental Health and Suicide Prevention's crisis line program and suicide prevention program
- Interviewed 51 coordinators at various medical facilities
- Administered an online survey to VISN and medical facility managers and coordinators at 43 sampled medical facilities

To assess coordinators' management of crisis line referrals, the team obtained and analyzed crisis line referrals from the call management system between March 21, 2019, and June 30, 2020. The data indicated that coordinators and other VA medical facility staff managed approximately 163,000 referrals (about 133,000 reached and an estimated 29,800 not reached) during the review period. For the subpopulation of approximately 133,000 referrals where the data indicated the veterans were reached, the team selected a sample of 990 referrals managed by 33 coordinators. For the subpopulation of about 29,800 referrals where the data indicated the veterans were not reached, team selected a sample of 157 referrals.

The team also sampled and reviewed 31 referrals from a subgroup of about 8,500 referrals (from the approximately 29,800 subpopulation) where the veterans were not reached at the time the referrals were closed and the call attempts were not made on separate days before the closure. For the samples where the coordinator did not reach the veteran, the team reviewed any related notes, communications, and appointments in the veterans' electronic health records made in the two-week period after the referral date to determine if veterans received assistance after the referrals were closed. The team subsequently conducted follow-up interviews with

15 coordinators from different medical facilities to identify reasons why the coordinators did not follow up with veterans after they closed the referrals or reasons why they did not space their call attempts on different days, as required.

Surveys of VISN and Medical Facility Staff about Crisis Line Referral Management

The team conducted an online survey from June 16 through July 1, 2020, of 192 coordinators at 43 medical facilities and their respective VISNs. This survey was designed to collect information about coordinators' roles and responsibilities when responding to crisis line referrals, as well as their communications with supervisors related to any oversight over referral management. The response rate was about 84 percent.

From August 31 through October 5, 2020, the team administered two separate online surveys of 114 managers at 43 medical facilities and their respective VISNs. The survey was designed to collect information on program oversight, monitoring, and reporting. The response rate was about 89 percent.

Internal Controls

The review team determined that internal controls were significant to the review objective. The team assessed the internal controls applicable to the review objective. This assessment of the five internal control components included control environment, risk assessment, control activities, information and communication, and monitoring.[56] The team identified the following two components and related principles as significant to the review objective:

- Component 3: Control Activities
    - Principle 10: Management should design control activities to achieve objectives and respond to risks.
- Component 4: Information and Communication
    - Principle 13: Management should use quality information to achieve the entity's objectives.

The team identified internal control weaknesses during the review and proposed recommendations 1–5 to address these control deficiencies.

[56] Government Accountability Office, *Standards for Internal Controls in the Federal Government*, GAO-14-70G, September 2014.

Fraud Assessment

The review team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during this review. The team exercised due diligence in staying alert to any fraud indicators and did not identify any instances of fraud or potential fraud during this review.

Data Reliability

The team used computer-processed crisis line referral data from the call management system. To assess the reliability of this data, the team performed tests to determine if there were any obvious errors, including data missing from key fields, calculation errors, data outside the time frame requested, duplicate records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Furthermore, the team compared the call management system data from the sampled referrals to include veterans' names, social security numbers, referral information, and referral dates with information disclosed in the patients' electronic health records.

During the team's review of the sampled referrals, the comparison of the data with the information in the patients' medical health records did not disclose any problems with data reliability related to basic veteran information and other pertinent information, such as referral date, coordinators' synopsis of outreach efforts, and summaries of their conversations with veterans. However, the team identified data accuracy issues in the data field where coordinators noted whether veterans were reached or not. The team sometimes found that coordinators noted they reached the veteran when they did not. The team addressed this concern in the report and developed recommendations to address this data integrity issue. Aside from this issue, the team concluded that the crisis line referral data were sufficient and reliable to achieve the review objective and develop the report's conclusions and recommendations.

Government Standards

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

Appendix B: Statistical Sampling Methodology

Approach

To accomplish the objective, the review team obtained crisis line referrals from the call management system database during the approximately 15-month review period ending June 30, 2020, to determine if the crisis line data was accurate, veterans referred from the crisis line were reached and provided with assistance, and coordinators followed the requirement to make call attempts on subsequent days during a three-month period (March to June 2020).

Population

The review team identified almost 163,000 crisis line referrals in the call management system that were sent to coordinators at 135 medical facilities during the review period of March 21, 2019, through June 30, 2020. From this population, the team also examined two subpopulations within this population. The first subpopulation included roughly 133,000 referrals where the coordinators reportedly reached the veterans and closed the referrals. The second subpopulation included about 29,800 referrals where the coordinators reported they did not reach the veterans. The team's review of the crisis line data also identified an attribute in the subpopulation indicating some coordinators had not interspersed the call attempts for just over 1,300 referrals after the issuance of the March 2020 COVID-19 memorandum.

Sampling Design

The team developed a stratified sample design and sampled a total of 1,147 referrals that coordinators received from March 21, 2019, through June 30, 2020, as shown in table B.1.

Table B.1. Crisis Line Referrals

Description	Number of referrals	Number of sampled referrals
Referrals recorded as "Veteran Reached"	133,000	990
Referrals recorded as "Veteran Not Reached"	29,800	157*
Total	**163,000**	**1,147**

Source: Call management system crisis line referral data and VA OIG statistician analysis.
Note: Of the 157 sampled referrals, 31 were processed and closed on the same day as the first call attempt.

For the subpopulation of approximately 133,000 referrals where the data indicated the veterans were reached, the review team stratified the subpopulation based on the volume of referrals each coordinator received and the coordinator's success rate in reaching the referred veterans. The statistician grouped referrals and coordinators into three strata and selected a sample of 990 referrals managed by 33 coordinators. The statistician divided the subpopulation to give all the coordinators, facilities, and referrals a chance of being selected. This allowed the team to project the results for coordinators, facilities, referrals, and veterans over this subpopulation. The sampling design was representative and provides projections for the entire subpopulation, with a 90 percent confidence.

For the subpopulation of approximately 29,800 referrals where VHA data indicated the veterans were not reached, the review team stratified the subpopulation according to the medical facilities' volume of referrals, the rate at which the facilities could not reach the veterans, and referral type (emergent, urgent, and routine). The team also took into consideration whether veterans had not received services in the past two years. Additionally, the team identified an attribute in the subpopulation of approximately 29,800 referrals where coordinators closed about 8,500 referrals on the same day as their first attempt to reach the veteran. Thus, the sample was designed to include referrals with this attribute.

Using these criteria, the statistician divided the medical facilities and coordinators into five strata based on the rates at which they did not reach veterans. The statistician then divided the stratified population into two subpopulations to determine if coordinators had implemented the required changes set forth in the March 2020 COVID-19 memorandum. The statistician used a statistical process control technique and divided the stratified population to give all the facilities and referrals an equal chance of being selected in the two subpopulations: the 12-month period before the issuance of the memorandum and the three-month period after the issuance.[57] From this population, the statistician then selected a sample of 157 referrals from the five strata, including 31 referrals that were closed on the same day as the coordinators' first attempts to reach the veterans.[58]

The statistical process control technique and hypergeometric distribution allowed the review team to use the testing results from the 12-month population and a limited test sample from the three-month period to evaluate probabilistically whether the coordinators had closed referrals on

[57] "Statistical process control" is defined as the use of statistical techniques to monitor a process. This technique can help monitor process behavior and determine if changes have occurred.

[58] See VHA technical comment 12 on page 34. VHA asserts that the OIG did not consider if veterans were not reachable or further follow-up was not needed based on responses received following the first attempt. The OIG did consider whether veterans were reachable or whether follow-up was needed when it reviewed these cases. The OIG team reviewed the veterans' call management system notes and electronic healthcare records for the 31 cases and did not count the cases as improperly closed on the same day of receipt if the records indicated the veterans were not reachable or no follow-up was needed. This part of the review methodology is discussed in detail on page 26 of Appendix B.

the same day without documenting a valid reason.[59] The team reviewed call management system information and veterans' electronic health records to determine if coordinators documented valid reasons, such as inaccurate contact information or the veteran was unavailable due to incarceration, for same-day closures.[60] This approach also allowed the team to project the results over medical facilities, referrals, veterans, and for each subpopulation. See table B.3 for projection results. The sampling design was representative and ensured projections described the entire population.

Weights

Samples were weighted to represent the population from which they were drawn, and the weights were used in the estimate calculations. For example, the team calculated the error rate estimates by first summing the sampling weights for all sample records that contained the given error, then dividing that value by the sum of the weights for all sample records. Since each medical facility and coordinator had a different number of crisis line referrals and the sample sizes varied across all medical facilities, the sampling weights also varied in size. This accounts for the percentages calculated being different from the percentages for the raw sample numbers.

Projections and Margins of Error

The projection is an estimate of the population value based on the sample. The associated margin of error and confidence interval show the precision of the estimate. If the OIG repeated this review with multiple sets of samples, the confidence intervals would differ for each sample but would include the true population value 90 percent of the time.

The OIG statistician employed statistical analysis software to calculate estimates, margins of error, and confidence intervals that account for the complexity of the sample design.

The sample size was determined after reviewing the expected precision of the projections based on the sample size, potential error rate, and logistical concerns of the sample review. While precision improves with larger samples, the rate of improvement decreases significantly as more records are added to the sample review.

Figure B.1 shows the effect of progressively larger sample sizes on the margin of error.

[59] In probability theory and statistics, the hypergeometric distribution is a discrete probability distribution that describes the probability of successes or failure in samples from a population of size that contains exactly objects with that feature, wherein each draw is either a success or a failure. Douglas C. Montgomery, *Introduction to Statistical Quality Control*, 2nd ed. (1991).

[60] See VHA technical comment 13 on page 34.

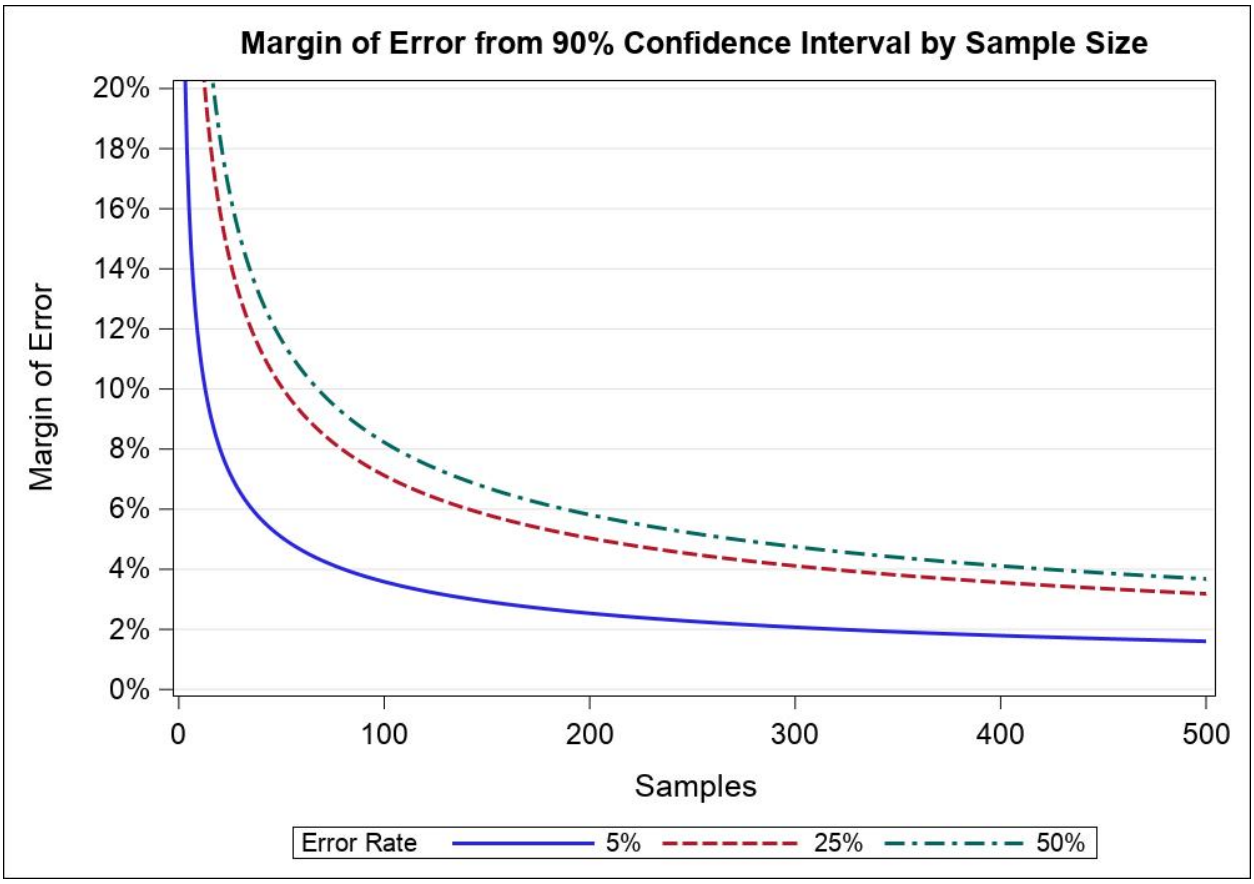

Figure B.1. *Effect of sample size on margin of error.*
Source: OIG statistician's analysis.

Projections

Based on the team's review results from the subpopulation of about 133,000 referrals indicating that the veterans had been "reached," the team could not confirm that the coordinators had reached approximately 32,000 veterans at the time the referrals were closed. Further analysis of these review results indicated the coordinators or medical facility had

- erroneously reported about 3,500 veterans had been reached, even though coordinators did not conduct any follow-up for these veterans who received suicide intervention care in the community;
- made reasonable efforts to follow up with about 2,700 veterans' referrals after their closure, but the veterans were not reached due to inaccurate or incomplete contact information or because the veterans were not responsive to outreach efforts; and
- continued following up with veterans after closing the referrals and reached and assisted about 25,000 veterans.

Table B.2. shows statistical projections of veterans affected based on referrals.

Table B.2. Statistical Projections for Referrals Recorded as "Veteran Reached"

Estimate name	Estimate number (referrals)	Margin of error based on 90% confidence interval (referrals)	90% confidence interval lower limit (referrals)	90% confidence interval upper limit (referrals)	Number of errors (referrals)	Total sample size (referrals)	Total population (referrals)
Inaccurate call management system data	31,858	23,937	7,921	55,795	143	990	133,000
Medical facility staff did not reach higher-risk veterans after referrals were closed	3,462	3,476	12	6,938	12	143	31,858
Medical facility staff reached veterans after referrals were closed	24,902	17,892	7,010	42,794	115	143	31,858
Medical facility attempted to reach veterans but were unsuccessful	2,698	2,075	623*	4,773*	10	143	31,858

Source: VA OIG statistician's analysis of call management system data and team's review of referrals.
Note: Projections are based on 90 percent confidence interval.
**Lower limit was adjusted if it was less than what was found in sample and upper limit was adjusted if it was greater than the known population.*

Based on the team's review results from the subpopulation of approximately 29,800 referrals where the data indicated veterans had not been reached at the time the referral was closed, the team projected that coordinators or medical facility staff

- did not follow up with approximately 6,100 veterans after referral closure,
- made reasonable efforts to follow up with approximately 1,020 veterans after the referrals were closed because of inaccurate or incomplete contact information, or the veterans were not responsive to outreach efforts, and

- continued following up with veterans after referral closure and had reached and assisted about 3,600 veterans.

The team also sampled and reviewed 31 referrals from a subgroup of about 8,500 referrals from the approximately 29,800 subpopulation where the veterans were not reached at the time the referrals were closed and the call attempts were not made on separate days. Based on this review, the team determined that about 97 percent of the referrals during the 15-month period of review did not have documented reasons for closure on the same day as the coordinators' first attempts to reach the veterans. The team applied this error rate to the approximately 1,300 referrals the crisis line made after the program office issued the March 2020 COVID-19 memorandum explicitly requiring coordinators to make their call attempts on separate days. Using this error rate, the team estimated that just over 1,290 veteran referrals lacked documented reasons for the closure of the referrals on the same day. Table B.3 summarizes the statistical projections.

Table B.3. Statistical Projections for Referrals Recorded as "Veteran Not Reached"

Estimate name	Estimate number (referrals)	Margin of error based on 90% confidence interval (referrals)	90% confidence interval lower limit (referrals)	90% confidence interval upper limit (referrals)	Number of errors (referrals)	Total sample size (referrals)	Total population (referrals)
Medical facility staff did not follow up with veteran after referrals were closed	6,120	1,234	4,885	7,354	72	126	29,800
Medical facility staff assisted veterans after referrals were closed	3,570	1,051	2,518	4,621	42	126	29,800
Medical facility staff attempted to reach veterans but were unsuccessful	1,020	513	507	1,533	12	126	29,800
Same-day closure of referral did not follow policy	1,290	60	1,191	1,311	30	*31*	1,300

Source: VA OIG statistician's analysis of call management system data and team's review of referrals.
Note: Projections are based on 90 percent confidence interval.

Appendix C: Management Comments

Department of Veterans Affairs Memorandum

Date: March 8, 2022

From: Deputy Under Secretary for Health, Performing the Delegable Duties of the Under Secretary for Health (10)

Subj: OIG Draft Report, Suicide Prevention Coordinators Need Improved Training Guidance and Oversight (2020-02186-R7-0002) (VIEWS #6455835)

To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report on suicide prevention coordinator training and oversight. The Veterans Health Administration (VHA) concurs with recommendations 1-4. VHA concurs in principle with recommendation 5 and provides an action plan to address all recommendations.
2. Since its launch in 2007, the Veterans Crisis Line (VCL) has answered nearly 5.9 million calls, initiated the dispatch of emergency services to callers in crisis more than 220,000 times, engaged in more than 704,000 chats, responded to nearly 239,000 texts and submitted more than 1.1 million referrals to local VA Suicide Prevention Coordinators. Suicide Prevention Coordinators follow up with Veterans to connect them with appropriate care and services after the call. This process is instrumental to ensuring at-risk Veterans are reached and provided with effective care.
3. By July 16, 2022, Veterans will be able to dial 988 then Press 1 to reach the VCL, giving Veterans an easy to remember way to reach caring responders. For more information, visit www.veteranscrisisline.net/about/988.
4. VHA and its Office of Mental Health and Suicide Prevention appreciates OIG's insight and recognizes the importance of validating data utilized to assess the management of referrals to safeguard at-risk Veterans, ensuring the Department of Veterans Affairs highest clinical priority.

The OIG removed point of contact information prior to publication.

(Original signed by)

Steven L. Lieberman, M.D.

Attachments

Attachment 1

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

Suicide Prevention Coordinators Need Improved Training,

Guidance, and Oversight (OIG 2020-02186-R7-0002)

Recommendation 1. Ensure program officials in collaboration with regional and local leaders address call management system data integrity issues before they use data to assess the management of referrals.

Comments: Concur

The Office of Inspector General (OIG) identified discrepancies related to patient outcome codes used to close referrals in the call management system and lack of verification of accuracy of the patient outcome information that was input. The Office of Mental Health and Suicide Prevention (OMHSP) recognizes the importance of validating data utilized to assess the management of referrals to local resources for Veterans contacting the Veteran Crisis Line (VCL). To address OIG's data integrity findings, OMHSP created a VCL Dashboard, titled "*SPC Monthly Request Report"*, in June 2021. The report metrics include data to identify timeliness in responding to requests and all current open request data including length of time a request has been open.

This dashboard is available to all Suicide Prevention (SP) teams and Veterans Integrated Services Network (VISN) Chief Mental Health Officers (CMHO). This dashboard:

provides facilities with real time data regarding the number, type and frequency of requests from the VCL;

assists facilities in identifying performance gaps in response to VCL requests;

provides facilities with the data needed to develop plans and processes for improvement in the VCL request process for quality assurance; and

allows for national Veterans Health Administration (VHA) monitoring of VCL requests.

The data in the dashboard goes back through 2014, and the data can be retrieved by year, quarter, month, or day. The dashboard is available through a Department of Veterans Affairs (VA) internal Power BI Report Server. To validate the data provided through the dashboard, VCL released the dashboard report to the field and asked field stakeholders to review the data and validate information collected. This process was iterative over a 2-month period. VCL reconciled the data to improve dashboard integrity and improve data definitions. VCL adjusted their databases and source collection to reflect outcomes of the validation process. A completed and finalized dashboard was then distributed to the field August 2021.

Moving forward, on a regular and recurring basis, VCL will sample call management system data (with special attention to contact with Veterans) and secure confirmation, via VISN CMHOs, of local Suicide Prevention Coordinator (SPC) and management validation of the sampled data. OMHSP will offer a copy of the finalized description of this validation process to OIG to satisfy this recommendation.

Status: In progress Target Completion Date: August 2022

Recommendation 2. Have the program office develop formal training and guidance for coordinators on how to use patient outcome codes and regional and local leaders ensure the training is completed.

Comments: Concur

OMHSP concurs that additional training and guidance is needed for instruction on coding appropriate patient outcomes in the data management process. OMHSP will provide a formal recorded training on the current Medora Users Guide (which includes all coding and data definitions) for SP teams and their local supervisors, including a review of relevant policy requirements for local implementation. VISN CMHOs will provide attestation that all SP team members reviewed the training, which will be provided as evidence of closure of this recommendation. OMHSP will also update the SPC Orientation checklist for new SP team members to include this required training.

OMHSP will ensure the SPC Guide references the Medora Users Guide which will provide local facility leadership and SP teams with information and written guidance on how to use patient outcome codes as reflected within the Medora Users Guide.

Status: In progress Target Completion Date: August 2022

Recommendation 3. Ensure regional and local managers regularly review crisis line referral information in the electronic health records to verify coordinators are completing and documenting appropriate follow-up on referrals and the program office performs regular audits, monitors, reports upon, and initiates actions, as needed, to ensure compliance with and completion of referral follow-up.

Comments: Concur

OMHSP will provide guidance and consultation on what a local quality assurance program would entail and develop an attestation procedure with the VISN CMHOs to ensure that a local process is in place. OMHSP will also provide monthly monitoring report to VISN CMHOs related to referral closures as well as identify where such performance results would be appropriate for further scrutiny.

Status: In progress Target Completion Date: August 2022

Recommendation 4. Consider guidance within coordinators' training tools to clarify the expectations for coordinators to follow up on referred veterans who have been hospitalized in a non-VA hospital, admitted to an emergency department (VA and non-VA), or provided a welfare check.

Comments: Concur

OMHSP will be reviewing current policy and procedures to clarify expectations on follow up procedures for referred Veterans in the instances referenced above and issue guidance as it is developed. OMHSP will provide OIG with evidence of updated guidance that clarifies expectations for SPCs related to follow up in non-VA hospitalized settings, emergency departments, and after a welfare check. VISN CMHOs will provide attestation that all SP team members have received updates to policy and procedures and provide this as evidence of closure of this recommendation. OMHSP will also update the SPC Orientation checklist for new SP team members to include this guidance.

Status: In progress Target Completion Date: August 2022

Recommendation 5. Have regional and local managers monitor coordinators' call attempts to ensure they are interspersed over a three-day period and provide them with referral closure information to assist in their monitoring.

Comments: Concur-in-principle

OMHSP will review and update, where needed, current resources to assist local managers with creating local quality assurance practices (reference Recommendation 3) to monitor implementation of this guidance. Local managers will also be responsible for sampling data of closed referrals to ensure calls were performed on three separate days as this data is not available at the national level. OMHSP will

provide guidance and tools for local monitoring and develop an attestation procedure for VISN CMHOs to ensure that a local process is in place.

Status: In progress Target Completion Date: August 2022

Attachment 2

VHA Technical Comments

OIG Draft Report: Suicide Prevention Coordinators Need Improved Training, Guidance, and Oversight (Project Number 2020-02186-R7-0002)

Comment 1

Draft location: Page iii first heading and on page 6, 4th paragraph, first bullet point [Final report page iii first heading and on page 6, 4th paragraph, first bullet point]

Paragraph Header: Coordinators Overstated the Number of Veterans Reached within Three days.

VHA finds the header does not accurately convey the related issue; coordinators did not overstate the number of Veterans they directly reached as opposed to miscoding the contacts also made by the other licensed Mental Health staff.

Comment 2

Draft location: Page iii, first paragraph, 2nd sentence [Final report page iii, first paragraph, 2nd sentence]

For purposes of accuracy, VA suggests OIG add a clause that provides information about the patients being contacted by another licensed staff such as, “Although the crisis line data indicated about 82 percent of veterans were reached, the team’s review of the call management system and the veterans’ electronic healthcare records revealed about 20 percent of veterans that were listed as reached had not actually been reached at the time the referrals were closed but may have been contacted by another licensed staff”.

Comment 3

Draft location: Page v, second paragraph [Final report page vi, first paragraph]

Per VHA policy, medical facility staff only have to perform follow-up when clinically indicated. Separately, VHA would like to further clarify that failure to make 3 phone attempts and sending a letter violates current policy regardless of documentation.

Comment 4

Draft location: Page v, last paragraph, second sentence [Final report page vi, first paragraph, second sentence]

For purposes of updating the public, VHA has established a regular monitoring report. The VCL Dashboard was implemented in June 2021 and validated for national use in August 2021. The data in the dashboard goes back through 2014.

Comment 5

Draft location: Page 1, footnote 13 [Final report page 1, footnote 17]

VHA would like to clarify it is appropriate clinical care for coordinators to engage a Veteran's treatment team to assist with meeting additional Veteran needs. VHA asks OIG to consider revising the sentence to: “However, VHA guidance does not include follow-up procedures for closed referrals; thus, other medical facility staff, such as social workers and doctors, may follow-up on the referred veterans as part of the veteran's clinical care."

Comment 6

Draft location: Page 2, second to last paragraph, #1 [Final report page 2, second to last paragraph, #1 and #2]

For purposes of accuracy VHA clarifies that VHA has two monitors and one accountability metric. VHA suggests OIG incorporate the revised comments below into its final report:

"The program office established two monitors to guide coordinator performance:
Timeliness of the first attempt to contact the veteran: Was it performed within one business day?

2. Consults closed with no contact: Was the consult closed with no documented contact made by the SPC?

The program office established one accountability metric:

Demonstrated attentiveness and timeliness of referral management: Was the referral to the coordinator properly closed within three business days?"

Comment 7

Draft location: Page 4, first paragraph and footnote 24 [Final report page 4, first paragraph and footnote 31]

For purposes of completeness, VHA suggests OIG incorporates the revised content into the final report regarding an update to the list of VAMCs and Very Large (VL) CBOCs provided to facilities with the publication of VHA Memorandum 2021-08-12, *Guidance for Reporting and Monitoring of Suicide Prevention Program Staffing*.

VHA asks OIG to consider revising the statement to: "In June 2020, VHA employed 540 coordinators at 135 health care systems to help monitor at-risk veterans and ensure they received proper care.[24]

In this context, 135 health care systems refer to the unique number of facilities included in the crisis line referral queue. Although VHA has a total of 171 VA medical centers (VAMCs) and 94 Very Large Community Based Outpatient Clinics (CBOCs) for a total of 265 stations, multiple medical centers or outpatient clinics may be reported under one facility site code in the queue."

Comment 8

Draft location: Page 6, fourth paragraph, first sentence [Final report page 6, fourth paragraph, first sentence]

VHA requests additional consideration and suggests OIG clarifies the following revised content: "These conditions may indicate VHA and VISN and medical facility management officials need to review and enhance internal processes for oversight of the management of crisis line referrals"

Comment 9

Draft location: Page 14, second to last paragraph, third sentence [Final report page 14, second to last paragraph, third sentence]

The VCL Director has a responsibility of monitoring the percentage of VCL consults that are responded and closed within established timeframes and reporting these to VISN and VA medical facility leadership for action as necessary, per VHA Directive 1503 section 5 e. (15). Medical facility supervisors can facilitate chart reviews to audit and monitor compliance with call attempts requirements; however, the OIG did not observe local supervisors monitoring this requirement. VHA Directive 1503 section 5.m.(2) notes

that VA Medical Facility Directors are responsible for "monitoring and improving the VA medical facility Consult performance and results on an ongoing basis."

There are responsibilities for policy oversight at local, VISN, and national levels. VHA reiterates relevant to local oversight, VHA Directive 1503, section 5.m.(2) states that VA Medical Facility Directors are responsible for "monitoring and improving the VA medical facility Consult performance and results on an ongoing basis." It would be helpful to reiterate this point in this section of the document.

Comment 10

Draft location: Page 15, first paragraph, last sentence [Final report page 15, last paragraph, last sentence]

For purposes of accuracy, VHA asks OIG to consider revising the following content to reflect the current efforts underway, to state: "As the program office training, improves clear guidance regarding follow-up calls, provides guidance on effective local quality assurance methods, and provides VISN and facility managers accurate program performance monitor data for their facilities, VHA can enhance engagement with at-risk veterans who receive the help they need from the Veterans Crisis Line."

Comment 11

Draft location: Page 8, second paragraph [Final report page 9 first paragraph, first sentence]

For purposes of accuracy, VHA asks OIG to consider revising the language related to "20% discrepancy was due to lack of training". As currently written, there is minimal evidence to suggest a causal relationship between lack of training and use of appropriate coding. VHA suggests stating that this may be due to lack of engagement in training. See page 8, third paragraph, "This approximate 20 percent discrepancy in the reported data occurred because coordinators lacked formal training on the appropriate codes to select when they completed call management system forms to close the referrals."

Comment 12

Draft location: Page 20, paragraph three, last sentence [Final report page 22, paragraph three, last sentence]

For purposes of completeness, VHA asks OIG to consider those cases where Veterans are not reachable or further follow-up was not needed based on the response received following the first attempt.

Comment 13

Draft Location: Page 20, fourth paragraph [Final report page 23, first paragraph]

For purposes of completeness, VHA asks OIG to consider clarifying the valid reasons considered for closures (beyond "inaccurate contact information", as listed on page 5) and how prevalent these were.

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Review Team	Janet Mah, Director Tony Barnes Gurpreet Kaur Corina Riba Andrea Salas LaTasha Smith
Other Contributors	Clifton Baker Kathryn Berrada Kim Cragg Lee Giesbrecht Milan Gokaldas Jesse Moyer Eric Sanford Clifford Stoddard Alex Timberman Nelvy Viguera Butler

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